Positive Practice

NEWS AND EDUCATION FOR POSITIVE HEALTHCARE PROVIDERS Issue 26 Winter 2022

In this Issue

PHP HMO SNP

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Helping Patients to Understand How Prevention Screenings Can be Rewarding

PHP is always working steadfast in engaging our members & providers on the importance of prevention screenings. In fact, PHP will reward members with a gift card for completing, a Colorectal Cancer Screening and/or Diabetic Retinal Eye Exam by December 31st of this year. We are partnered in our commitment to ensure that our members have access to quality care and relevant information to assist with keeping them healthy. As we close out this year, PHP would like to challenge our network providers to encourage members to get necessary prevention screenings to improve the quality of their care while being rewarded in the process.

How Does it Work?

PHP is offering two different ways for members to receive Colorectal Cancer Screenings; COLOGUARD & COLONOSCOPY

Cologuard (noninvasive, done in home, no special preparation, to be completed every 3 years, Receive a $40 Gift Card for Completion)

Colonoscopy (Invasive screening, implemented by a GI Specialist, special preparation required, to be completed every 10 years, Receive a $100 Gift Card for Completion)

People Living with Diabetes are at risk of diabetic retinopathy and are advised to complete a Diabetic Retinal Eye Exam.

Members can simply, call their doctor's office to request a diabetic retinal exam, complete the eye exam by December 31, 2022, have the office who did the Diabetic Retinal Eye Exam sign the PHP Retinal Exam Form, Mail completed form to P.O. Box 46160 Los Angeles, CA 90046, Receive a $20 Gift Card after test completion is verified in the member's medical record.

Ultimately, when you think about prevention screenings, there are many rewards to consider...

Happy Holidays

Happy holidays from all of us at PHP! Every year we are grateful for our entire team of staff and providers and the essential care that you give to each of our plan members! We thank you for your work and professional care, and we are wishing you and your families a very happy, healthy and safe holiday season!

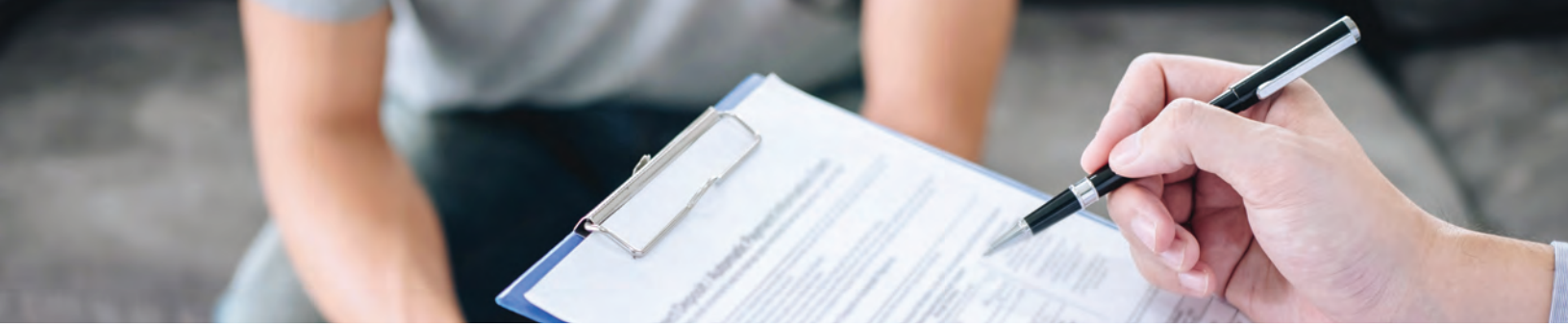
We look forward to continue to work together on this mission for all patients in the new year of 2023!

Love,
Donna Stidham , AHF Chief, Managed Care

2023 PHP Benefits

For 2023, AHF has made positive changes to its Medicare Advantage plan, PHP. We removed the outpatient hospital services copay along with authorization requirements for many routine services. See the table below.

COST	2022	2023
Ambulatory Surgery Center	$0 copay for outpatient surgery and ambulatory surgery center services done at an ambulatory surgery center. Referral and authorization required. If outpatient surgery and/or surgery services are done at a hospital facility, patient will be subject to an outpatient hospital copay of $100.	$0 copay for outpatient surgery and ambulatory surgery center services done at an ambulatory surgery center. Referral and authorization required.
Cardiac and Pulmonary Rehabilitation Services	$0 copay for cardiac and pulmonary rehabilitation services. Referral and authorization required.	$0 copay for cardiac and pulmonary rehabilitation services. Referral required. Certain cardiac and pulmonary rehabilitation procedures require authorization.
Chiropractic Services	$0 copay for Medicare-covered chiropractic services limited to manual manipulation of the spine to correct subluxation. Referral and authorization required.	$0 copay for Medicare-covered chiropractic services limited to manual manipulation of the spine to correct subluxation. Referral required. No authorization required.
Dental Services	$0 copay for limited Medicare-covered dental services (this does not include services in connection with care, treatment, filling, removal or replacement of teeth). Referral and authorization required. $0 copay for preventive dental services: • Cleaning (for up to 2 every year) • Dental x-ray(s) (for up to 1 every year) • Fluoride treatment (for up to 2 every year) • Oral exams (unlimited) $0 copay for comprehensive dental services such as the following: • Non-routine services • Diagnostic services • Restorative services • Endodontics/periodontics/extractions • Prosthodontics, other oral/maxillofacial surgery, other services **Comprehensive dental services are limited to $850 every year.** No referral or authorization required for preventive or comprehensive dental services.	$0 copay for limited Medicare-covered dental services (this does not include services in connection with care, treatment, filling, removal or replacement of teeth). Referral and authorization required. $0 copay for preventive dental services: • Cleaning (for up to 2 every year) • Dental x-ray(s) (for up to 1 every year) • Fluoride treatment (for up to 2 every year) • Oral exams (unlimited) $0 copay for comprehensive dental services such as the following: • Non-routine services • Diagnostic services • Restorative services • Endodontics/periodontics/extractions • Prosthodontics, other oral/maxillofacial surgery, other services **Comprehensive dental services are limited to $1,150 every year.** No referral or authorization required for preventive or comprehensive dental services.
Diagnostic Services/ Labs/Imaging	$0 copay for the following services: • Diagnostic radiology services, e.g., MRI, CT, PET scans • Lab services • Diagnostic tests and procedures • Outpatient x-rays • Colonoscopy, sigmoidoscopy, endoscopy Referral required. Some tests and services require authorization. If diagnostic, lab or imaging services are done at a hospital facility, patient will be subject to an outpatient hospital copay of $100.	$0 copay for the following services: • Diagnostic radiology services, e.g., MRI, CT, PET scans • Lab services • Diagnostic tests and procedures • Outpatient x-rays • Colonoscopy, sigmoidoscopy, endoscopy • Radiation therapy Referral required. The following services require authorization: • Certain diagnostic procedures and tests • Certain diagnostic radiological services • Certain therapeutic radiological services The following services do not require authorization: • Lab • X-rays



COST	2022	2023
Hearing Services	$0 copay for the following services every year: • One routine hearing exam • One fitting-evaluation for a hearing aid • Up to two hearing aids **$1,000 plan coverage limit for up to 2 hearing aids every year.** Authorization required.	$0 copay for the following services every year: • One routine hearing exam • One fitting-evaluation for a hearing aid • Up to two hearing aids **$2,500 plan coverage limit for up to 2 hearing aids every year.** Authorization required
Outpatient Hospital Observation	$0 copay for outpatient hospital observation. Referral and authorization required.	$0 copay for outpatient hospital observation. No referral or authorization required.
Outpatient Hospital Services	$100 copay per outpatient hospital service, i.e., outpatient surgery and surgery services and diagnostic radiology services, tests and procedures done at a hospital facility. Some services require referral and authorization.	$0 copay for outpatient hospital services. Some services require referral and authorization.
Outpatient Rehabilitation Services	$0 copay for physical therapy, occupational therapy and speech language therapy. Referral and authorization required.	$0 copay for physical therapy, occupational therapy and speech language therapy. Referral required. No authorization required.
Outpatient Substance Abuse Services	$0 copay for outpatient substance abuse services. Referral and authorization required.	$0 copay for outpatient substance abuse services. Referral required. No authorization required.
Physician Specialist Services	$0 copay for physician specialist visits. Referral required.	$0 copay for physician specialist visits. Referral required. Some specialist procedures require authorization.
Podiatry Services	$0 copay for podiatry services. Referral and authorization required.	$0 copay for podiatry services. Referral required. Certain podiatric procedures require authorization.
Vision Care	$0 copay for Medicare-covered vision care services. Referral and authorization required for the following: • Diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration • For patients who at high risk for glaucoma, one glaucoma screening each year • For patients with diabetes, one diabetic retinopathy screening each year • One (1) pair of eyeglasses or contact lenses after cataract surgery that includes insertion of an intraocular lens $0 copay for supplemental vision care benefits. No referral or authorization required for the following: • One (1) routine eye exam every year • One (1) pair of eyeglasses (lenses and frames or lenses) or contact lenses every year **$200 plan coverage limit for eyewear every year.**	$0 copay for Medicare-covered vision care services. Referral and authorization required for the following: • Diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration • For patients who at high risk for glaucoma, one glaucoma screening each year • For patients with diabetes, one diabetic retinopathy screening each year • One (1) pair of eyeglasses or contact lenses after cataract surgery that includes insertion of an intraocular lens $0 copay for supplemental vision care benefits. No referral or authorization required or the following: • One (1) routine eye exam every year • One (1) pair of eyeglasses (lenses and frames or lenses) or contact lenses every year **$250 plan coverage limit for eyewear every year.**

Quality STAR Ratings

The Centers for Medicare and Medicaid (CMS) created the Five-Star Quality Rating System to help compare all health plans' quality and performance. These ratings are updated annually and are presented in the form of Stars. CMS uses information from member satisfaction surveys, plans, and health care providers to give overall performance star ratings to plans. The program is a key component in financing health care benefits for PHP and PHC plan enrollees. Five stars is the highest possible score and fewer start indicate lower quality. CMS provides the following guidance regarding the different star ratings.

• 5 Stars – Excellent • 4 Stars - Above Average
• 3 Stars - Average • 2 Stars - Below Average • 1 Star – Poor

Each health plan is evaluated on several items to produce their overall star ratings. These items include:

PART C

Domain I: Staying Healthy: Screenings, Tests and Vaccines
Domain II: Managing Chronic (Long Lasting) Conditions
Domain III: Rating of Health Plan Responsiveness and Care
Domain IV: Member Complaints, Appeals and Choosing to Leave the Health Plan
Domain V: Customer Service

PART D

Domain I: Drug Plan Customer Service
Domain III: Member Experience with the Health Plan
Domain IV: Drug Pricing and Patient Safety

2023 Star Rating	Score
Part C Ratings	Part C Score
AHF PHP Florida	4.5
Part D Ratings	Part D Score
AHF PHP Florida	4
Overall 2023 Star Rating	Overall Score
AHF PHP Florida	4

The measures on which the evaluations are based come from five different rating systems. These include the following:

- CAHPS (Consumer Assessment of Healthcare Providers and Systems) comprise roughly 1/3 of the rate. The percentage increased and carried more weight in 2022.
- HEDIS (Healthcare Effectiveness Data and Information Set) which accounts for 26% of the rates
- HOS (Health Outcomes Survey) 10% of the rates
- PDE (Prescription Drug Event) data affected 13% of the rates
- 9% of the Star Ratings are affected by comparing to the prior year's star ratings. If the plan's ratings stay the same, they will receive a 3 in "Quality Improvement"
- The Call Center, CMS Administrative Data, CTM (Complaints tracking module) and Medicare Beneficiary Database Suite of Systems (MBDSS) affect 4% each.
- Independent Review Entity (IRE) will affect 2% in relation to customer service and Part C Plan reporting
- Part D Plan Reporting and MPF Pricing Files each affect 1% of the star ratings.

Ways to improve your HEDIS, CAHPS and HOS Documentation

- Submit claims or encounter data timely and coded appropriately
- Ensure medical records are complete, legible, and accurate
- Ensure HEDIS preventive screenings, tests, and vaccines are performed in a timely manner
- Allow access to your electronic medical record (EMR) or provide medical records as requested
- Communicate effectively to patients in a manner they can understand
- Ensure specialists are communicating the status, tests, medications, and outcomes to the primary physician
- Have patient bring back a copy of the consult report
- Submit referrals and obtain authorizations as appropriate
- Follow-up with patient to make sure referral appointment was completed
- Call specialist to make sure PCP is sent copy of consult report
- Limit patient wait times, provide time for urgent appointments, and provide timely appointments
- Listen and ensure patients understand any orders or communications
- Discuss and provide counseling for urinary incontinence, physical activity, fall risk and osteoporosis testing
- Use codes for social determinants of health, palliative care, history of cancer, history of depression, advanced illness and nursing home care

Patient Perception on Survey Gains More Weight

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey is sent out to our plan members annually. Data for this survey was collected from PHP and PHC members between the months of March and May of 2021 and is solely based on the members' overall satisfaction with their experience at your practice. Patient experience is a critical component of quality improvement activities, public reporting and increasing accountability for improving member's satisfaction with quality of care and services received. It also allows us to better serve our members.

CAHPS is now more important than ever! *The significance of CAHPS is that it factors into our STARS scores currently weighted double!* The Star Ratings is significant for both health plan and providers. CAHPS now makes up about 32% of a health Plan's STARS composite score from 20%. This puts a greater priority on providing the best patient experience for all health plans!

These measures had the lowest percentile rankings in comparison to the Plan's 2022 performance. These are unofficial and come from our vendor. They are not the CMS official results. However, these do tend to align.

Florida PHP

- Getting Needed Prescription Drugs – 54th percentile
- Customer Service – 49th percentile
  - o *We will be looking at this closely through 2023*
- Getting Needed Care – 32nd percentile

Since these measures are such major contributors for the CAHPS outcomes, improving the way we communicate and provide access to care can produce positive improvements on patient health outcomes.

Recommendations to improve patient experience:

- Make getting care, tests, and specialty referrals easier
- Facilitate timely appointments, access to care, and accessibility to specialists and health information
- Improve coordination of care and tests between providers
- Improve information delivery and patient-health plan interactions
- Helpful, Courteous, and Respectful Office Staff
- Return calls within 24 hours
- Maintain thoughtful communication with your patients

Identify gaps prior to CAHPS survey

- Reach out to patients before appointments
- Understand their needs to help triage patient appointments
- Encourage patients to schedule their follow-up appointment before they leave the office
- Close loop with specialist referrals and results

Offer patients other ways in getting the needed care.

- Make greater effort to accommodate urgent care requests
- Provide education around urgent care versus visiting the ER
- Offer alternate options for your patients to access care during off hours

Working together on improving member experience will have a significant benefit to your practice/clinic such as:

- Increase patient engagement and retention
- Increase compliance with clinical recommendations
- Improve patient's overall wellness and health outcomes
- Ensure preventive care needs are addressed more timely
- Decrease no show rates

How can you partner to facilitate coordination of care and service as a provider?

- The partnership is strengthened when the Health Plan, Registered Nurse Care Team Manager (RNCTMs), and providers maintain open lines of communication with regard to patient care, referrals and authorization timelines

UPCOMING CHANGES

IMPORTANT NOTE: Beginning with the 2023 Star Ratings, the eight experience measures from CAHPS listed below will significantly change in weight, increasing from 2 to 4.

Medical Record Documentation Requirements

Federal, State, and Accreditation standards require Health Plan providers to follow guidelines regarding medical record documentation, authentication, storage, filing, collection, processing, maintenance, retrieval identification, distribution and handling. More information on this can be found in the provider contracts and provider manual. However, the following is an excerpt of AHF PHP Policy and Procedure as a quick reference guide.

1. Requirements for in each member's medical record:

a. A unique medical record number. Member identification on each page; personal/biographical data in the record.
b. Demographic information: name, identification number, date of birth, gender, primary language, communication needs (vision, hearing etc.), emergency contact and preferred language (if other than English) prominently noted in the record, as well as the request or refusal of language/interpretation services.
c. Primary care provider
d. Allergies or absence of allergies and untoward reaction to drugs and materials in a prominent location
e. Histories and physicals that are updated at least annually or as needed
f. A problem list, a complete record of immunizations and health maintenance or preventive services rendered.
g. Advance directive information and/or executed.
h. Consent forms where applicable including the human sterilization consent procedures required by Title 22 CCR Sections 51305.1 through 51305.6.
i. Health education behavioral assessment and referrals to health education services.
j. Significant medical advice given to a member by phone, including after-hours telephone information
k. Members involved in any research activity is identified
l. Reports of emergency care provided (directly by the contracted Provider or through an emergency room) and the hospital discharge summaries for all hospital admissions.
m. Consultations, referrals, Specialists', pathology, and laboratory reports. Any abnormal results shall have an explicit notation in the record.
n. Records shall be kept current in detail consistent with good medical and professional practice and shall describe the services provided to each patient.
o. All entries shall be dated and be authenticated with name, professional title and classification of person making the entry.

2. Requirements for each member encounter where applicable:

a. Date of the encounter and department
b. Member's chief complaint or purpose of visit
c. Medication reconciliation including over-the-counter products and dietary supplements
d. Physical, mental exams and clinical findings
e. Studies ordered, such as laboratory or diagnostic imaging and the results
f. Referrals/consultation ordered and the results
g. Objective Findings/Diagnosis
h. Plan for Findings/Diagnosis
i. Treatment Plan
j. Care rendered and therapies administered including preventive care provided or refusal of care or therapies
k. Documentation of follow-up instructions and a definite time for return visit or other follow-up care. Time period for return visits or other follow-up care is definitely stated in number of days, weeks, months or PRN (as needed).
l. Previous complaints and unresolved or chronic problems are addressed in subsequent notes until problems are resolved or a diagnosis is made. Each problem need not be addressed at every visit but all problems must be addressed within the calendar year. Documentation must demonstrate that provider follows-up with member about treatment regimens, recommendations and counseling.
m. Care plan or discharge plan including prescriptions, recommendations, education, instructions, necessity of surgery or other procedures etc.
n. Provider signature

There are codes for some of the SDOH conditions as illustrated below. Use these on your claims to identify problems and risks for your patients.

Z59 Problems related to housing and economic circumstances

- Z59.0 Homelessness
- Z59.01 Sheltered homelessness
- Z59.02 Unsheltered homelessness
- Z59.1 Inadequate housing
- Z59.2 Discord with neighbors, lodgers and landlord
- Z59.3 Problems related to living in residential institution
- Z59.4 Lack of adequate food
- Z59.41 Food insecurity
- Z59.48 Other specific lack of adequate food
- Z59.5 Extreme poverty
- Z59.6 Low income
- Z59.7 Insufficient social insurance and welfare support
- Z59.8 Other problems related to housing and economic circumstances
- Z59.81 Housing instability, housed
- Z59.811 Housing instability, housed with risk of homelessness
- Z59.812 Housing instability, housed, homeless in the past 1 2 months
- Z59.89 Problem related to housing and economic circumstances, unspecified

Z58 Problems related to physical environment

- Z58.6 Inadequate drinking - water supply

Z55 Problems related to education and literacy

- Z55.0 Illiteracy and low-level literacy
- Z55.1 Schooling unavailable and unattainable
- Z55.2 Failed school examinations
- Z55.3 Underachievement in school
- Z55.4 Educational maladjustment and discord with teachers and classmates
- Z55.5 Less than a high school diploma
- Z55.8 Other problems related to education and literacy
- Z55.9 Problems related to education and literacy, unspecified

Z56 Problems related to employment and unemployment

- Z56.0 Unemployment, unspecified
- Z56.1 Change of job
- Z56.2 Threat of job loss
- Z56.3 Stressful work schedule
- Z56.4 Discord with boss and workmates
- Z56.5 Uncongenial work environment
- Z56.6 Other physical and mental strain related to work
- Z56.8 Other problems related to employment
  - o Z56.81 Sexual harassment on the job
  - o Z56.82 Military deployment status
  - o Z56.89 Other problems related to employment
  - o Z56.9 Unspecified problems related to employment

Z65 Problems related to other psychosocial circumstances

- Z65.0 Conviction in civil and criminal proceedings without imprisonment
- Z65.1 Imprisonment and other incarceration
- Z65.2 Problems related to release from prison
- Z65.3 Problems related to other legal circumstances
- Z65.4 Victim of crime and terrorism
- Z65.5 Exposure to disaster, war and other hostilities
- Z65.8 Other specified problems related to psychosocial circumstances
- Z65.9 Problem related to unspecified psychosocial circumstances

CERVICAL CANCER SCREENING

Women's Health: Cervical and Breast Cancer Screening - Healthy Reproduction

Cervical Cancer Screening for HIV Women

HIV-infected women are at elevated risk of cervical dysplasia and cervical cancer. Cervical cancer is highly associated with type 16 and 18 human papillomavirus (HPV) infection (high-risk subtypes). HPV prevalence is higher among HIV-infected women than among HIV-uninfected women, and HIV-infected women have increased persistence of HPV and greater likelihood of infection with high-risk types of HPV.

Although the time between diagnosis of carcinoma in situ (CIS) and development of invasive disease is shorter among HIV-infected women who are not on ART than among HIV uninfected women, ART has not been shown consistently to prevent or alter the course of cervical dysplasia in HIV infected women. Women with advanced immunosuppression (CD4 count of <200 cells/μL) are at higher risk of cervical abnormalities than women with CD4 counts of >200 cells/μL. Vaccination against HPV has been shown to be effective in preventing cervical dysplasia in HIV-uninfected women; studies in HIV-infected women are ongoing.

PHP/PHC California are currently working to improve the rates for cervical cancer screenings amongst the female member population. The current screening rate is approximately 65% for the eligible population. Encourage all of your female patients to get a cervical cancer screening to protect their health and detect cancer. Cervical cancer screening is also a HEDIS measure, so when members complete this screening it improves our HEDIS rates and has many benefits for the plan.

The USPSTF and VA/DoD recommend cervical cancer screening using Pap smear or liquid-based cytology in sexually active women with a cervix. In sexually active women, screening should be started at age 21. For HIV-infected women, most authorities recommend more frequent screening than for HIV uninfected women.

Epidemiology/pathogenesis

Cervical cancer is associated with genital HPV infection; cancer is preceded by identifiable neoplastic changes (cervical intraepithelial neoplasia, or CIN) in the transformation zone of the cervix. Localized cervical cancer is highly curable (5-year survival of 92%), whereas disseminated disease is not (5-year survival of 13%). HIV-infected women progress from CIS to invasive disease faster than HIV-uninfected women. Cervical cancer is an AIDS defining condition. Women at increased risk of cervical cancer include those with:

- Immunosuppression (including HIV infection)
- Tobacco use (smoking)
- Increased risk of HPV infection, such as:
  - o Earlier onset of sexual intercourse
  - o Multiple sexual partners
  - o Sexual partners who have had multiple sexual partners

Screening methods

- Pap smear: Cervical epithelial cells, collected by brush and spatula, are either smeared directly on a slide and fixed, or suspended in a liquid fixative and spun onto a slide. Liquid-based cytology is preferred, if available, owing to its higher sensitivity. The smear should be examined by an experienced cytopathologist.
- Cervical detection of HPV has higher sensitivity but lower specificity than traditional Pap smear for cervical cancer. The 2003 USPSTF recommendations do not propose HPV DNA testing as a screening method in HIV-infected women. However, recent data suggest that in women with CD4 cell counts of >500 cells/μL, the combination of a normal PAP smear and the absence of oncogenic HPV is associated with a l ow risk of cervical dysplasia in the subsequent 3 years.

Effectiveness of Screening and Screening Interval

- Sensitivity of a single Pap smear for high-grade CIN is 60- 80%; specificity is approximately 98%.
- Effectiveness of cervical cancer screening on incidence and mortality of cervical cancer has not been studied prospectively. Nevertheless, data from good-quality case control and ecological studies show a strong association between screening and reductions in cervical cancer incidence and disease-specific mortality.

Screening recommendations

- Screen HIV-infected women at the time of diagnosis and 6 months thereafter.
- If initial results are normal, rescreen annually if CD4 count is >200 cells/μL or every 6 months if CD4 count is <200 cells/μL.
- HIV-infected women also should be screened annually for anal carcinoma using Pap smears (see Anal Dysplasia).
- Because of the increased risk of vaginal cancer associated with HIV infection, HIV-infected women with a history of high-grade CIN or invasive cervical cancer should be screened with regular vaginal cuff Pap smear following hysterectomy.

November is National Diabetes Month

This is a time when communities across the country team up to bring attention to diabetes and the importance of prevention and proper management.

Diabetes

Metabolic disorders, metabolic syndrome (MetS), and type II diabetes mellitus (DM) are increasingly common in people living with HIV/AIDS (PLWHA) as the population ages. Approximately 25% of our plan members have a diabetes diagnosis.

Antiretroviral (ARV) medications, protease inhibitors in particular, can increase the risk of DM and hinder the control of blood glucose levels in PLWHA up to 4 times compared to treatment negative patients. PLWHA should have their blood glucose levels checked before they start taking HIV medicines. People with higher-than-normal glucose levels may need to avoid taking some HIV medicines and use other HIV medicines instead. Blood glucose testing is also important after starting HIV medicines. If testing shows high glucose levels, a change in HIV medicines may be necessary.

The US estimates incidence of diabetes at 1 million each year with an annual price tag of $98 billion. Risk of cardiovascular and renal complications increases with uncontrolled diabetes. Excess morbidity and mortality from DM is preventable with effective medical and self-management practices.

Risk Factors for Diabetes

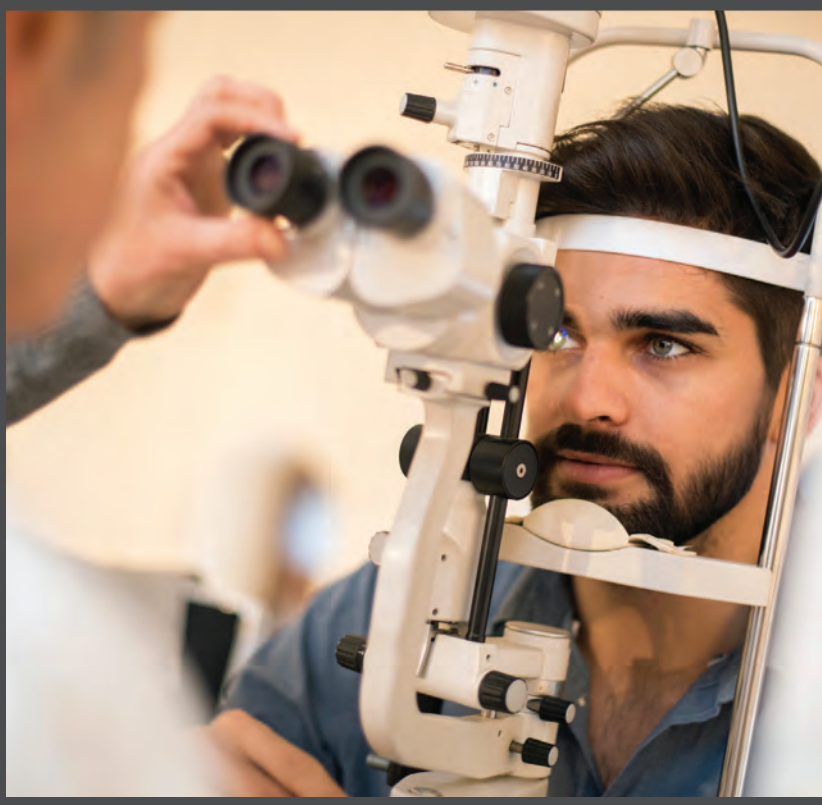
Patients are at higher risk for type 2 diabetes if they are:

- are over age 45
- have a family history of diabetes
- are overweight
- do not exercise regularly
- have low HDL Cholesterol or high triglycerides, or high blood pressure
- are a member of certain racial and ethnic groups (e.g., African American, Hispanic/Latino Americans, Asian Americans, Pacific Islanders, and American Indians)
- have had gestational diabetes, or have had a baby weighing 9 pounds or more at birth
- have a history of prediabetes

Diabetic Eye Exams (REE)

Diabetic retinopathy is the number one cause of blindness in persons aged 20-64. Cataracts develop earlier and there is a higher risk of glaucoma in the population as well. In diabetic retinopathy, microvascular complications of diabetes cause fragile, abnormal blood vessels to develop and spill blood into the center of the eye (proliferative retinopathy) or into the macula (macular edema). People with proliferative retinopathy can reduce their risk of blindness by 95% with early detection, treatment and follow-up care.

Annual retinal eye exams (REE) by an eye care professional are an essential component of comprehensive diabetes care. Encourage all of your diabetic patients to get a retinal eye exam every year to help protect their vision. REE is also a HEDIS measure, so when members complete this screening it improves our HEDIS rates and has many benefits for the plan.



Risk Adjustment and Medicare

Medicare Advantage plans, such as PHP, record enrollees' chronic conditions that are documented in a member's medical records. They then submit this information and encounter data to Medicare Risk Adjustment so that the chronic conditions are included in each Medicare beneficiaries' risk score. Medicare pays plans more to care for sicker patients in relation to the risk scores. Plan Revenue is used to compensate the providers for caring for their patients.

All chronic conditions must be evaluated every year for recapture and documented in the assessment and plan at an accurate severity level during face-to-face visits.

Risk Scores and Face-to-Face Visits

All Chronic Conditions Must be Evaluated Every Year for Recapture and Documented

- If Conditions Are Not Documented, They Fall Off the Patient's Medicare Record
- Reimbursement Based on Most Severe Manifestation of a Disease When Less Severe Manifestations Are Present
- Face-to-Face Visits (Such as In-Office Follow-Up Visits and Annual Wellness Visits) Are Risk Adjustable
- Audio-Visual Telehealth Visits Are Considered Face-to-Face During the Public Health Emergency
- Document Enrollee Consent to Telehealth in the Medical Record and Indicate that the Visit Is an Audio-Visual Visit Each Time
- Telephone Only Visits Are Not Considered Face-to-Face Visits

At AHF and PHP we encourage our PCPs to see each member for an Annual Wellness Visit (AWV) each year, and to pay particular attention to the Risk Adjustment and recapture during that visit. AWVs can generate practice revenue for taking the time to get the risk adjustment right.

The Plan provides PCP with 1-Pagers for each enrollee that summarize the enrollee's recent risk adjustable chronic conditions. Providers can use the 1-Pager as a checklist to address the current status of each condition. Our Risk Adjustment coders then review the medical notes and completed 1-pagers to help the PCPs ensure the clinical documentation is accurate, clear and complete. They can provide the feedback to the providers through queries in the EMR or via email or meeting. Copies of completed 1-Pagers can be attached to the bottom of the AWV medical note in AthenaOne.
Phone Contact Information for Risk Adjustment:
Tom Twentyman, Director Risk Adjustment, Phone: (323) 337-9147
Edna Cabalquinto, Lead Risk Adj. Coder, Phone: (323) 337-9156

We've included our 2022/2023 ICD 10 Coding Summary which highlights the most common chronic conditions of our members in this newsletter.

HIV/AIDS Clinical Practice Guidelines Approved by AHF

Providers should manage their HIV-positive patient according to the latest Clinical Guidelines

The federally approved clinical practice guidelines for HIV/AIDS are developed by panels of experts in HIV care. More information about the panels can be found in each set of guidelines. These Clinical Guidelines provide best-evidence recommendations for ARV treatment of adolescents and adults (as well as pediatrics), opportunistic infection prevention and treatment, and perinatal care.

More information about the panels can be found in each set of guidelines at https://clinicalinfo.hiv.gov/en/guidelines