PRIVIA HEALTH™

2024 Value-Based Care Program for Medicare Advantage

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

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

Date of revision: 12/2023

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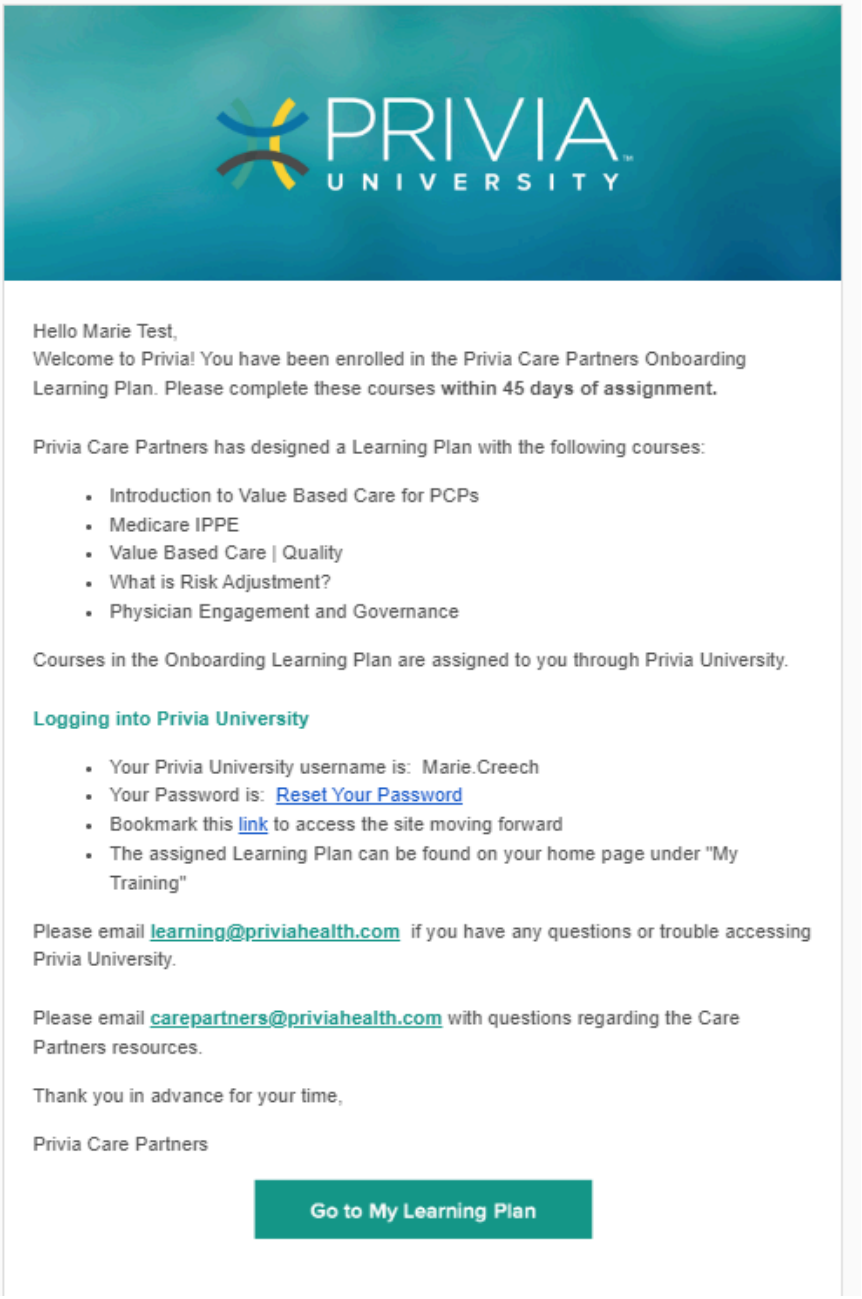
Welcome to your Value-Based Care Program with Privia Care Partners

Privia University: Privia Care Partners Onboarding

Privia Care Partners designed an Onboarding Learning Plan for you. Be on the lookout for an email notification and follow the instructions to enroll.



PRIVIA UNIVERSITY

Hello Marie Test,
Welcome to Privia! You have been enrolled in the Privia Care Partners Onboarding Learning Plan. Please complete these courses **within 45 days of assignment.**

Privia Care Partners has designed a Learning Plan with the following courses:

- Introduction to Value Based Care for PCPs
- Medicare IPPE
- Value Based Care | Quality
- What is Risk Adjustment?
- Physician Engagement and Governance

Courses in the Onboarding Learning Plan are assigned to you through Privia University.

Logging into Privia University

- Your Privia University username is: Marie.Creech
- Your Password is: Reset Your Password
- Bookmark this link to access the site moving forward
- The assigned Learning Plan can be found on your home page under "My Training"

Please email learning@priviahealth.com if you have any questions or trouble accessing Privia University.

Please email carepartners@priviahealth.com with questions regarding the Care Partners resources.

Thank you in advance for your time,

Privia Care Partners

Go to My Learning Plan

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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

Patient Attribution

What is Attribution?

The attribution process is fundamentally about identifying and formalizing relationships between primary care providers and patients. Quality and Value-Based Care programs rely on algorithms, or predetermined methodologies, to yield valid performance results and these algorithms start with attribution by assigning or “attributing” certain patients to a particular provider and then evaluating that patient’s data.

For Value-Based Care Programs, there are generally two phases to attribution:

- Attribution to the provider group - This step is driven by the Health Plan or payer with whom we are in a value-based arrangement.
- Attribution to an individual provider - This step is driven by processes and workflows and fine-tuned to better represent natural patterns of care.

Attribution to the Provider Group: Health Plan-driven

This step assigns patients to the group of providers operating as Primary Care providers (PCPs) associated with Privia Care Partners, either as employed or Independent providers. While patients are assigned to a provider during this step, think of the assignment as not confirmed.

Attribution to the Provider: Privia or Health Plan-driven

In 2024, for patients assigned to Privia Care Partners, the provider attribution will be determined as follows:

- Patients will be preliminarily assigned to the provider identified by the health plan/payer.
- If the assigned provider is a traditional Primary Care Provider, few changes will be made.
- Other patients, initially assigned to another provider (e.g. specialist providers) **may** experience changes to attribution if deemed necessary.

Patient Rosters

What is a Patient Roster?

Patient rosters are a list of your currently attributed patients. The patient listing is updated monthly. Patients who have termed with the health plan or who have expired may not be represented on your patient roster. Additionally, there may be newly attributed patients that have selected you as their PCP that may not be in your EHR. Providers often refer to this as "The Whole List" of patients who have an action to be taken at some point during the year.

In addition to the Patient Roster, you will also receive a Worklist on a monthly basis. This is a listing of all your patients that have outstanding care gaps with the Payer that need to be closed. You should review this list and if gaps have already been closed, then a record of the care should

be provided to your Population Health Specialist to ensure the record is sent to the payer to close the gap and give you credit for the care. Patients on this list may also need an AWV.

And lastly, you will receive a list of patients that are only in need of an Annual Wellness Visit. These visits are extremely important as they give you an opportunity to recapture all the clinically appropriate chronic diagnosis codes for a patient.

When will I receive my Patient Roster?

Patient rosters will be either emailed to you, your designee, your Pod Leader, and your Practice Manager, (or loaded to your shared Google drive) by your Population Health Specialist by the 10th business day of each month. The report will be shared at the same time as Pod reports, described in a separate document.

What is the benefit of utilizing a Patient Roster?

The patient level detail assists you and your care teams in identifying outstanding health assessments, open care gaps, and unaddressed HCCs.

Changing Attributed Providers

Exception 1: Attribution after AWV provider assignment

- Some patients will be attributed to a AWV-dedicated provider by a health plan because the patient completed an AWV with a AWV APRN and had one (1) or zero (0) appointments with a Primary Care provider in the previous calendar year. In that event, patients will be assigned to the PCP who saw the patient most recently within the last 18 months ending on the first day of the Performance Year. Updated patient attribution will be applied automatically within 30 business days of receiving the attribution file from the health plan/payer.

Exception 2: Attribution to a Privia Care Partners provider after provider termination

- Some patients will be attributed to a provider who termed from Privia Care Partners in the base period or the performance year. Patients attributed to the termed provider will continue to be attributed to the termed provider until the patient has accumulated more visits with another Privia Care Partners PCP, or the next calendar year.

Exception 3: Attribution to a new provider during the Performance Year

- Patients may elect to receive care from a different provider due to patient preference, move, or other reasons. Patients may be reattributed to a new PCP (e.g. a PCP other than the PCP to whom they are attributed as of the beginning of the Performance Year) when the total number of visits with the new PCP exceeds the total number with the original PCP. Please note, movement between supervising physician and APP will be ignored, thus freezing attribution between the two providers after it is set.

Concerned about significant errors?

- Attribution is driven by patients' care patterns, not the “Primary Provider” field in your EHR, new appointment visit types, or an agreement between a patient and provider. Below are some common concerns:
    - I have an attributed patient has expired, termed with the plan, moved out of state:
        - Attribution from the health plan will be updated to reflect that change as data flows to the health plan. There is no need to request a change in attribution. For deceased patients, you can also add a deceased date in your EHR and submit it to your Population Health Specialist (PHS) on your monthly roster.
    - I have patients attributed to me because I cared for patients when another PCP was ill for an extended period last year.
        - You can submit a request to change attribution or wait for the count of visits with their original provider to reassign the patients automatically.
    - I can’t find a patient that I know is mine.
        - Please send an email to your Population Health Specialist and we can research the patient.
- If you are concerned about errors in your attributed patient counts that are not explained by one of the attribution rules above, please contact your Population Health Specialist using the following Patient Transfer Process. Please note, some requests for patient transfers will not be processed as the reason for the process will be covered automatically by one of the exceptions above.

Patient Transfer Process

1. “Sending” PCP or their MA will send an email to PHS including the name, date of birth, and health insurance ID of the patient they wish to transfer and the reason for transfer (e.g. “patient should be assigned to my supervising physician, Dr. Smith”).
2. PHS confirms receipt of request, logs request reason type, and requests confirmation with affected provider (e.g. “Dr. Smith, Nurse Jones has indicated that this is your patient. Do you confirm?”)
3. Upon confirmation from affected PCP or MA, PHS submits a request to the appropriate party (analytics team or payer/health plan).
4. Approved reassignments will be made within 30 days if in Privia control. Health Plan controlled changes may take longer, so patient rosters should be reviewed regularly to ensure the changes are made.

Anthem Attribution Logic

Eligible patients who are covered by Anthem may either select or be attributed to a primary care provider based on an analysis of visit history reflected in claims.

Covered individuals have the option to select a PCP via their employer or online on Anthem's website. If they are a member of an HMO-style plan, they may be assigned a PCP if they do not select one. **Beginning 1/1/2023, an Anthem visit check will be in place to ensure patient had at least one visit to assigned PCP in the past 18 months. If there is no visit to the PCP of record, then their affinity will be assigned based on their visit-based logic. If there are no visits to any physician in the past 24 months, then affinity will stay with the PCP of record.** Visit-based attribution comes into play where neither member selection nor assignment has occurred.

If a patient selects more than one PCP during the covered period, then they will be assigned to each PCP only during the months where that PCP was selected.

VISIT-BASED ATTRIBUTION

Where visit-based attribution is used, Anthem uses a visit-based approach to attribute patients based on historical claims data. Anthem uses an algorithm that takes into account office-based and telehealth evaluation and management (E&M) visits over a 24-month period. **Beginning 1/1/2023, Anthem will include physician assistants in their visit-based attribution logic.** Attribution goes to the PCP with the most E&M visits.

In order to attribute a patient to a given provider, that patient must have had Anthem coverage for at least three of the prior 24 months. After initial attribution, visit-based attribution is updated every month.

Attribution Scenarios:

1. The patient has selected a PCP and has had at least one visit with that PCP in the past 18 months. OR the patient has not seen their selected PCP nor have they seen any other provider for the past 24 months. The patient is attributed to their selected PCP.
2. The patient has selected a PCP, but has not seen the PCP of record in the past 18 months and has seen other providers in the past 18 months, then the visit based attribution algorithm will run and the patient will be attributed based on that logic, outlined below.
    a. The patient visited a single PCP with E&M claims over the prior 24 months. The patient is attributed to the PCP.
    b. The patient has seen multiple PCP's, but one PCP has submitted more E&M claims than the others. The patient is attributed to the PCP with the most E&M claims/visits.

c. The patient has seen multiple PCP's that have submitted the same number of E&M claims. In this case, the algorithm selects the PCP that has the E&M visits separated by the greatest length of time.

d. The patient has seen multiple PCP's, but each only once. In this case, the algorithm selects the PCP with the most recent visit.

e. The patient has not seen a PCP, but has seen a specialist in the past 24 months, so attribution will go to the specialist.

f. The patient has not seen a PCP or a specialist, but has visited a surgical specialist in the past 24 months, so attribution will go to the surgical specialist.

For visit-based affinity, PCP visits are always considered first before medical specialists, and medical specialists are always considered before surgeons.

If there is no selected PCP and no qualifying PCP, medical, or surgical specialist claims over the last 24 months, then the patient will not have any visit-based affinity.

If a patient is not covered by Anthem for more than 3 of the past 24 months, then that patient is not included in their attribution logic.

Exclusions to attribution

- Patients covered by Medicare supplement products
- Hospital-only products (PPO, EPO, FFS-based)
- Professional-only products
- Products subject to significant other PMPM payments (e.g., global capitation)
- Specialty-only products (e.g., vision or dental products)
- Network rental products where Anthem does not pay the claims
- Products where care is normally delivered through specific types of providers and facilities other than contracted network providers and facilities other than contracted network providers, such as student health plans
- ER, urgent care, and retail clinics are excluded based on place of service and CPT codes

Overview of Medicare Advantage (MA) Stars Program

The Center for Medicare and Medicaid Services (CMS) utilizes a 5-star quality rating system to measure Medicare beneficiaries' experiences and care with their health plan and healthcare providers. The MA Star rating program aims for an accomplished healthcare system delivering the highest quality care to its patients. CMS rates each Medicare Advantage and drug plan contract on a 1-5 star scale with five stars representing excellent performance.

CMS requires all Medicare Advantage plans to submit data for Stars performance. Data submitted for specific measures set forth by HEDIS, Pharmacy Quality Alliance (PQA), CAHPS/HOS and others are analyzed to ensure quality metrics are met. These quality metrics determine the overall star rating of both the health plan and providers. It also assists Medicare beneficiaries select a high performing Medicare Advantage plan during Fall open enrollment.

Performing well in the Medicare Advantage Star measures will aid in improved care delivery, better patient outcomes, increased patient base populations and a potential increase in financial incentives paid by health plans. Performing at a 4+ star will also allow for better negotiations during healthplan-provider contract renewals.

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2024 Value-Based Care Program Components & Targets

PATIENT POPULATIONS

Below is the 2023 Value-Based Care Program for Anthem BCBS Medicare Advantage (MA) . **If shared savings are achieved in this program, the following metrics will be used to calculate the funds flow distribution.**

Measure	Description	Threshold	Target
Value-Based Performance Metrics			
Physician Engagement	Physicians (or their staff) attend scheduled POD and/or performance meetings. **This is a gating measure, but is not intended to be punitive.** If you and your staff have a conflict, please notice us in advance and attendance will be 'excused'. The purpose is to ensure rewards are provided to providers that are engaged in the success of the program and helping other providers succeed as well.	80%	100%
MA Quality	Deliver best practice care as measured by Medicare Stars quality metrics	3.75 Stars	4.25 Stars
MA AWV Completion	Ensure that a portion of attributed Medicare Advantage patients have completed an annual wellness exam.	70%	80%
MA HCC Recapture Rate	Ensure Medicare advantage patients have chronic health conditions addressed at least once annually.	80%	90%

After the gating thresholds are achieved, funds will be distributed between the providers based on Individual, POD, and overall Program performance. **Our experience is that all providers achieve higher levels of rewards when they are engaged and helping each other learn. Privia Care Partners is here to support you and help you maximize your performance, so please reach out if you have any questions or need additional help in any of these areas.**

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2024 Anthem Program Measures & Cut Points for MA

Quality Measures	Weight	1-Star	2-Star	3-Star	4-Star	5-Star
Breast Cancer Screening (BCS-E)	1	<52%	52%	63%	71%	79%
Care for Older Adults: Medication Review (COA-Med Rev)	1	<72%	72%	84%	93%	98%
Care for Older Adults: Pain Assessment (COA-Pain)	1	<74%	74%	83%	91%	96%
Colorectal Cancer Screening - ECDS	1	<48%	48%	60%	71%	80%
Controlling High Blood Pressure (CBP)	3	<58%	58%	68%	74%	82%
Hemoglobin A1C Control for Patients with Diabetes (HBD)	3	<57%	57%	72%	80%	87%
Eye Exam for Patients with Diabetes (EED)	1	<53%	53%	65%	73%	81%
F/U after ED for People w Multiple High-Risk Chronic Conditions (FMC)	1	<44%	44%	53%	60%	68%
Kidney Health Evaluation for Patients with Diabetes	1					
Medication Adherence for Cholesterol (MAC)	3	<82%	82%	86%	88%	91%
Medication Adherence for Diabetics (MAD)	3	<80%	80%	84%	88%	90%
Medication Adherence for Hypertension (MAH)	3	<82%	82%	86%	89%	91%
Program Completion Rate for CMR (MTM-CMR)	1	<67%	67%	77%	85%	92%
Osteoporosis Management in Women who had a Fracture (OMW)	1	<28%	28%	39%	50%	60%
Plan All-Cause Readmission (PCR)	3	>13%	13%	11%	10%	8%
Statin Therapy for Patients with Cardiovascular Disease (SPC)	1	<79%	79%	84%	86%	90%
Statin Use in Persons with Diabetes (SUPD)	1	<81%	81%	86%	88%	92%
Transitions of Care (TRC): Medication Reconciliation Post-Discharge	0.5	<31%	31%	51%	68%	82%
Transitions of Care (TRC): Patient Engagement after IP Discharge	0.5	<40%	40%	52%	64%	78%

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Example STARS Aggregate Calculation

Quality Measures	Weight	Your Star Rating per Measure	Weighted Rating (Weight x Your Star)
Breast Cancer Screening (BCS-E)	1	4	4
Colorectal Cancer Screening	1	3	3
Care for Older Adults: Medication Review (COA- Med Rev)	1	4	4
Care for Older Adults: Pain Assessment (COA-Pain)	1	3	3
Controlling High Blood Pressure (CBP)	3	4	12
Eye Exam for Patients with Diabetes (EED)	1	2	2
F/U after ED for People w Multiple High-Risk Chronic Conditions (FMC)	1	4	4
Hemoglobin A1C Control for Patients with Diabetes (HBD)	3	4	12
Medication Adherence for Cholesterol (MAC)	3	5	15
Medication Adherence for Diabetics (MAD)	3	3	9
Medication Adherence for Hypertension (MAH)	3	5	15
Osteoporosis Management in Women who had a Fracture (OMW)	1	4	4
Plan All-Cause Readmission (PCR)	3	5	15
Program Completion Rate for CMR (MTM-CMR)	1	4	4
Statin Therapy for Patients with Cardiovascular Disease (SPC)	0.5	3	1.5
Statin Use in Persons with Diabetes (SUPD)	0.5	4	2
Transitions of Care (TRC): Medication Reconciliation Post-Discharge	1	4	4
Transitions of Care (TRC): Patient Engagement after IP Discharge	1	4	4
Sum of all weighting	**29 (Available Weighted Points)**		**117.5 (Points Total)**
Points total divided by available weighted points (117.5/29)= Aggregate Stars Rating			**4.05**

Information Only Measures Collected and Tracked for Anthem Medicare Advantage

Adult Immunization Status (AIS-E) → CMS is proposing AIS-E become a Star measure beginning in measurement year 2023. The final rule did not move this into the weighting, so pending future notice.

- Pneumococcal
- Td/Tdap
- Zoster
- Influenza

Care for Older Adults - Functional Status Assessment → CMS is proposing COA-FSA to become a Star measure with a weight of one beginning in measurement year 2024. The final rule did not move this into the weighting, so pending future notice.

Polypharmacy Use of Multiple Anticholinergic Medications in Older Adults

Polypharmacy Use of Multiple Central Nervous System-Active Medications in Older Adults

Concurrent Use of Opioids and Benzodiazepines

Depression Screening and Follow-Up for Adolescents and Adults

Patient Experience- Care Coordination → Current Star measure with a weight of 4.

Patient Experience- Getting Care Quickly → Current Star measure with a weight of 4.

Patient Experience- Getting Needed Care → Current Star measure with a weight of 4.

Medicare Annual Planned Visits (APVs)

Medicare Advantage plans for Anthem Blue Cross and Blue Shield (Anthem) will offer coverage for routine physicals in 2023 for individual and group-sponsored members. Anthem does offer an incentive for the below types of visits based on the percentage of APVs performed during 2023.

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.**

2024 Medicare Advantage Star Measure Quality Tip Sheets

Breast Cancer Screening (BCS-E) 2024

Medicare, Medicaid and Commercial

Measure Description

The percentage of patients 50-74 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 hospice services anytime during 2024
- Patients who received palliative care or had an encounter with palliative care any time during 2024
- Patients who passed away any time during 2024
- History of a bilateral mastectomy or both right and left unilateral mastectomies any time during the patient's history through 2024
- Patients who had gender-affirming chest surgery with a diagnosis of gender dysphoria any time during the patient's history through 2024
- 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 any time during 2024
- Patients 66 years of age and older as of December 31, 2024 with at least two frailty indications on different dates of service in 2024 and an advanced illness diagnosis on at least two different dates of service *or* dispensed dementia medication during 2023 or 2024

Documentation Tips

- Utilize appropriate coding to capture unilateral/bilateral mastectomies procedures on any claim- document the hx of this procedure within the record.
- If a mammogram report is not available documentation must include at least the year the mammogram was completed. This can be taken as part of the patient's history by the care provider. The result is not required.
- If the mammogram occurred between October 1, 2022-December 31, 2022, you must document the month and year in order to show compliance for the measure.
- Mammogram includes all types and methods: screening, diagnostic, film, digital or digital breast tomosynthesis
- *Note*: A mammogram screening is still required if one breast has been removed and the other is present.
- Data for BCS-E can be obtained through clinical registries, health information exchanges, administrative claims, immunization information systems or disease and case management registries

Common Codes

ICD 10 (Exclusion)

Z90. 11 - acquired absence of right breast

Z90.12 - acquired absence of left breast

Z90. 13 - acquired absence of bilateral breast

CPT (Exclusions)

19318 - gender affirming chest surgery

CPT (Mammography)

77061-77063, 77065-77067

LOINC (Mammography)

24604-1, 24605-8, 24606-6, 24610-8, 26175-0, 26176-8, 26177-6, 26287-3, 26289-9, 26291-5, 26346-7, 26347-5, 26348-3, 26349-1, 26350-9, 26351-7, 36319-2, 36625-2, 36626-0, 36627-8, 36642-7, 36962-9, 37005-6, 37006-4, 37016-3, 37017-1, 37028-8, 37029-6, 37030-4, 37037-9, 37038-7, 37052-8, 37053-6, 37539-4, 37542-8, 37543-6, 37551-9, 37552-7, 37553-5, 37554-3, 37768-9, 37769-7, 37770-5, 37771-3, 37772-1, 37773-9, 37774-7, 37775-4, 38070-9, 38071-7, 38072-5, 38090-7, 38091-5, 38807-4, 38820-7, 38854-6, 38855-3, 39150-8, 39152-4, 39153-2, 39154-0, 42168-5, 42169-3, 42174-3, 42415-0, 42416-8, 46335-6, 46336-4, 46337-2, 46338-0, 46339-8, 46342-2, 46350-5, 46351-3, 46354-7, 46355-4, 46356-2, 46380-2, 48475-8, 48492-3, 69150-1, 69251-7, 69259-0, 72137-3, 72138-1, 72139-9, 72140-7, 72141-5, 72142-3, 86462-9, 86463-7, 91517-3, 91518-1, 91519-9, 91520-7, 91521-5, 91522-3

SNOMED (Mammography)

12389009, 24623002, 43204002, 71651007, 241055006, 241057003, 241058008, 258172002, 439324009, 450566007, 709657006, 723778004, 723779007, 723780005, 726551006, 833310007, 866234000, 866235004, 866236003, 866237007, 384151000119104, 392521000119107, 392531000119105, 566571000119105, 572701000119102

Resources

HEDIS MY2024 Technical Specs Vol 2. Pg. 558-568

Care for Older Adults (COA): Medication Review 2024

Medicare (only SNP and MMP benefit packages)

Measure Description

Percentage of adults ages 66 and older who had a medication review by a clinical pharmacist or prescribing practitioner **and** the presence of a medication list in the medical record (signed and dated) or transitional care management services any time during 2024

Required Exclusions

- Patients in hospice or using hospice benefits any time in 2024
- Patients who passed away any time during 2024

Documentation Tips

- Medication list must be included in the medical record and the medication review must be completed by a prescribing provider or clinical pharmacist
- A medication list signed and dated, in 2024, by the appropriate provider (prescribing provider or clinical pharmacist) meets numerator compliance
- Notation within the medical record that the medications were reviewed
- Notation that the patient is not taking medications meets compliance
- A Registered Nurse can collect the medications during the visit, but the appropriate provider must review and sign
- An outpatient visit is not required to meet criteria

Non-compliant documentation hints

- Documentation that the medications aren't tolerated does not meet numerator compliance.
- A review of side effects for a single medication does not meet numerator compliance.
- Medication review conducted in an acute inpatient setting will not meet numerator compliance.

Codes

CPT/CPT II

1159F and 1160F- medication list documented **and** review of all medications by a prescribing practitioner or clinical pharmacist documented – These codes must be on the same date of service

99605, 99606, 90863, 99483, 1160F- Medication review

99495, 99496- Transitional Care Management

Resources

HEDIS MY2024 Technical Specs Vol 2. Pg. 101-106

Care for Older Adults (COA): Pain Assessment 2024

Medicare (Only SNP and MMP benefit packages)

Measure Description

The percentage of adults 66 years of age and older who were assessed for pain anytime in 2024

Required Exclusions

- Patients in hospice or using hospice benefit any time in 2024
- Patients who passed away any time during 2024

Documentation Tips

- Documentation must include an assessment for pain anytime during 2024. The assessment may have positive or negative findings.
- A standardized tool may be used to assess the patient's pain.
- All documentation or tools used must contain the date the assessment was completed.
- Pain can be assessed from an acute condition, ie. sore throat, abdominal pain, etc.
- Pain assessment may be documented in the Review of Systems (ROS) and be related to a single body part, except for the chest .
- Pain scales, using numbers or faces, used in 2024 do meet numerator compliance.
- Pain may be assessed during an in person, telephonic or virtual visit and is not limited to a clinician only assessment.
- **Use CPT II codes** to lessen the administrative burden of manual chart reviews.

Non-compliant documentation hints

- Documentation of pain management alone or pain treatment alone does **not** meet numerator criteria.
- A pain assessment performed in an acute inpatient setting does **not** meet numerator criteria.
- Screening or documentation of chest pain will **not** meet numerator compliance.

Code

CPT II Codes

1125F- Pain Severity quantified, pain present

1126F- Pain Severity quantified, no pain present

Resources : HEDIS MY2024 Technical Specs Vol 2. Pg. 101-106

Colorectal Cancer Screening (COL-E) 2024

Medicare, Medicaid and Commercial

Important Update for Medicare Advantage

NCQA has removed the Colorectal Cancer Screening (COL) administrative reporting measure and transitioned into ECDS reporting (COL-E) methodology. CMS will apply this update to the Star Measure for measurement year 2024. This new method broadens the reporting options available. ECDS measures allows plans to use administrative claims and clinical data that may come from a variety of sources such as, EHRs, HIEs/Clinical Registries, Case Management systems and Claims.

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 2024

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.

*CMS Stars continues to measure patients 50-75 years of age.

Required Exclusions

- Patients in hospice or elect to use a hospice benefit any time during 2024
- Patients receiving palliative care or had an encounter for palliative care any time during 2024
- Patients who passed away any time during 2024
- Patients who had a colorectal cancer or a total colectomy any time during the patient's history through December 31, 2024

*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 any time during 2024
- Patients 66 years of age and older as of December 31, 2024 with two frailty indications on different dates of service in 2024 **and** an advanced illness diagnosis on at least two different dates of service *or* dispensed dementia medication during 2023 or 2024.

Measure Tips

- Documentation in the medical record must include a note indicating the date (year only is acceptable) when the colorectal cancer screening was performed. A result is not required if the documentation is clearly part of the patient's "medical history"; if this is not clear, the result or finding must also be present (this ensures that the screening was performed and not merely ordered).
- A pathology report that indicates the type of screening (e.g., colonoscopy, flexible sigmoidoscopy) and the date when the screening was performed meets criteria.
- For pathology reports that do not indicate the type of screening and for incomplete procedures:
    - Evidence that the scope advanced to the cecum meets criteria for a completed colonoscopy.
    - Evidence that the scope advanced into the sigmoid colon meets criteria for a completed flexible sigmoidoscopy.
- It's important to submit any codes that reflect a patient's history of malignancy for colorectal cancer so the patient can be excluded.
- **Use CPT/HCPCS/SNOMED codes (for lookback period)** to capture care for this ECDS measure.

Non-compliant Documentation Hints

- Tests performed in an office setting or from any specimen collected during a digital rectal exam (DRE) does not meet numerator compliance.
- CT scan of the abdomen and pelvis will not meet numerator compliance.
- Patient refusal or referrals alone does **not** meet numerator compliance.

Common Codes

Colonoscopy

CPT®: 44388, 44389, 44390, 44391, 44392, 44394, 44401, 44402, 44403, 44404, 44405, 44406, 44407, 44408, 45378, 45379, 45380, 45381, 45382, 45384, 45385, 45386, 45388, 45389, 45390, 45391, 45392, 45393, 45398

HCPCS: G0105, G0121

SNOWMED: 851000119109 (history of colonoscopy)

Computed Tomography (CT) Colonography

CPT®: 74261, 74262, 74263

Stool DNA (sDNA) with FIT Test

CPT®: 81528 (specific to Cologuard)

SNOMED: 708699002 (positive finding)

Flexible Sigmoidoscopy

CPT®: 45330, 45331, 45332, 45333, 45334, 45335, 45337, 45338, 45340, 45341, 45342, 45346, 45347, 45349, 45350

HCPCS: G0104

SNOWMED: 841000119107 (history of flexible sigmoidoscopy

FOBT

CPT®: 82270

HCPCS: G0328

FIT

CPT®: 82274

History of Total Colectomy:

SNOWMED: 119771000119101

Resources

HEDIS MY2024 Technical Specs Vol 2. Pg. 578-587

Controlling High Blood Pressure (CBP) 2024

Medicare, Medicaid and Commercial

Measure Description

The percentage of patients 18-85 years of age who had at least two outpatient visits on different dates of service, with a diagnosis of hypertension (HTN) on or between January 1, 2023 and June 30, 2024 and whose **most recent** blood pressure (BP) was adequately controlled (**<140/90 mm Hg**) during 2024.

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 hospice services anytime during 2024
- Patients who receive palliative care or had an encounter for palliative care anytime during 2024
- Patients who passed away anytime during 2024
- Evidence of end-stage renal disease (ESRD), dialysis, nephrectomy or kidney transplant anytime during the patient's history through December 31, 2024
- Patients with a diagnosis of pregnancy anytime during 2024
- Patients who had a non-acute inpatient admission during 2024

*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 any time during 2024
- Patients 66-80 years of age and older as of December 31, 2024 with two frailty indications on different dates of service in 2024 and an advanced illness diagnosis on at least two different dates of service or dispensed dementia medication during 2023 or 2024.
- Patients 81 years of age and older as of December 31, 2024 with at least two frailty indications on different dates of service during 2024.

Documentation Tips

- Document BP on every patient encounter.
- Retake BP when found to be ≥140 systolic or ≥90 diastolic after the patient has been seated and visited with the clinician. Document all blood pressure readings. 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.
- **Use CPT II codes** to lessen the administrative burden of manual chart reviews.

Documentation Tips Continued…

- Blood pressures cannot be abstracted from an inpatient visit note, ED visit, or on the same day as a diagnostic test or procedure that requires a change in diet or medication or or one day prior to the test/procedure. Exception: Fasting labs
- **Remember, the last blood pressure of the measurement year is the abstracted BP and will determine gap compliance.**

Codes (choose one systolic and one diastolic code for submission)

3074F- Most recent systolic BP < 130
3075F- Most recent systolic BP 130-139
3077F- Most recent systolic BP ≥ 140

3078F- Most recent diastolic BP < 80
3079F- Most recent diastolic BP <80-89
3080F- Most recent diastolic BP ≥90

Resources

HEDIS MY2024 Technical Specs Vol 2. Pg. 132-140

Glycemic Status Assessment for Patients With Diabetes (GSD) 2024 formerly Hemoglobin A1c Control for Patients with Diabetes (HBD)

Medicare, Medicaid and Commercial

Measure Description

The percentage of patients ages 18-75 with diabetes (type 1 and type 2) whose most recent whose most recent glycemic status (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) was at the following levels during the measurement year:

- Glycemic Status <8.0%
- Glycemic Status >9.0% (a lower rate indicates better performance and better care)

Note: Medicare Stars only measures ≤9.0%

Required Exclusions

- Patients who passed away anytime during 2024
- Patients receiving hospice or elect to use a hospice benefit anytime during 2024
- Patients receiving palliative care or had a palliative care encounter anytime during 2024

*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 any time during 2024
- Patients 66 years of age and older as of December 31, 2024 with two frailty indications on different dates of service in 2024 **and** an advanced illness diagnosis on at least two different dates of service *or* dispensed dementia medication during 2023 or 2024.

Documentation Tips

- Documentation in the medical record must include a note indicating the date when the glycemic status assessment (HbA1c or GMI) was performed along with the result.
- If multiple glycemic status assessments were recorded for a single date, use the lowest result.
- When identifying the most recent glycemic status assessment (HbA1c or GMI), GMI values must include documentation of the continuous glucose monitoring data date range used to derive the value.
- GMI results collected by the member and documented in the member's medical record can be used to meet numerator compliance.
- Ranges and thresholds do not meet criteria for this indicator. A distinct numeric result is required for numerator compliance.
- **Use CPT II codes** to lessen the administrative burden of manual chart reviews.
- **Remember, the last GMI or HbA1C of the measurement year is the abstracted value and will determine gap compliance.**

Codes

3044F- **Most recent A1c level < 7%**

3051F- **Most recent A1c level ≥ 7.0% and ＜8.0%**

3052F- **Most recent A1c level ≥ 8.0% and ≤ 9.0%**

3046F- **Most recent A1c level ＞9.0**

Resources

HEDIS MY2024 Technical Specs Vol 2. Pg. 162-171

Eye Exam for Patients with Diabetes (EED) 2024

Medicare, Medicaid and Commercial

Measure Description

The percentage of patients 18-75 with diabetes (type 1 or type 2) who had any one of the following:

- A retinal or dilated eye exam by an optometrist or ophthalmologist in 2024
- A **negative** retinal or dilated eye exam by an optometrist or ophthalmologist in 2023
- Bilateral eye enucleations any time during the patient's history through Dec 31, 2024

Required Exclusions

- Patients who use hospice services or elect to use a hospice benefit any time during 2024
- Patients who passed away any time during 2024
- Patients receiving palliative care or who had an encounter for palliative care any time during 2024

  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 any time during 2024
- Patients 66 years of age and older as of December 31, 2024 with two frailty indications on different dates of service in 2024 and an advanced illness diagnosis on at least two different dates of service or dispensed dementia medication during 2023 or 2024.

Documentation Tips

- Utilize appropriate coding to capture reduce the need for administrative manual chart reviews
- A note prepared by an ophthalmologist or optometrist that indicates that an eye care professional completed a retinal or dilated eye exam and includes the date of service and result.
- Patient reported retinal or dilated eye exams are acceptable and included in the patient's history. The documentation must include: type of eye professional, type of procedure, year and result.
- Eye exams read by artificial intelligence (AI) are acceptable documentation reports.
- Fundus photography with the date of service, result, and evidence an eye care professional reviewed the images meets criteria.
- Positive Hypertensive retinopathy is counted positive for diabetic retinopathy.
- Negative Hypertensive retinopathy is counted negative for diabetic retinopathy.

  Note: Patient blindness is NOT an exclusion for the measure

Common Codes

CPT Codes

67028, 67030-31, 67036, 67039-43, 67101, 67105, 67107-08, 67110, 67113, 67121, 67141, 67145, 67208, 67210, 67218, 67220-21, 67227-28, 952002, 92004, 62012, 92014, 92018-19, 92134, 92201-02, 92225-92228, 92230, 92235, 92240, 92250, 92260, 99203-05, 99213-15, 99242-45, 92225-92228, 92230, 92235, 92240, 92250, 92260, 99203-05, 99213-15, 99242-45

Automated Eye Exam -92229

CPT II Codes– You may code one of these codes based on an eye professional consultation report or patient history documentation

2022F, 2023F, 2024F, 2025F, 2026F, 2033F

3072F– Negative exam for diabetic retinopathy the year prior

Resources

HEDIS MY2024 Technical Specs Vol 2. Pg. 179-188

Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions (FMC) 2024

Medicare

Measure Description

The percentage of ED visits for patients who are 18 years of age and older with multiple high-risk chronic conditions and who received appropriate follow-up care **within seven days of discharge**.

- ED visits must occur between January 1, 2024-December 24, 2024.

Note: The patient may fall into this measure several times throughout the year. This measure is based on visits, not on patients.

Chronic Conditions

Patients are included in the measure who have **two or more** of the following chronic conditions diagnosed during 2023 or 2024 **and** before the ED visit.

- COPD
- Asthma or Unspecified Bronchitis
- Alzheimer's disease and related disorders
- Chronic Kidney Disease
- Depression
- Heart Failure
- Acute myocardial infarction
- Atrial fibrillation
- Stroke and transient ischemic attack

Required Exclusions

- Patients in use hospice services or elect to use a hospice benefit anytime during 2024
- Patients who pass away any time during 2024
- ED visits that result in an inpatient stay
- ED visits that result in admission to an acute or non acute setting on the date of ED discharge or within 7 days of the ED discharge regardless of the principal admission diagnosis

Follow-Up Care

ED follow-up care can include any of the following on the day of discharge through seven days post-discharge (8 days total)

- An outpatient visit
- A telephone visit
- Transitional care management services
- Case management visits
- Complex Care Management Services
- An outpatient or telehealth behavioral health visit
- An outpatient or telehealth behavioral health visit

- An intensive outpatient encounter or partial hospitalization
- An intensive outpatient encounter or partial hospitalization
- A community mental health center visit
- Electroconvulsive therapy
- A telehealth visit
- An observation visit
- A substance use disorder service
- An e-visit or virtual check-in
- A domiciliary or rest home visit

Documentation Tips

Submit claims timely and include the appropriate codes for diagnosis, health conditions and the services provided

Resources

HEDIS MY2024 Technical Specs Vol 2. Pg. 304-308

Kidney Health Evaluation for Patients with Diabetes (KED) 2024

Medicare, Medicaid and Commercial

Measure Description

The percentage of patients 18-85 years of age with diabetes (type 1 and type 2) who received a kidney health evaluation defined by an estimated glomerular filtration rate (eGRF) **and** an urine albumin creatinine ratio (uACR) during 2024 on the same or different dates of service.

Required:

- At least one eGFR during 2024
- At least one uACR during 2024 identified by either of the following:
  - A quantitative urine albumin test and a urine creatinine test with service dates four or less days apart
  - A uACR

Required Exclusions

- Patients receiving palliative care or had an encounter for palliative care anytime during 2024
- Patients who use hospice services or elect to use a hospice benefit any time during 2024
- Patients who passed away anytime during 2024
- Patients with evidence of end stage renal disease (ESRD) or dialysis anytime during the patient's history through Dec 31, 2024

*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 any time during 2024
- Patients 66-80 years of age and older as of December 31, 2024 with two frailty indications on different dates of service in 2024 and an advanced illness diagnosis on at least two different dates of service *or* dispensed dementia medication during 2023 or 2024.
- Patients 81 years of age and older as of December 31, 2024 with two frailty indications on different dates of service during 2024.

Documentation Tips

- **Use CPT codes** to lessen the administrative burden of manual chart reviews.
- Reminder: A urinalysis alone will NOT close this care opportunity.

Common Codes

82043- Quantitative Urine Albumin Lab Test **AND 82570-** Urine Creatinine Lab Test

80047, 80048, 80053, 80069, 82565- Estimated Glomerular Filtration Rate Lab Test

Resources: HEDIS MY2024 Technical Specs Vol 2. Pg. 189-195

Medication Adherence for Cholesterol (MAC) 2024

Measure Description

Percentage of members ages 18 and older who adhere to their cholesterol (statin) medication(s) at least 80% of the time during the measurement period. These claims can be either for the same medication or other medications in the same drug class.

Patients fall into the MAC denominator when there are two pharmacy claims for their cholesterol medication(s) on unique dates of service during 2024.

Required Exclusions

- Hospice or hospice services any time during 2024
- End stage renal disease (ESRD) diagnosis during 2024

Actions

- **Prescription fills are captured via pharmacy claim only**. Only prescriptions filled with a patient's health plan ID card can be used to measure a patient's adherence to their medication.
- Consider writing 90-100 day prescriptions with 3 refills to help improve medication adherence when clinically appropriate
- Ensure the second refill date is on time. The patient will fall into the denominator with this fill, but the treatment begin date will be the date of the 1st fill.
- Assess, document and address clinical barriers for non-adherence with the patient at every visit
- Work medication adherence reports by making outreach to the patients who are coming up due or past due for a refill
- Encourage patients to fill medications using a mail order service, if available
- When clinically appropriate, prescribe low cost generic medications to reduce patient out of pocket overall costs
- Avoid using samples or discount medication programs during the middle of the treatment period. If samples or programs are going to be used, please continue this action through the end of the measurement year.
- Write a discontinuation order for previous scripts when medications are discontinued or doses are changed. The intent of this action is to notify the pharmacy of the discontinuation of the medication.

***The medication adherence measure is adapted from the Medication Adherence Proportion of Days Covered measure that was developed and endorsed by the Pharmacy Quality Alliance (PQA). CMS also uses internal Medicare data to generate the rates for the medication adherence measures.**

Resources: Pharmacy Quality Alliance (PQA) 2023–PQA typically releases new measures specifications from Feb-March 2024. This tip sheet will be updated upon release of those specifications.

Medication Adherence for Diabetes (MAD) 2024

Measure Description

Percentage of patients 18 years of age and older who are adherent to their prescribed diabetic medications at least 80% or more of the time during the treatment period ending in 2024. These claims can be either for the same medication or other medications in the same drug class.

Diabetes medication classes included in this measure include:

- Biguanides
- DPP-4 inhibitors
- Incretin mimetics
- Meglitinides
- SGLT2 inhibitors
- Sulfonylureas
- Thiazolidinediones

Patients fall into the MAD denominator when there are two pharmacy claims for their diabetic medication(s) on unique dates of service during 2024.

Required Exclusions

- Hospice or hospice services any time during 2024
- End stage renal disease (ESRD) diagnosis during 2024
- One or more prescriptions for insulin during the treatment period

Actions

- **Prescription fills are captured via pharmacy claim only**. Only prescriptions filled with a patient's health plan ID card can be used to measure a patient's adherence to their medication.
- Consider writing 90-100 day prescriptions with 3 refills to help improve medication adherence when clinically appropriate
- Ensure the second refill date is on time. The patient will fall into the denominator with this fill, but the treatment begin date will be the date of the 1st fill.
- Assess, document and address clinical barriers for non-adherence with the patient at every visit
- Work medication adherence reports by making outreach to the patients who are coming up due or past due for a refill
- Encourage patients to fill medications using a mail order service, if available
- When clinically appropriate, prescribe low cost generic medications to reduce patient out of pocket overall costs
- Avoid using samples or discount medication programs during the middle of the treatment period. If samples or programs are going to be used, please continue this action through the end of the measurement year.
- Write a discontinuation order for previous scripts when medications are discontinued or doses are changed. The intent of this action is to notify the pharmacy of the discontinuation of the medication

***The medication adherence measure is adapted from the Medication Adherence Proportion of Days Covered measure that was developed and endorsed by the Pharmacy Quality Alliance (PQA). CMS uses Medicare data to generate the rates for the medication adherence measures.**

Resources

Pharmacy Quality Alliance (PQA) 2023–PQA typically releases new measures specifications from Feb-March 2024. This tip sheet will be updated upon release of those specifications.

Medication Adherence for Hypertension (MAH) 2024

Measure Description

Percentage of patients 18 years of age and older with a blood pressure prescription who fill their prescription at least 80% or more of the time during the treatment period ending in 2024.

These claims can be either for the same medication or other medications in the same drug class.

Prescriptions include ACE inhibitors (angiotensin-converting enzymes), ARBs (angiotensin receptor blockers) and DRIs (direct renin inhibitors). Patients fall into the MAH denominator when there are two pharmacy claims for their blood pressure medication(s) on unique dates of service during 2023.

Required Exclusions

- Hospice or hospice services any time during 2024
- End stage renal disease (ESRD) diagnosis during 2024
- One or more prescriptions for sacubitril/valsartan during the treatment period

Actions

- **Prescription fills are captured via pharmacy claim only**. Only prescriptions filled with a patient's health plan ID card can be used to measure a patient's adherence to their medication.
- Consider writing 90-100 day prescriptions with 3 refills to help improve medication adherence when clinically appropriate
- Ensure the second refill date is on time. The patient will fall into the denominator with this fill, but the treatment begin date will be the date of the 1st fill.
- Assess, document and address clinical barriers for non-adherence with the patient at every visit
- Work medication adherence reports by making outreach to the patients who are coming up due or past due for a refill
- Encourage patients to fill medications using a mail order service, if available
- When clinically appropriate, prescribe low cost generic medications to reduce patient out of pocket overall costs
- Avoid using samples or discount medication programs during the middle of the treatment period. If samples or programs are going to be used, please continue this action through the end of the measurement year.
- Write a discontinuation order for previous scripts when medications are discontinued or doses are changed. The intent of this action is to notify the pharmacy of the discontinuation of the medication.

***The medication adherence measure is adapted from the Medication Adherence Proportion of Days Covered measure that was developed and endorsed by the Pharmacy Quality Alliance (PQA). CMS uses Medicare data to generate the rates for the medication adherence measures.**

Resources

Pharmacy Quality Alliance (PQA) 2023–PQA typically releases new measures specifications from Feb-March 2024. This tip sheet will be updated upon release of those specifications.

Medication Therapy Management Program Completion Rate for Comprehensive Medication Review 2024

Measure Description

Percentage of patients 18 or older who were enrolled in a medication therapy management (MTM) program for at least 60 days during 2024 and received a comprehensive medication review (CMR).

Required Exclusions

- Patients in hospice or using hospice services during 2024
- Patients who were enrolled in an MTM program for less than 60 days in 2024 and didn't receive a CMR.

Measure Tips

- Discuss the benefits of completing CMR with your patients at every visit
- Let patients know what to expect and other benefits from the program
    - A pharmacists makes outreach via telephone to discuss their medications
    - The patient will receive documentation of the discussion with recommendations such as:
        - Taking the prescribed medications
        - Understanding the benefits of the medications
        - Side effect education to lower the risk of adverse reactions
- Continue to educate patients on taking medications as prescribed
- Develop a process to make outreach to encourage CMR

Resource

2023. Pharmacy Quality Alliance–PQA typically releases new measures specifications from Feb-March 2024. This tip sheet will be updated upon release of those specifications.

Osteoporosis Management in Women with a Fracture (OMW) 2024

Medicare

Measure Description

The percentage of female patients 67-85 years of age as of December 31, 2024 who suffered a fracture and who had either a bone mineral density test (BMD) or prescription for a drug to treat osteoporosis in the six months after the fracture.

The measurement intake period for this measure, which is used to capture the first fracture, is July 1, 2023-June 30, 2024.

Required Exclusions

- Patients use hospice services or elect to use a hospice benefit any time during 2024
- Patients who received palliative care or who had an encounter for palliative care any time during July 1, 2023-December 31, 2024.
- Patients who passed away any time during 2024
- Patients who had a bone mineral density test during the 24 months prior to the fracture
- Patients who had osteoporosis therapy or a prescription to treat osteoporosis during the 12 months prior to the fracture

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

- Patients 67 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 any time during 2024
- Patients 67-80 years of age and older as of December 31, 2024 with two frailty indications on different dates of service in 2024 and advanced illness diagnosis on at least two different dates of service *or* dispensed dementia medication during 2023 or 2024.
- Patients 81 years of age and older as of December 31, 2024 with two frailty indications on different dates of service during 2024.

Documentation Tips

- **Use CPT and SNOMED codes** to lessen the administrative burden of manual chart reviews.
- Patient reported BMD tests are acceptable and can be retrieved via supplemental data. This information must be taken as part of the patient's history and must include the month and year of the test.
- If the fracture resulted in an inpatient stay, a BMD test or long acting osteoporosis therapy administered during the stay will close the care opportunity. Please have a copy within the outpatient medical record.
- Osteoporosis medication therapy is identified through pharmacy data; therefore, these medications must be filled using the member's Part D prescription drug benefit.

Documentation Tips Continued...

- BMD reports located in the patient's outpatient medical record will close the care opportunity as long as the test was completed within the appropriate time frame.
- Fractures of finger, toe, face and skull are **not** included in this measure.

Common Codes

CPT Codes- Bone Mineral Density Tests

76977- Ultrasound bone density peripheral site

77078- CT bone mineral density axial skeleton

77080- DXA axial skeleton

77081- DXA appendicular skeleton

77085- DXA axial skeleton, (hips, pelvis, spine) including vertebral fracture assessment

SNOWMED Codes- Bone Mineral Density Tests

22059005, 312681000, 385342005, 391057001, 391058006, 391059003, 391060008, 391061007, 391062000, 391063005, 391064004, 391065003, 391066002, 391069009, 391070005, 391071009, 391072002, 391073007, 391074001, 391076004, 391078003, 391079006, 391080009, 391081008, 391082001, 440083004, 440099005, 440100002, 449781000, 707218004, 4211000179102

HCPCS- Osteoporosis Medication Therapy

J0897, J1740, J3110, J3111, J3489

Plan All-Cause Readmissions 2024

Medicare, Medicaid and Commercial

Measure Description

For patients ages 18 and older, the number of acute inpatient and observation stays during 2024 that were followed by an **unplanned** acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission.

A *lower* rate indicates a better score for this measure.

This measure is based on the number of discharges, not patients. A patient may fall into this measure several times in 2024.

For Medicaid and Commercial patients – The included age range is 18–64 only.

Required Exclusions

- Patients who use hospice services or elect to use a hospice benefit any time in 2024
- Patients who passed away during the inpatient stay
- Patients with a principal diagnosis of pregnancy on the discharge claim
- Principal diagnosis of a condition originating in the perinatal period on the discharge claim
- Acute hospitalizations where the discharge claims has a diagnosis for:
    - Chemotherapy maintenance
    - Principle diagnosis of rehabilitation
    - Organ transplant
    - Potentially planned procedure without a principal acute diagnosis
- Patients who were admitted and discharged on the same day

Important Measure Notes

- This measure is based on claims and encounters. Supplemental data may be submitted to verify exclusion criteria.
- An acute discharge can be from any type of facility, including behavioral health facilities.
- A lower readmission rate and comprehensive diagnosis documentation will drive better scores for this measure.
- Patients with multiple comorbidities are expected to return post inpatient or observation discharge at a higher rate. Ensure all suspect conditions are appropriately identified in the patient's medical record and claims.
- Encourage members to engage in palliative care or hospice programs as appropriate to drive lower readmissions for high risk patients to reduce hospitalizations.

Important Measure Notes Continued...

- Remember to document Transition of Care Indicators, including medication reconciliation (Code 111F).
- Discharges are excluded if a direct transfer takes place after Dec. 1, 2024

Resources

HEDIS MY2024 Technical Specs Vol 2. Pg.448-461

Statin Therapy for Patients with Cardiovascular Disease (SPC) 2024

Medicare, Medicaid and Commercial

Measure Description

The percentage of males 21–75 years of age and females 40–75 years of age during 2024 who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and met the following criteria. The following rates are reported:

1) Received Statin Therapy. Patients who were dispensed at least one high-intensity or moderate-intensity statin medication anytime during 2024.
2) Statin Adherence 80%. Patients who remained on a high-intensity or moderate-intensity statin medication for at least 80% of the treatment period.

**CMS Medicare Advantage Stars only includes the sub-measure 'Received statin therapy'.

Required Exclusions

- Patients use hospice services or elect to use a hospice benefit any time during 2024
- Patients receiving palliative care or had an encounter for palliative care any time during 2024
- Patients who have passed away anytime during 2024
- Myalgia, myositis, myopathy or rhabdomyolysis diagnosis any time during 2024
- Cirrhosis any time during 2023 or 2024
- End-stage renal disease (ESRD) any time in 2023 or 2024
- Dialysis during 2023 or 2024
- Patients with a diagnosis of pregnancy, in-vitro fertilization, or dispensed at least one prescription for clomiphene anytime in 2023 or 2024

*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 any time during 2024
- Patients 66 years of age and older as of December 31, 2024 with two frailty indications on different dates of service in 2024 and an advanced illness diagnosis on at least two different dates of service *or* dispensed dementia medication during 2023 or 2024.

Documentation and Measure Tips

- Prescribe at least one high-intensity or moderate-intensity statin medication during 2024 to patients diagnosed with ASCVD
- Intermittent dosing will close the gap for the MA population. Ex. 2x/week

- Instruct patients to fill prescriptions using their pharmacy benefit. Claims filed through pharmacy discount programs, cash claims, and medication samples do not count. Gap closure is dependent on pharmacy claims.
- Once patients demonstrate they can tolerate statin therapy, encourage them to obtain 90-day supplies at their pharmacy.
- In order to exclude patients from this measure who cannot tolerate statin medications, a claim MUST be submitted annually using the appropriate ICD-10-CM code for the above exclusions.
- Patients who also have diabetes fall into the SUPD measure. This measure may overlap. Remember with the SPC measure, the patient must have a **moderate-high intensity statin**. Prescribing this statin will close both gaps.

Drug Category Medications: High-intensity statin therapy

Atorvastatin 40–80 mg
Amlodipine-atorvastatin 40–80 mg
Rosuvastatin 20–40 mg
Simvastatin 80 mg
Ezetimibe-simvastatin 80 mg

Drug Category Medications: Moderate-Intensity Statin Therapy

Atorvastatin 10–20 mg
Amlodipine-atorvastatin 10–20 mg
Rosuvastatin 5–10 mg
Simvastatin 20–40 mg
Ezetimibe-simvastatin 20–40 mg
Pravastatin 40–80 mg
Lovastatin 40 mg
Fluvastatin 40–80 mg
Pitavastatin 1–4 mg

Resources

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Statin Use in Persons with Diabetes (SUPD) 2024

Measure Description

Percentage of patients with diabetes, ages 40–75, who fill at least one statin or statin combination medication, in any strength or dose, using their Part D benefit during 2024.

*Patients with diabetes are defined as those who have at least 2 fills of diabetes medications during the measurement year.

Required Exclusions

Patients are excluded from the measure if they meet any of the following during 2024:

- Patients in hospice or using hospice services
- End-stage renal disease (ESRD)
- Beneficiaries with rhabdomyolysis or myopathy
- Pregnancy, lactation or fertility
- Cirrhosis
- Pre-diabetes
- Polycystic ovary syndrome (PCOS)

Actions

- In order to exclude patients from this measure who cannot tolerate statin medications, a claim MUST be submitted annually using the appropriate ICD-10-CM code.
- Prescriptions must be filled through Part D insurance to close this care opportunity.
- Prescribe at least one statin medication during 2024 to patients diagnosed with diabetes. Remember, medication samples are not captured as a billed pharmacy claim and do not close the SUPD gap.
- Patients who also have ASCVD fall into the SPC measure. This measure may overlap. Remember with the SPC measure, the patient must have a moderate-high intensity statin.
- Consider intermittent dosing ie. QOD, 3X/week, etc., a lower dose statin than previously attempted
- Consider 90-100 day supplies

Exclusion Codes

Cirrhosis– K70.30, K70.31, K71.7, K74.3, K74.4, K74.5, K74.60, K74.69

Pregnancy and/or lactation– O00.101, O00.102, O00.109, O00.111, O00.112, O00.119, O00.201, O00.202, O00.209, etc.

Polycystic Ovarian Syndrome– E28.2

Prediabetes– R73.03

Other abnormal blood glucose– R73.09

Drug induced myopathy– G72.0

Other specified myopathies– G72.89

Myopathy, unspecified– G72.9

Other myositis– M60.80, M60.819, M60.829, M60.839, M60.849, M60.859, M60.869, M60.879

Myositis, unspecified– M60.9

Rhabdomyolysis– M62.82

***Adverse effect of antihyperlipidemic and antiarteriosclerotic drugs, initial encounter–** T46.6X5A

*The condition must be reflected as a 'history of' in the medical record and it does not need to occur during the same year the code is billed. These exclusion codes do not guarantee payment and are only used to close the SUPD measure.

Resources

Pharmacy Quality Alliance (PQA) 2023–PQA typically releases new measures specifications from Feb-March 2024. This tip sheet will be updated upon release of those specifications.

Transitions of Care (TRC) - Medication Reconciliation Post-Discharge 2024

Medicare

Measure Description

The percentage of discharges between Jan. 1, 2024-Dec. 1, 2024, for patients 18 years of age and older, who had a medication reconciliation performed on the date of discharge thru 30 days post discharge (31 days total).

Provider Specialties Allowed: prescribing practitioner, clinical pharmacist, physician assistant or registered nurse

Required Exclusions

- Patients using hospice services or elect to use a hospice benefit any time during 2024
- Patients who passed away any time during 2024

Documentation Tips

- Documentation in the outpatient medical record must include evidence of medication reconciliation and the date when it was performed. Any of the following meet criteria:
    - Documentation of the current medications with a notation that the provider reconciled the current and discharge medications.
    - Documentation of the current medications with a notation that references the discharge medications (e.g., no changes in medications since discharge, same medications at discharge, discontinue all discharge medications).
    - Documentation of the member's current medications with a notation that the discharge medications were reviewed.
    - Documentation of a current medication list, a discharge medication list and notation that both lists were reviewed on the same date of service.
    - Documentation of the current medications with evidence that the member was seen for post-discharge hospital follow-up with evidence of medication reconciliation or review. Evidence that the member was seen for post- discharge hospital follow-up requires documentation that indicates the provider was aware of the member's hospitalization or discharge.
    - Documentation in the discharge summary that the discharge medication was reconciled with the most recent medication list in the outpatient medical record. There must be evidence that the discharge summary was filed in the outpatient chart on the date of discharge through 30 days after discharge (31 total days).
    - Notation that no medications were prescribed or ordered upon discharge.
- Use the appropriate **CPT/CPT II codes** to capture medication reconciliation post-discharge and to reduce the burden of administrative chart review
- Develop a process to gather timely admission/discharge information for your patients.
- Medication reconciliation can be performed without the patient present.

Non-compliant documentation hint

- Documentation of post-op/surgery follow-up *without a reference* to hospitalization, admission or inpatient stay does not meet compliance for medication reconciliation post-discharge numerator

Important Measure Note

This measure consists of 4 different rates:

1) **Notification of Inpatient Admission** - documentation of receipt of notification of inpatient admission on the day of admission through 2 days after admission (3 days total)
2) **Receipt of Discharge Information**-Documentation of receipt of discharge information on the day of discharge through 2 days after the discharge (3 total days).
3) **Patient Engagement After Inpatient Discharge**-Documentation of patient engagement (office visits, visits to the home, telehealth) provided within 30 days after discharge.
4) **Medication Reconciliation Post-Discharge-**Documentation of medication reconciliation on the date of discharge through 30 days after discharge (31 total days).

Common Codes for Medication Reconciliation

CPT®/CPT II: 1111F, 99483, 99495, 99496

Resources

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PRIVIA HEALTH

From Volume To Value,
With Care.

Transitions of Care (TRC) - Patient Engagement After Inpatient Discharge 2024

Medicare

Measure Description

The percentage of discharges between Jan. 1, 2024-Dec. 1, 2024, for patients 18 years of age and older, who had patient engagement documented within 30 days of discharge. Patient engagement can be met by any of the following criteria: an outpatient visit, a telephone visit, transitional care management services, an e-visit or virtual check in.

*Note: Patient engagement **cannot** occur on the day of discharge.

Required Exclusions

- Patients using hospice or elect to use a hospice benefit any time during 2024
- Patients who passed away any time during 2024

Documentation Tips

- Use the appropriate **CPT/CPT II/HCPCS codes** to capture engagement post-discharge and to reduce the burden of administrative chart review
- Remember that a medication reconciliation will need to be completed on this patient as well for the TRC measure. Code appropriately. See tip sheet: TRC- MRP for more information.
- Documentation indicating a live conversation occurred with the patient will meet criteria, regardless of provider type. For example, medical assistants and registered nurses may perform the patient engagement; however, please note the scope of practice and assessment capabilities. Remember, the goal is to keep the patient from being readmitted within 30 days of discharge.
- If the patient is unable to communicate with the practitioner, interaction between the patient's caregiver and the provider meets criteria.
- Develop a process to gather timely admission/discharge information for your patients.

Important Measure Note

This measure consists of 4 different rates:

1) **Notification of Inpatient Admission** - documentation of receipt of notification of inpatient admission on the day of admission through 2 days after admission (3 days total)
2) **Receipt of Discharge Information**-Documentation of receipt of discharge information on the day of discharge through 2 days after the discharge (3 total days).
3) **Patient Engagement After Inpatient Discharge**-Documentation of patient engagement (office visits, visits to the home, telehealth) provided within 30 days after discharge.
4) **Medication Reconciliation Post-Discharge-**Documentation of medication reconciliation on the date of discharge through 30 days after discharge (31 total days).

Common Codes

Outpatient Visits

- ➔ **CPT®/CPT II :** 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99429, 99455, 99456, 99483
- ➔ **HCPCS:** G0402, G0438, G0439, G0463, T1015

Telephone Visits

- ➔ **CPT®/CPT II :** 98966, 98967, 98968, 99441, 99442, 99443

Online Assessment (e-visit/virtual check-in)

- ➔ **CPT®/CPT II :** 98970, 98971, 98972, 99421, 99422, 99423, 99457
- ➔ **HCPCS :** G0071, G2010, G2012

Transitional Care Management

- ➔ **CPT®/CPT II :** 99495, 99496

Resources

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PRIVIA HEALTH

Additional Care Management Services

Transitional Care Management (TCM)

What is TCM?

Transitional Care Management appointments are one form of post-discharge appointment that helps to drive better health outcomes. Research supports that early initial outpatient follow-up favorably impacts readmissions and helps to manage total cost of care.

The best practice for post discharge appointments is that they occur within 5 days of discharge.

TCM Components

- An Interactive Contact
- Certain Non-Face-to-Face Services
- Face-to-Face Visit

Telehealth Services

You may furnish CPT codes 99495 and 99496 via telehealth. Medicare pays for a limited number of Part B services a physician or practitioner furnishes to an eligible beneficiary via a telecommunications system. Using eligible telehealth services substitutes for an in-person encounter.

Billing TCM Services

This list provides billing TCM services information

- Only one health care professional may report TCM services.
- Report services once per beneficiary during the TCM period. The same health care professional may discharge the beneficiary from the hospital, report hospital or observation discharge services, and bill TCM services. The required face-to-face visit may not take place on the same day you report discharge day management services.
- Report reasonable and necessary evaluation and management (E/M) services (except the required face-to-face visit) to manage the beneficiary's clinical issues separately.
- You may not bill TCM services and services within a post-operative global surgery period (Medicare does not pay TCM services if any of the 30-day TCM period falls within a global surgery period for a procedure code billed by the same practitioner.

Chronic Care Management (CCM)

What is CCM?

The Medicare Chronic Care Management program was established in January of 2015 by CMS. The goal of the program is to provide financial compensation to providers for delivering proactive care management to eligible, chronically ill patients outside of regularly scheduled face-to-face office visits to better manage their chronic medical conditions.

As of January 2017, Medicare has expanded their coverage for providing the CCM service, to include enhanced reimbursement amounts for incremental non face-to-face time spent with a patient during a given calendar month.

Who is Eligible for CCM?

Medicare Advantage patients diagnosed with 2 or more chronic conditions, that are:

- Last 12 months or until the patient expires.
- Place patients at risk of exacerbation, functional decline, or death.

Traditional Medicare patients can also be referred by their provider.

Program Recommendation and Referral

We recommend enrolling patients with unmanaged chronic conditions.

Privia Care Partners will periodically send lists of priority patients who would benefit from additional care management of chronic medical conditions.

Provider Responsibility

The provider should discuss program with patient, obtain and document patient consent in a patient case in the EHR. Providers should share clinical documentation with the RN Care Manager.

RN Care Manager Responsibility

The RN Care Manager will connect with their patients, complete a health assessment, and support goal development. They will educate, coach and motivate patients to adhere to treatment and action plans. Comprehensive intake and progress reports will be shared with patients and PCP. The RN CM will consult with an interdisciplinary care team, as needed, while maintaining a single point of contact for the patient.

Virtual Behavioral Health Collaborative Care

What is Collaborative Care Management (CoCM)?

Collaborative Care is a healthcare philosophy that integrates the provision of behavioral health and substance use services in primary care. The goal is to augment primary care by encouraging and facilitating health promotion and the prevention of illness, by including access to the skills of a range of health care professionals. The collaborative care team consists of PCP, consulting psychiatrist, behavioral care manager and patient.

Privia Care Partners offers virtual collaborative care via Mindoula at participating provider locations.

Who is Eligible for CoCM?

Patient with Medicare and most commercial insurance that fit any of the following categories:

1. Positive PHQ2/9 scores or
2. Positive AUDIT-C score suggesting alcohol use disorder
3. Experiencing depression or anxiety as exhibited by anxiety, flashbacks, mood lability or grief, or
4. Have medical conditions that are often associated with BH needs, ie HTN, DM, CHF, Obesity to name a few, or
5. Any patient for whom you want a second opinion and/or additional resources

How are Patients identified for CoCM?

Patients can be identified for referral when:

1. The provider identifies who would benefit from Collaborative Care and sends a referral
2. The Quality Care Coordination team identifies a patient during TCM calls and sends a patient case to the PCP to review and refer.
3. CCM RN Care Manager identifies a patient with a need and sends the patient case to PCP to review.

Patients may receive a text or email from an external organization that assesses patient needs and sends results to virtual Collaborative Care teams.

Program Recommendation and Referral

Virtual CoCM: The PCP submits a referral in their EHR and the CoCM team will contact the patient within 48hrs of referral.

Patient Financial Responsibility

The program is covered by Medicare and most commercial insurances. The patient's usual copay will apply, but some plans may elect to waive the copay.

Provider Responsibility

The provider is responsible for:

- Documenting verbal consent from the patient.
- Placing an order for CoCM
- Reviewing reports
- Approving treatment plans
- Prescribing medications or modifying diagnoses as appropriate based on suggestions from the consulting psychiatrist.
- Discharging the patient from CoCM.

Behavioral Health Care Manager Responsibility

The Behavioral Care Manager will provide brief therapeutic interventions, such as behavioral activation, motivational interviewing, and problem-solving therapy. They will also research, suggest, schedule, and confirm appointments as recommended by the consulting psychiatrist and requested by the patient. The BCM will also document the minute of patient contact each month to support proper billing.

PRIVIA HEALTH

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

Medicare Advantage & Prescription Drug Plan (MA PDP)

This survey is used to measure patients' perception of their health plan and quality of health care services they receive from providers. Results from this survey provide information to Medicare beneficiaries on the quality of health services provided through Medicare Advantage and Part D programs. Consumer evaluations of health care, such as those collected through the Medicare Advantage and Part D CAHPS® surveys, measure important aspects of a patient's experience that cannot be assessed by other means.

Timeline & Methodology

Survey	Timeline	Sample Size (Minimum)	Methodology
Medicare Advantage & Prescription Drug Plan CAHPS (MAPDP)	Late February/ March - May	800 (H-Plans are allowed to oversample)	Mail & Telephonic

CAHPS is responsible for approximately 30% of your overall Star Rating.

PRIVIA HEALTH

2023 CAHPS Survey for Medicare Advantage

1. Our records show that in 2023 your health services were covered by the plan named on the back page. Is that right?

- ☐ Yes →**If Yes, Go to Question 3**
- ☐ No

2. Please write below the name of the health plan you had in 2023 and complete the rest of the survey based on the experiences you had with that plan.
(Please print)

_____

Your Health Care in the Last 6 Months

These questions ask about your own health care from a clinic, emergency room, or doctor's office. This includes care you got in person, by phone, or by video.

3. In the last 6 months, did you have an illness, injury, or condition that needed care right away?

- ☐ Yes
- ☐ No →**If No, Go to Question 5**

4. In the last 6 months, when you needed care right away, how often did you get care as soon as you needed?

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

5. In the last 6 months, did you make any in-person, phone, or video appointments for a check-up or routine care?

- ☐ Yes
- ☐ No →**If No, Go to Question 7**

6. In the last 6 months, how often did you get an appointment for a check-up or routine care as soon as you needed?

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

7. In the last 6 months, not counting the times you went to an emergency room, how many times did you get health care for yourself in person, by phone, or by video?

- ☐ None →**If None, Go to Question 9**
- ☐ 1 time
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5 to 9
- ☐ 10 or more times

8. Wait time includes time spent in the waiting room and exam room. In the last 6 months, how often did you see the person you came to see within 15 minutes of your appointment time?

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

PRIVIA HEALTH

9. Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 6 months?

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

10. In the last 6 months, how often was it easy to get the care, tests, or treatment you needed?

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

Your Personal Doctor

11. A personal doctor is the one you would talk to if you need a check-up, want advice about a health problem, or get sick or hurt. Do you have a personal doctor?

- ☐ Yes
- ☐ No **→If No, Go to Question 27**

12. In the last 6 months, how many times did you have an in-person, phone, or video visit with your personal doctor about your health?

- ☐ None **→If None, Go to Question 27**
- ☐ 1 time
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5 to 9
- ☐ 10 or more times

13. In the last 6 months, how often did your personal doctor explain things in a way that was easy to understand?

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

14. In the last 6 months, how often did your personal doctor listen carefully to you?

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

PRIVIA HEALTH

15. In the last 6 months, how often did your personal doctor show respect for what you had to say?

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

16. In the last 6 months, how often did your personal doctor spend enough time with you?

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

17. Using any number from 0 to 10, where 0 is the worst personal doctor possible and 10 is the best personal doctor possible, what number would you use to rate your personal doctor?

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

18. In the last 6 months, when you talked with your personal doctor during a scheduled appointment, how often did he or she have your medical records or other information about your care?

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

19. In the last 6 months, did your personal doctor order a blood test, x-ray or other test for you?

- ☐ Yes
- ☐ No **→If No, Go to Question 22**

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

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

21. In the last 6 months, when your personal doctor ordered a blood test, x-ray or other test for you, how often did you get those results as soon as you needed them?

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

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

- ☐ Yes
- ☐ No → **If No, Go to Question 24**

23. In the last 6 months, how often did you and your personal doctor talk about all the prescription medicines you were taking?

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

24. In the last 6 months, did you get care from more than one kind of health care provider or use more than one kind of health care service?

- ☐ Yes
- ☐ No → **If No, Go to Question 27**

25. In the last 6 months, did you need help from anyone in your personal doctor's office to manage your care among these different providers and services?

- ☐ Yes
- ☐ No → **If No, Go to Question 27**

26. In the last 6 months, did you get the help you needed from your personal doctor's office to manage your care among these different providers and services?

- ☐ Yes, definitely
- ☐ Yes, somewhat
- ☐ No

Getting Health Care From Specialists

When you answer the next questions, include the care you got in person, by phone, or by video.

27. Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors, and other doctors who specialize in one area of health care. Is your personal doctor a specialist?

- ☐ Yes → **If Yes, Please include your personal doctor as you answer these questions about specialists**
- ☐ No

28. In the last 6 months, did you make any appointments with a specialist?

- ☐ Yes
- ☐ No → **If No, Go to Question 33**

29. In the last 6 months, how often did you get an appointment with a specialist as soon as you needed?

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

30. How many specialists have you talked to in the last 6 months?

- ☐ None → **If None, Go to Question 33**
- ☐ 1 specialist
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5 or more specialists

PRIVIA HEALTH

31. We want to know your rating of the specialist you talked to most often in the last 6 months. Using any number from 0 to 10, where 0 is the worst specialist possible and 10 is the best specialist possible, what number would you use to rate that specialist?

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

32. In the last 6 months, how often did your personal doctor seem informed and up-to-date about the care you got from specialists?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always
- ☐ I do not have a personal doctor
- ☐ I have not talked with my personal doctor in the last 6 months
- ☐ My personal doctor is a specialist

Your Health Plan

33. In the last 6 months, did you get information or help from your health plan's customer service?

- ☐ Yes
- ☐ No **→If No, Go to Question 36**

34. In the last 6 months, how often did your health plan's customer service give you the information or help you needed?

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

35. In the last 6 months, how often did your health plan's customer service staff treat you with courtesy and respect?

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

36. In the last 6 months, did your health plan give you any forms to fill out?

- ☐ Yes
- ☐ No **→If No, Go to Question 38**

37. In the last 6 months, how often were the forms from your health plan easy to fill out?

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

PRIVIA HEALTH

38. Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your health plan?

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

39. A co-pay is the amount of money you pay at the time of a visit to a doctor's office or clinic. In the last 6 months, did your health plan offer to lower the amount of your co-pay because you have a health condition (like high blood pressure)?

- ☐ Yes
- ☐ No
- ☐ I am not sure
- ☐ I do not have a co-pay
- ☐ I do not have a health condition
- ☐ I was offered a lower co-pay for another reason

40. Your health plan benefits are the types of health care and services you can get under the plan. In the last 6 months, did your health plan offer you extra benefits because you have a health condition (like high blood pressure)?

- ☐ Yes
- ☐ No
- ☐ I am not sure
- ☐ I do not have a health condition
- ☐ I was offered extra benefits for another reason

About You

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

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

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

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

PRIVIA HEALTH

43. What language do you mainly speak at home?

- ☐ English
- ☐ Spanish
- ☐ Chinese
- ☐ Korean
- ☐ Tagalog
- ☐ Vietnamese
- ☐ Some other language
  ↓
  Please print:_____

44. In the last 6 months, did you spend one or more nights in a hospital?

- ☐ Yes
- ☐ No

45. In the last 6 months, how often was it easy to get the medicines your doctor prescribed?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always
- ☐ My doctor did not prescribe any medicines for me in the last 6 months

46. Do you have insurance that pays part or all of the cost of your prescription medicines?

- ☐ Yes
- ☐ No
- ☐ Don't know

47. In the last 6 months, did you delay or not fill a prescription because you felt you could not afford it?

- ☐ Yes
- ☐ No
- ☐ My doctor did not prescribe any medicines for me in the last 6 months

48. In the last 6 months, did anyone from a clinic, emergency room, or doctor's office where you got care treat you in an unfair or insensitive way because of any of the following things about you?

	Yes	No
a. Health condition	☐	☐
b. Disability	☐	☐
c. Age	☐	☐
d. Culture or religion	☐	☐
e. Language or accent	☐	☐
f. Race or ethnicity	☐	☐
g. Sex (female or male)	☐	☐
h. Sexual orientation	☐	☐
i. Gender or gender identity	☐	☐
j. Income	☐	☐

49. Has a doctor ever told you that you had any of the following conditions?

	Yes	No
a. A heart attack?	☐	☐
b. Angina or coronary heart disease?	☐	☐
c. Hypertension or high blood pressure?	☐	☐
d. Cancer, other than skin cancer?	☐	☐
e. Emphysema, asthma, or COPD (chronic obstructive pulmonary disease)?	☐	☐
f. Any kind of diabetes or high blood sugar?	☐	☐

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

- ☐ Yes
- ☐ No

51. Do you have difficulty dressing or bathing?

- ☐ Yes
- ☐ No

52. 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

53. Have you had a flu shot since July 1, 2023?

- ☐ Yes
- ☐ No
- ☐ Don't know

54. Have you ever had one or more pneumonia shots? Two shots are usually given in a person's lifetime and these are different from a flu shot. It is also called the pneumococcal vaccine.

- ☐ Yes
- ☐ No
- ☐ Don't know

55. Do you now smoke cigarettes or use tobacco every day, some days, or not at all?

- ☐ Every day
- ☐ Some days
- ☐ Not at all **→If Not at all, Go to Question 57**
- ☐ Don't know **→If Don't know, Go to Question 57**

56. In the last 6 months, how often were you advised to quit smoking or using tobacco by a doctor or other health provider?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always
- ☐ I had no in-person, phone, or video visits in the last 6 months

PRIVIA HEALTH

57. 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

58. Are you of Hispanic or Latino origin or descent?

- ☐ Yes, Hispanic or Latino
- ☐ No, not Hispanic or Latino

59. What is your race? Please mark one or more.

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African-American
- ☐ Native Hawaiian or other Pacific Islander
- ☐ White

60. How many people live in your household now, including yourself?

- ☐ 1 person
- ☐ 2 to 3 people
- ☐ 4 or more people

61. Do you ever use the internet at home?

- ☐ Yes
- ☐ No

62. May the Medicare Program follow up with you to learn more about your health care, or to invite you to a group discussion or interview on topics related to health care?

- ☐ Yes
- ☐ No

63. Did someone help you complete this survey?

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

64. How did that person help you? Please 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

Thank you.

Resource: https://ma-pdpcahps.org/

CAHPS: Care Coordination 2023

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 needed 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 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

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CAHPS: Access to Care 2023

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:

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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

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PRIVIA HEALTH

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

Annual flu vaccine and pneumonia vaccine

Percent of sampled patients who received an influenza vaccination since the prior July and the percent of sampled patients who reported ever having received a pneumococcal vaccine.

- Ask patients if they received flu and pneumonia vaccines

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 falls

PRIVIA HEALTH

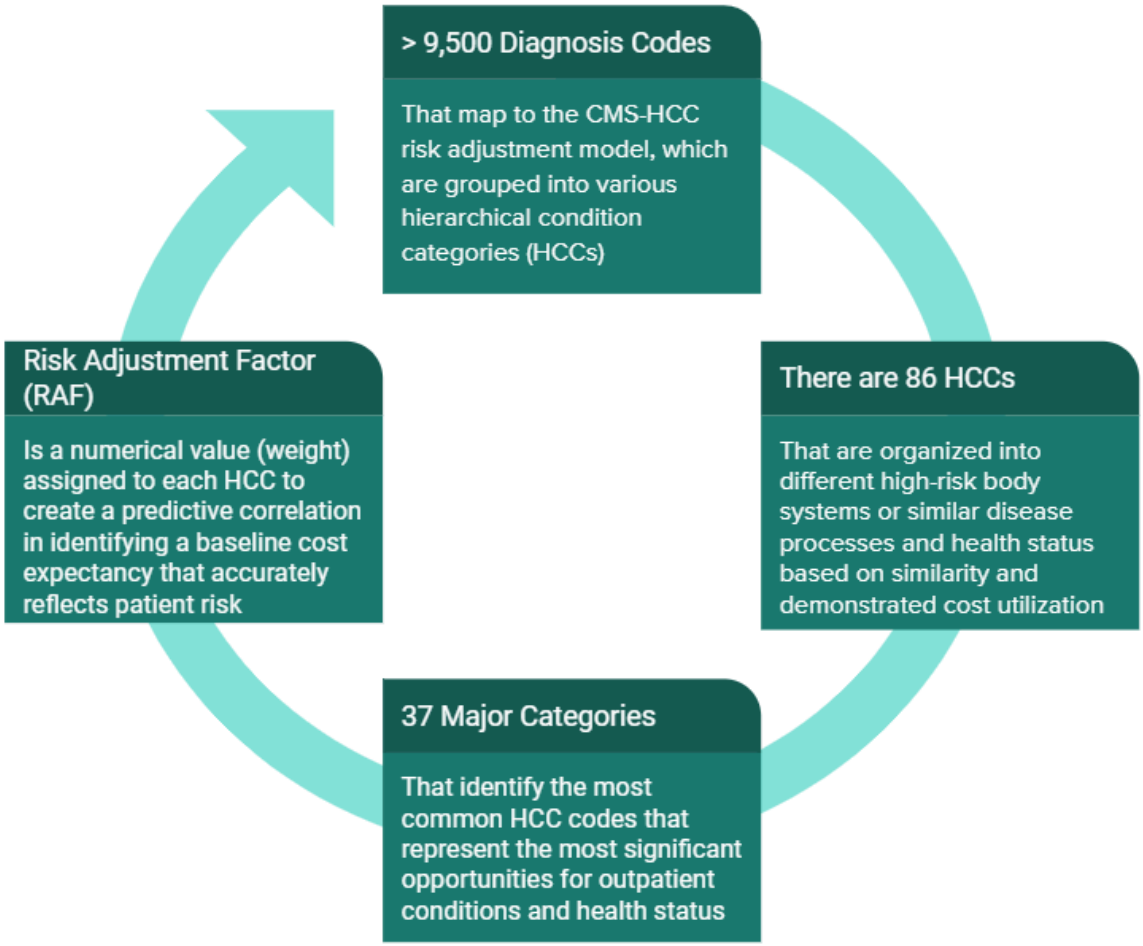
Risk Adjustment

What is Risk Adjustment

Risk Adjustment (RA) is an essential methodology created by The Centers for Medicare and Medicaid (CMS) to reimburse health plans based on the overall 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 for Medicaid and commercial Value-Based Care programs, so it is important to use the strategies noted here for the entire patient population.

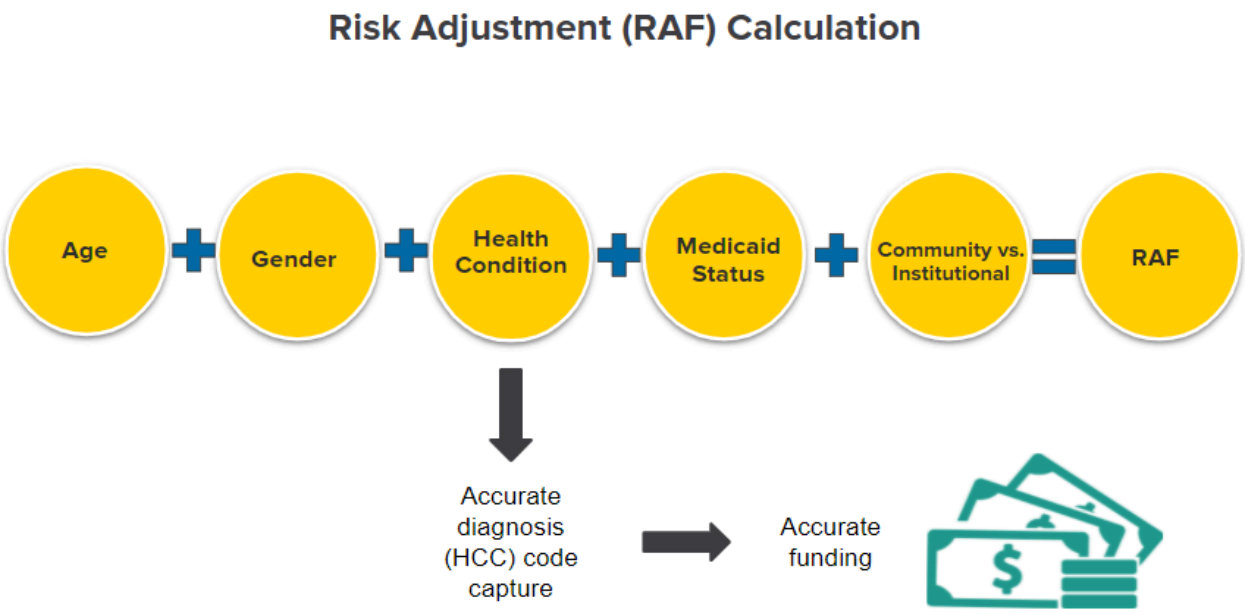
What is an HCC?

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



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 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 an HCC, as well as demographic factors such as Medicaid full benefit dual eligibility status (defined as having at least one month of Medicaid dual eligibility coverage 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. Those individuals with a personal or family history of certain conditions may garner a higher RAF than individuals
without such a history. Therefore, it is important to focus on assessing and addressing early stages of chronic conditions, focus on preventative care and early intervention to promote improved quality of care to keep beneficiaries healthy, and to minimize disease progression.

CMS requires that a qualified healthcare provider identify all conditions that may fall within an HCC at least once, each calendar year. Accurate, specific and complete documentation and coding of diagnoses by clinicians is a critical component of the risk adjustment program. High

quality clinical documentation in the medical record ensures that beneficiaries receive the appropriate care management and related services they need based on the presence and severity of each beneficiaries' condition(s). Also, documentation must 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 condition data annually.**

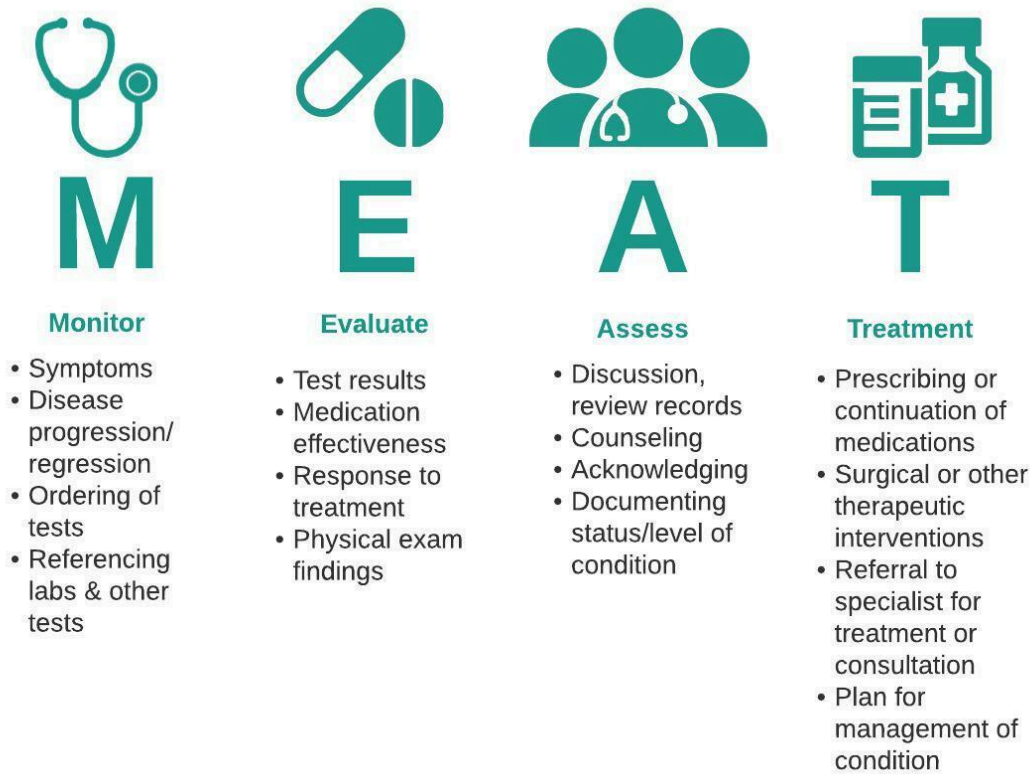
Extend high quality clinical documentation practices across all patients regardless of provider incentives.

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.

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

Many 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 Coexisting Conditions

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

> Choose the first listed ICD-10-CM code for the diagnosis, condition, problem, or other reason for the encounter/visit that is chiefly responsible for the services provided, 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 ICD-10-CM guidelines also provides general instruction applicable to risk adjustment coding regarding coexisting conditions as follows:

> 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.

Coexisting 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 coexisting 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 always 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.

Impact of Accurate vs. Inaccurate RAF Coding

(Represents Community, NonDual Aged Eligibility)

No conditions documented & coded (No encounters or lack of documentation and coding)		**Some conditions documented & coded** (Encounters not assessed to the highest level of specificity)		**All conditions documented & coded** (Encounters are assessed to the highest level of specificity)	
76-year-old female	**0.451**	**76-year-old** female	**0.451**	**76-year-old** female	**0.451**
DM not documented & coded	—	**DM** w/o complications (HCC 19)	**0.105**	**DM** w/ complication (HCC 18)	**0.302**
CKD not documented & coded	—	**CKD** unspecified (no HCC)	—	**CKD** stage 5 (HCC 136)	**0.289**
CHF not documented & coded	—	**CHF** not documented & coded	—	**CHF** (HCC 85)	**0.331**
Morbid obesity not documented & coded	—	**Morbid obesity** not documented & coded	—	**Morbid obesity** (HCC 22)	**0.250**
				★ 4 condition payment HCCs	**0.006**
				★ Disease interaction (CHF+DM)	**0.121**
				★ Disease interaction (CHF+Renal)	**0.156**
Total RAF	**0.451**	**Total RAF**	**0.556**	**Total RAF**	**1.906**
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**	**$17,392**

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.**