CSMS -IPA January 2022 Newsletter

Welcome to 2022, a year in which we can apply lessons learned from two pandemic years to better care for our patients and ourselves. In this newsletter, we will review 2022 CSMS-IPA goals for improved patient outcomes and better practice reimbursement. To achieve these goals, please take full advantage of IPA resource material, the expertise of your practice resource, and our population health software programs. Since CSMS-IPA Payer Collaborations measure the performance of the whole IPA network, every practice must complete its own value-based tasks to achieve success. See the CSMS-IPA website for supplemental material on each of the goals.

Goal 1: Annual Care Visits (AWVs) completed on 80% of Medicare Advantage members and 70% of Commercial members. AWVs are a key element of success in value-based care. These comprehensive visits help physicians engage with patients, code chronic conditions, assess social determinants of health, order preventive tests, and implement updated chronic care plans. Get an early start on scheduling AWVs and Comprehensive Physical Exams (CPEs) by reviewing IPA reports or checking population health tools for lists of patients who are due or overdue for AWVs and contacting them to schedule visits. Plans allow telehealth visits (audio and video) for AWVs. Note that M*edicare FFS* covers AWVs but **not** CPEs. *Medicare Advantage* plans cover both AWVs and CPEs. Use Modifier 25 when these two types of visits are combined.

Goal 2: Improve the accurate and complete coding of all disease states for all attributed members. Hierarchical Chronic Condition (HCC) coding is used by Medicare and health plans to determine the health status and acuity of a patient population. Scores are used to determine the cost of care. Providers must code all active diagnoses to the highest level of specificity, yearly. HCC codes are not carried over from year to year. Proper documentation of each diagnosis must demonstrate that the provider is Monitoring, Evaluating, Assessing/Addressing, and Treating (MEAT) the condition yearly. Carescreen® and other population health tools allow providers to enter updated HCC codes.

Goal 3: **Achieve a 4-star quality rating in Medicare Advantage metrics and reach at least the 75-90th percentile in all commercial HEDIS measures.** Each plan has its own priority quality metrics and practices should become familiar with them. Practices can achieve the highest level of quality ratings by checking for open gaps in care (for example medication refills and compliance or missing test results) at each visit, by reviewing gaps in care reports between patient visits, contacting patients who are missing test results, and entering data into population health tools or submitting supplemental quality information to plans.

Goal 4: Effective management of patients with high-risk and/or chronic conditions
Effective high-risk patient management requires a regular schedule of patient visits, teaching self-care skills, referring to preferred network specialists, monitoring medication adherence and closing care gaps. IPA clinical staff schedule regular care rounds to identify new strategies for the care of high-risk patients. The IPA provides multiple tools for patient management including a toolkit with checklists and forms that help guide chronic care best practices. If you are interested in a printed or electronic copy of the toolkit reach out to your IPA resource.

Goal 5: Increase the number of Transitional Care Management (TCM) visits completed using the Transitional Care Management codes. Historically, the IPA network has not used post discharge transitional care visits and codes very extensively. TCM includes: a review of discharge information, medication reconciliation, reviewing inpatient test results, coordinating care, and self-care education for families and patients. Some population health tools like Carescreen® identify recent patient discharges. The two main components of the TCM process are an interactive communication with the patient within two business days (phone, in-person or virtual) and a provider face-to-face visit with 7 days (high complexity code 99495) or 14 days (moderate complexity code 99496). See the IPA website for more in-depth information on TCM. Medicare Advantage and Commercial insurers generally use the same process and codes.