THE PARADIGM

Our Journey to Value-based Healthcare

1ST QUARTER 2018 ISSUE OF THE PARADIGM!

Physician Alliance of the Rockies (PAR) wishes you a New Year of health, happiness, and prosperity! Our goals continue to focus on improved patient care quality outcomes, improved patient experience, lower cost of care, and improved physician practice satisfaction.

DID YOU KNOW?

One of the main ways that Accountable Care Organizations (ACO's) seek to reduce health care costs is by encouraging doctors, hospitals, and other health care providers to form clinically integrated networks and partnerships that coordinate patient care and become eligible for bonuses when they deliver that high-quality care more efficiently.

As the payment model continues to evolve, payers, hospital systems, and providers increasingly bear more risk. As a result, efforts to continue to strengthen care coordination are a high priority.

To that end, we are considering utilizing a physician-vetted list of preferred specialist partners for further care coordination. We will keep you updated as we have more information.

New Medicare Advantage ACO Incentive Model for 2018

In conjunction with Physician Alliance of the Rockies, United Healthcare has developed and implemented a Medicare Advantage ACO Incentive Model for 2018 dates of service. There is a Financial Performance Program in the model that includes the potential for incentive payments based on ACO's Medical Loss Ratio (MLR), which is defined as the actual medical costs compared to total premium revenues. Any payments made to ACO PCPs will be in addition to the fee-for-service payment you receive and other incentive programs in which you currently participate.

Based on historical data, a baseline Medical Loss Ratio (MLR) target has been established at 86% for 2018. Below demonstrates how the model will make payments based on achievement level:

- Actual MLR less than 86% but greater than or equal to 83%, the ACO PCP percentage share of the surplus would be 50%
- Actual MLR below 83%, the ACO PCP percentage share of the surplus would be 85%

If Medical Loss Ratio achievement levels do not reach less than 86%, there will not be any incentive payment for the ACO PCPs, and you will not be required to pay a percentage of the share of the deficit. This is an **upside only** ACO Incentive Model for 2018 dates of service.

There are many tools and support Physician Alliance of the Rockies provides to assist with achieving these incentive payments, while maintaining or improving quality of care. We will continue to work closely with you to discuss and implement these tools as well as share your performance metrics.

PCP PHYSICIANS: PLEASE MARK YOUR CALENDARS

In the 1st quarter of 2018, we will be coordinating two dinner meetings **(only need to attend one)** to discuss further details around this program, as well as the vision for 2019 and beyond.

On Tuesday, March 6, 2018 our first dinner meeting option will be at the Denver West Office, located at 1707 Cole Boulevard, Suite 100, Golden, CO, 80401.

OR

On Wednesday, March 7, 2018 our second dinner meeting option will be at the DoubleTree Denver Tech Center (DTC) located at 7801 East Orchard Road, Greenwood Village, CO, 80111.

Plan to attend the location which is most convenient for you. Please keep an eye out in the next week or two for an invitation to RSVP for this important meeting.

Risk Adjustment Factor (RAF)

What is RAF?

Risk adjustment is a method of adapting payment to medical practices using hierarchical condition categories (HCCs). HCCs are diagnoses selected for this payment method based on factors influencing patient care. Disease hierarchies are a way to determine the severity of a disease, which is used by Medicare to assign the premium—the sicker the patient, the higher the reimbursement. Some of these factors are age, demographics, disability, and chronic conditions. There are only limited selections of diagnosis codes included in the Centers for Medicare & Medicaid Services (CMS) HCC model.

Healthcare in the United States is moving away from Fee-For-Service (FFS) reimbursement which incentivizes more care, not better care. Value-based, or risk, contracts are much better suited to helping achieve the quadruple aim of lower cost/higher efficiency/increased patient and provider satisfaction. In value-based care, providers/groups are evaluated more on the total cost of care rather than individual episodes of care. To reduce the cherry-picking of lower cost patients, the RAF system was created to level the playing field so that all patients/providers could be treated with fairness.

How is RAF determined and what is the criteria?

1) A demographic RAF based on age & sex
2) Additional demographic risk factors are added for Medicaid status & if patient was eligible for Medicare due to a disability
3) A RAF for the total of all chronic conditions (HCC) & some disease interactions are reported

HCC diagnosis codes need to be documented yearly for that addition to the RAF score to be captured. CMS regularly readjusts the ICD-10 codes (and RAF adjustment) to target a nationwide average RAF of 1.0. A reasonable goal for each physician/practice is an average RAF score > 1.0.

Are you *assessing* all chronic health conditions such as hypertension, chronic kidney disease, depression, etc., at least once a year? If not, you are not receiving the reimbursement due to your facility—even if your provider is actively treating these conditions.

Are you listing all coexisting conditions such as diabetes mellitus and congestive heart failure or chronic obstructive pulmonary disease and congestive heart failure? These and other condition combinations increase the cost to care for the patient and, if not documented, cannot be coded. Ultimately, this decreases your reimbursement.

A typical 75-year old senior patient with DM, CHF, and PAD who is not seen (no RAF codes captured) might have a RAF score of 0.6 based on demographics alone. This could translate into premium dollars of ~ $6,000/yr. The same patient with strong and accurate documentation of these conditions might have a RAF score of 2.0, leading to ~ $20,000/yr in premium dollars.

So why does it matter?

Provider documentation ensures patients' health status is conveyed accurately and completely while capturing appropriate reimbursement. Increased RAF score directly translates into increased premium dollars to be able to care for patients and cover the cost of medications, hospitalizations, specialists care, imaging, etc. High functioning group practices/IPA groups practicing Value Based Contracts (no FFS) generate revenue with higher RAF scores coupled with cost-efficient care. Higher numbers of Medicare Advantage members/RAF score and lower total cost of care, position the individual provider to earn bonus dollars in this type of risk arrangement.

Thank you for your time and let us know if you have any questions or comments about the information provided.

Warm regards,

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