PHYSICIAN ALLIANCE OF THE ROCKIES

THE PARADIGM

Our Journey to Value-based Healthcare

1ST QUARTER 2019 ISSUE OF THE PARADIGM!

Incentive Performance Results are in for 4th Quarter!

The first incentive is regarding the accurate completion of the attestation form for UHC Medicare Advantage member condition documentation on an annual physical during the performance quarter. Overall, **609** attestations were submitted during the 4th quarter 2018, representing 44 PAR physicians and 29 PAR practices. This was an increase of **17%** for submitted attestations compared to 3rd quarter 2018. Approximately **60%** of the total submitted attestations in the 4th quarter were approved for payment, which was a similar percentage compared to the 3rd quarter.

AS AN IMPORTANT REMINDER TO MAXIMIZE THIS INCENTIVE:
For each accurately completed attestation form submitted with the patient's clinical health maintenance/physical visit charted notes, where the high-risk conditions have been appropriately documented and coded, an incentive payment of $100 will be paid to the PCP. All of the attestation forms and clinical notes will be reviewed to determine the clinical note support for designated diagnoses. The attestations with either no or insufficient documentation and coding for the high-risk conditions checked on the attestation form will not be eligible for the incentive payment. Details regarding this submission process of the completed attestation form to earn this incentive are on our website at www.paotr.com.

The second incentive is regarding the use of the PAR Preferred Specialist Network. The overall percentage use of the PAR Preferred Specialist Network during the 4th quarter remained steady from the 3rd quarter at **66%**. However, during the 4th quarter, **97%** of the PAR PCP providers achieved at least the tier 1 performance (>= 50%) for Preferred Network referrals compared to 3rd quarter with only **83%** of the PAR PCP providers achieving at least the tier 1 performance.

To assist with Preferred Specialist Network usage, a flag will appear on the Physician Portal when you have **not** selected a Preferred Specialist **(see snapshot of Referral Submission screen below)**.

AS AN IMPORTANT REMINDER TO MAXIMIZE THIS INCENTIVE:
Prior to proceeding with a non-preferred specialist, you have the option to edit your specialist referral to a preferred specialist, which will significantly impact your incentive payout.

DID YOU KNOW?

PAR will be distributing the 4th quarter 2018 incentive checks at the dinner meeting.

Attending the upcoming PAR Dinner meeting is also a great way to interact with your colleagues, in addition to hearing about the exciting plans we have for 2019.

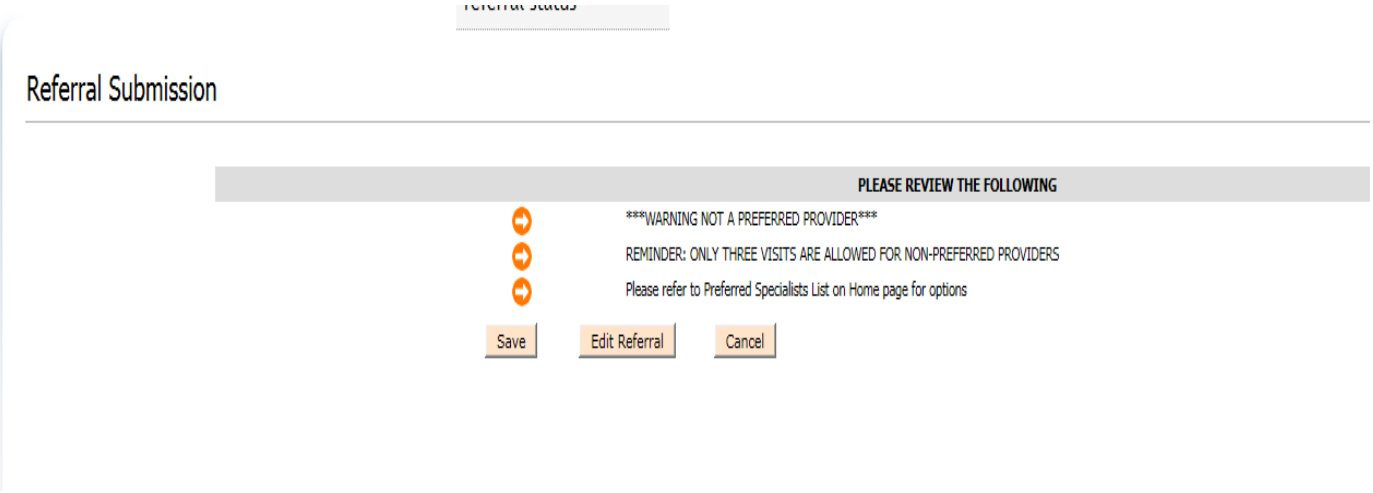
The next PAR Dinner meeting is scheduled for Tuesday, January 22, 2019.

Mark your calendar and remember to RSVP to Lynn Diamond at lynn.diamond@paotr.com by Friday, January 11th. See you there!

All you need to do is click the **"Edit Referral"** button rather than **"Save"** button. Please visit our website at www.paotr.com, click on Forms and Documents for the latest updated Preferred Specialist Network list.

PAR calculates the number of preferred specialist referrals as a percentage of total specialist referrals on a quarterly basis. There are three performance tiers for this Preferred Specialist Network incentive and they are as follows:

- Tier 1: 50-69% preferred specialist use = $1 PMPM
- Tier 2: 70-84% preferred specialist use = $3 PMPM
- Tier 3: 85-100% preferred specialist use = $5 PMPM



Similar to the Attestation Completion incentive program, this Preferred Specialist Network incentive will be calculated quarterly and will be paid out after each quarter end. We must have a W-9 form on file prior to distributing any incentive fund payment.

PAR IPA Advisory Committee Meeting Updates

PAR IPA Advisory Committee had its inaugural meeting in October with a good discussion on how best we can support each PAR practice to achieve the Quadruple Aim:

- Improved patient care quality
- Improved patient experience
- Lower cost of care through appropriate medical care
- Improved physician practice satisfaction

Some of the initial agenda items discussed included the following:

- PAR communication effectiveness to include the mode of communication and topics/content of communication
- Review of data/metrics including PMPM trending reports and utilization reports
  - PCP specialist referral data
  - Risk Adjustment Factor (RAF)
  - Coding and quality data (HCC performance)
- ACO Medicare Advantage Shared Savings model and structure:
  - Financial Performance Program that includes the potential for shared savings incentive payments
  - Financial target is the ratio of Total Medical Costs to Total Revenue
  - Must also meet defined Eligibility Criteria Requirements in order to receive shared savings payments
- Identify provider education topics based upon review of performance data
- Medicare FFS to MA Conversion
- ACO Commercial strategy and input to determine value proposition

PAR ACO Medicare Advantage (MA) Shared Savings Program Summary

The PAR ACO MA shared savings program is a vehicle for facilitating the clinical integration and coordination of ACO providers in order to promote quality and efficiency gains in the delivery of health care. To accomplish those goals, United Healthcare has created an incentive program to reward ACO for achieving specific objective measures in the delivery of care by ACO providers to United MA members.

Included in this model is a Financial Performance Program that includes the potential for shared savings incentive payments based on aggregate of all ACO Provider's actual performance against an established target/budget of **86%**. The financial target is the ratio of Total Medical Costs to Total Revenue.

The ACO is not eligible to receive payment under the Financial Performance Program, if ACO has not met the applicable Eligibility Criteria Requirements described below, which can be amended from time to time.

Eligibility Criteria Requirement	Description	Performance / Threshold
HbA1c Screening – Diabetic	Percent of eligible members who have had a HbA1c test this calendar year.	90% / 80%
Nephropathy Screening – Diabetic	Percent of eligible members who have had a Kidney function test this calendar year.	69% / 85%
BMP/CMP/Renal Panel - Congestive Heart Failure and/or Renal Disease	Percent of eligible members who have had a BMP or CMP or Renal Panel test this calendar year.	66% / 65%
Annual Comprehensive PCP Visit	Percent of eligible members who have had a comprehensive office visit with a PCP this calendar year.	81% / 75%

Commercial Accountable Care Organization (ACO) Opportunities

PAR is beginning to assess the opportunity to support your commercial patients through Commercial ACOs for the major health plans you are currently contracted. Our vision is for PAR to medically manage all commercial membership in your panel for the identified plans and establish performance-based incentive programs through shared savings.

Data has shown that a successful care management program begins with embedded care coordinators who are skilled in:

1) Identifying your high-risk patients
2) Providing the best transitions of care
3) Reviewing high utilizers of ER
4) Following hospital discharges for appropriate follow-up care with PCP

We will be discussing ACO Commercial opportunities in more depth at the upcoming dinner meeting on Tuesday, January 22, 2019. In the meantime, **please complete the attached interest form and send back to us by Friday, January 18, 2019**, which will allow us to better facilitate the conversation at the dinner meeting.

We are excited about this opportunity and believe there would be benefit from an ACO Commercial agreement with PAR. We look forward to working with you to achieve this vision.

RAF Education/Coding Tip

HCC 108 - VASCULAR

We are all aware that vascular disease is common in patients across all age groups and tends to worsen over time. As a group our capture of RAF vascular codes is only about 15% of the population and would be predicted to be closer to 40%. Many diagnoses “map” to this RAF score, including atherosclerosis of the aorta, arterial aneurysms, diabetic peripheral angiopathy, generic PAD/PVD, arteriosclerosis of specific vascular beds, and even venous thromboembolic disease (though not always a yearly recurring diagnosis of course). The vast majority of vascular diagnoses can be found on existing imaging reports. Once an ASCVD code is placed you should immediately review whether or not the patient is being appropriately treated with a statin. Current HEDIS/STAR measures for adults (males age 21-75 and females 40-75) are for a moderate to high dose statin AND 80% adherence to the statin medication during the year.

HCC 75 - POLYNEUROPATHY

It is predicted that upwards of 10% of the Medicare population suffers from neuropathy, however we are only capturing this RAF code 2.2% of the time. Part of the issue is simply technical as only very specific ICD-10 codes count towards a patients RAF score (idiopathic peripheral neuropathy or peripheral neuropathy do NOT count). Different conditions can lead to peripheral polyneuropathy, including:

Diabetes which is the most common cause (RAF adjusts to a different HCC)

Drugs including certain chemotherapy and HIV medications.

Vitamin deficiencies (B12).

Hereditary diseases like Charcot-Marie-Tooth Syndrome and Friedreich's ataxia.

Infections like Guillain-Barré.

Alcohol usage.

Chronic conditions like Kidney and Liver.

Hypothyroidism.

Inflammatory conditions like Sarcoidosis and Celiac Disease.

Symptoms can include a pins and needles sensation, electric or shooting pain, numbness and weakness, inability to sense temperature changes, loss of coordination, and muscle wasting or atrophy. It is important to consider and rule out any CNS or nerve root cause of symptoms otherwise suggestive of neuropathy. History and simple exam go a long way to diagnose peripheral neuropathy. Common physical exam findings include loss of ankle jerk reflexes, pinprick loss, and vibration sense decrease. The 128 Hz tuning fork is probably the most powerful tool to aid in diagnosis. I recommend skipping the monofilament exam in most patients. Lab testing should initially include: blood sugar, thyroid, B12/MMA, and then further consideration of SPEP/IFE, ESR/ANA/RF, and HIV, Hep B/C testing if clinically appropriate.

While some codes are obvious—chemotherapy induced peripheral neuropathy (G62.0) or alcoholic peripheral neuropathy (G62.1), others require more nuance in documentation. Prediabetes, B12 deficiency, or hypothyroidism induced neuropathy require a LINKING of the G63 (neuropathy in medical condition) code WITH the prediabetes/B12/thyroid code at the same office visit. The provider needs to directly imply the causative intent of neuropathy. Otherwise, it does not appropriately capture the RAF and meet coding guidelines.

For more information about education and medical management insights, please see attached **OptumCare Forum for Evidence-Based Medicine - November/December, 2018 issue.**

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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Medical Director

Glenn Kjosen, MBA
Vice President and Executive Director