McLaren HIGH PERFORMANCE NETWORK, LLC

MHPN ACO Newsletter

June 10, 2025

Welcome to the fifth edition of the McLaren High Performance Network Accountable Care Organization (ACO) Newsletter. You are receiving this communication as an ACO provider. Please click on the links below to review the keys to be successful in our ACO.

Over the course of the last six years our ACO providers have earned exceptional Quality scores designation from CMS while generating $84 million in savings.

IN THIS EDITION:

GETTING THE FULL PICTURE: WHY ACCURATE HCC AND CPT II CODING MATTER

In value-based care, documentation isn't just paperwork—it's the foundation for accurate risk scoring, fair reimbursement, and true insight into your patient population's health. Two of the most powerful tools in capturing this data are Hierarchical Condition Category (HCC) coding and CPT Category II codes.

HCC Risk Adjustment Coding: Telling the Whole Story
HCC coding ensures that the complexity of a patient's health status is fully captured. It's especially important in risk-adjusted payment models.

Why it matters:

- Accurate risk adjustment reflects the true cost of care and ensures fair payment for managing high-risk patients.
- Helps align performance metrics with clinical reality, especially in population health and
- ACO settings.
- Supports proactive care planning by identifying patients at greatest risk for complications, readmissions, or disease progression.

Common Pitfall: Failing to document active chronic conditions annually (e.g., diabetes,

COPD, depression) leads to under-representation of the patient's risk and potential loss of reimbursement.

Inadequate Coding		Better Coding		Properly Coded	
65 Yr Old Female	0.435	65 Yr Old Female	0.435	65 Yr Old Female	0.435
Medicaid/Disabled Eligible	0.160	Medicaid/Disabled Eligible	0.160	Medicaid/Disabled Eligible	0.160
Diabetes w/no complications	0.166	Type 2 Diabetes Mellitus w/Diabetic CKD	0.166	Type 2 Diabetes Mellitus w/Diabetic CKD	0.166
Chronic Kidney Disease Stage 4 (severe) (***Not Coded***)	0.000	Chronic Kidney Disease Stage 4 (severe)	0.514	Chronic Kidney Disease Stage 4 (severe)	0.514
Congestive Heart Failure (***Not Coded***)	0.000	Congestive Heart Failure	0.360	Congestive Heart Failure	0.360
Morbid Obesity (***Not Coded***)	0.000	Morbid Obesity ***(Coded w/o BMI)***	0.000	Morbid Obesity ***(Must include BMI)***	0.186
BMI 50-59.9 (***Not Coded***)	0.000	BMI 50-59.9 (***Not Coded***)	0.000	BMI 50-59.9 ***(Code with Obesity)***	0.000
Paraplegia, Unspecified (***Not Coded***)	0.000	Paraplegia, Unspecified (***Not Coded***)	0.000	Paraplegia, Unspecified	0.942
Total RAF	**0.761**	**Total RAF**	**1.635**	**Total RAF**	**2.763**
Annual Payment	**$7,916**	**Annual Payment**	**$17,008**	**Annual Payment**	**$28,742**

*2025 Weights, *Assumes Medicare payment of $10,402.34/annual before adjustments

CPT Category II Codes: Quality Measures in Action

CPT II codes are tracking codes used to report performance on quality measures. They're optional but crucial for closing care gaps and achieving quality benchmarks in programs like Medicare Advantage, ACOs, HEDIS, and MIPS.

What they report:

- Screening completion (e.g., colorectal, breast cancer)
- Chronic condition management (e.g., A1c levels)
- Behavioral interventions (e.g., smoking cessation counseling)
- Vital documentation (e.g., blood pressure, BMI)

Example CPT II Codes:

- 1000F – Tobacco use assessed
- 4000F – Smoking cessation counseling
- 3008F – BMI documented
- 3044F – 3052F – HbA1c levels
- 3074F – 3080F Blood pressure measurements

Why it matters:

- Drives success in quality reporting programs
- Supports bonus payments and shared savings
- Highlights care your practice is already providing, but might not be capturing

Bottom Line

HCC and CPT II coding are more than compliance—they're about giving patients credit for the care they receive and ensuring your practice is recognized for the work it does.

Capturing this data means:

- Better patient outcomes
- More accurate population health data
- Improved financial performance
- Stronger positioning in value-based care

Accurate, consistent coding is the bridge between great care and great results.

Resources
Visit MPP's coding resource page here for coding guides by specialty and condition, videos and pocket card coding tools.

MAXIMIZING THE VALUE OF ANNUAL WELLNESS VISITS

The Medicare Annual Wellness Visit (AWV) remains one of the most underutilized yet impactful tools in preventive care and value-based practice transformation. With national utilization rates estimated between 18% and 45%, (varying on geographical location), many eligible patients are missing a vital opportunity for preventive planning—and practices are missing key advantages in quality performance and revenue capture. McLaren High Performance Network has a completion rate of approximately 46%. High performing organizations have a completion rate between 70-75%.

The CPT codes for the AWV services are G0402 (IPPE – Initial Preventive Physical Exam), G0438 (Initial AWV) and G0439 (Subsequent AWV). Reimbursement is up to $160.76 for the IPPE, $165.44 for the Initial AWV, and $126.47 for the Subsequent AWV.

What is the Annual Wellness Visit (AWV)?
The AWV is not a routine physical exam (which Medicare does not cover), but an annual visit focused on creating or updating a Personalized Prevention Plan. It includes risk factor identification, cognitive screening, functional assessments, and planning for necessary preventive services.

Why It Matters
Practices that successfully implement AWVs report measurable improvements in patient engagement, chronic condition management, and quality performance scores. AWVs are linked to reduced overall healthcare costs and improved clinical outcomes across diverse populations.

Opportunities Within the AWV
AWVs provide a unique platform to close care gaps and support hierarchical condition category (HCC) coding. Providers can document and code all active chronic conditions and include CPT II codes that reflect services such as:

- 3016F–3018F – Smoking/tobacco use status
- 4000F – Smoking cessation counseling
- 1036F – Blood pressure documented

- 2022F – BMI documented

Best Practices for AWV Implementation
Top-performing practices use the following strategies to boost AWV utilization:

- Convert annual physicals into AWVs where appropriate
- Use EHR templates and checklists to streamline workflow
- Pre-schedule AWVs and utilize lists provided to your practice to identify patients who have not had an AWV
- Engage team-based care (e.g., RNs, LPNs, care managers)
- Educate patients that AWVs are fully covered by Medicare and of the value of the visit
- Gather information on patients who are 64 years of age and eligible for the IPPE on their 65th birthday

The Annual Wellness Visit is a cornerstone of Patient-Centered Medical Homes and population health management. When implemented effectively, AWVs elevate patient experience, enhance documentation accuracy, and support a proactive approach to preventive care.

Resources
The Medicare Learning Network Educational Tool on Medicare Wellness Visits is a comprehensive guide to everything related to Medicare Wellness Visits: **Medicare Learning Network - Medicare Wellness Visits**
Other Resources:
AAFP - A Guide to Implementing and Coding Medicare's Annual Wellness Visit
ChartSpan - The Ultimate Guide to Medicare Annual Wellness Visits

Sources

- CMS: MCBS 2020 Preventive Use Data – https://www.cms.gov/data-research/research/medicare-current-beneficiary-survey/data-tables/mcbs-2020-puf-use-preventive-care-services-among-medicare-beneficiaries
- CareTrack Health: 2023 Utilization Report – https://caretrack.com/2023/12/04/annual-wellness-visit-completion-2023/
- ChartSpan Health: AWV Implementation Guide – https://www.chartspan.com/blog/the-ultimate-guide-to-medicare-annual-wellness-visits/

MPP IS WORKING TO REDUCE AVOIDABLE ED VISITS

The Care Coordination team currently reviews all ED discharges. Patients deemed high-users, or on a trajectory (4 or more visits in 90 days) to be a high-user, are contacted with the intent of addressing the root cause, aligning with the PCP, and engaging the patient in Care Management Services. The team reaches out to the provider if assistance is needed.

More recently, Care Coordination and the Quality Department teamed up to work on reducing avoidable ED visits. We have been scheduling meetings with practices and physicians to review patients with high use and ensure PCMH capabilities are in place.

PCMH capabilities having an impact on ED use include:

- Same day appointments available
- After-hours access to a provider/decision maker
- Referral to aligned Urgent Care if unable to see

Common Reasons for high-use and expected actions:

- Problem or issue has not been addressed yet
    - Assist with facilitating referrals to Specialist or an interim plan
- Convenience
    - Reinforce your expectations with the patient around what can be treated on the office, same day appointments etc.
- Multiple chronic conditions often requiring hospitalization
    - Consider a Palliative Care referral

If you would like to review a list of your “high-users”, please contact Andrea Phillips at andrea.phillips1@mclaren.org.

COMPLIANCE

Just a reminder to let us know when your practice has a change in your provider roster, or to your EHR system (upgrades or a change to a different system), per CMS Compliance Requirements. These changes can be reported to the ACO Program Manager and Compliance Officer, Dawn Smith, at **Dawn.Smith@mclaren.org**. Look for a questionnaire later this summer to confirm your practice’s details.

Thank you for reading the sixth edition of the MHPN ACO Newsletter.

More ACO Information

Contact MHPN