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Jason Jobes

SVP Norwood Solutions

The State of Value-Based Care

Are you on track for 2030?

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About The Author

Jason Jobes, MSPA

is the Senior Vice President of Norwood Solutions and oversees all solution partnerships and delivery for Norwood's healthcare partners.

These partnerships focus on bringing health to hospitals' bottom lines, improving performance across the revenue cycle and value-based care terrains.

During his career, Jobes has delivered over $500 million in return on investment for partners.

Reach Jason through:
jason@norwood.com
linkedin.com/in/jason-jobes-norwood/

The State of Value-based Care
Introduction

CMS has set an ambitious goal:

Every Traditional Medicare beneficiary in an accountable care relationship by

2030

Each day is a step closer to nationwide value-based care (VBC). But just having a VBC contract with a health plan isn't enough. Success in VBC requires rethinking documentation, code capture, provider education, and compliance. And not just in your CDI or coding departments, but across your entire organization.

Forward-thinking organizations are living in 2030 today. Some are. While others approach the future with dread, stuck in a fee-for-service mindset or treading water with unrecognized opportunity and unaddressed risk.

We need to get to the 2030 finish line.

This paper will answer these questions:

1. **Where are we with Value Based Care?**
2. **Where are other organizations on their respective VBC journeys?**
3. **How can your organization ensure not just financial viability, but actually thrive in a VBC environment?**

This report will show you how to beat CMS to the 2030 deadline. But let me be clear:

You don't need a CMS objective to get you moving.

Good VBC practices should start today.

Countdown 2030... Where Are We?

Will the nation meet CMS' ambitious goal?
The jury is out.

In April 2023 when CMS announced its 2030 goal, fewer than half (46%) of primary care practices were receiving any form of value-based payment. In the same year internal CMS analyses showed over half of primary care practices were not participating in CMS' Accountable Care Organization (ACO) initiatives.

Since then we've made progress.

As of January 2025, CMS reports that 53.4% of Traditional Medicare patients are in an accountable care relationship with a provider. This represents more than 14.8 million beneficiaries and a 4.3 percentage point increase from January 2024.

It's the largest annual increase since CMS began tracking this measure and a big step toward the 100% goal, but we're still far from declaring victory.

Why aren't we there? I think I found the culprit. We're underfunding OP CDI.

According to the latest survey data from the Association of Clinical Documentation Integrity Specialists (ACDIS), only 31% of healthcare organizations have a dedicated OP CDI program. That represents a 5% increase over 2024—but it's still way too low.

Outpatient CDI is the fastest lever for accelerating accountable care adoption because it directly addresses the core currency of value-based models: accurate risk adjustment

Just as important, outpatient CDI scales clinical understanding of VBC in ways contracts and dashboards cannot. Provider education embedded in CDI workflows helps clinicians connect documentation to downstream impacts on quality scores, utilization patterns, and patient management.

Outpatient CDI is the runway to VBC.
You must be on it before 2030. Too few are.

How Do You Succeed in Value-based Care?

As noted outpatient CDI is a non-negotiable for VBC success. CMS believes that capitated payments are the future, stating that "primary care practices benefit from predictable, prospective, non-visit-based revenue." In short, this means risk adjustment.

Risk Adjustment and Outpatient CDI are synonymous

Risk Adjustment *is the goal* ⇄ **Outpatient CDI** *the mechanism*

But given the state of heightened regulatory activity, including current federal scrutiny at the very highest levels, we firmly believe your OP CDI north star should be on risk score **accuracy**...

...by simultaneously evaluating how to maximize revenue and mitigate risk.

We believe that every organization should get every penny it deserves—just not a penny more.

Many organizations have started outpatient, or ambulatory, CDI programs focused solely on risk score maximization. Don't do that.

If you aren't trying to ensure the accuracy of the medical record and the patient's risk score then you are doing it wrong.

You should be:
looking for ways to capture what the patient has
&
not capture those conditions that are no longer clinically relevant

Accurate and Complete Revenue + Mitigating Risk

Norwood's philosophy is that the only CDI program approach acceptable is one that focuses on risk score accuracy.

The organization pictured started their CDI program with three CDI specialists across six pilot departments. The CDI team has reviewed over 9,000 patients through October. Each day they track what they did and bucket activities into three groups:

Definitions for CDI Query Metrics

OPPORTUNITY
These are conditions CDI has identified that clinicians should evaluate and ultimately document/bill as appropriate. These conditions are not on the problem list and reflect an opportunity to improve accuracy of risk scores in alignment with the patient's complexity.

CLARIFICATION
These are conditions that are clinically relevant but a different diagnosis is recommended. These are often tied to condition specificity or clinical evolution. These clarification support risk score accuracy and balance risk score and compliance.

RISK
These are conditions that the CDI team has identified that are no longer clinically supported or are suspects that would prompt to clinicians unless suppressed. Removing these helps reduce risk of errors and associated RADV audit take-backs.

Volume of CDI Prompts for Clinicians

Year to Date 2025 - Through October

We segment the volume of this by provider and clinical category to drive education back to the clinicians. This creates a feedback loop for providers, supports medical record accuracy, and enhances compliance efforts.

The results are that this organization has seen complexity rise, all but eliminated any compliance risk for the CDI reviewed patients, and engaged providers by getting rid of excess noise in prompts at the point of care.

Oh, we also estimate that by year end it will drive **$9.6M in care funding** into their value-based care contracts.

Three Tips for Success in VBC

Success in VBC is a team sport.

If you don't have a well thought-out gameplan and roadmap, engaged providers, aggressive patient scheduling practices, skilled case managers and social workers, and a reasonable tech stack—all backed by coding and CDI teams who understand how it all works--you'll struggle.

It might seem overwhelming, but it's not.

A low-investment pilot program is a great way to begin and demonstrate ROI with minimal risk.

Here are three tips all VBC adopters should adopt.

1 Manage your Problem Lists

Problem list maintenance is a facility-specific decision.

We recommend you create a policy; appoint a group that can resolve/remove conditions no longer relevant and can also add conditions, as long as they have been previously coded/billed and are supported with documentation.

2 Eliminate Provider Alert Fatigue

Get rid of the noise; don't put prompts in front of the provider that aren't relevant to the patient or the provider's medical decision making.

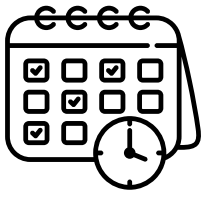
Doing so might result in fewer queries, but fewer succinct, clinically relevant questions will result in improved trust and long-term engagement.

3 Improve Your Scheduling

Patient visits are your biggest driver of risk capture, more impactful than even skilled CDI review.

Every January risk scores adjust to their baseline. Capture and recapture RAF.

Strive to see 95% of your patients in the new year.

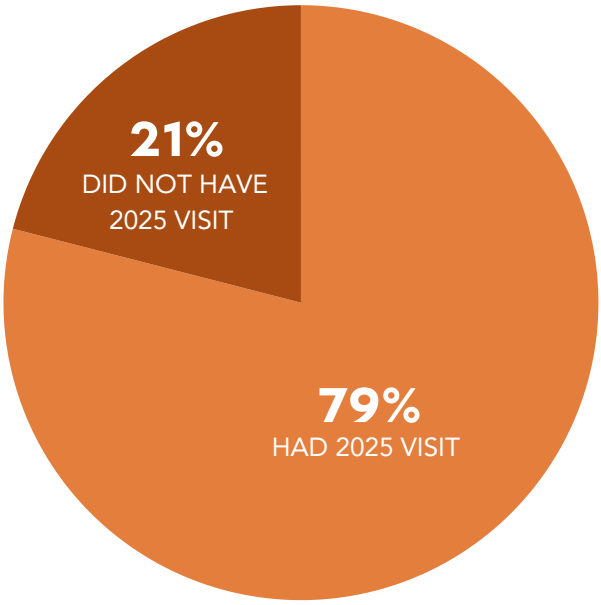


2026 Imperative: Ensure 95% of Patients Are Seen

Organizations in risk arrangements must see 95% of their patients annually to not only ensure accurate risk adjustment but also drive health outcomes. Based on the data provided, one partner hospital only saw 79% of patients through October 2025.

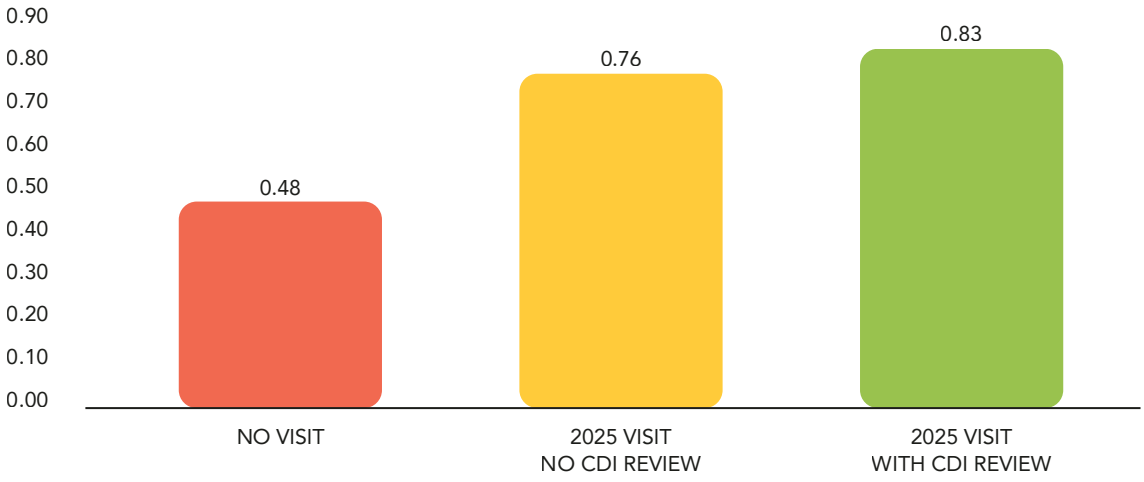
When patients are seen their complexity is 60.4% higher than those without a visit.

Percent of Patients with YTD 2025 Visit



Average RAF Score per Patient

Year to Date 2025



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Norwood: Your VBC Partner

Ask About Our 45 BEST Practices

Norwood has developed **a proprietary set of 45 best practice**s for optimal performance in value-based care. We've implemented dozens of outpatient CDI programs for large and small organizations with a playbook and blueprint no one else can match.

If you want to learn more, send me an email or connect with me on Linkedin. Let's have a conversation without any obligation.

Jason Jobes
SVP Norwood Solutions
jason@norwood.com
linkedin.com/in/jason-jobes-norwood/

NORWOOD

Your Mid-revenue Cycle Problems, Our Solutions

Norwood helps you solve your most difficult revenue cycle challenges.
Partner with us and become the hero of your healthcare organization.

Our suite of services includes:

On-demand Talent

- Facility and Profee Coders
- Clinical Documentation Integrity
- HCC Auditors and Coders
- Trauma Registry Professionals
- Oncology Registry Professionals
- Department Leadership

CDI

Inpatient | Outpatient

Pediatric CDI

Chart Reviews & Compliance

CDI Program Implementations

Inpatient | Outpatient

Data Analysis

Payer Partnerships

Denials Management

Supplemental Diagnosis Submissions

Coding Audits

- CPT
- E/M
- HCPCS
- ICD-10-CM
- ICD-10-PCS
- HCC

MS-DRG

Optimization & Compliance

Managed Services

Outsourced Revenue Cycle Management

Risk Adjustment Factor (RAF)

Optimization & Compliance

Education

Live and Remote/Online

- CDI
- Coding
- Providers
- Outpatient CDI Boot Camp

If you don't see something here, ask. We're all about customization. You wouldn't expect to pluck an EHR off the shelf and use it. We feel the same about our solutions.

What Makes Us Different?

FLEXIBILITY

Whether implementing an outpatient CDI program, staffing your department, or auditing charts, we deliver flexibility with exceptional performance.

PEOPLE

We offer big-corporation resources with a small-company feel—Norwood is privately owned, independent, and values-driven.