GLIN IPA

Quarter 4 - 2023

Quality Newsletter

A quarterly newsletter to inform the network of any updates relating to metrics, reporting, and business updates.

GLIN Q4 Newsletter

2024 NCQA PCMH Standards & Annual Submission Updates

In July 2023, NCQA presented updates to the 2024 NYS PCMH Standards and the 2024 Annual Reporting Requirements. Let us highlight the changes for 2024 and look at one organization's experience with an audit of their processes during a recent annual reporting submission.

Read About One (1) Organization's Audit & Challenges

2024 Standards & Guidelines Major Changes

KM 09 Removed Pronouns and language as 'other aspect' of Diversity and clarified that evidence must be in the form of a report with a **numerator, denominator** and a percentage for each category.

AC 01 Added specific guidance around the criterion focusing on patient preference specific to appointments, giving examples of the types of questions practices should be asking in their surveys or on comment cards.

CM 04 Added guidance around the use of after-visit summaries as patient-centered care plans clarifying, 'After-visit summaries may only be used if they contain plain language and show patient involvement in the plan's creation.' **It was further stated that** 'The care plan is written at a health literacy level accessible to the patient (i.e., does not contain medical jargon, abbreviations/acronyms or billing codes).'

CM 11 New Criterion - Credit: Person-Driven Outcomes Approach: Monitoring and Follow Up.

QI 01 & QI 02 Standardized measures must be used and reported through the Measures Reporting Tile in Q-PASS. **This pertains to both transforming practices and those in annual reporting**.

NCQA PCMH Standards & Annual Submission Updates (continued)

2024 Annual Reporting Requirement Changes

AR TC 1 Pre-visit Planning Activities – Attestation – NEW

AR TC 2 Medical Home Information – Evidence – NEW

AR KM 1 Diversity – Report for all 5 areas of Diversity – NEW

AR KM 2 Language – Report – NEW

AR KM 3 Clinical Decision Support – Attestation – NEW

AR AC 1 Same Day Appointments – Attestation – NEW

AR CM 1 Care Plans for Care Managed Patients – Report with 2 de-identified patient care plan examples – NEW

AR CM 2 Additional Information Collected in the Care Plan – Attestation – NEW

AR CC 1 Lab and Imaging Test Tracking – Report – NEW

Requirements Removed from 2024 Annual Reporting

AR TC 1 Staff Involvement in Quality Improvement; **AR KM 1** Medication Lists; **AR AC 1** Appointments outside of Business Hours; **AR AC 2** Patient Visits with Clinician Team; **AR CC 1** Hospital and ED Care Coordination and **AR CC 2** Specialist Referrals.

NCQA PCMH Standards & Annual Submission Updates (continued)

Read About One (1) Organization's Audit & Challenges with Annual Reporting

**please note: this example pertains to 2023 PCMH Annual Reporting requirements

We submitted four (4) primary care sites for annual renewal and were audited for additional information on two (2) attestation criteria. The request from NCQA was to provide our documented process and two examples of our staff meeting minutes from a recent 12-month period. In addition, they requested our documented process for how we identify unplanned ED visits and hospitalizations along with evidence of implementation. In response, we provided this information and uploaded it into Q-PASS.

Another audit request followed when the Review Oversight Committee (ROC) questioned our numbers for KM-1 Medication Lists vs. CM-1 Total Patient Population. We were tasked to look at the data reported in KM-1 Medication Lists and compare it to the data reported in CM-1 Total Patient Population defined as unique patients seen in the prior 12 months. KM-1, also calls out unique patients in the denominator. Unique patients are defined as each patient counted only once. For KM-1 we submitted a 90-day report of patients seen in that 90 days who had their medication list reviewed. Because the number of patients seen in the 90-day medication report was over half the patients seen in the past 12 months, our evaluator questioned our numbers.

Working with our eHr department, we were able to validate our canned reports. We reported back to NCQA explaining our organizational push to get preventable exams completed in the first half of the year which carried into this 3rd quarter. In addition, and as recommended by the evaluator, we submitted a 30-chart audit confirming these patients as having their medication list being reviewed.

The explanation and information was accepted, and the sites received their Annual Recognitions.

Lessons Learned

- Complete the self-assessments so you know where to retrieve and prove your data if required.
- Review reports submitted and be prepared with evidence to support the reports.
- Submit your Annual Reporting data with at least a 30-day cushion in the event of any data verification issues.

Final Thoughts

As part of Annual Renewal Requirements, you are attesting that your practice/organization is meeting all 40 Core Criteria, 16 NYS Elective Criteria and 9 additional Elective Criteria of your choice. Be prepared to provide evidence for them at the time of submission.

Coding Corner: Upcoming Changes to the 2024 CMS-HCC Risk Adjustment Model Include Reliable Predictors of Future Costs

Hierarchical Condition Categories (HCCs) and their effects on coding have been an increasingly hot topic in the industry over the past several years. HCCs were initially developed for risk adjustment in Medicare Advantage, but their use has expanded to other payers. HCCs require more comprehensive coding, capturing specific diagnoses for accurate risk adjustment. In the 2024 CMS-HCC risk adjustment model, CMS has made changes by including reliable predictors of future costs and excluding unreliable ones (CMS, 2023).

In summary, the CY2024 CMS-HCC model classifies the ~74,000 ICD-10-CM diagnoses codes into 266 CMS-HCCs, 115 of which are included in the 2024 payment model. This increase in condition categories from the 2020 CMS-HCC model (204 MCS-HCCs and 86 in payment) is due to the greater level of detail within ICD-10-CM diagnosis codes. In aggregate, the 2024 model contains approximately 20% fewer ICD-10-CM codes than the 2020 model, resulting from the removal of diagnoses per CMS' risk adjustment principles.

Important Updates to the 2024 CMS-HCC Risk Adjustment Model

Important updates were made to the risk adjustment model categories for the 2024 CMS-HCC model, which will impact coders and providers.

Vascular Disease

Three new HCCs (263, 264, and 267) were created by reconfiguring HCCs 107-108 in the 2024 CMS-HCC model.

The updated model focuses on more severe cases of atherosclerosis of arteries of extremities, while less severe manifestations are mapped to lower-level HCCs.

Metabolic Diseases

The Metabolic disease group in the 2024 CMS-HCC model expanded to four (4) payment HCCs from three (3) in the 2020 model.

High-cost lysosomal storage disorders were split into a new HCC (49).

Metabolic and endocrine disorders were separated into HCCs 50 & 51 based on cost and clinical considerations.

Other conditions with lower cost implications or indicating lab test results were mapped to non-payment HCCs.

Coding Corner (continued)

Heart Diseases

The Heart disease group in the 2024 CMS-HCC model expanded to 10 payment HCCs from five (5) in the 2020 model.

HCC 85 Congestive Heart Failure was split into five (5) payment heart failure HCCs (222-226) based on clinical severity and cost differences.

HCC 221 (Heart Transplant Status/Complications) was added to the hierarchy, and HCC 227 (Cardiomyopathy/Myocarditis) was split out as a separate HCC.

Blood Disease

The Blood disease group in the 2024 CMS-HCC model expanded to seven (7) payment HCCs from three (3) in the 2020 model.

Coagulation defects, hemorrhagic conditions, and purpura were mapped to payment HCC 112 or non-payment HCC based on clinical severity and specificity.

Immune conditions were split into HCCs 114 & 115, with costlier and clinically severe conditions in HCC 114 and other specified disorders in HCC 115.

Amputation

The Amputation disease group in the 2020 CMS-HCC model was reconfigured in the 2024 CMS-HCC model to cover initial complications or ongoing costs of lower limb amputation.

Acquired absence codes for toe and finger were mapped to non-payment HCC to classify them accurately based on disease burden and cost prediction.

Neurological Diseases

The Neurological disease group in the 2024 CMS-HCC model expanded to twelve payment HCCs from eight in the 2020 model.

HCC 75 was reconfigured into HCCs 193-196 based on under-predicted and chronic codes.

Acute Guillain-Barre Syndrome became a non-payment HCC, and Myasthenia gravis codes were reconfigured into two payment HCCs based on clinical severity and cost differences.

Coding Corner (continued)

Diabetes

The Diabetes disease group in the 2024 CMS-HCC model has four payment HCCs, including HCC 35 added at the top of the hierarchy.

Diagnosis codes for diabetes with unspecified complications and complications related to glycemic control were moved to the lowest payment (HCC 38).

Severe acute complications related to glycemic control remain in the highest payment (HCC 36), while some drug-induced diabetes codes were mapped to non-payment HCCs.

Kidney Disease

The Kidney disease group in the 2024 CMS-HCC model has four payment HCCs, replacing HCC 138 with more granular HCCs (328 & 329) based on new ICD-10 codes.

HCCs related to dialysis status and acute kidney failure were removed from the payment model, and new HCCs (324 & 325) were added based on chronic kidney disease (CKD) stages.

What are the key updates in the 2024 CMS-HCC model for vascular diseases?

✓ The 2024 CMS-HCC model introduces three new HCCs (263, 264, & 267) by reconfiguring HCCs 107-108. The updated model focuses on more severe cases of atherosclerosis of arteries of extremities, while less severe manifestations are mapped to lower-level HCCs.

How has the metabolic disease group changed in the 2024 CMS-HCC model?

✓ In the 2024 CMS-HCC model, the metabolic disease group expanded to four payment HCCs from three in the 2020 model. High-cost lysosomal storage disorders were split into a new HCC (49), and metabolic and endocrine disorders were separated into HCCs 50 and 51 based on cost and clinical considerations. Other conditions with lower cost implications or indicating lab test results were mapped to non-payment HCCs.

What updates have been made to the heart disease group in the 2024 CMS-HCC model?

✓ The heart disease group in the 2024 CMS-HCC model expanded to ten payment HCCs from five in the 2020 model. HCC 85 Congestive Heart Failure was split into five (5) payment heart failure HCCs (222-226) based on clinical severity and cost differences. HCC 221 (Heart Transplant Status/Complications) was added to the hierarchy, and HCC 227 (Cardiomyopathy/Myocarditis) was split out as a separate HCC.

These FAQs cover important updates in the 2024 CMS-HCC model and can be used to inform coders and providers about the changes related to HCCs and coding for accurate risk adjustment. If you have any further questions, please reach out to coding@glin.com

For more information on: Upcoming Changes to 2024 CMS-HCC Model

Featured Measure: Focus on Pediatrics

Well-Child & Adolescent Well Visits (0-17 years old)

Measure Definition

The percentage of members who had the following number of well-child visits with a PCP during the last 15 months. The following rates are reported:

- Well-child in the first 15 months. Children who turned 15 months old during the measurement year: Six (6) or more well-child visits.
- Well-child Visits for Age 15 months-30 months. Children who turned 30 months old during the measurement year: Two (2) or more well-child visits.
- The percentage of members 3-17 years of age who had at least one (1) comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.

Exclusions

- Hospice Care

CPTII Codes

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

Did You Know?

- Well-child visits need to be performed by a Primary Care Physician (PCP), but do not have to be with an assigned PCP.

Tips for Success

- Schedule the next well visit at check-out
- Have a recall process for those that are not scheduled such as outreach calls letters, texts, or patient portal reminder blasts

Featured Measure: Focus on Pediatrics (continued)

Adolescent BMI Screening

Measure Definition

The percentage of members 3-17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of the following during the measurement year:

- BMI percentile documentation
- Counseling for nutrition
- Counseling for physical activity

Exclusions

- Hospice care

CPT Codes

- BMI Percentile codes: Z68.51, Z68.52, Z68.53, Z68.54
- Nutrition Counseling codes: Z71.3, CPT: 97802, 97803, 97804
- Physical Activity Counseling Code Z71.82

Did You Know?

- BMI ranges, thresholds or BMI values alone do not meet the metric
- A notation of “well nourished” does not meet the nutrition counseling metric
- A notation of “cleared for gym class” will not meet the counseling for activity metric

Tips for Success

Always record height and weight in your medical record and confirm your EMR includes a plotted age growth chart for the BMI percentile

Weight assessment and counseling for proper nutrition can be done at any visit. Counseling may include a discussion of current nutrition behaviors, a checklist indicating nutrition was addressed, counseling or referral for nutrition education, that the patient received educational materials on nutrition during a face-to-face visit with anticipatory guidance for nutrition, weight, or obesity counseling

Promote physical activity at every visit. Provide parents of children ages 4+ age-appropriate handouts that include a section on physical activity outside of developmental milestones. A checklist indicating that physical activity was addressed or evidence of a sport will meet the metric

Adolescent Immunizations (Combo 2)

Measure Definition

The percentage of adolescents 13 years of age who had the following vaccinations by their 13 birthday:

- (1) Meningococcal conjugate vaccine
- (1) Tdap vaccine
- Complete HPV series

Exclusions

- Hospice Care

Codes

Meningococcal 90619, 90733, 90734, Tdap 90715, HPV series 90649, 90650, 90651

Did You Know?

- Parent refusal of vaccine does not remove a patient from the denominator
- Documentation that immunizations are up to date does not meet compliance

Tips for Success with HPV Series

- Bundle your recommendation-recommend all adolescent immunizations at one time. "Now that your child is 11, they need three vaccines to help protect against meningitis, HPV cancers, and whooping cough"
- Ensure a consistent message-office staff should receive training on how to communicate with parents about the vaccine. Starting with the front office, everyone should be on the same page when it comes to proper vaccination practices, recommendations, and how to answer questions.
- Use every visit as an opportunity to educate and vaccinate.
- Provider personal examples. Give examples of how you support vaccinations for your family members to show you believe they are important. Share how you recommended or administered the HPV vaccine for your own children, grandchildren, or family members.
- Effectively answer questions. Be prepared to answer parents' questions accurately and empathetically by using terms they understand.

Childhood Immunizations (Combo 3)

Measure Definition

The percentage of children two (2) years of age who had the following vaccines by their second birthday:

- (4) DTaP
- (3) IPV
- (3) HIB
- (3) Hep B
- (1) MMR
- (1) VZV
- (4) PCV

Exclusions

- Hospice Care, adverse vaccine reactions

Codes

DTap-90696, 90697, 90698, 90700, 90723 IPV- 90697, 90698, 90713, 90723 HIB- 90645-48, 90697, 90698, 90748 Hep B-90723, 90740, 90744, 90747 MMR-90710, VZV-90670, 90710, 90716, PCV-90670

Tips for Success

- Record all immunizations given in the hospital in the medical record
- Consider chart alerts for immunizations due or overdue
- Review vaccine status with parents and give immunizations at visits other than well appointments
- Schedule appointments for the next vaccinations before the patient leaves the office
- Use phone calls, postcards, texts letters to keep parents engaged
- Offer extended hours, walk-in clinics or drive-up immunization sites
- Enter all immunizations in the NYSIIS at the time of vaccination

Supplemental Data Submission

2023 Final Submissions Dates					
Insurance	**Submissions Portal Name**	**Submissions Fax Number**	**Submissions Secure Email Address**	**Data Acceptance**	**Last Date to Submit Date**
BCBS Amerigroup	N/A	Secure fax to: 1-844-759-5955	N/A	Now	December 29, 2023
Monroe/Molina	Flat file transfer. Email stolbert@monroeplan.com for details	Secure fax to 1-877-244-3771 or 1-844-879-4471	Quality@monroeplan.com	Now	December 29, 2023
IHA	Upload data to the IHA provider portal	N/A	N/A	Now	January 3, 2024
United Healthcare	PDF and upload gaps submissions to the UHC OPTUM Practice assist website.	N/A	N/A	Now	January 10, 2024 AC1 only January 31. 2024
Highmark BCBS	Axway portal/desktop (preferred). Do not need a compliance form if using Axway.	Complete the Quality Compliance form and fax it along with supplemental data to 1-888-297-0771 (new fax number for 2023)	N/A	Now	January 17, 2024
Fidelis	Can be uploaded to secure FTP account	Secure fax to QCI records: 1-833-418-0922	N/A	Now	February 1, 2024
Univera	Can be uploaded to secure FTP account	Year-end PDF of supp data to GLIN to forward to the insurer. Utilize the gap report as a worklist to outreach to patients. Make sure their AWV, physical exam is completed for the year along with any screening or disease management testing that is due to prepare for year end submissions.	N/A	Year End	TBD

ACO REACH Update

Please review the chart for the 2024 voluntary alignment form submission dates, and payment schedule.

At this time, we continue to recommend that if your office has elected to complete the VA forms, you continue to do so and send them to us **weekly** so GLIN IPA can keep track and be ready to process them for the next submission window. Please remember that the VA process is for patients you are truly managing or are assuming management of long-term primary care services for new patients.

Did you know that patients are able to log into the www.medicare.gov website to list their primary care physician (PCP) as another option? If you would like to post flyers in your practice site educating patients about this process, please see the link below.

It's important to know that even if you choose not to complete the forms, the patients will still be attributed to your practice by the CMS's claims attribution algorithm through their claims look-back period. If you have any questions or concerns, please feel free to reach out to your Practice Transformation Consultant (PTC).

To download the Medicare Beneficiaries Flyer

Practice VA Form Submission

Practice VA Form Submission Deadline	Payment Month
February 9, 2024	May 2024 Payment
May 10, 2024	August 2024 Payment
August 9, 2024	November 2024 Payment

Pharmacy Update

Independent Health Prediabetes Outcome Metric 2023

What is the prediabetes metric?

Members who are between the ages of 18 and 75 years old at of the start of the measure year will be included in this Independent Health specific metric if they have two of the following qualifying events:

- An abnormal lab test result:
  - Fasting blood glucose between 100 and 125 mg/dL
  - Glucose tolerance test between 140 and 199 mg/dL
  - HbA1C between 5.7 and 6.4%
- A prediabetes diagnosis (R73.03)

The two qualifying events may or may not be of different types. For example, a member could qualify with two abnormal HbA1C tests on different dates of service or two prediabetes diagnoses dates on different dates of service, or one abnormal fasting blood glucose test and one abnormal glucose tolerance test on different dates of service.

What excludes patients from this quality metric?

- Pregnancy during the measure year
- Diabetes during the measure year or prior to the measure year
- Palliative care during the measure year
- Hospice during the measure year
- Dialysis
- Dementia
- Eating Disorder
- Active Cancer

How to close this quality gap?

Members are considered compliant if they have a claim for one of the following interventions at any point in the timeframe of January 2021 to March 2024:

1. CDC-recognized diabetes prevention program (DPP)
   - Physical attendance
   - Remote attendance via Brook+
2. Nutrition therapy with a registered dietitian
3. Non-reversed metformin prescription

Pages 13 & 14 include additional details about these programs and interventions.

CDC-Recognized Diabetes Prevention Program (DPP)

A CDC-recognized diabetes prevention program is an organization that has agreed to use a CDC-approved curriculum that meets the duration, intensity, and reporting requirements described in the Diabetes Prevention Recognition Program Standards. A health care professional may refer participants to the program, however a referral is not required for participation.

Local Diabetes Prevention Programs

If a patient is interested in attending an in-person DPP, consider referring patients to one of the programs below. Patients are required to attend in person once a week for 16 weeks then taper to once per month for a total of 22 sessions. The curriculum will focus on education surrounding physical activity, healthy eating, and stress management. This program is covered by most insurance plans. Information regarding available programs and how to sign up is detailed below.

Site	Address	Contact	CDC Recognition Level	In person (Y/N)	Who can attend?
WNY Integrated Care Collaborative	742 Delaware Ave Buffalo, NY 14209	716-431-5100	Full	Y Classes are offered at a variety of WNY locations, refer to their website for a listing of available programs	Open to the public
Rapha Family Wellness Center	3610 Main St Amhert, NY 14214	716-200-4122	Full	Y	Open to the public

Remote Diabetes Prevention Program via Brook+

Brook+ is a CDC-recognized diabetes prevention program that offers the flexibility of completing the program via an app or web-based delivery. In addition to the CDC-required curriculum, Brook+ offers 1:1 lifestyle coaching and a Bluetooth scale to easily track progress during the program. Patients can determine if they are eligible by visiting www.brook.health/plus-dpp-ih/. Brook+ and Independent Health have created a partnership allowing the program to be covered in full for Independent Health members. Additional handouts regarding this program can be provided by the GLIN team upon request.

Nutrition Therapy

Clinicians may consider referring patients to a local nutritionist who is able to bill for their services. Please refer to GLIN's 2023 "Nutritional Services" handout for information on local nutritionists who can meet with patients. There are options for both in-person services as well as telehealth. A one-time consult completed with a nutritionist that is billed through the patient's insurance company would complete the prediabetes outcome measure.

Non-Reversed Metformin Therapy

Patients may be prescribed a minimum of one prescription of metformin at any dose or quantity between January 2021 and March 2024. Consider prescribing metformin in the setting of prediabetes for patients 25 to 59 years of age with a BMI > 35 kg/m2, higher fasting glucose > 110mg/dL and A1C > 6%, and/or in women with a history of gestational diabetes. Additional information regarding metformin treatment can be provided by the GLIN team upon request.

References

1. National Diabetes Prevention Program: Registry of all Recognized Organizations from dprp.cdc.gov. Accessed May 3rd 2023. https://dprp.cdc.gov/Registry
2. Centers for Disease Control and Prevention Diabetes Prevention Recognition Program: Standards and Operating Procedures from cdc.gov. Published May 1 2021, Accessed May 3rd 2023. https://www.cdc.gov/diabetes/prevention/pdf/dprp-standards.pdf

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Nutritional Services

GLIN: GPPC Nutrition Team

(716) 800-CARE (2273) OPT 5

(716) 631-8408

* Telehealth is available.

Kaleida Health

(716) 859-2821 (BGMC)

(716) 568-3664 (MFSH)

(716) 568-3019

www.kaleidahealth.org

Buffalo General Medical Center (BGMC)
100 High Street
Buffalo, NY 14203

Millard Fillmore Suburban Hospital (MFSH)
1540 Maple Road
Williamsville, NY 14221

Lifestyle Nutrition WNY, PLLC

(716) 222-0297

(716) 794-9466

www.lifestylenutritionwny.com

Amherst:
1306 Sweet Home
Clarence:
9097 Main Street
Niagara Falls:
10175 Niagara Falls Blvd
Orchard Park:
3065 Southwestern Blvd, Suite 102
Williamsville:
30 North Union Rd, Suite 101

* Telehealth is available.

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Custom Dietetics, P.C.

(716) 626-7415

(716) 632-0389

www.customdietetics.com

info@customdietetics.com

Williamsville:
2801 Wehrle Drive, Suite 4
Williamsville, NY 14221

* Telehealth is available
Does not accept: Wellcare, BCBS Medicaid, BCBS Essential Plans

Personalized Health Nutrition, PLLC

(716) 710-7022 *Diabetes/Pre-Diabetes Nutrition Counseling Only

(716) 710-7022

www.phnutritiondiabetes.com/visit-us

Amherst:
6000 N. Bailey Ave, Suite 1D
Orchard Park
3675 Southwestern Blvd, Suite 100
3671 Southwestern Blvd, Suite 101
West Amherst:
3950 East Robinson Rd, Suite 207
West Seneca:
1026 Union Road
Williamsville:
1150 Youngs Rd, Suite 104
300 International Drive, Suite 125

AMS Nutrition Counseling, PLLC

(716) 266-6056

(716) 332-6412

www.amsnutritioncounseling.com

amy@AMSnutritioncounseling.com

Lockport:
6411B Dysinger Road

* Telehealth is available
Does not accept: BCBS Medicaid, BCBS Child Health Plus Plans and Healthier Life Plans

Things to consider:
- MVS Medicaid and Fidelis do not cover any dietician visits.
- Only Medicare patients with diagnoses of CKD (stage 3 through stage 5) or diagnosis of diabetes are covered for dietician services.
- Referrals may or not be needed based on the specific payer, so referrals would be suggested to streamline patient scheduling with a dietitian.

Upcoming Events & Meetings

2023 Q4 Stategic TownHall Meeting

Wednesday
November 15
7-8 a.m.

2023 Quality Roundtable Dates

Wednesday
December 13
7:45 a.m.

2023 Virtual GLIN & UBFM Clinical Care Pathway Didactic Presentations

Social Determinants of Health (SDoH)
Thursday, December 7
12:30 - 1 p.m.

For additional questions, please reach out to your assigned Practice Transformation Consultant.

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