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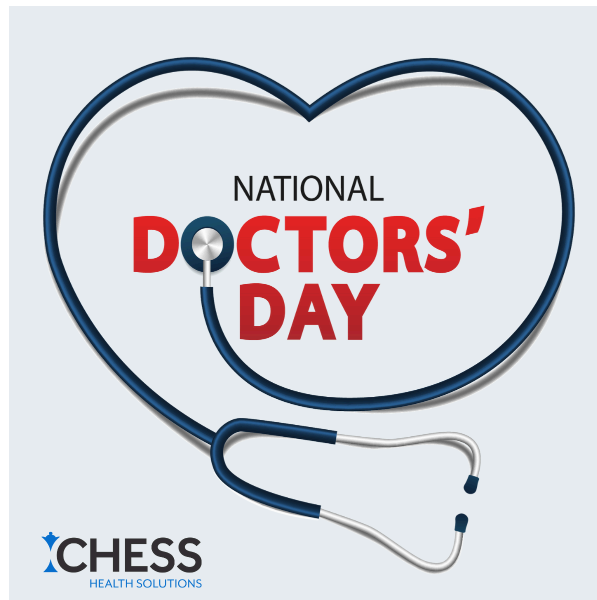
Value-based Care Chronicle: Guide to Improving Performance

March 2026



On National Doctors' Day, we simply want to say thank you for your dedication, your expertise, and the compassion you bring to patient care each day. Your work truly makes a difference.

Driving Better Outcomes

Key Diabetes Quality Measures

Among chronic diseases, diabetes has been a focus of quality performance measurement for many years. Focusing on a few key measures can significantly improve outcomes and performance:

Kidney Health Evaluation for Patients with Diabetes (KED)

- Requires both a blood (eGFR) and urine (uACR) test.
- Educate patients about the effects of diabetes on the kidneys and the importance of annual testing and medication adherence.
- Order and complete labs prior to patient appointments.
- Create automatic EHR flags to alert for due screenings.

- Leverage CHESS Care Coordination and Pharmacy teams for outreach and medication support.

KED Quality Flyer

Eye Exam for Patients with Diabetes (EED)

- Reinforce the importance of annual eye exams and the effect of diabetes on the eyes.
- Fundus photography reviewed by an optometrist or ophthalmologist counts.
- When documenting history of a retinal eye exam, list date of service, test, result, and the eye care professional's name and credentials.
- Use appropriate coding and documentation:
  - 3072F - no evidence of retinopathy in the prior year
  - 2022F - dilated eye exam with interpretation by an ophthalmologist or optometrist, WITH evidence of retinopathy
  - 2023F - dilated eye exam with interpretation by an ophthalmologist or optometrist, WITHOUT evidence of retinopathy

EED Quality Flyer

Glycemic Status for Patients with Diabetes (GSD)

- For quality reporting, the last A1c of the year is evaluated.
- Always list the date of service, result, and test together.
- Adjust appointment frequency for out-of-range patients, ensuring patients with insulin or uncontrolled diabetes are seen quarterly.
- Educate patients on the importance of diet and exercise. When available, refer to diabetic education program.
- Refer patients to CHESS Pharmacy team for medication reviews or to your care coordination team for additional chronic condition support.
- Ensure staff are knowledgeable about appropriate documentation of A1c results in EMR.
- GMI results collected by the patient and documented in EMR can be used for reporting.
- Submit claim using CPT II codes to close the gap:
  - 3044F HbA1c < 7%
  - 3051F HbA1c ≥ 7% and < 8%
  - 3052F HbA1c ≥ 8% and ≤ 9%
  - 3046F HbA1c > 9%

GSD Quality Flyer

Don't Forget: If a patient meets the criteria for remission, be sure to code Diabetes in Remission (E11.A). A patient is considered in remission if they meet the following criteria:

- ***HbA1c < 6.5% for at least 3 months***
- ***Off all glucose-lowering medications***

- ***No active diabetic complications***
- ***Must be explicitly documented as "in remission"***

KED Quality Article | Diabetic Eye Exams | Diabetes Med Adherence | Diabetes in Remission

CODING CORNER: HCC Recapture

The Risk Adjustment payment model identifies patients with serious and/or chronic illnesses, using ICD-10-CM codes that map to hierarchical condition categories (HCC), and assigns a risk adjustment factor (RAF) score to each patient. The average RAF score for a patient is 1.00. If a patient has a RAF score of 0.800, then it is presumed that the patient is 20% healthier than the average population, and you would generally not expect high-cost utilization.

CMS resets the RAF score every January to only include demographics. Failure to report each chronic condition, **every calendar year,** will skew the patient profile and negatively affect funding for the care and resources required to care for patients.

Use MEAT criteria to confirm and document chronic and active conditions. Showing what was Monitored, Evaluated, Assessed, and Treated ensures risk scores reflect the patient's true clinical picture and supports appropriate resources.

2026 HCC Recapture Guide

MEAT the Chronic Condition			
Monitor	**Evaluate**	**Assess**	**Treat**
Signs Symptoms Disease Progression Disease Regression	Test Results Medication Effectiveness Response to Treatment	Ordering Tests Discussion Review Records Counseling	Medications Therapies Other Modalities

Patient Education Pointer of the Month

Zone Tools

Zone tools are one-page reference tools used to assist patients in managing common health conditions at home.

These guides use the colors of a stoplight to guide self-management and symptom awareness. For each zone (green zone - all clear; yellow zone - caution; red zone - medical alert), the tool provides signs, symptoms, and specific instructions for managing the conditions, including guidance on when to seek medical assistance.

Encourage patients to hang these Zone Tools in a prominent place where they are frequently during the day to help them know what they're looking for and what to do once they find something out of the ordinary.

By teaching patients to recognize signs and symptoms and take an active role in their care, we can build their confidence to manage their health effectively.

Download the Diabetes Zone Tool and learn more about implementing these tools in your practice: Implementing Zone Tools for Better Outcomes and Diabetes Zone Tool.

Additional Resources

- VBC in 2026: Key Trends Health Care Leaders Should be Planning for Now
- Behavioral Health Integration in VBC: What's Working and What's Not

Past VBC Chronicle Editions

CHESS Education
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