PHP PARTNERS HEALTH PLAN

Dear Partner Physician,

Each calendar year CMS develops a "complexity score" for every patient based on the conditions documented in encounters from the year prior. This score is used to determine the resources that are then allocated for their care in the next year. If a condition that is present but historical and stable (e.g. old amputation) is not accounted for in any calendar year, it is not factored in their complexity score for that year. As a nonprofit health plan serving the IDD community, ensuring we have a complete view of every patient, every year, will support our ability to develop new plans and services, and ensure your patient's needs are completely accounted for by CMS.

Attached please find pages for each of your patients with a list of conditions that have been documented over the last two years. If they are still present, even if historical and stable, please make sure each is a subject of attention and documentation during at lease one E&M visit during the year; even if you did not make the diagnosis or it is under the care of a specialist, you can document your acknowledgement, assessment, and plan for any condition in your encounter note. Making this part of regular healthcare maintenance visits will reduce the number of medical record requests from our health plan.

Additionally, we have prepared a preventive services checklist below, to support your efforts and to ensure a comprehensive plan of care is completed during the calendar year. Every Partners Health Plan (PHP) member has an assigned Care Manager that you or your office staff can reach out to, who can support your patient's needs for referrals, transportation and other ways of achieving your plan of care. To confirm who a patient's PHP Care Manager is, you can call our Provider Services line at 855-747-5483.

Healthcare Maintenance

- ☐ Due to the unique risks of patients with IDD, we would encourage you to reach out and schedule a healthcare maintenance visit with this patient during the first six months of 2025, review early preventive interventions and consider preventive services needs even during a problem-oriented encounter.

- ☐ In addition, we strongly suggest additional proactive preventive services visits over the year. This is a best practice with the IDD community and allows for:

  a) focus on preventive care outside of problem-oriented encounters
  b) monitoring and 'early intervention' for chronic medical and behavioral health conditions
  c) reduction in use of emergency services for ambulatory care sensitive conditions.

Preventive Services

People with IDD have distinct patterns of risks and conditions, and we suggest some screening and assessments that are especially relevant to the IDD community. PHP Care Managers can support your efforts with referrals, scheduling, transportation or providing validated screening tools.

- ☐ Immunizations (Flu, Pneumonia, RSV, Covid-19, as appropriate)
- ☐ Dental Care
- ☐ Hearing/Vision Testing
- ☐ Nutrition screening
- ☐ Physical activity assessment (If non-ambulatory, consider physical therapy)
- ☐ Cancer Screenings (Colon, Breast, Cervical)
- ☐ Functional Status (Activities of daily living)
- ☐ Falls Risk
- ☐ Mental Health (Depression, anxiety, loneliness)
- ☐ Choking/Aspiration Risk

Continued

Condition Management

PHP members have a higher prevalence of common conditions, we recommend appropriate testing, documentation, medication management and nutrition/physical activity programs for these conditions.

Hypertension	Monitor/Prescribe/Treat to Target Encourage 90-day prescriptions; adherence reminder at each encounter
Diabetes	Monitor HgbA1c Monitor blood pressure Preventive prescription of ACE Inhibitor and Statin Annual eye exam; kidney health evaluation
Cardiovascular Disease	Monitor/Prescribe/Treat to Target Encourage 90-day prescriptions; adherence reminder at each encounter
COPD/Asthma	Encourage 90-day prescriptions; adherence reminder at each encounter
Behavioral Health	Encourage 90-day prescriptions; adherence reminder at each encounter

Advance Care Plan (ACP)

With their growing life expectancy, the numbers of older adults with IDD continues to expand, and community agencies and families now face the challenge of providing support as these adults experience age-related changes. In comparison with adults without long-term disabilities, adults with IDD are more likely to experience earlier age-related health changes, limited access to quality health care, and fewer financial resources. In addition, they are more likely to be living with parents into adulthood and have more limited social supports and friendships outside the family. This all speaks to the need for Advance Care Planning (ACP) in early adulthood for individuals with IDD.

☐ We recommend a discussion about Advance Care Planning take place annually during a preventive services encounter. It is not necessary to generate an ACP, simply to share the forms and discuss the ACP for at least 16 minutes during a face-to-face visit (billable as CPT 99497). If an ACP is developed there are additional billing codes that can be used.

In closing, PHP has an "open-door" policy for all the members of our professional network, so please feel free to reach out with any questions or other considerations regarding your role in caring for our shared service community.

Regards,

Maulik M. Trivedi, MD, FACEP
Medical Director
Partners Health Plan

Comprehensive Conditions List

Patient Name	DOB	CONDITION & ICD 10 Code
		E6601: Morbid (severe) obesity due to excess calories I422: Other hypertrophic cardiomyopathy Z6841: Body mass index [BMI] 40.0-44.9, adult Z6842: Body mass index [BMI] 45.0-49.9, adult