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Payer Strategy & Alignment for HBPC

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Tuesday, February 3, 2026

Agenda

1. Value Contracting and Quantifying the Value to Potential Partners
2. FFS Billing Considerations/Enhancements
3. Risk Adjustment: Hierarchical Condition Category (HCC) Coding
4. APM Framework & Value Contracts
5. Key Takeaways

Value Contracting and
Quantifying the Value to Potential Partners

Why Diversify?

Risk Mitigation

Payor concentration creates risk because it positions the agency to lose a significant revenue source if that payor is lost

Competitive Advantage

The more payors an agency can accept creates market opportunities otherwise unavailable

Higher Profitability

Optimizing higher margin payors and clients creates higher profits so long as support costs are understood and managed

Caregiver Retention

Caregiver satisfaction & retention are critical in our industry. An agency's ability to offer higher pay rates and varying opportunities supports retention.

Increased Referrals

The more payor sources an agency accepts, allows for a more diverse array of referral sources.

Business Stability

As payor sources shift and government rules change, a broader mix of payors minimizes disruption

Increased Access to Care

Increasing referral sources and accepted payors expands client reach and increased access to care.

Payer Contracting & Engagement

Contracting Strategy

- Understand your value
- Conduct contract and financial analysis
- Benchmark against market data
- Define a negotiation strategy
- Build relationships
- Use data to support negotiations
- Consider outside expertise

Key Aspects of Contract

- Reimbursement Rates
- Covered Services
- Prior Authorization
- Claims Processing
- Utilization Management
- Quality Reporting

Clinical Model is the Foundation

- Before you do anything else: is your clinical model ready?
- What are your strengths and weaknesses?
- Who do you need on-board before you're ready?

Signing a risk contract today and expecting a different outcome tomorrow = ?!

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The Devil is in the Details

Questions to ask:

- **What is your value proposition?**
  - What can you prove? What are your strengths and weaknesses?
  - BE HONEST WITH YOURSELF!
- **How to think about your area within the larger healthcare system?**
- **How do you leverage that and with whom?**
  - Who is willing to **PARTNER** with you?
- **What data will you get from your partner?**
  - What do you formalize around your partner relationship?

Building the Relationship

Building a relationship with payers and other potential partners takes time

You must:

- ❑ Have a persuasive champion on your team to lead the discussions on your behalf
- ❑ Understand what the potential partner values
  - What are their goals? Is it less days in hospital beds? If so, come prepared to demonstrate how you will impact that particular metric!
- ❑ Be able to speak directly to the particular gap or need you would be filling for them

Consider creating a scorecard for your practice

- Utilize connections to ensure you get in front of the right people to tell your story!
- Track the key metrics that make your team valuable to payers
  - Consider tracking your sickest patients. How many times were they in the hospital prior to becoming your patient, and how many times have they been admitted in the year post acceptance to your practice. Keep this information by payer

FFS Billing Considerations/Enhancements

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Home-Based Medical Care: Superbill Worksheet – Itemized CMS Codes – 2025

Purpose

A comprehensive list of the primary services that a home-based medical care practice would bill and submit for reimbursement. Includes CPT codes, location of service (if applicable), service descriptor, 2025 wRVU, 2025 Medicare National Fee Schedule Payment, and precalculated 85% of Medicare allowable payment (NP/PA). This information allows programs to estimate revenue, create an internal fee schedule, and guide the setup of EHR templates and claim submissions. All content was gathered utilizing Centers for Medicare & Medicaid Services (CMS) guidelines[1].

Service Descriptor	CPT	2025 wRVU	2025 Medicare National Fee Schedule Payment	85% of MC allowable (NP/PA)
New patient: straight-forward MDM, minimal complexity of problems addressed Typical time: 15 minutes	99341	1.00	$47.55	$40.42
New patient: low MDM, low complexity of problems addressed Typical time: 30 minutes	99342	1.65	$75.69	$64.34

Risk Adjustment: Hierarchical Condition
Category (HCC) Coding

Overview of Risk Adjustment

- Risk adjustment allows CMS to pay plans for the risk of the beneficiaries they enroll, instead of an average amount for Medicare beneficiaries. By risk adjustment plan payments, CMS is able to make appropriate and accurate payments for enrollees with differences in expected costs. *Medicare Managed Care Manual, Chapter 7.*

- CMS maintains the following risk adjustment models: CMS-HCC ESRD, CMS-HCC and RxHCC

- The CMS-HCC model is used to adjust payments for Part C (Medicare Advantage) benefits. It includes both diseases and demographic factors to determine potential patient-level risks.

- Medicare Part B beneficiaries may enroll in any Medicare Advantage plan offered in their counties. Medicare Advantage plans present an outline of their benefits, provider networks and premiums to CMS annually. Plans must accept all enrollees.

Medicare Hierarchal Condition Categories

CMS HCC V28

Used by CMS for Medicare Advantage plans. Started in 2004 with full utilization for reimbursement in 2007.

ICD-10 codes are grouped into Condition Categories. Hierarchies of these conditions are given a numeric code which is used to generate a RAF value. Each of the dx code in that HCC model carries value through a RAF coefficient like RVUs.

Not all ICD-10 codes carry a value or "risk-adjust". Each year, CMS publishes the list of dx codes that risk adjust and the HCC that is adjusts to in the model.

In 2013, version 22 (v22) was published and was used for payment year (PY) 2014.

Diagnosis Code	Description	CMS-HCC ESRD Model Category V21	CMS-HCC ESRD Model Category V24	CMS-HCC Model Category V22	CMS-HCC Model Category V24	CMS-HCC Model Category V28	RxHCC Model Category V08
A0103	Typhoid pneumonia	115	115	115	115		
A0104	Typhoid arthritis	39	39	39	39	92	
A0105	Typhoid osteomyelitis	39	39	39	39	92	
A021	Salmonella sepsis	2	2	2	2	2	
A0222	Salmonella pneumonia	115	115	115	115		
A0223	Salmonella arthritis	39	39	39	39	92	
A0224	Salmonella osteomyelitis	39	39	39	39	92	
A065	Amebic lung abscess	115	115	115	115	283	
A072	Cryptosporidiosis	6	6	6	6	6	5

In 2020, v24 was released. This included the Alternative Payment Condition Count (APCC) which accounted for the needs of patients with multiple chronic diseases by adding a RAF value when four to ten HCCs were reported.

Medicare Hierarchal Condition Categories

CMS HCC V28

In 2023, CMS HCCs **created v28** which restructured categories and reduced the number of ICD-10 that risk adjust.

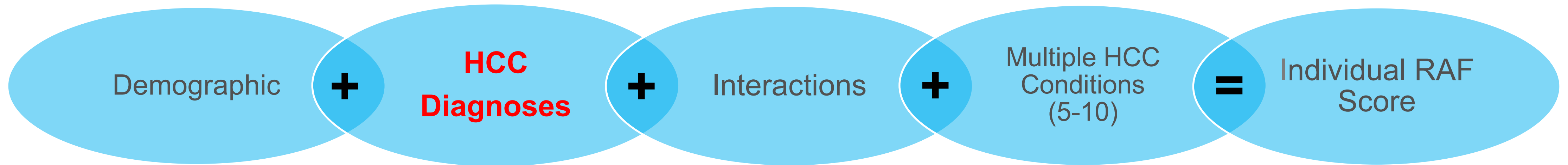
- For v24, 9,797 ICD-10s risk adjusted to 86 HCCs
- For v28, 7,770 ICD-10s risk adjust to 115 HCCs. Increased the multiple HCC payment from 4 to 5 HCCs.

A hybrid of both v24 and v28 were used in calendar years 2023 to 2025 with projected 100% use of V28 in 2026.

- 2024 v24 was 67% and v28 was 33%
- 2025 v24 was 33% and V28 was 67%

RAF	V24 RAF		V28 RAF
Total 2025 RAF Score	1.505		3.903
33% of 1.505	.496	67% of 3.903	2.615
Final RAF Score (.496 + 2.615) is 3.111			

Keys to VBC Success: Coding & Documentation Hierarchical Condition Diagnoses & Categories



- **Yearly CMS publishes a "denominator" to convert risk scores into dollars**
- **The 2024 Average Payment / Year denominator = $10,842.13**
- **RAF score X $10,842.13 = Estimated annual expenditure**

WHY IS THIS IMPORTANT?

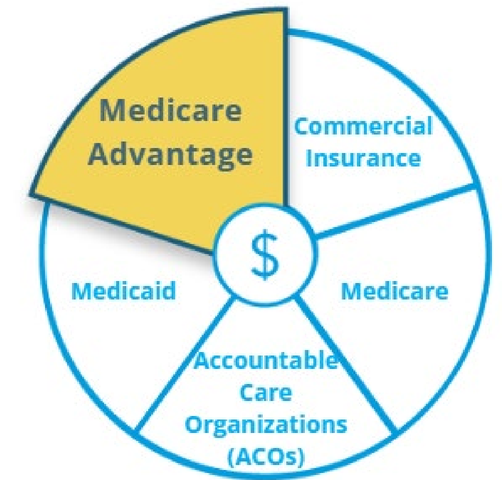
- Accurate coding shows disease burden for determining appropriate payments for care.
- Accurate HCC scores aid high-needs attribution: require > 3.0 or 2.0-3.0 with ≥ 2 unplanned hospitalizations in previous 12 months, or documented mobility impairment code, or 45 days in SNF, or 90 days in home health past 12 months.

APM Framework & Value Contracts

Types of Value Contracts

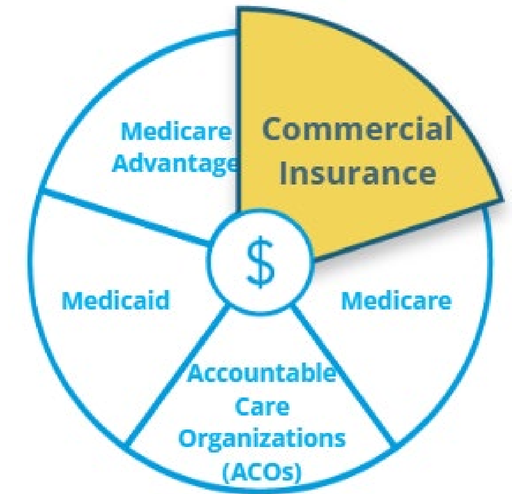
Type of Value Contract	Description	Risk Sharing Arrangement
FFS + Care Coordination (PMPM)	The practice submits claims for each visit or service provided. In addition, the practice receives a care management fee per patient per month for providing complex care coordination and management services.	The practice receives an additional Care Coordination payment for meeting certain requirements for organizing care, transitions, necessary services, etc. Typically, the practice also has clinical quality goals that need to be met.
Quality Bonus (Pay for Performance)	Typically, the practice still bills FFS, but also agrees to certain quality targets and is expected to reduce utilization.	If the practice performs well against a benchmark, they receive either a flat amount or a percentage of the shared savings produced.
Shared Savings	The practice participates in an Alternative Payment Model or joined an Accountable Care Organization (ACO) who offers the opportunity to receive bonus payments based on performance.	The practice is measured on benchmarked quality metrics. If the practice produces quality outcomes and reduces utilization which results in cost savings to Medicare, it can receive shared saving dollars back at year-end.
Episode of Care Payment (Bundled Payments)	A method of payment that isolates just one type of service and all expense and revenue that goes with it (e.g., total knee replacement).	Incentivizes the practice to manage the entire episode of care (e.g., post-acute transitions). If the practice successfully decreases the number of medically unnecessary services, they profit from the episode of care.
Gainsharing	Sharing in the overall performance of the product, but with no risk. Typically, this is associated with less upside because there is no downside for the entity if the product doesn't perform.	The hospital or system uses this payment methodology as an incentive for providers to reduce costs and consistently implement best practices. Providers are then rewarded with a portion of the cost savings.
Full Risk Capitation	The practice is paid a capitated (fixed) rate for each member they agree to serve. The practice also assumes full risk for the performance of the product and will receive upside or downside financial opportunity depending on performance.	The practice is financially responsible for all of the care their attributed patients receive.

Payer Types: Medicare Advantage



- Medicare Advantage (MA) plans must cover everything traditional Medicare covers.
- MA plans are paid by Medicare based on a county-level rate that uses a "score," including diagnosis codes.
- Advantage payers tend to be more open to negotiations; deductibles or copays may apply.
- MA payers have more flexibility than traditional Medicare to cover telehealth services.
- Growing emphasis on value-based care has led more MA plans to invest in or contract with home-based providers.
- This creates negotiation opportunities for home-based practices with MA payers.
- Dual-eligible patients (Medicare + Medicaid) may enroll in Dual Eligible Special Needs Plans (D-SNPs), which serve individuals entitled to both Medicare and state Medicaid assistance.

Payer Types: Commercial Insurance



- Commercial insurance payers usually reimburse the highest amounts for fee-for-service (FFS).
- Commercially insured patients typically make up a small portion of a home-based practice's panel.
- Homebound frail/disabled patients with commercial insurance often have it due to:
  - Spousal coverage
  - Federal employee plans
  - Automobile accidents
  - Workers' compensation
- Commercial insurance often offers strong coverage but can be challenging for claims processing and credentialing because insurers may not understand home-based services.
- Some commercial insurers also offer Medicare Advantage plans and may provide stipends across various plans.
- Patient cost-sharing may include copays, coinsurance percentages, or deductibles.

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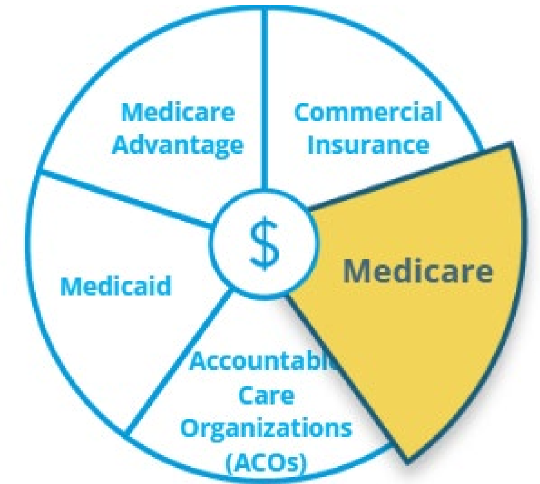
Payer Types: Medicare

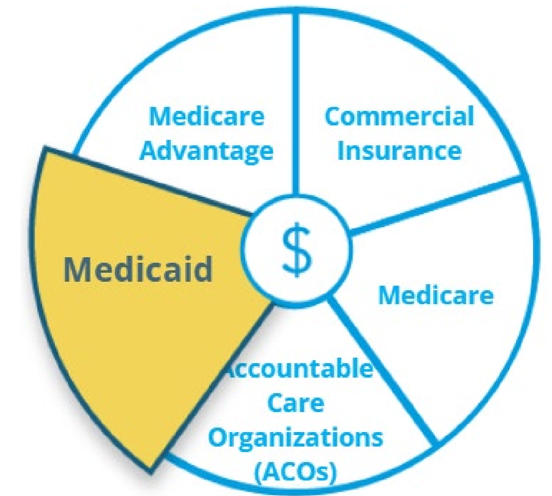


- Original (traditional) Medicare operates on a fee-for-service model for adults aged 65+ and qualifying individuals with disabilities.
- For home visits billed by physicians, NPs, or PAs, patients do not need to be homebound (unlike skilled home health services).
- Providers no longer need to document a “why home instead of office” reason in progress notes; the decision is left to the provider and patient.
- Medical necessity remains the key criterion for payment, so documenting patient complexity is still essential.
- In contrast, Medicare-certified home health (e.g., nursing, therapy) requires patients to meet homebound criteria.

Payer Types: ACOs

- Accountable Care Organizations (ACOs) are groups of healthcare providers (doctors, hospitals, others) that voluntarily collaborate to deliver coordinated, high-quality care to Medicare patients.
- ACOs focus on ensuring patients, especially those with chronic illnesses, receive the right care at the right time while reducing unnecessary services and preventing medical errors.
- When an ACO both improves quality and reduces Medicare spending, it shares in the savings it generates for the Medicare program.
- Practices that join an ACO can shift toward value-based payment, receiving compensation tied to quality and performance instead of volume.
- Participating practices may earn shared savings and gain access to ACO resources such as advanced analytics and reporting tools.

Payer Types: Medicaid



- Medicaid coverage varies by state and may provide equal or less coverage than Medicare.
- Working with Medicaid can be more challenging due to greater bureaucracy and slower administrative processes, but relationships with the payer are still manageable.
- Many Medicaid patients may have no other insurance because they fall below the poverty level.
- For dually eligible patients (Medicare + Medicaid), Medicaid typically functions as the secondary payer.
- At the start of each year, Medicaid usually pays the Medicare deductible, and dual-eligible patients often have no copay expectations.

Key Takeaways