PRIVIA HEALTH

2024 Value-Based Care for Medicare Shared Savings Program (MSSP)

This toolkit is to assist care centers in executing the four longstanding objectives of value-based care:

1. Build trust with patients and payers that providers are working together to meet their needs.
2. Create an environment that rewards providers for cultural fit and best practice care.
3. Leverage technology to hardwire Value-Based Care foundation without disrupting patient care.
4. Connect medical, clinical, and community experts to improve health outcomes.

Table of Contents

PRIVIA HEALTH

Getting Started in a Value-Based Care Program

PRIVIA HEALTH

Top 10 Best Practices to Perform Well in a Value-Based Contract

1) **Review your patient roster monthly** and submit corrections to maintain an accurate roster.

2) **Schedule Annual Wellness Visits** early in the year, as eligible.

3) **Chart prep to identify gaps** in care before your patient's visit and **utilize standing orders** where appropriate to close gaps.

4) Conduct open discussions with patients to **identify barriers to medication adherence. Consider 90-100 day prescriptions.**

5) Adequately **support diagnosis codes in the EHR** to ensure compliance and continuity of care when you are unavailable.

6) Establish **cadence for chronic disease management services** and **see non-adherent patients more often.**

7) Allow your **sickest patients to be seen without an appointment,** and utilize an after-hours virtual care service to help keep patients out of the emergency department

8) Establish a **transition of care program**. Call patients recently discharged or that have been to the emergency department to schedule follow-up appointments and conduct medication reconciliation

9) Establish a **quality team within your practice** and engage in POD meetings

10) **Review performance and discuss quality action plans**

Introduction to Medicare Shared Savings Program (MSSP)

The Medicare Shared Savings Program (MSSP) is a voluntary program encouraging healthcare providers and suppliers to come together in an Accountable Care Organization (ACO), aimed at incentivizing value-based outcomes for Medicare beneficiaries. The ACO agrees to be held accountable for the cost, quality, experience, coordination and outcomes of the assigned Medicare Fee-For-Service (FFS) beneficiary population. MSSP offers different tracks based on an ACO's preferred arrangement.

Fee for Service VS Value-Based Care

Fee for Service

Payments are based on patient **services provided**

The more you sell...

The more $ you receive

This system incentivizes providers to provide **more** health care services, because their income comes from the **quantity** of services provided

Value-Based Care

Payments are based on **health outcomes**

Patient health outcomes

Lower total cost of care

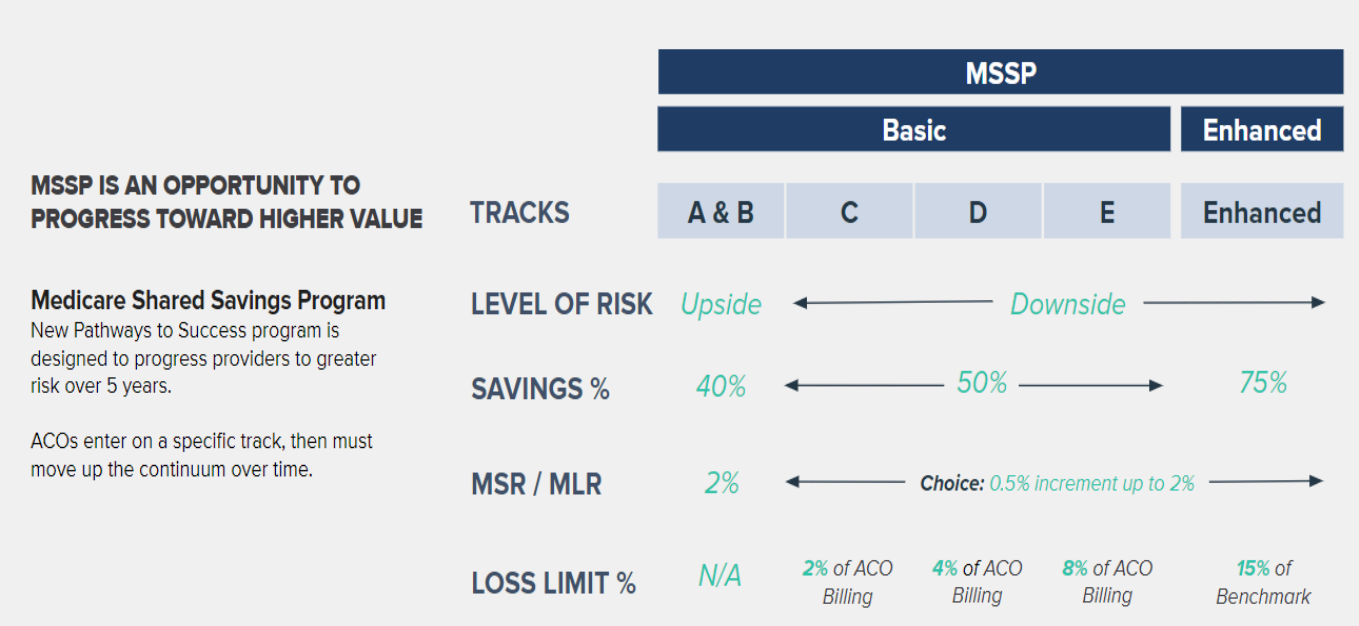
More $$$ you receive

This system incentivizes providers with **reward** payments for **improving** the quality of care they provide

Value-based care is the shift from traditional fee for service payments to quality based payments. In value-based care models, providers are paid based on outcomes rather than the number of services they render, number of patients seen, or how much they charge. Again, it is **rewarding** providers for transforming the delivery of care to patients by **focusing on improving quality of care, lowering the total cost, and improving the patient experience**.

MSSP Risk Tracks

MSSP offers different risk tracks with a range of levels and rewards. Each track has a different combination of shared losses (risk) and shared savings (reward) based on the ACO's desire.



Upside Risk/Minimum Savings Rate (MSR)

Levels A and B of the BASIC Track are models offered with an "upside risk" only. Upside risk refers to the amount of shared savings a participating ACO may receive, without any potential for shared losses. However, in order to receive shared savings, the ACO must satisfy the minimum quality performance standards. These performance standards are calculated in the form of a minimum savings rate (MSR), which is a percentage of the ACO's benchmark, and is adjusted by the number of assigned beneficiaries. Typically, a smaller ACO has higher MSRs. Once an ACO achieves savings beyond its MSR, it is eligible to receive 40% of those savings if in Level A or B of the BASIC Track.

Downside Risk/Minimum Loss Rate (MLR)

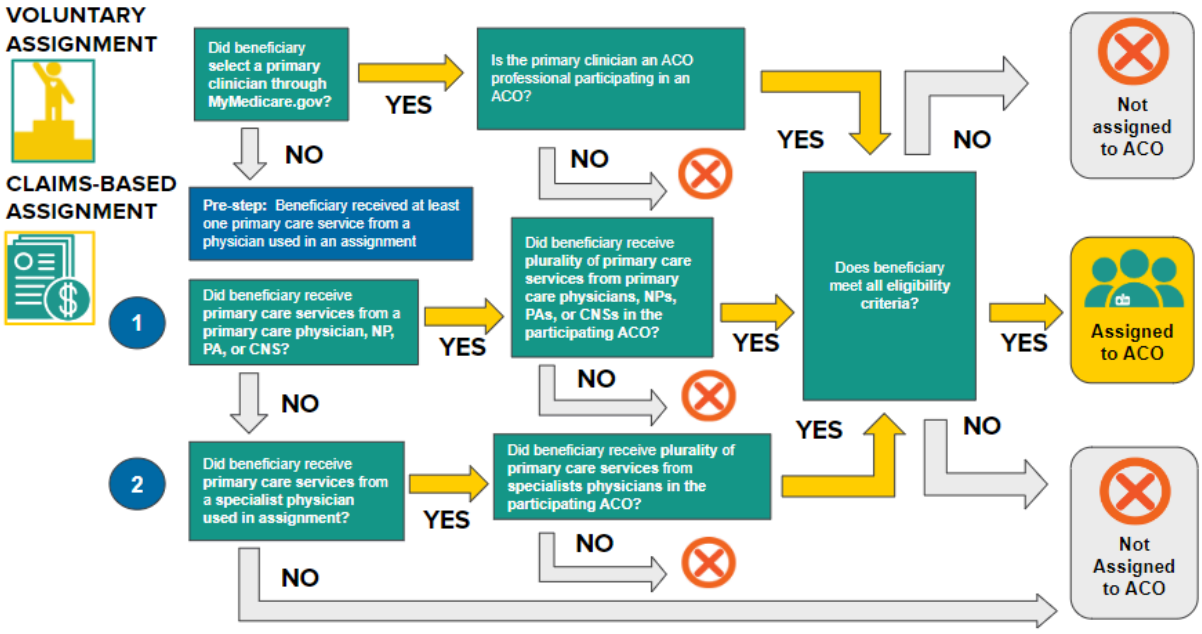
All remaining tracks for MSSP incorporate downside risk. These tracks also have shared savings opportunities. Downside risk refers to the shared losses a participating ACO is responsible for if its costs exceed the minimum loss rate (MLR) threshold. The MLR is also a percentage of the ACO's benchmark.

MSSP Benchmark Calculations

CMS first establishes a cost, or expenditure, benchmark during the initial ACO agreement period based on three years of historical data, using risk-adjusted average per capita expenditures for Medicare Parts A and B FFS beneficiaries to calculate an ACO's shared savings or shared loss payments. CMS also applies a national average growth rate and a regional growth rate to trend forward benchmark years.

Patient Attribution

Attribution or "patient assignment" is a key program methodology used to identify the beneficiaries associated with an ACO and defines the population for which the ACO is held accountable. Beneficiary assignment lists are used for program operations such as developing quarterly program reports, determining the ACO's financial and quality performance, and determining whether an ACO is eligible to share in savings or losses. Assignment is determined based on the use of primary care services. See the diagram below to understand how CMS attributes lives to an ACO.



2024 Medicare Shared Savings Program Quality Measures

To meet quality targets and score points for any measure, a minimum of 60% compliance is required. As our shared savings payments start at the maximum shared savings rate and fall with lower quality scores, our targets are 95% compliance to earn the maximum savings payment.

Measures

- Breast Cancer Screening
- Colorectal Cancer Screening
- Controlling High Blood Pressure
- Depression Remission at Twelve Months
- Diabetes: Hemoglobin A1c (HbA1c) Poor Control
- Falls: Screening for Future Fall Risk
- Preventive Care and Screening: Influenza Immunization
- Preventive Care and Screening: Screening for Depression and Follow-up Plan
- Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
- Statin Therapy for the Prevention and Treatment of Cardiovascular Disease

Survey Measures

- CAHPS for MIPS

Administrative Measures

- Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions
- Hospital-Wide, 30-day, All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician Groups

Medicare Annual Planned Visits (APVs)

Medicare patients' AWVs serve a variety of purposes. During these visits, providers can proactively engage patients in preventive care, assess risks, and close documentation gaps. Unlike routine exams, AWVs take an expansive look into patients' emotional, psychological, and physical well-being while developing and reviewing personalized plans to improve health. We have a goal of 80% completion for AWVs.

APVs and Coding

Initial Preventive Physical Exam (IPPE)	Annual Wellness Visit (AWV)	Annual Routine Physical (ARP)
G0402 • Service is limited to new beneficiaries during the first 12 months of Medicare enrollment • Face-to-face visit • Includes a preventive evaluation and management service • Once per beneficiary per lifetime **Note:** This is a preventive service and not a comprehensive physical checkup.	**G0438 Initial AWV** • Services limited to beneficiary during the second year of Medicare Part B eligibility • Face-to-face visit • Includes a personalized prevention plan of services • Once per beneficiary per lifetime **G0439 Subsequent AWV** • Face-to-face visit • Includes a personalized prevention plan or services • Once per calendar year **Note:** • This is a preventive service and not a comprehensive physical checkup. • The AWV is intended to build upon the previously established IPPE visit.	**99381-99397** • Service is coded based on beneficiary's age • Face-to-face visit • Comprehensive, multi-system physical exam based on the patient's age, gender, and identified risk factors • Includes system review, family and social history, comprehensive assessment • Is not problem-oriented and does not involve a chief complaint or present illness • Once per calendar year **Note:** Additional Cost share may apply for additional services or testing performed during the visit. Contact the member's health plan to verify eligibility and benefits.

****NOTE: Modifier -25 may be used when there is a significant identifiable E/M service provided on the same day.**

Examples on when to use the Modifier -25

Annual Wellness Visit plus Office Visit: G0438 or G0439 & appropriate office visit code with Modifier -25

Annual Routine Physical plus Office Visit: 99381-99397 & appropriate office visit code with Modifier -25

Annual Wellness Visit & Annual Routine Physical: G0438 or G0439 & 99381-99397 with Modifier -25

Initial Preventive Physical Exam & Annual Routine Physical: G0402 & 99381-99397 with Modifier -25

***If treatment for an existing medical condition occurs during the preventative service, or other services are billed in addition to the preventative service, cost sharing for the care received may also apply.**

MSSP Quality Program Measure Tip Sheets

CARE-2: Falls: Screening for Future Fall Risk

2024 Performance Year

Medicare (MSSP)

Measure Description

Percentage of patients 65 years of age and older, at the start of the measurement period, and were screened for future fall risk at least once during the performance year

Definitions

Screening for Future Fall Risk: Documented assessment of whether an individual has experienced a fall or problems with gait or balance. A specific screening tool is not required for this measure, however potential screening tools include the Morse Fall Scale and the timed Get-Up-And-Go test.

Fall: A sudden, unintentional change in position causing an individual to land at a lower level, on an object, the floor, or the ground, other than as a consequence of sudden onset of paralysis, epileptic seizure, or overwhelming external force.

Exclusions

- Patients receiving hospice or palliative care at any time during the performance year
- Patients who moved out of country during the performance year
- Patients who passed away during the performance year

Measure Tips

- A clinician with appropriate skills and experience may perform the screening
- Setting of screening is not restricted to an office setting
- Documentation of no falls is sufficient Medical record must include documentation of screening performed Any history of falls screening during the measurement period is acceptable as meeting the intent of the measure
- A gait or balance assessment meets the intent of the measure
- Screening for future fall risk may be completed during a telehealth encounter

Resources

2024 CMS WebInterface V8.0

DM-2: Diabetes: Hemoglobin A1C Poor Control >9

2024 Performance Year

Medicare (MSSP)

Description

The percentage of patients ages 18-75 with diabetes (type 1 and type 2) whose most recent hemoglobin A1c result in 2024 is >9% (poor control) or is missing or not performed during the year.

Note: Lower rates of poor control indicate better care.

Required Exclusions

- Patients who passed away anytime during the performance year
- Patients receiving hospice or palliative care services anytime during the performance year
- Patients who did not have a diagnosis of diabetes during the performance year

*Note: The following exclusions are closed by **claims only**.*

- Medicare patients 66 years of age and older as of December 31, 2024 who meet either of the following: enrolled in an an Institutional SNP (I-SNP) or residing in long-term care as identified by the LTI flag in the CMS Monthly File for more than 90 consecutive days at any time during the year.
- Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period AND either
    - a dispensed medication for dementia, OR
    - one acute inpatient encounter with a diagnosis of advanced illness OR two outpatient, observation, ED, or non-acute inpatient encounters on different dates of service with an advanced illness diagnosis during 2023 or 2024.

Documentation Tips

- Patients fall into the numerator if the most recent HbA1c level is > 9%, the most recent HbA1c result is missing, or if there are no HbA1c tests performed and results documented during the performance year. These patients are NON-compliant and a lower number indicates better care.
- Do not include HbA1c levels reported by the patient.
- If the HbA1c test result is in the medical record, the test can be used to determine numerator compliance.
- Ranges and thresholds **do not** meet criteria for this indicator. A distinct numeric result is required for numerator compliance.
- Documentation should include a note during the patient's encounter or lab report with either noting the date of the A1c test and the result of the A1c test.
- Documentation of the most recent HbA1c result may be completed during a telehealth encounter.
- HbA1c finger stick tests administered by a healthcare provider at the point of care are allowed.

Resources

2024 CMS Web Interface V8.0

HTN-2: Controlling High Blood Pressure

2024 Performance Year

Medicare (MSSP)

Description

Percentage of patients 18-85 years of age who had a diagnosis of essential hypertension starting before and continuing into, or starting during the first six months of the performance year, and whose most recent blood pressure was adequately controlled (<140/90 mmHg) during the performance year.

Note: **The 2024 BP reading must occur on or after the date of the second diagnosis of hypertension and within the above date range.**

Required Exclusions

- Patients who receive hospice or palliative care services anytime during the performance year
- Patients who passed away anytime during the performance year
- Patients with evidence of end stage renal disease (ESRD), dialysis, or renal transplant before or during the performance year
- Patients with a diagnosis of pregnancy during the performance year

Note: The following exclusions are closed by ***claims only****.*

- Medicare patients 66 years of age and older as of December 31, 2024 who meet either of the following: enrolled in an an Institutional SNP (I-SNP) or residing in long-term care as identified by the LTI flag in the CMS Monthly File for more than 90 consecutive days at any time during the year.
- Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period AND either
    - a dispensed medication for dementia, OR
    - one acute inpatient encounter with a diagnosis of advanced illness OR two outpatient, observation, ED, or non-acute inpatient encounters on different dates of service with an advanced illness diagnosis during the performance year or year prior.
- Patients 81 years of age and older with two frailty indications on different dates of service during the performance year.

Documentation Tips

- Document BP on every patient encounter.
- Retake BP when found to be ≥140/90 after the patient has been seated and visited with the clinician. The lowest systolic and diastolic value may be used if the readings are from the same visit.
- Patient reported blood pressures can be used as long as the patient did not use a manual cuff and stethoscope.
- Blood pressures can be taken from a Remote Patient Monitoring device.
- If no blood pressure is recorded during the performance year, the patient's blood pressure is assumed "not controlled".
- **Remember, the last blood pressure of the performance year is the abstracted BP and will determine gap compliance.**

Resources

2024 CMS Web Interface 8.0

MH-1: Depression Remission at Twelve Months

2024 Performance Year

Medicare (MSSP)

Measure Description

Adolescent patients 12 to 17 years of age and adult patients 18 years of age and older with a diagnosis of major depression or dysthymia and a PHQ-9 or PHQ-9M with a score of less than five (5) twelve months (+/- 60 days) after the initial PHQ-9 or PHQ-9M greater than nine (9).

Patients may be assessed using PHQ-9 or PHQ-9M up to seven days prior to the encounter (including the day of the encounter).

Required Exclusions

- Patients with a diagnosis of bipolar disorder
- Patients with a diagnosis of select personality disorders (cyclothymic, borderline, histrionic and factitious),
- Patients with a diagnosis of schizophrenia or psychotic disorder
- Patients with a diagnosis of pervasive developmental disorder
- Patients with a diagnosis of personality disorder emotionally labile
- Patients who were permanent nursing home residents
- Patients who utilize hospice or palliative care services
- Patients who passed away anytime during the performance year

Documentation Tips

- Remission is defined as a PHQ-9 or PHQ-9M score of less than five.
- Full PHQ-9 or PHQ-9M must be documented, a PHQ-2 is not accepted.
- PHQ-9 or PHQ-9M administration does not require a face-to-face visit; multiple modes of administration are acceptable (telephone, mail, e-visit, email, patient portal, iPad/tablet, or patient kiosk)

Best Practices

- Clinicians should establish and maintain follow-up with patients.
- Consider collaborative care as it has been shown to significantly lower depression severity.
- Use the PHQ-9 to monitor treatment outcomes and severity and modify the treatment plan as necessary.
- Urgent referral to crisis specialty health care is advised if the suicidality is of high risk on the PHQ-9
- Remember, response and remission take time. It can take 6 weeks of treatment or longer for patients to respond.
- Educate patients on the need for treatment of depression.

Resources

2024 CMS WebInterface V8.0

PREV-5: Breast Cancer Screening

2024 Performance Year

Medicare (MSSP)

Measure Description

The percentage of women 40-74 years of age who had a mammogram to screen for breast cancer any time on or between October 1, 2022 and December 31, 2024.

Required Exclusions

- Patients using hospice or palliative care services anytime during the performance year
- Patients who passed away any time during the performance year
- Patients who had a bilateral mastectomy or who have a history of a bilateral mastectomy or for whom there is evidence of a right and a left unilateral mastectomy

*Note: The following exclusions are closed by **claims only**.*

- Medicare patients 66 years of age and older as of the end of the current performance year who meet either of the following: enrolled in an an Institutional SNP (I-SNP) or residing in long-term care as identified by the LTI flag in the CMS Monthly File for more than 90 consecutive days at any time during the year.
- Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period AND either
    - a dispensed medication for dementia, OR
    - one acute inpatient encounter with a diagnosis of advanced illness OR two outpatient, observation, ED, or non-acute inpatient encounters on different dates of service with an advanced illness diagnosis during the current performance year or 12 months prior year.

Documentation Tips

- **Documentation in the medical record must include both of the following: A note indicating the date the breast cancer screening was performed AND the result or findings**
- Documentation of ‘normal’ or ‘abnormal’ is acceptable
- Total lookback period for a mammogram includes the measurement year, the year prior to the measurement year, and a 3 month grace period for a total of 27 months
- Patient Reported Requirement: Date and type of test AND result/finding. Patient reported mammograms, when recorded in the medical record, are acceptable for meeting the numerator.
- Screening includes: screening, diagnostic, film, digital or digital breast tomosynthesis (3D) mammography
- MRI, Ultrasound and Biopsies are not considered breast cancer screening for this measure
- Documentation of screening for breast cancer may be completed during a telehealth encounter

Resources

2024 CMS Web Interface V8.0

Colorectal Cancer Screening

2024 Performance Year

Medicare (MSSP)

Measure Description

Percentage of patients ages 45–75 who had an appropriate screening for colorectal cancer.

Any of the following meet the criteria for a colorectal cancer screening:

- Colonoscopy during 2015-2024
- Flexible Sigmoidoscopy during 2020-2024
- CT Colonography during 2020-2024
- Stool DNA w FIT Test (Cologuard) during 2022-2024
- Fecal occult blood test (FOBT)/gFOBT (guaiac), FIT/iFOBT (immunochemical) during the current performance year

Note: A Stool DNA w FIT Test is a Cologuard. A FIT test is the FOBT immunochemical test. They are not the same. Ensure the appropriate test falls within the appropriate time range.

Required Exclusions

- Patients in hospice or using hospice services any time during the performance year
- Patients receiving palliative care any time during the performance year
- Patients who passes away any time during the performance year
- Patients who had a colorectal cancer or a total colectomy any time during the patient's history through the end of the current performance year

*Note: The following exclusions are closed by **claims only**.*

- Medicare patients 66 years of age and older as of the end of the current performance year who meet either of the following: enrolled in an an Institutional SNP (I-SNP) or residing in long-term care as long-term care with a POS code 32, 33, 34, 54, or 56 for more than 90 consecutive days during the current performance year
- Patients 66 years of age and older with at least one claim/encounter for frailty during the measurement period AND either
    - a dispensed medication for dementia, OR
    - one acute inpatient encounter with a diagnosis of advanced illness OR two outpatient, observation, ED, or non-acute inpatient encounters on different dates of service with an advanced illness diagnosis during the current performance year or the year prior.

Documentation Tips

- FOBT: It is up to the organization to determine whether the specific test or brand meets the definition
- Do not count digital rectal exams (++DRE), FOBT tests performed in an office setting or performed on a sample collected via DRE
- Documentation in the medical record must include both of the following: A note indicating the date the colorectal cancer screening was performed AND the result or findings
- Documentation of 'normal' or 'abnormal' is acceptable
- Patient Reported Requirement: Date (year) and type of test AND result/finding. Patient reported procedures and diagnostic studies, when recorded in the medical record, are acceptable for meeting the numerator
- Documentation of colorectal cancer screening may be completed during a telehealth encounter

Resources

2024 CMS Web Interface Measure Specifications V8.0

PREV-7: Preventive Care and Screening: Influenza Immunization

2024 Performance Year

Medicare (MSSP)

Measure Description

Percentage of patients aged 6 months and older seen for a visit during August 1, 2023-March 31, 2024 and/or between August 1, 2024 and March 31, 2025 and who received an influenza immunization OR who reported previous receipt of an influenza immunization. NOTE: The patient must have a qualifying encounter between January 1 and March 31, 2024. In order to submit the flu season 2024-2025, the patient must have a qualifying encounter between October 1 and December 31, 2024. A qualifying encounter needs to occur within the flu season that is being submitted; any additional encounter(s) may occur at any time within the measurement period.

Definition

Previous Receipt – receipt of the current season's influenza immunization from another provider OR from the same provider prior to the visit to which the measure is applied (typically, prior vaccination would include influenza vaccine given since August 1st).

Exclusions

- Anaphylaxis due to the vaccine during or before the performance year
- Patients receiving hospice or palliative care at any time during the performance year
- Patients who moved out of country during the performance year
- Patients who passed away during the performance year

Denominator Exceptions

- Documentation of medical reason(s) for not receiving influenza immunization (e.g., patient allergy, other medical reasons)
- Documentation of patient reason(s) for not receiving influenza immunization (e.g., patient declined, other patient reasons)
- Documentation of system reason(s) for not receiving influenza immunization (e.g., vaccine not available, other system reasons)
- Patients using hospice or palliative care services during the measurement period
- Patients who passed away during the measurement period

Documentation Tips

- During intake, ask your patients if they've received their flu shot.
    - If yes, document the vaccine "influenza, injectable, quadrivalent" in the patient's medical record with the date administered (this can be an approximate date if the patient is unsure of the exact date).
    - If no, offer the patient the flu shot. If they accept, create an order for the vaccine and administer it.
    - If the patient declines, document the patient's refusal.

Resources

2024 CMS WebInterface V8.0

PREV-10: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

2024 Performance Year

Medicare (MSSP)

Measure Description

Percentage of patients aged 18 years and older who were screened for tobacco use one or more times during the performance year AND who received tobacco cessation intervention during or anytime during the 6 months prior to the performance year, if the patient is identified as a tobacco user

Definitions

Tobacco Use – Includes **any** type of tobacco including, but not limited to: cigarettes, cigars (including cigarillos and little cigars), dissolvables, hookah tobacco, nicotine gels, pipe tobacco, roll-your-own tobacco, smokeless tobacco products (including dip, snuff, snus, and chewing tobacco), vapes, electronic cigarettes (e-cigarettes), hookah pens, and other electronic nicotine delivery systems

Tobacco Cessation Intervention – Includes brief counseling (3 minutes or less), and/or pharmacotherapy

Required Exclusions

- Patients receiving hospice or palliative care at any time during the performance year
- Patients who moved out of country during the performance year
- Patients who passed away during the performance year

Denominator Exceptions

- *Population 1:* Documentation of medical reason(s) for not screening for tobacco use (e.g., limited life expectancy, other medical reason)
- *Population 2:* Documentation of medical reason(s) for not providing tobacco cessation intervention (e.g., limited life expectancy, other medical reason)
- *Population 3:* Documentation of medical reason(s) for not screening for tobacco use OR for not providing tobacco cessation intervention for patients identified as tobacco users (e.g., limited life expectancy, other medical reason)

Documentation Tips

- **NOTE: Written self-help materials (e.g., brochures, pamphlets) and complementary/alternative therapies do NOT qualify to satisfy the intent of the measure per CMS**
- To satisfy the intent of this measure, a patient must have at least one tobacco use screening during the measurement period. If a patient has multiple tobacco use screenings during the measurement period, only the most recent screening, which has a documented status of tobacco user or tobacco non-user, will be used to satisfy the measure requirements.
- If a patient uses any type of tobacco (i.e., smokes or uses smokeless tobacco), the expectation is that they should receive tobacco cessation intervention: either counseling and/or pharmacotherapy.
- The tobacco cessation intervention can be performed by another healthcare provider; therefore, the tobacco use screening and tobacco cessation intervention do not need to be performed by the same provider or clinician.
- Screening for tobacco use must occur during the encounter and may be completed during a telehealth encounter.

Resources: 2024 CMS WebInterface V8.0

PREV-12: Preventive Care and Screening: Screening for Depression and Follow-Up Plan

2024 Performance Year

Medicare (MSSP)

Measure Description

Percentage of patients aged 12 years and older screened for depression during the encounter or up to 14 days prior to the date of the encounter using an age appropriate standardized depression screening tool in the performance year **and** if positive, a follow-up plan documented on the date of or two days after the date of the eligible encounter in the performance year.

Intent: The intent of the measure is to screen for depression in patients who have never had a diagnosis of depression or bipolar disorder prior to the eligible encounter.

Required Exclusions

- Patients who have been previously diagnosed with bipolar disorder or depression
- Patients receiving hospice or palliative care at any time during the performance year
- Patients who moved out of country during the performance year
- Patients who passed away during the performance year

Denominator Exceptions

- Patient refuses to participate during the performance year
- Documentation of medical reason for not screening patient for depression (e.g., cognitive, functional, or motivational limitations that may impact accuracy of results; patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status) in the performance year.

Documentation Tips

- Depression screening can be performed before the office visit (no more than 14 days prior) but must be reviewed and documented in the medical record on the date of the encounter or up to days after. The plan must be provided to and discussed with the patient.
- Documented follow-up for a positive depression screening must include one or more of the following:
    - Referral to a provider for additional evaluation and assessment to formulate a follow-up plan for a positive depression screen
    - Pharmacological interventions
    - Other interventions or follow-up for the diagnosis or treatment of depression
- It is recommended that both a score and clinician interpretation of the score is documented, especially when a patient screens positive. **At a minimum, the medical record must contain documentation of the tool's name and results of the screening with a score OR clinician interpretation of positive or negative for depression.** Each standardized screening tool provides guidance on whether a particular score is considered positive for depression.
- The patient only has to be screened once during the performance year.
- Screening for depression may be completed during a telehealth or home-based encounter.

Resources

2024 CMS WebInterface v8.0

PREV-13: Statin Therapy for the Prevention and Treatment of Cardiovascular Disease

2024 Performance Year

Medicare (MSSP)

Measure Description

Percentage of the following patients - all considered at high risk of cardiovascular events - who were prescribed or were on statin therapy during the performance year for one of the following:

- All patients who were previously diagnosed with or currently have an active diagnosis of clinical atherosclerotic cardiovascular disease (ASCVD), including an ASCVD procedure, OR
- Patients aged 20 to 75 years who have ever had a low-density lipoprotein cholesterol (LDL-C) level >= 190 mg/dL or were previously diagnosed with or currently have an active diagnosis of familial hypercholesterolemia
- Patients aged 40-75 years with a diagnosis of type 1 or type 2 diabetes
- Patients aged 40 to 75 with a 10-year ASCVD risk score of ≥ 20 percent

Required Exclusions

- Patients who are breastfeeding at any time during the performance year
- Patients who have a diagnosis of rhabdomyolysis at any time during the performance year
- Patients receiving hospice or palliative care at any time during the performance year
- Patients who moved out of country during the performance year
- Patients who passed away during the performance year

Denominator Exceptions

- Patients with statin-associated muscle symptoms or an allergy to statin medication
- Patients with active liver disease or hepatic disease or insufficiency
- Patients with end-stage renal disease (ESRD)
- Patients with documentation of a medical reason for not being prescribed statin therapy

Documentation Tips

- Prescription or order does NOT need to be linked to an encounter or visit; it may be called to the pharmacy.
- Statin medication “samples” provided to patients can be documented as “current statin therapy” if documented in the medication list in health/medical record.
- ONLY statin therapy meets the measure (NOT other cholesterol lowering medications).
- Note: Clinical atherosclerotic cardiovascular disease (ASCVD) includes: acute coronary syndromes, history of myocardial infarction, stable or unstable angina, coronary or other arterial revascularization, stroke or transient ischemic attack (TIA), peripheral arterial disease of atherosclerotic origin
- Documentation of statin therapy actively being taken or ordered (prescribed) during the measurement period can be completed during a telehealth encounter

Resources: 2024 CMS WebInterface v8.0

Patient Satisfaction and CAHPS Surveys

What are CAHPS Surveys?

CAHPS surveys ask patients to report on their experiences with a range of health care services at multiple levels of the delivery system. Some CAHPS surveys ask about patients' experiences with health care providers, such as doctors, clinics, and hospice teams, or with care for specific health conditions. Other surveys ask enrollees about their experiences with health plans and related programs. Finally, several surveys ask about experiences with care delivered in facilities, including hospitals, dialysis centers, and hospital outpatient surgery departments and ambulatory surgery centers.

The Medicare Consumer Assessment of Healthcare Providers and Systems (CAHPS®) program is a multiyear survey administered by the Centers for Medicare & Medicaid Services (CMS) to assess patients' experiences with health care. These surveys focus on aspects of quality that patients are best qualified to assess, such as the communication skills of physicians and practitioners and the ease of access to health care services.

CMS selects a random sample of health plan members from eligible Medicare Advantage (MA) contracts to participate in CAHPS each year between March and June.

Types of CAHPS Surveys that impact Privia Care Partners' Value Based Contracts

CAHPS for MIPS (Formerly known as ACO CAHPS)

The CAHPS for MIPS survey measures key domains of patients' experiences of care. This survey is sent to patients who are participants in an Accountable Care Organization (ACO). The survey contains the core CAHPS Clinician & Group Survey (CG-CAHPS), plus additional items to meet the Centers for Medicare & Medicaid Services' (CMS) information needs.

Timeline & Methodology

Survey	Timeline	Sample Size (Minimum)	Methodology
CAHPS for MIPS	October - January	860	Mail & Telephonic

Financial Impact of CAHPS for MIPS

25% of the overall MSSP Score is CAHPS (Patient Satisfaction/ Experience)

Market Example: Received $16.9M in Medicare Shared Savings

$4.2M is CAHPS (Patient Satisfaction/ Experience)

CAHPS: Care Coordination 2024

Introduction

The Center of Medicare and Medicaid Services (CMS) utilizes the CAHPS survey to better understand the patient's perception and evaluation of their providers and health care systems. Year after year, CMS has put more and more emphasis on the CAHPS survey. In addition, the CAHPS survey measures weights have dramatically increased in the overall Medicare Star score and is the single most critical component in the Stars calculation.

Frequency:

- Medicare Advantage & Prescription Drug Plan CAHPS: Annually between Feb. and June
- CAHPS for MIPS (ACO CAHPS): Annually between Oct. and January

Target Population: Medicare Advantage, commercial and Medicaid members

Measurement Year Look-Back: 6 months for Medicare and Medicaid, 12 months for commercial

Access to Care Survey Questions

Care Coordination (CC)):

Did you personal doctor:

- Have your medical records or other information about your care?
- Follow up to give you test results as soon as you need them?
- Talk with you about all the prescription medications you were taking?
- Manage your care among different providers and services?
- Seem informed and up-to-date about the care you received from specialists?

Best Practices

Review medical records and be informed about the care from specialists

- Obtain a visit or consult notes from specialists before the patient's appointment. Have an office assistant or MA prep the chart to ensure consult notes are available.You may need to reach out and request these. Be proactive.
- Ensure the provider references these consult notes during the patient visit. This aids the patient in understanding that the medical record was reviewed prior to their visit.
- Use *familiar phrases* such as:
    - Based on your medical records…."
    - "After reviewing your medical records…."
    - "Your medical records show….."
    - "I see Dr. <SPECIALIST> seen you for…..

Managing care among different providers/specialists

- Remind patients that you have coordinated care with their other providers by using phrases such as, "I received the report from your specialist"
- Other *familiar phrases* for managing care amongst different providers:
    - "To provide the best care, I'm going to take a moment to review your record for any new information, such as prescriptions, tests or consult notes from your specialist. I want to manage your care well"
    - "Our office can help coordinate your care between other doctors or specialists. Is there anything you need from us right now?"

Review Prescription Medications

- Remind patients to bring all medications in their original bottle so the doctor may review them. This request is best sent during scheduling of the sending appointment or appointment reminders.
- It may speed up workflow to have MA review and update medications before provider entrance.
- Discuss the importance of taking medication as prescribed. Medication adherence is important. Barriers can be addressed by asking open ended questions.
- Always ask about medication changes and over the counter medications.
- Use a familiar phrase such as, “Let’s review and discuss the medications you are currently taking”.

Test Results

- Have staff check for lab or test results prior to the patient’s visit.
- Establish a workflow for checking on tests/labs daily.
- Call for results if your office has not received them.
- Explain all labs or tests, including how long it takes to get the results and how the patient can expect to hear the results. If there will be delays, explain the reasoning.
- Use a patient portal for patient access.
- When results are given, ensure the patient understands what follow up actions or future care needed.
- Make eye contact if reviewing the results in-person with the patient.

Resources

HEDIS MY2023 Technical Specs Vol 2. Pg. 431-464

CAHPS: Access to Care 2024

Introduction

The Center of Medicare and Medicaid Services (CMS) utilizes the CAHPS survey to better understand the patient's perception and evaluation of their providers and health care systems. Year after year, CMS has put more and more emphasis on the CAHPS survey. In addition, the CAHPS survey measures weights have dramatically increased in the overall Medicare Star score and is the single most critical component in the Stars calculation.

Frequency:

- Medicare Advantage & Prescription Drug Plan CAHPS: Annually between Feb. and June
- CAHPS for MIPS (ACO CAHPS): Annually between Oct. and January

Target Population: Medicare Advantage, Commercial and Medicaid members

Measurement Year Look-Back: 6 months for Medicare and Medicaid, 12 months for commercial

Access to Care Survey Questions

Getting Needed Care (GNC):

- How easy was it to get care, tests or treatment you needed?
- How easy was it to get appointments with specialists?

Getting Appointments and Care Quickly (GCQ):

- How often were you able to get care as soon as you needed?
- How often were you able to get appointments for routine care at a doctor's office as soon as you needed?
- How often were you able to see the person you came to see within 15 minutes of your appointment time?

Best Practices

Goal: Positive Patient Experience

- Assist patients with getting care, tests, and treatment from other specialists
- When visiting with a patient, it is helpful to summarize the care given by past providers, recent tests and current status to show an understanding and holistic approach to the patient's care
- Remember to review and discuss all medications the patient is taking, both prescription and OTC
- Test results are important to the patient. Follow and review these results with the patient in a timely manner.
- Schedule routine visits. Ongoing care helps prevent illness and controls chronic conditions.
- Wait times are one of the biggest complaints. Ensure you are consistently monitoring wait times and ensuring the patient is able to see the healthcare provider within that 15 min window.
- Listen attentively. Paraphrase what the patient is saying. Use language from the survey questions.
- Call patients that are waiting in the virtual waiting room to give them status updates of their appointment. Give them a time estimate if the wait is over 30 minutes.
- Train staff members on customer service and how they are the face of the care center for the patients. Remind them of AIDET:
    - Acknowledge
    - Introduce
    - Duration
    - Explanation
    - Thank You
- Take time to reference the patient satisfaction survey results and try to make improvements.

Appointment Scheduling

- Verbalize the need for timely appointments, procedures and tests to ensure the patient understands expectations. Also take the time to discuss any barriers or constraints as appropriate.
- Offer to schedule those follow up appointments at the end of every patient visit. You want it to be easy for the patient to access care.
- Educate the patients on length of appointments or any reason the appointment may need to be set further out with a specialist.

- Educate patients on telehealth capabilities, PCP vs. Urgent Care vs ED use, and last minute appointment needs
- Give your patients the option to see another healthcare provider if their provider does not have an appointment available on the requested date.

Waiting Room

- Remember, it's the patient's perception of time that will be the source of some of the CAHPS questions. Engage the patients in the waiting room by using some of the following methods:
    - Completion of health screening forms
    - Reading materials
    - Health-related posters and brochures
    - TV

Capacity

- Utilize NPs and PAs to add available appointments
- Keep a schedule blocked during certain parts of each day for walk-ins or last minute appt needs
- Extend office hours to include evenings and weekends
- Offer telehealth visits. You may also ask the patient if assistance is needed to install the app during face to face visits for potential future needs

Familiar Phrases to Use Daily

-
- "We understand the importance of getting needed care right away."
- "We want to get you an appointment for your next check-up as soon as you need it."
- "We do offer other virtual visits to help you get care as soon as you need it."
- "We want to make scheduling your appointments for routine care as easy as we can. How may I help?"
- "Thank you for waiting. We do respect your time. If your provider is not in within the next 15 minutes, I will come by and check on you and provide you with an update."

Resources

HEDIS MY2023 Technical Specs Vol 2. Pg. 431-46

Other Best Practices to Increase CAHPS scores

Know your Numbers

- Use a survey method to survey your patients after visits. This gives you valuable information, but also shows your patients that you care about the service you provide
- Work with your practice manager to review your ratings and comments
- By reviewing comments, it can provide you with valuable insight to how your patient perceive your care
- Look to other providers who are consistently performing well and find out what strategies they are employing.

Overall service best practices that improve scores

- Speak with the patient on their level. For example, if they are sitting, pull up a chair and talk to them at eye level
- Portray empathy with the patient and acknowledge their issue
- Explain things in an easy, simple way. Individualize the use of medical jargon when communicating so that you are speaking in a way they understand
- Use visual aids to assist in communication
- Solicit the patient's feedback for their care and ask open-ended questions whenever possible
- Review the chart before walking into the room. Often the patient has already relayed the reason for the visit, and it may be frustrating to restate what has been already reviewed
- Speak positively about all of the members of the care team and manage up
- Help the patient remember key takeaways from the appointment such as medication changes by giving them cards or patient handouts
- Ensure you are giving your full attention to the patient during the visit and stay engaged
- Narrate what you are doing during the visit. Point out when you are washing your hands or closing the door for privacy. If you are typing on the computer, explain that you are updating the patient's medical record during the discussion so that you don't miss anything important

Obtaining needed care

Patients rate how often it was easy to get appointments with specialists and how often it was easy to get the care, tests or treatment they needed through their health plan in the prior six months.

- Make scheduling as easy as possible. Ask staff to schedule specialist appointments and write down the details for your patients

Getting appointments and care quickly

Patients rate how often they were able to schedule an appointment and get care as soon as needed in the previous six months. Patients also rate how often they saw the person they came to see within 15 minutes of their appointment time.

- Break up wait times by moving patients from the waiting room into an exam room to take vitals
- Contact your patients when delays are expected using telephone, text or email
- Advise patients of the best days or times to schedule appointments

Overall rating of healthcare quality

On a 0-to-10 scale, patients rate their health care in the previous six months

- Ask open-ended questions to give your patients a chance to disclose health issues and concerns
- A quick explanation for lengthy wait times has been shown to markedly improve patient satisfaction
- Use a shared decision making model for patient care and leverage the patient's experience and desire for their care. This also increases compliance with the care plans that are established

Coordination of care composite measure

Patients rate their physicians' familiarity with their medical history and prescriptions, how well physicians are following up with patients after tests and how well "personal doctors" are managing care with specialists or other health care providers.

- Expedite the time it takes to follow up on blood tests, X-rays and other tests
- Remind patients to bring a list of their prescriptions
- Prior to appointments, review the care provided by specialists

Obtaining medications

Patients rate how often in the last six months it was easy to use their health plan to get prescribed medicines; to fill a prescription at a local pharmacy; and to use their health plan to fill prescriptions by mail.

- Please use the formulary, consider 90-day fills, synchronize medications when appropriate, work prior authorizations in a timely manner and set expectations with patients regarding resolution time if a prior authorization is needed

Improving or maintaining physical health

Patients report whether their physical health is the same as or better than expected in the past two years.

- Applaud your patients' physical health when possible, and encourage them to stay positive

Improving or maintaining mental health

Patients report whether their mental health is the same as or better than expected in the past two years.

- Ask about your patients' mental health. Simple recommendations, such as increased social activity, exercise and healthy eating, can have a big impact on a patient's sense of emotional well-being

Monitoring physical activity:

Patients report whether they have discussed exercise with their doctor and if they were advised to start, increase or maintain their physical activity level during the year

Strengthen recommendations by being specific. For example, suggest walking at a particular local park or shopping mall so patients have a specific, actionable idea

Improving bladder control

Patients who report having a urine leakage problem are asked whether they have discussed it with their doctor. Those who have are asked whether they received treatment for the problem.

- When you recommend Kegel exercises or other less- conventional remedies, emphasize that you are, in fact, providing treatment options so patients will take your recommendations seriously
- Recommend treatment options no matter the frequency or severity of the bladder-control problem

Reducing the risk of falling

Patients who had a fall or problems with balance and discussed it with their doctor or other health care provider are asked whether they received a fall-risk intervention in the last year.

- Falls are the leading cause of hospital admissions among older adults, according to the Centers for Disease Control and Prevention
- Remind patients that installing handrails or using a cane can prevent fall

Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS Survey Sample

EXAMPLE

1. Do you wear a hearing aid now?
   - ☐ Yes
   - ☒ No ➔ **If No, go to #3**

2. How long have you been wearing a hearing aid?
   - ☐ Less than one year
   - ☐ 1 to 3 years
   - ☐ More than 3 years
   - ☐ I don't wear a hearing aid

3. In the last 6 months, did you have any headaches?
   - ☒ Yes
   - ☐ No

Your Provider

1. Our records show that you visited the provider named below in the last 6 months.

Name of provider label goes here

Is that right?

- ☐ Yes
- ☐ No ➔ **If No, go to #24**

The questions in this survey will refer to the provider named in Question 1 as "this provider." Please think of that person as you answer the survey.

2. Is this the provider you usually see if you need a check-up, want advice about a health problem, or get sick or hurt?
   - ☐ Yes
   - ☐ No

3. How long have you been going to this provider?
   - ☐ Less than 6 months
   - ☐ At least 6 months but less than 1 year
   - ☐ At least 1 year but less than 3 years
   - ☐ At least 3 years but less than 5 years
   - ☐ 5 years or more

Your Care From This Provider in the Last 6 Months

These questions ask about **your own** health care. Do **not** include care you got when you stayed overnight in a hospital. Do **not** include the times you went for dental care visits.

4. In the last 6 months, how many times did you visit this provider to get care for yourself?
   - ☐ None ➔ **If None, go to #24**
   - ☐ 1 time
   - ☐ 2
   - ☐ 3
   - ☐ 4
   - ☐ 5 to 9
   - ☐ 10 or more times

5. In the last 6 months, did you contact this provider's office to get an appointment for an illness, injury or condition that **needed care right away**?
   - ☐ Yes
   - ☐ No ➔ **If No, go to #7**

6. In the last 6 months, when you contacted this provider's office to get an appointment for **care you needed right away**, how often did you get an appointment as soon as you needed?
   - ☐ Never
   - ☐ Sometimes
   - ☐ Usually
   - ☐ Always

7. In the last 6 months, did you make any appointments for a **check-up or routine care** with this provider?

   ☐ Yes
   ☐ No ➔ **If No, go to #9**

8. In the last 6 months, when you made an appointment for a **check-up or routine care** with this provider, how often did you get an appointment as soon as you needed?

   ☐ Never
   ☐ Sometimes
   ☐ Usually
   ☐ Always

9. In the last 6 months, did you contact this provider's office with a medical question during regular office hours?

   ☐ Yes
   ☐ No ➔ **If No, go to #11**

10. In the last 6 months, when you contacted this provider's office during regular office hours, how often did you get an answer to your medical question that same day?

    ☐ Never
    ☐ Sometimes
    ☐ Usually
    ☐ Always

11. In the last 6 months, how often did this provider explain things in a way that was easy to understand?

    ☐ Never
    ☐ Sometimes
    ☐ Usually
    ☐ Always

12. In the last 6 months, how often did this provider listen carefully to you?

    ☐ Never
    ☐ Sometimes
    ☐ Usually
    ☐ Always

13. In the last 6 months, how often did this provider seem to know the important information about your medical history?

    ☐ Never
    ☐ Sometimes
    ☐ Usually
    ☐ Always

14. In the last 6 months, how often did this provider show respect for what you had to say?

    ☐ Never
    ☐ Sometimes
    ☐ Usually
    ☐ Always

15. In the last 6 months, how often did this provider spend enough time with you?

    ☐ Never
    ☐ Sometimes
    ☐ Usually
    ☐ Always

16. In the last 6 months, did this provider order a blood test, x-ray, or other test for you?

    ☐ Yes
    ☐ No ➔ **If No, go to #18**

17. In the last 6 months, when this provider ordered a blood test, x-ray, or other test for you, how often did someone from this provider's office follow up to give you those results?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

18. In the last 6 months, did you and this provider talk about starting or stopping a prescription medicine?

- ☐ Yes
- ☐ No ➔ **If No, go to #20**

19. When you and this provider talked about starting or stopping a prescription medicine, did this provider ask what you thought was best for you?

- ☐ Yes
- ☐ No

20. In the last 6 months, did you and this provider talk about how much of your personal health information you wanted shared with your family or friends?

- ☐ Yes
- ☐ No

21. Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?

- ☐ 0 Worst provider possible
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ 10 Best provider possible

Clerks and Receptionists at This Provider's Office

22. In the last 6 months, how often were clerks and receptionists at this provider's office as helpful as you thought they should be?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

23. In the last 6 months, how often did clerks and receptionists at this provider's office treat you with courtesy and respect?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

Your Care From Specialists in the Last 6 Months

24. Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors, and other doctors who specialize in one area of health care. Is the **provider named in Question 1** of this survey a specialist?

- ☐ Yes ➔ **If Yes, Please include this provider as you answer these questions about specialists**
- ☐ No

25. In the last 6 months, did you try to make any appointments with specialists?

- ☐ Yes
- ☐ No ➔ **If No, go to #27**

26. In the last 6 months, how often was it easy to get appointments with specialists?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

All Your Care in the Last 6 Months

These questions ask about **all your** health care. Include all the providers you saw for health care in the last 6 months. Do **not** include the times you went for dental care visits.

27. Your health care team includes all the doctors, nurses and other people you see for health care. In the last 6 months, did you and anyone on your health care team talk about a healthy diet and healthy eating habits?

- ☐ Yes
- ☐ No

28. In the last 6 months, did you and anyone on your health care team talk about the exercise or physical activity you get?

- ☐ Yes
- ☐ No

29. In the last 6 months, did you take any prescription medicine?

- ☐ Yes
- ☐ No ➔ **If No, go to #32**

30. In the last 6 months, how often did you and anyone on your health care team talk about all the prescription medicines you were taking?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

31. In the last 6 months, did you and anyone on your health care team talk about how much your prescription medicines cost?

- ☐ Yes
- ☐ No

32. In the last 6 months, did anyone on your health care team ask you if there was a period of time when you felt sad, empty, or depressed?

- ☐ Yes
- ☐ No

33. In the last 6 months, did you and anyone on your health care team talk about things in your life that worry you or cause you stress?

- ☐ Yes
- ☐ No

About You

34. In general, how would you rate your overall health?

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor

35. In general, how would you rate your overall **mental or emotional** health?

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor

36. In the **last 12 months**, have you seen a doctor or other health provider 3 or more times for the same condition or problem?

- ☐ Yes
- ☐ No ➔ **If No, go to #38**

37. Is this a condition or problem that has lasted for at least 3 months?

- ☐ Yes
- ☐ No

38. Do you now need or take medicine prescribed by a doctor?

- ☐ Yes
- ☐ No ➔ **If No, go to #40**

39. Is this medicine to treat a condition that has lasted for at least 3 months?

- ☐ Yes
- ☐ No

40. In the last 6 months, were any of your visits for your own health care…

	Yes	No
a. In person?	☐	☐
b. By phone?	☐	☐
c. By video call?	☐	☐

41. During the last 4 weeks, how much of the time did your physical health interfere with your social activities (like visiting with friends, relatives, etc.)?

- ☐ All of the time
- ☐ Most of the time
- ☐ Some of the time
- ☐ A little of the time
- ☐ None of the time

42. What is your age?

- ☐ 18 to 24
- ☐ 25 to 34
- ☐ 35 to 44
- ☐ 45 to 54
- ☐ 55 to 64
- ☐ 65 to 69
- ☐ 70 to 74
- ☐ 75 to 79
- ☐ 80 to 84
- ☐ 85 or older

43. Are you male or female?

- ☐ Male
- ☐ Female

44. What is the highest grade or level of school that you have completed?

- ☐ 8th grade or less
- ☐ Some high school, but did not graduate
- ☐ High school graduate or GED
- ☐ Some college or 2-year degree
- ☐ 4-year college graduate
- ☐ More than 4-year college degree

45. How well do you speak English?

- ☐ Very well
- ☐ Well
- ☐ Not well
- ☐ Not at all

46. Do you speak a language other than English at home?

- ☐ Yes
- ☐ No ➔ **If No, go to #48**

47. What is the language you speak at home?

- ☐ Spanish
- ☐ Chinese
- ☐ Korean
- ☐ Russian
- ☐ Vietnamese
- ☐ Some other language

↓

Please print: _____

48. Are you deaf or do you have serious difficulty hearing?

- ☐ Yes
- ☐ No

49. Are you blind or do you have serious difficulty seeing, even when wearing glasses?

- ☐ Yes
- ☐ No

50. Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions?

- ☐ Yes
- ☐ No

51. Do you have serious difficulty walking or climbing stairs?

- ☐ Yes
- ☐ No

52. Do you have difficulty dressing or bathing?

- ☐ Yes
- ☐ No

53. Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping?

- ☐ Yes
- ☐ No

54. Do you ever use the internet at home?

- ☐ Yes
- ☐ No

55. Are you of Hispanic, Latino, or Spanish origin?

- ☐ Yes, Hispanic, Latino, or Spanish
- ☐ No, not Hispanic, Latino, or Spanish
  ➔ **If No, go to #57**

56. Which group best describes you?

- ☐ Mexican, Mexican American, Chicano
  ➔ **Go to #57**
- ☐ Puerto Rican ➔ **Go to #57**
- ☐ Cuban ➔ **Go to #57**
- ☐ Another Hispanic, Latino, or Spanish origin ➔ **Go to #57**

57. What is your race? Mark one or more.

- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian
- ☐ Native Hawaiian
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Other Pacific Islander

58. Did someone help you complete this survey?

- ☐ Yes
- ☐ No ➔ **Thank you. Please return the completed survey in the postage-paid envelope.**

59. How did that person help you? Mark one or more.

- ☐ Read the questions to me
- ☐ Wrote down the answers I gave
- ☐ Answered the questions for me
- ☐ Translated the questions into my language
- ☐ Helped in some other way

Please print: _____

Thank you
Please return the completed survey in the postage-paid envelope.
[VENDOR NAME AND ADDRESS HERE]

Resource: https://qpp.cms.gov/resources/resource-library

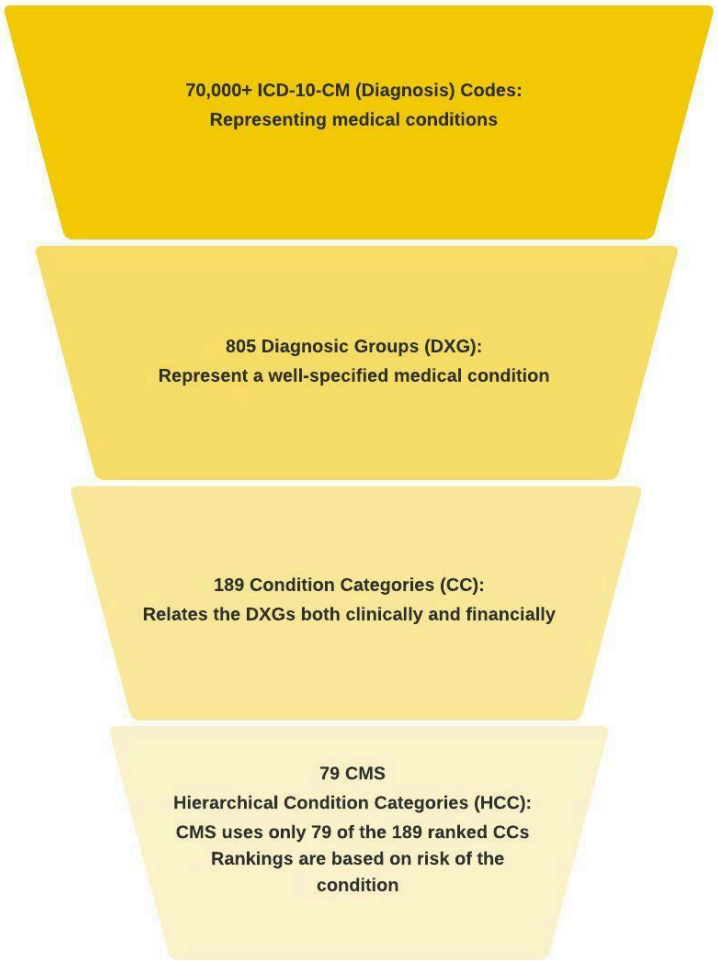
Risk Adjustment

What is Risk Adjustment

Risk Adjustment is a methodology created by CMS to reimburse health plans based on the health status and demographics of their members. Payers use Risk Adjustment to set baseline costs each performance year based on the patient's risk score. While Risk Adjustment was created by CMS for use in the Medicare population, it is important to note that Risk Adjustment is also used in Commercial Value-Based Care programs, so it is important to use the strategies noted here for the entire patient population.

What is an HCC?

HCC is an acronym for Hierarchical Condition Category. A portion of ICD-10-CM codes map to an HCC organized into body systems or similar disease processes. A good way to understand this is the diagram below:



What is a Risk Score?

A risk score (also called the Risk Adjustment Factor or RAF score) is the **numeric representation of a patient's expected healthcare service use in a given year**. The Center for Medicare & Medicaid Services' (CMS) HCC risk adjustment model assigns a risk score to each eligible beneficiary. A beneficiary's RAF is based on health conditions the beneficiary may have (specifically, those that fall within a HCC), as well as demographic factors such as Medicaid status (defined as having at least one month of Medicaid eligibility during the base year), gender, Aged/disabled status, and whether a beneficiary lives in the community (i.e., beneficiaries who reside in the community or have been in an institution for fewer than 90 days) or in an Institution (i.e., beneficiaries who have been in an institution for 90 days or longer). The risk score data is derived from CMS files.

Since the RAF is a **relative measure of the probable costs to meet the healthcare needs of the individual beneficiary** older individuals typically have a higher RAF than younger individuals; and, those individuals with a personal or family history of certain conditions may garner a higher RAF than individuals without such a history.

CMS requires that a qualified healthcare provider identify all conditions that may fall within an HCC at least once, each calendar year. Documentation in the medical record must support the presence of the condition and indicate the provider's assessment and plan for management of the condition. Incorrect or non-specific diagnoses (or patient demographic information) can affect both patient outcomes and reimbursement for the care of that patient, moving forward.

Maintaining Value in VBC Programs

RAF scores are used to adjust capitated payments for beneficiaries enrolled in Medicare Advantage (MA) plans and certain demonstration projects to ensure the payments cover the cost of providing care for sicker patients. **As such, accurate payments depend on complete and accurate coding and reporting of patient data annually.**

Extend high quality clinical documentation practices across all patients regardless of provider incentives.

Begin each year with high quality clinical documentation including diagnosis coding to the highest level of specificity

Assume that today's efforts set up patients for success in any current or future Value-Based Care programs. Our target is 90% recapture rate for MSSP (or a 95% addressed rate).

Important! Risk scores reset January 1st of every year! Therefore, all HCC diagnoses must be reported annually to accurately represent the severity of illness of our patient population. Risk scores impact payment models at the group and provider level.

Some organizations use the acronym "TAMPER" as a guide for supporting documentation in the EHR.

T: Treatment

- Prescribing or continuation of medications
- Surgical or other therapeutic interventions

A: Assessment

- Discussion, review records
- Counseling
- Acknowledging
- Documenting status or level of condition

M: Monitor or Medicate

- Symptoms
- Disease progression/regression
- Ordering of tests
- Referencing labs/other tests

P: Plan

- Plan for management of condition

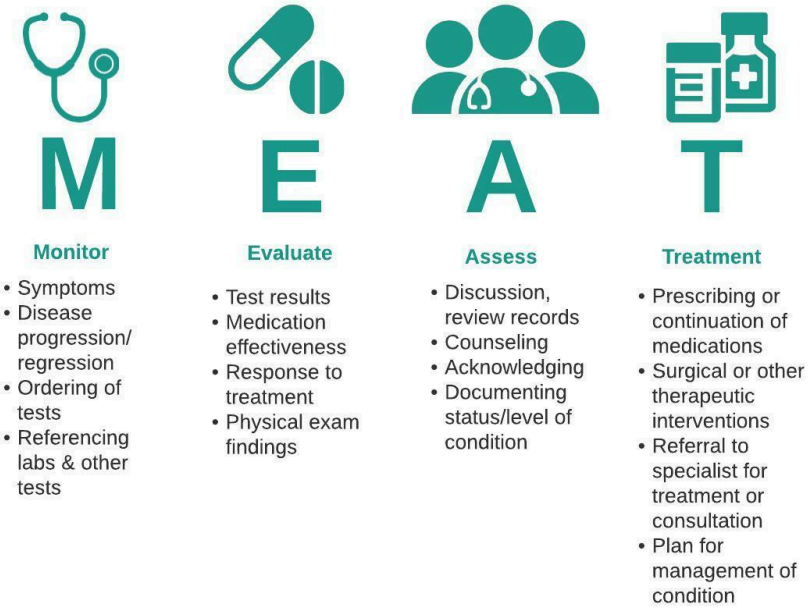
E: Evaluate

- Test results
- Medication effectiveness
- Response to treatment
- Physical exam findings

R: Referral

- Referral to specialist for treatment of condition

Other organizations follow the acronym "MEAT" as a guide for its simplicity:



Choose the method that works for your practice to help guide complete documentation.

Additional clinical documentation resources can be located in Privia University. Your Population Health Specialist(s) are also available for one-on-one training.

Reporting Co-existing Conditions

In the outpatient setting, the ICD-10 guidelines instruct:

> Choose the first-listed diagnosis which is used to describe the main reason for the visit/encounter, AND code all documented conditions that coexist at the time of the encounter/visit, and require or affect patient care, treatment or management.

The Centers for Medicare & Medicaid Services (CMS) 2013 Participant Guide for risk adjustment further supports this instruction:

> Physicians should code for all documented conditions that coexist at the time of the encounter/visit, and require or affect patient care, treatment or management. Do not code conditions that were previously treated and no longer exist. However, history codes may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.

Co-existing conditions include chronic, ongoing conditions, such as diabetes, congestive heart failure, atrial fibrillation, COPD, multiple sclerosis, hemiplegia, rheumatoid arthritis, Parkinson's disease, etc. These diseases are generally managed by ongoing medication and have the potential for acute exacerbations if not treated properly, particularly if the patient is experiencing other acute conditions. It is likely that these diagnoses would be part of a general overview of the patient's health when treating co-existing conditions for all but the most minor of medical encounters.

Ask: **Do these conditions affect my medical decision making?**

Collecting these diagnoses is not for the purpose of submitting a claim, but rather to send the diagnoses via a claim to account for all the conditions the patient has documented as a current condition each year.

These diagnosis codes are converted to a risk adjustment factor (eg, HCC) and the patient's risk score is steadily and yearly adjusted according to those diagnosis codes that have weight and therefore, risk adjust.

The end result is not the storage of a group of diagnosis codes, but instead, their affiliated diagnosis values, as documented and reported.

Clinical Documentation Best Practices: "Every patient, every time"

1. Ensure patients are seen every year. Take the opportunity the Annual Wellness or Physical gives to reach out and schedule visits.
2. Ensure the problem list is accurate and up to date by removing inaccurate and inactive diagnoses and capturing any new diagnoses.
3. Prepare for each patient visit as this will help address chronic conditions and allow for more accurate documentation of findings.
4. Document all coexisting conditions related to the patient's health status and don't forget to document obesity/morbid obesity.
5. Document current status of the condition including any complications
6. Document severity of illness
7. Document the episode of care (initial, subsequent)
8. Be as specific as possible in coding. Sign/Symptom and "unspecified" codes may not be appropriate.
9. Reference the ICD-10-CM codebook

Clinical Documentation Matters

The example below highlights the impact of thorough clinical documentation for a patient. In the fictional representation below, a provider could miss documentation entirely (red column), document some conditions (yellow column), or fully document the chronic conditions for the patient. The impact on risk adjusted premium for the patient is highlighted in green.

PRIVIA HEALTH

Impact of Accurate or Inaccurate RAF coding

NO Conditions Documented or Coded — (No Encounters or Poor Documentation/Coding)		SOME Conditions Documented or Coded — (Not to Highest Level of Specificity)		ALL Conditions Documented and Coded Appropriately — (To Highest Level of Specificity)	
76-year-old female	.451	76-year-old female	.451	76-year-old female	.451
DM not documented/coded		DM w/o Complications (HCC 19)	.105	DM w/Complications (HCC 18)	.302
CKD not documented/coded		CKD Unspecified (No HCC)		CKD Stage 5 (HCC 136)	.289
CHF not documented/coded		CHF not documented/coded		CHF (HCC 85)	.331
Morbid Obesity not on claim		Morbid Obesity not on claim		Morbid Obesity (HCC 22)	.150
				4 payment HCCs	.006
				Disease Interaction (CHF + DM)	.121
				Disease Interaction (CHF + Renal)	.156
Total RAF	**.451**	**Total RAF**	**.556**	**Total RAF**	**1.806**
PMPM Base Rate	**$812**	**PMPM Base Rate**	**$812**	**PMPM Base Rate**	**$812**
Risk-Adjusted PMPM Rate	**$366**	**Risk-Adjusted PMPM Rate**	**$451**	**Risk-Adjusted PMPM Rate**	**$1,466**
Risk-Adjusted PMPY Rate	**$4,392**	**Risk-Adjusted PMPY Rate**	**$5,412**	**Risk-Adjusted PMPY Rate**	**$17,592**

One last note: Risk adjustment is about complete and accurate coding and documentation of a patient's conditions. It is NOT upcoding or adding conditions/diagnoses were not clinically appropriate. **Please ensure that all coding is well supported in documentation and clinically appropriate.**