PRIVIA HEALTH™

2024 Value-Based Care Program for Primary Care for Commercial Line of Business: Anthem Commercial Program

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

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

TABLE OF CONTENTS

PRIVIA HEALTH

Getting Started in a Value-Based Care Program

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.

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

PRIVIA HEALTH

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

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

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

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

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

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

6) Establish c**adence 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.

PRIVIA HEALTH

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, 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

2024 Value-Based Care Program Components & Targets for Commercial

PATIENT POPULATIONS

The 2024 Value-Based Care Programs for Anthem BCBS Commercial & Individual Exchange (ACA)

Measure	Description	Threshold	Target
Value-Based Performance Metrics			
CML Quality Score	Provider will deliver best practice care as measured by Anthem's FPCC quality metrics	60 or 3.25	80 or 4.0
CML HCC Addressed	Ensure Commercial patients have chronic health conditions addressed at least once annually.	80%	85%
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.	75%	100%

2024 Commercial Anthem Program Measures

Adult Measures

Asthma Medication Ratio

*Brand Formulary Compliance

Breast Cancer Screening

Colorectal Cancer Screening

Kidney Health Evaluation

Medication Adherence Cholesterol

Medication Adherence Hypertension

*Plan All-Cause 30 Day Readmission Rate

7 Day Follow-up After Emergency Department Visit for Mental Illness

*Observed/Expected Emergency Department Utilization (EDU)

Pediatric Measures

Asthma Medication Ratio

*Brand Formulary Compliance

Pediatric Readmission

*Potentially Avoidable ED Visits

Vaccinations - MMR

Well Child: 15-30 Months

Child and Adolescent Well-Care Visits - Age 3-21

* These measures are utilization measures and represent approximately 17% of your overall Anthem Scorecard.

2024 Commercial Quality Measures

Asthma Medication Ratio (AMR)

2024 Performance Year

Commercial and Medicaid

Measure Description

Percentage of patients ages 5–64 who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the performance year

Required Exclusions

- Patients in hospice or using a hospice benefit anytime during the performance year
- Patients who passed away anytime during the performance year
- Patients who weren't dispensed an asthma controller or reliever medication during the performance year
- Exclude patients with any of the following conditions during the patient's history through the end of the performance year:
    - Acute respiratory failure
    - Chronic obstructive pulmonary disease (COPD)
    - Chronic respiratory conditions due to fumes/vapors
    - Cystic fibrosis
    - Emphysema
    - Obstructive chronic bronchitis

Important Measure Notes

- Simplify treatment regimen, when possible.
- Use clear and simple language when providing directions on how to use inhalers.
- Help patients learn to identify and avoid asthma triggers.
- Educate patients on the difference between controller and reliever medications and applicable usage.
- Reminder: Dyphylline Guaifenesin Medications Lists have been removed

Medication Charts

To comply with this measure, a member must have the appropriate ratio of controller medications to total asthma medications

Asthma Controller Medications

Drug Category	Medications
Antibody inhibitors	Omalizumab
Anti-interleukin-4	Dupilumab
Anti-interleukin-5	Benralizumab, Mepolizumab, Reslizumab
Inhaled corticosteroids	Beclomethasone, Budesonid , Ciclesonide, Flunisolide, Fluticasone, Mometasone
Inhaled steroid combinations	Budesonide-formoterol, Fluticasone-salmeterol, Fluticasone-vilanterol, Formoterol-mometasone
Leukotriene modifiers	Montelukast, Zafirlukast, Zileuton
Methylxanthines	Theophylline

Asthma Reliever Medications

Drug Category	Medications
Short-acting, inhaled beta-2 agonists	Albuterol, Levalbuterol

Resources

HEDIS MY2024 Technical Specs Vol 2. Pg. 124-130

Breast Cancer Screening (BCS-E)

2024 Performance Year

Commercial, Medicaid, Medicare

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 the performance year
- Patients who received palliative care or had an encounter with palliative care any time during the performance year
- Patients who passed away any time during the performance year
- History of a bilateral mastectomy or both right and left unilateral mastectomies any time during the patient's history through the end of the performance year
- Patients who had gender-affirming chest surgery with a diagnosis of gender dysphoria any time during the patient's history through the end of the performance year
- Medicare patients 66 years of age and older as of the end of the performance year who meet either of the following: enrolled in an an Institutional SNP (I-SNP) or residing in long-term care as identified by the LTI flag in the CMS Monthly File any time during the performance year
- Patients 66 years of age and older as of the end of the performance year with at least two frailty indications on different dates of service during the performance year and an advanced illness diagnosis on at least two different dates of service *or* dispensed dementia medication during the end of the performance year or 12 months prior to the performance year

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

Brand Formulary Compliance Rate

2024 Performance Year

Adult and Pediatric

Measure Description

This measure identifies the overall percentage of brand prescriptions filled as formulary based on the prescriptions filled for Attributed Members with an Anthem prescription drug benefit during the applicable Data Collection period.

Measure Exclusions

- 3rd party pharmacy claims
- Prescriptions dispensed for treatment of any of the following during 2024
    - HIV/AIDS or Substance Use Disorder
    - Select Specialty medications
    - Exclusion vaccines
    - Albuterol AER HFA
    - Exclusion medical supplies
    - Select medications that were previously formulary, but have since become non-formulary and would negatively impact the measure
    - Discounted Rx dispensed by Plan Enhancement for Non-Covered Drugs (PENCD) program

Note: List of excluded drugs will be updated quarterly to incorporate new products that meet exclusion criteria.

Measure Notes

- Informational only baseline benchmarks will be provided at the beginning of the Measurement Period.
- Throughout the Measurement Period, your performance will be compared to the claims experience of the market, which represents the actual claims for all Providers within your defined market.
- At the close of your Measurement Period, we will compare your compliance rate during your Measurement Period to the defined market compliance rate which will be used to compute the earned percentage of shared savings.
- The compliance rates calculated at the end of the Measurement Period will be inclusive of pertinent formulary changes that may have occurred during the period.

Resources

MULTIBCBS CM 022137 23 CPN21871, MP Jan 1, 2024 Scorecard

Childhood Immunization Status

2024 Performance Year

Commercial and Medicaid

Measure Description

The percentage of children 2 years of age who had the following immunizations by their second birthday:

- Four diphtheria, tetanus and acellular pertussis (DTaP)
- Three polio (IPV)
- One measles, mumps and rubella (MMR)
- Three haemophilus influenza type B (HiB)
- Three hepatitis B (HepB)
- One chicken pox (VZV)
- Four pneumococcal conjugate (PCV)
- One hepatitis A (HepA);
- Two or three rotavirus (RV)
- Two influenza (flu) vaccines

The measure calculates a rate for each vaccine and three combination rates.

Note: Elevance Commercial contract is tracking patients who have had at least one MMR vaccination between their first and second birthday

Required Exclusions

- Children who had a contraindication to a childhood vaccine on or before their second birthday.
- Patients in hospice or using a hospice benefit anytime during the performance year
- Patients who passed away anytime during the performance year

Documentation Tips

- For immunization evidence obtained from the medical record, count members where there is evidence that the antigen was rendered from one of the following:
  - A note indicating the name of the specific antigen and the date of the immunization.
  - A certificate of immunization prepared by an authorized health care provider or agency including the specific dates and types of immunizations administered.
- For documented history of illness or anaphylaxis, there must be a note indicating the date of the event, which must have occurred by the member's second birthday.
- Notes in the medical record indicating that the member received the immunization "at delivery" or "in the hospital" may be counted toward the numerator only for immunizations that do not have minimum age restrictions (e.g., before 42 days after birth).
- A note that the "member is up to date" with all immunizations but which does not list the dates of all immunizations and the names of the immunization agents does not constitute sufficient evidence of immunization for HEDIS reporting.
- Immunizations documented using a generic header or "DTaP/DTP/DT" can be counted as evidence of DTaP.
- Immunizations documented using a generic header (e.g. polio vaccine) or "IPV/OPV" can be counted as evidence of IPV.
- For rotavirus, if documentation does not indicate whether the two-dose schedule or three-dose schedule was used, assume a three-dose schedule and find evidence that three doses were administered.

Codes for MMR

- **MMR Injection**
  - **CPT:** 90707, 90710
- **Anaphylaxis due to the measles, mumps and rubella vaccine on or before the child's second birthday**
  - **SNOMED:** 471331000124109
- **History of Measles**
  - **ICD-10:** B05.0, B05.1, B05.2, B05.3, B05.4, B05.81, B05.89, B05.9
- **History of Mumps**
  - **ICD-10:** B26.0, B26.1, B26.2, B26.3, B26.81, B26.82, B26.83, B26.84, B26.85, B26.89, B26.9
- **History of Rubella**
  - **ICD-10:** B06.00, B06.01, B06.02, B06.09, B06.81, B06.82, B06.89, B06.9

Resources

HEDIS MY2024 Technical Specs Vol 2. Pg. 74-81

Colorectal Cancer Screening (COL-E)

2024 Performance Year

Commercial, Medicaid, Medicare

Important Update for Medicare Advantage NCQA has removed the Colorectal Cancer Screening (COL) administrative reporting measure and transitioned into ECDS reporting (COL-E) methodology. 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.

Required Exclusions

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

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

- Medicare patients 66 years of age and older as of the end of the performance year who meet either of the following: enrolled in an an Institutional SNP (I-SNP) or residing in long-term care as identified by the LTI flag in the CMS Monthly File any time during the performance year
- Patients 66 years of age and older as of the end of the performance year with two frailty indications on different dates of service the performance year **and** an advanced illness diagnosis on at least two different dates of service *or* dispensed dementia medication during the performance year or the 12 months preceding the performance year.

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

Emergency Department Utilization (EDU)

2024 Performance Year

Commercial and Medicare

Measure Description

The risk-adjusted ratio of observed to expected emergency department (ED) visits for patients 18 years of age and older during the performance year

Patient ED visits for the following reasons will **not** be included in the denominator:

- Principal diagnosis of mental health or chemical dependency
- Psychiatry
- Electroconvulsive therapy
- Result in an inpatient stay

Measure Exclusions

- Patients in hospice or using a hospice benefit anytime during the performance year
- Patients who passed away anytime during the performance year

Measure Tips

- Educate your patients on the appropriate access to care ie. when to use an urgent care or emergency department
- Offer services such as: telehealth, same day appointments or after hours access
- Encourage annual routine check ups to identify any health conditions, focus on prevention screenings and promote follow-ups as needed
- See patients with chronic diseases quarterly to prevent potential complications and improve disease management compliance

Resources

HEDIS MY2024 Technical Specs Vol 2. Pg. 482-489

Follow-Up After Emergency Department Visit for Mental Illness (FUM)

2024 Performance Year

Commercial, Medicaid, Medicare

Measure Description

The percentage of ED visits for patients ages 6 years and older with a principal diagnosis of mental illness or intentional self-harm, who then had a follow-up visit for mental illness with any practitioner type.

Two rates are reported:

- The percentage of ED visits for which the member received follow-up for mental illness within the 7 days after the visit (8 days total)
- The percentage of ED visits for which the member received follow-up for mental illness within the 30 days after the visit (31 days total)

Required Exclusions

- ED visits followed by admission to an inpatient care setting on the date of the ED visit or within the 30 days after the ED visit (31 total days), regardless of the principal diagnosis for the admission

Follow-Up Care and Types of Visits that satisfy the numerator

ED follow-up care can include any of the following on the day of discharge through seven days and/or 30 days post-discharge.

Note: a principle diagnosis of a mental health disorder **or** a diagnosis of intentional self-harm and a diagnosis of a mental health disorder is required.

- Behavioral Health Outpatient Visit With Any Practitioner Type
- Intensive Outpatient or Partial Hospitalization With Any Practitioner Type
- Observation Visit With Any Practitioner Type
- Outpatient Visit With Any Practitioner Type and With Appropriate Place of Service Code
- Intensive Outpatient Visit or Partial Hospitalization With Any Practitioner Type and With Appropriate Place of Service Code
- Community Mental Health Center Visit With Any Provider Type and With Appropriate Place of Service Code
- Electroconvulsive Therapy With Any Practitioner Type and With Appropriate Place of Service Code
- Telehealth Visit With Any Practitioner Type and the Appropriate Place of Service Code
- Telephone Visit With Any Practitioner Type
- E-Visit or Virtual Check-In With Any Practitioner Type

Measure Tips

- When notified of a patient's discharge, proactively reach out to set up a follow-up appointment within the first few days of discharge.
- Bill appropriately and promptly to capture rendered care

- If a patient cannot be seen within the first 7 days, ensure they have an appointment within the first 30 days of discharge
- Keep 1-2 open office appointments open to meet patient needs.
- Educate your patients on the importance of follow-up appointments.
- For children and adolescents, engage parents and/or caregivers in the treatment plan.
- Reassure your member that they are not alone and mental illness affects a large portion of the population
- Identify any barriers to follow up care, ie. transportation
- Encourage the use of a telehealth appointment when appropriate

Resources

HEDIS MY2024 Technical Specs Vol 2. Pg. 234-239

Kidney Health Evaluation for Patients with Diabetes (KED)

2024 Performance Year

Commercial, Medicaid, Medicare

Measure Description

The percent of patients 18-85 years old 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 the performance year on the same or different dates of service.

Required:

- At least one eGFR during the performance year
- At least one uACR during the performance year 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 the performance year
- Patients in hospice or using a hospice benefit anytime during the performance year
- Patients who passed away anytime during the performance year
- Patients with evidence of end stage renal disease (ESRD) or dialysis anytime during the patient's history through the end of the performance year

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

- Medicare patients 66 years of age and older as of the end of the performance year who meet either of the following: enrolled in an an Institutional SNP (I-SNP) or residing in long-term care as identified by the LTI flag in the CMS Monthly File any time during the performance year
- Patients 66-80 years of age and older as of the end of the performance year with two frailty indications on different dates of service in the performance year and an advanced illness diagnosis on at least two different dates of service *or* dispensed dementia medication during the performance year or 12 months preceding the performance year.
- Patients 81 years of age and older as of the end of the performance year with two frailty indications on different dates of service during the performance year.

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 Performance Year

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 the performance year.

Required Exclusions

- Patients in hospice or using a hospice benefit anytime during the performance year
- End stage renal disease (ESRD) diagnosis during the performance year

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 Hypertension (MAH)

2024 Performance Year

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 during the performance year.

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

Required Exclusions

- End stage renal disease (ESRD) diagnosis during the measurement period
- 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.

Plan All-Cause Readmissions

2024 Performance Year

Commercial, Medicaid, Medicare

Measure Description

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

NOTE: 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 during the performance year.

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

Required Exclusions

- Patients in hospice or using a hospice benefit anytime during the performance year
- Patients who passed away during the hospital stay
- Patients with a principal diagnosis of pregnancy on the discharge claim or a 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 patients to engage in palliative care or hospice programs as appropriate.
- **Remember to document Transition of Care Indicators, including medication reconciliation (Code 1111F)**.
- Discharges are excluded if a direct transfer takes place after the end of the performance year.

Resources

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

Potentially Avoidable Pediatric Emergency Room Visits

2024 Performance Year

Commercial and Medicaid

Measure Description

This measure was developed using research that determines ER visits that were potentially avoidable by identifying visits that could have been treatable in a non-emergent ambulatory care setting.

Visits for treatment of conditions, such as the following, are considered potentially avoidable:

- Conjunctivitis
- Otitis media
- Sinusitis
- Bronchitis
- Gastritis
- Constipation
- Urinary tract infection
- Menstrual disorders
- Cellulitis
- Dermatitis
- Sunburn
- Joint pain
- Backache
- Cramps
- Insomnia
- Malaise and fatigue
- Cough
- Nausea or vomiting alone
- Diarrhea
- Sprains
- Abrasions
- Contusions
- First degree burns
- Strep throat
- Vaccinations
- Routine child
- Prenatal
- Gynecological and adult exams
- Change of wound dressings
- Radiology and laboratory exams
- Health screenings
- Throat pain

Measure Exclusions

- Emergency room visits that resulted in an inpatient admission
- Emergency room visits with a patient reason for visit (PRFV) considered potentially unavoidable

Measure Tips

- Educate your patients on where to appropriately seek care
- Offer an after hours nurse line and/or extended hours during evenings and weekends
- Ensure your patients understand virtual visits can be utilized
- Address questions, potential needs and barriers during your patient visits
- Offer literature that explains where to seek care and provide examples of each

Resources

MULTIBCBS CM 022137 23 CPN21871, MP Jan 1, 2024 Scorecard

Well-Child Visits in the First 30 Months of Life (W30)

2024 Performance Year

Commercial and Medicaid

Measure Description

Percentage of patients who turned 15–30 months old during the performance year and had the recommended number of well-child visits with a primary care provider.

- Children 0-15 months old during the performance year : 6 or more well-child visits in the first 15 months of life.
- Children 15-30 months old during the performance year : 2 or more well-child visits between 15–30 months of age.

****Note: Anthem Commercial is tracking bullet 2 (children 15-30 months)**

Required Exclusions

- Patients in hospice or using a hospice benefit anytime during the performance year
- Patients who passed away anytime during the performance year

Measure Tips

- If a provider is seeing a patient for Evaluation and Management (E/M) services and **all** well-child visit components are completed: Attach modifier -25 or -59 to the well-child procedure code so it's reviewed as a significant, separately identifiable procedure.
    - **Modifier -25** is used to indicate a significant and separately identifiable evaluation and management (E/M) service by the same physician on the same day another procedure or service was performed.
    - **Modifier -59** is used to indicate that 2 or more procedures were performed at the same visit, but to different sites on the body.
- Utilize reporting made available to you to identify the patients who need well-child visits
- The well-child visit must occur with a PCP, but the PCP does not have to be the practitioner assigned to the child.

Codes

Well Care Visits

CPT: 99381, 99382, 99383, 99384, 99385, 99391, 99392, 99393, 99394, 99395, 99461

HCPCS: G0438, G0439, S0302, S0610, S0612, S0613

ICD-10 Diagnosis: Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.2, Z00.3, Z01.411, Z01.419, Z02.5 Z76.1, Z76.2

Resources

HEDIS MY2024 Technical Specs Vol 2. Pg. 426-431

Child and Adolescent Well-Care Visits (WCV)

2024 Performance Year

Commercial and Medicaid

Measure Description

Percentage of patients ages 3-21 years who had one or more comprehensive well-care visits with a primary care provider or OB-GYN during the performance year.

Required Exclusions

- Patients in hospice or using a hospice benefit anytime during the performance year
- Patients who passed away anytime during the performance year

Measure Tips

- If a provider is seeing a patient for Evaluation and Management (E/M) services and **all** well-child visit components are completed: Attach modifier -25 or -59 to the well-child procedure code so it's reviewed as a significant, separately identifiable procedure.
    - **Modifier -25** is used to indicate a significant and separately identifiable evaluation and management (E/M) service by the same physician on the same day another procedure or service was performed.
    - **Modifier -59** is used to indicate that 2 or more procedures were performed at the same visit, but to different sites on the body.
- Utilize reporting made available to you to identify the patients who need well-child visits
- The well-child visit must occur with a PCP, but the PCP does not have to be the practitioner assigned to the child.

Codes

Well Care Visits

CPT: 99381, 99382, 99383, 99384, 99385, 99391, 99392, 99393, 99394, 99395, 99461

HCPCS: G0438, G0439, S0302, S0610, S0612, S0613

ICD-10 Diagnosis: Z00.00, Z00.01, Z00.110, Z00.111, Z00.121, Z00.129, Z00.2, Z00.3, Z01.411, Z01.419, Z02.5 Z76.1, Z76.2

Resource

HEDIS MY2024 Technical Specs Vol 2. Pg. 432-435

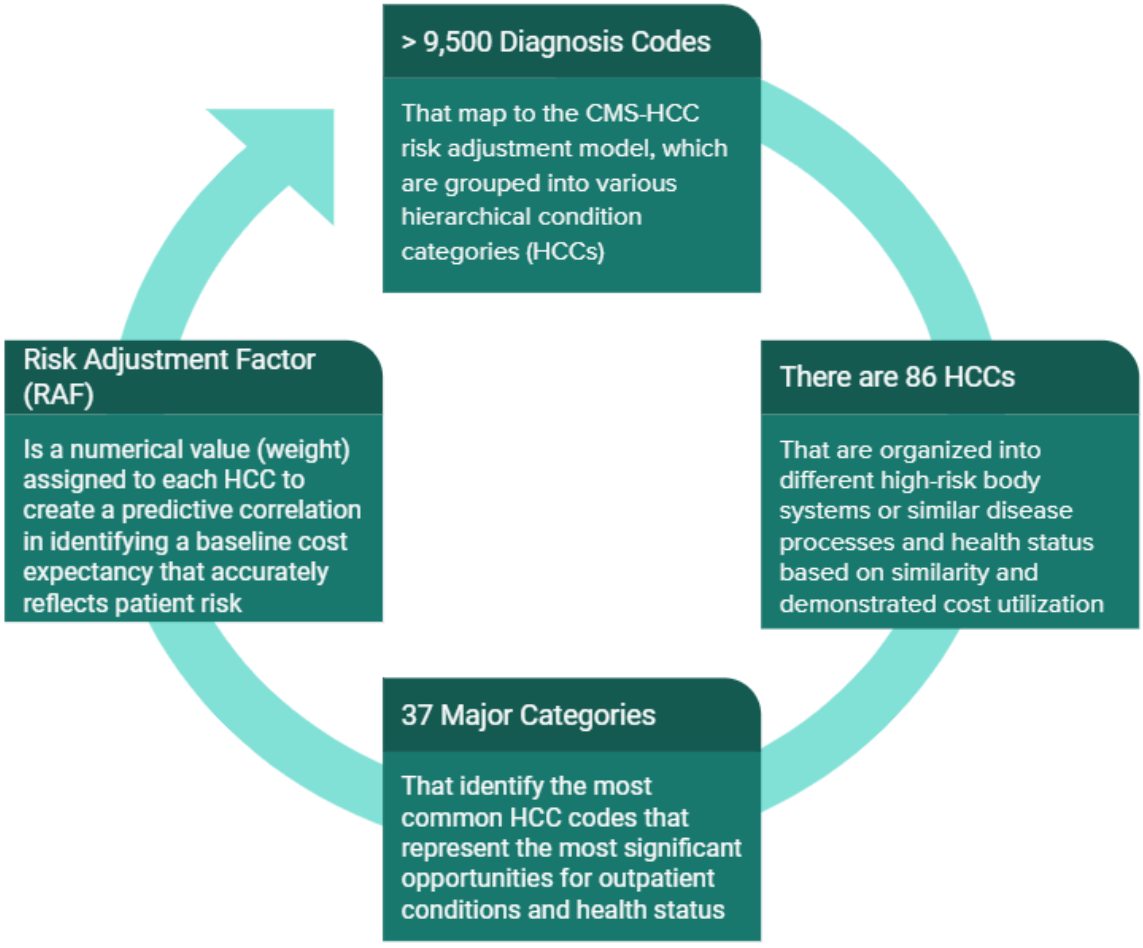
Risk Adjustment

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?

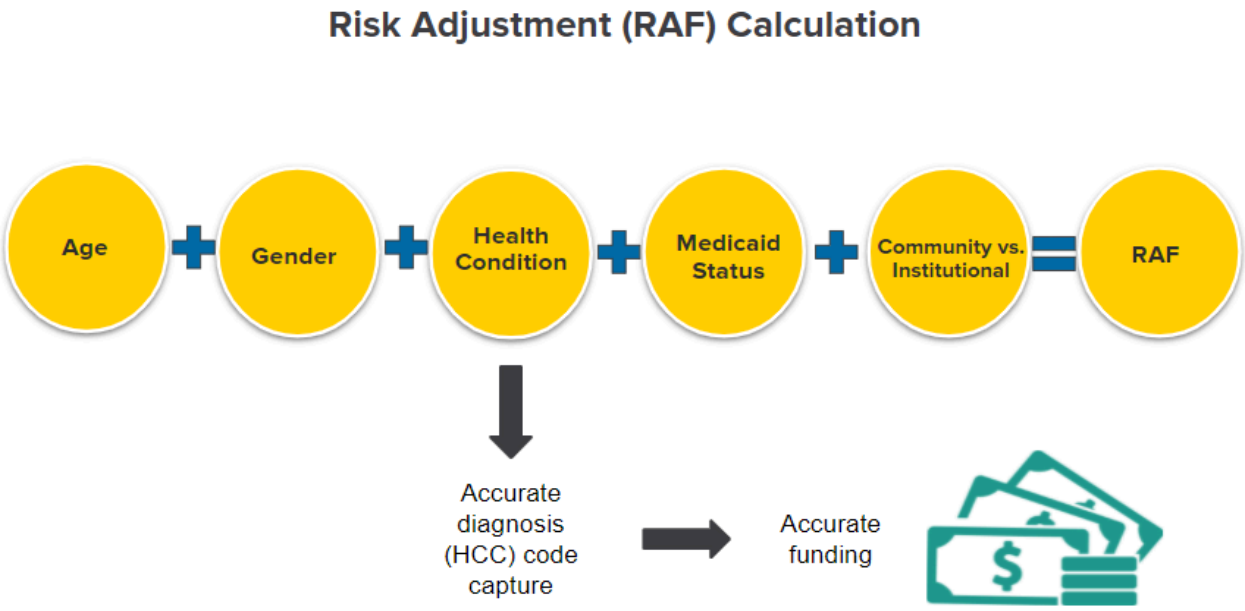
HCC is an acronym for Hierarchical Condition Category. A portion of ICD-10-CM codes map into an HCC organized body systems or similar disease processes and health status. A good way to understand this concept is illustrated using the following diagram:



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.**

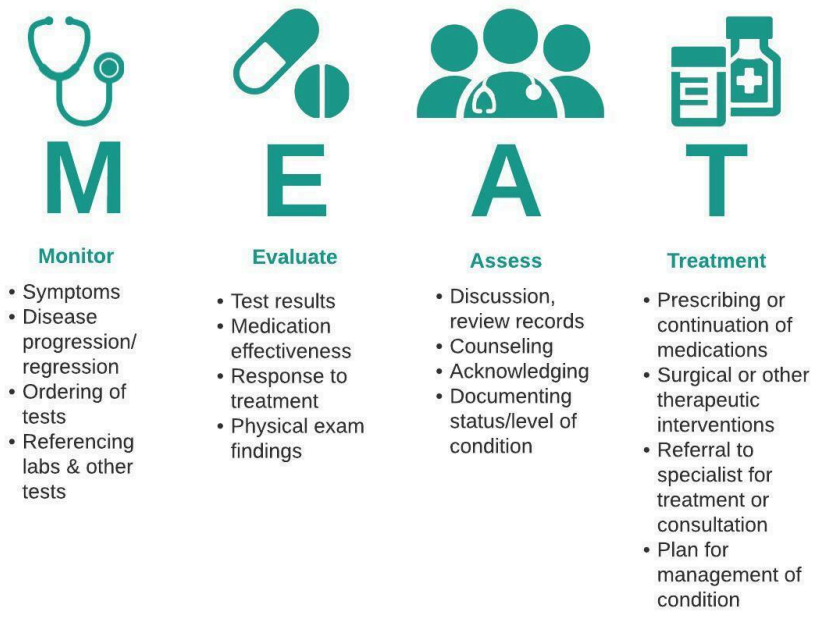
Extend high quality clinical documentation practices across all patients regardless of provider incentives.

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.

PRIVIA HEALTH

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.**