Mission: We provide superior healthcare and value through an integrated partnership among patients, providers, and community resources.

Chairman of MWMD Board

Message from Thomas A. Janus, DO

Information regarding the Alliance's participation in NextGen ACO(NGACO) is still embargoed by CMS/CMMI. Because this newsletter is available to non Alliance members, I am not permitted to discuss our status with the NGACO application at this time.

I would like to review the advantages of moving to the NGACO program rather than staying in the MSSP plan or doing MIPS. Embedded within NGACO are unique features, some designed to improve quality and efficiency and some which will clearly improve our financial success.

Being of the mindset when we succeed in improving our quality and efficiency our financial performance will improve, let's address these aspects first. NextGen offers the opportunity to utilize certain waivers of standard care, which when employed will provide new treatment approaches enabling better outcomes and enhancing efficiency.

The first of these waivers is the ability to implement a Telehealth program, in which physicians can have virtual interactions with patients who are not in the office/hospital and be reimbursed for these services. Imagine the ability to better assess patients not in the office as to whether an ER visit is required or not. Our goal of the right care at the right place at the right time is more achievable. The expansion of this waiver to other settings is so powerful in our ability to create improvements of how we care for patients.

Another waiver granted by participating in NGACO permits physicians to send licensed clinicians, including nurses, into the homes of NGACO patients post discharge and likewise be reimbursed for these services. This should assist in smoother transitions from hospital to home, leading to fewer readmissions and better patient outcomes.

Other waivers will eliminate the need for a three-day hospital stay for patients requiring nursing home admissions from home. Still another waiver will actually pay patients $25 to complete their Annual Wellness Visit.

The financial benefits of NGACO are likewise quite extensive and likely more familiar to our Alliance members. Included would be the 5% bonus all physicians would receive to their part B Medicare reimbursements as NGACO qualifies as an Advanced APM model. This exonerates Alliance physicians from the potential risk of downside reimbursements associated with the MIPS world. Likewise, being in an aAPM alleviates the tedious reporting required by physicians in MIPS.

NextGen also has unique features that permit the Alliance to bring home 100% of the dollars we saved in caring for our patients. These features include the elimination of a minimum savings rate, every dollar saved below our target is ours. Our benchmark year is 2014 for the first three years of the program. So all the work the Alliance has done in the past 4 years to reduce spending will play to our advantage. And perhaps most comforting for all physicians within the Alliance, in a financial risk program, there is absolutely no financial risk imposed upon the physicians.

NextGen can clearly be a revenue source for the Alliance. Considering our Medicare patients are typically our most complex group of patients to treat, yet reimbursement for theses services is near the lowest, any additional stream of income for caring for these patients is welcome. Additionally, as CMS/CMMI test new care management approaches, we are very fortunate to be on the ground level of offering these services, which will benefit not only our patients but also streamline our workload. I anticipate great outcomes for the Alliance and our patients in the NextGen program. Clearly this is the best option for MWMD as we move forward.

Thomas A. Janus, DO

Inside this Issue:

Message from the Medical Director—Richard Lewis, MD

Alliance Notes on Quality, 2017

Many feel that **Quality** as it applies to healthcare is a difficult thing to define. I favor the following definition from the Institute of Medicine (especially as it applies to a clinically integrated network like the Alliance dedicated to promoting Population Health): Quality is "**The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge**."

Not only is quality in healthcare difficult to define, it is difficult to measure and quantify. It reminds me of what Justice Potter Stewart said about pornography in the famous obscenity case of Jacobellis v.Ohio in 1964 when he commented that "hard-core pornography" was hard to define, but that "I know it when I see it". Things like compassion, empathy and deductive reasoning are all important features in caring for patients but are very hard to measure. Our quality measures need to be discreet, quantifiable, relatively simple to measure and reproducible. GPRO (Group Practice Reporting Option) measures, which are a component of the MSSP (Medicare Shared Savings Program) which we have been participating in since 2015, meet these criteria. The following table documents our GPRO performance in both 2015 and 2016. The embargo on releasing this data to the public was recently lifted by CMS and, therefore, you are now free to discuss this excellent quality performance outside the confines of the Alliance. The "Status" column shows that 11 of the 18 measures were performance measures in 2016. 2015 was a reporting year only. "Statin Therapy" was not a reported measure in 2015. It is apparent that 11 of the measures improved year over year, some dramatically so (Fall Risk Screening, Composite Diabetes Score and Depression Screening). The only one that went down significantly was "Breast Cancer Screening" and this is only because CMS did not accept 3-D mammograms in 2016. 3-D mammography will be accepted as complying with the measure in 2017.

Module Name	Total Patients Sampled	Worked	Status	2016 PY Compliance	2015 PY Compliance
Fall Risk (CARE-2)	616	573	P	59.04%	30.16%
Documentation of Current Medications in the Medical Record (CARE-3)	616	569	P	92.36%	85.58%
Coronary Artery Disease (CAD-7)	616	587	R	74.23%	79.60%
Diabetes Mellitus HbA1c < 9% (DM2)	616	574	P	53.01%	30.79%
Diabetes Mellitus Retinopathy Screening (DM7)	616	574			
Heart Failure (HF-6)	532	516	R	98.79%	96.37%
Hypertension (HTN-2)	616	586	P	77.42%	75.34%
Ischemic Vascular Disease (IVD-2)	616	587	P	90.91%	89.75%
Depression Remission at Twelve Months (MH-1)	616	586	R	n=7 0	0.00%
Breast Cancer Screen (PREV-5)	616	581	R	45.01%	63.53%
Colorectal Cancer Screen (PREV-6)	616	544	R	68.80%	61.75%
Flu Immunization (PREV-7)	616	573	P	56.05%	57.79%
Pneumonia Vaccination (PREV-8)	616	573	P	78.71%	57.07%
Body Mass Index Screen (PREV-9)	616	569	P	82.14%	70.55%
Tobacco Use (PREV-10)	616	569	P	95.00%	95.96%
High Blood Pressure Screen (PREV-11)	616	424	R	76.53%	58.79%
Clinical Depression Screen (PREV-12)	616	569	P	30.68%	18.07%
Statin Therapy for Prevention Treatment of Cardiovascular Disease (PREV-13)	750	569	R	81.12%	n/a

This improvement is a testament to the Alliance IT team which accurately quantified our performance, mined real-time data from our EMRs, reported this to you regularly throughout the year and instructed our practices on how best to comply with these measures. And, of course, it reflects our practices and providers having cooperated with our Alliance team in doing the work necessary and having documented it accurately in their EMRs. This bodes well for the future success of the Alliance; i.e. that we can identify opportunities for improvement, put together an appropriate plan and then put that plan into action. We have made a commitment to value-based care. As such, our payer partners will continue to monitor our performance to ensure that we are delivering more efficient care without compromising the quality of the care we deliver. Our quality performance to date is testimony to our capacity to do so.

Rick Lewis, MD

Committee Corner...

Message from Patrick McManus, MD
Chair, Membership & Operations Committee, Board of Managers

Membership and Operations committee continues to meet on a routine basis throughout the year primarily to review membership concerns and continually reassess and plan our distribution formula and incentives. The committee is made up of a broad cross section of specialists and primary care physicians both hospital and community based.

The Board of Managers approves the total amount of funds to be distributed annually once the Finance Committee has determined the monies needed to sustain the Health Alliance. The surplus funds are distributed to the physicians using the distribution formula developed by the Membership & Operations committee.

As a matter of review, we have set forth as a committee and approved by our board of managers, Core Eligibility Criteria that must be met by the entire system before any distribution of shared savings occurs. The savings is then distributed based on a formula weighted differently for specialists and primary care providers according to achieving certain benchmarks for quality management.

Our core eligibility criteria include:

Timely payment of dues - annually
Review of Individual Quality Cards, attested annually

The total available monies will be distributed based on:
Shared Savings realized (all or none)

1. Core network metric improvement for all specialties
   - Unplanned readmission rate
   - Admissions per 1000 lives
   - Emergency Department visits per 1000 lives
   - Generic fill rate
2. PCP specific metric improvement
   - Attribution of lives: weighted per physician
   - Preventative metric: yearly hemoglobin A1c check in diabetic patient
   - Utilization: annual flu vaccine
   - Medication adherence: including blood pressure medications, statin therapies, oral diabetic medications
   - Anthem Enhanced Personal Healthcare program compliance with program web portal
     (Access portal monthly)
   - Next generation ACO-Risk Adjustment Factor (RAF) compliance
     Completion of at least 85% ≥ of RAF forms pays 10%

The weighting of each of these categories is illustrated below:

Weighted Percentage of Dollars Distributed	Primary Care Provider (IM, FP, Ped.)	Specialist Physician
1. Network Metrics		
70% of Total Savings		
[Metric 1] 17.5% of total'	✓	✓
[Metric 2] 17.5% of total'	✓	✓
[Metric 3] 17.5% of total'	✓	✓
[Metric 4] 17.5% of total'	✓	✓
2. PCP Specific Metrics		
30% of the Total Savings		
[Metric 5] '4% of total'	✓	
[Metric 6] '4% of total'	✓	
[Metric 7] '4% of total'	✓	
[Metric 8] '4% of total'	✓	
[Metric 9] '4% of total'	✓	
[Metric 10] '10% of total' **Does not apply to Pediatricians**	✓	

(Please note Metric 10 does not apply to Pediatricians as they do not have a sufficient number of RAF forms to comply. Therefore, metrics 5-9 will be weighted 6% each .)

As we as an organization continue to grow with our multiple contracts, now > 75,000 lives, we as a committee are continually discussing how to avoid making the distribution formula too complex that it is difficult to understand and measure but also to avoid over simplification of the process to provide incentives to and reward those physicians that improve quality of care with cost savings most effectively.

Care Coordination Team Update *from Joan Snyder, RN, MS*

The Alliance has had two solid quarters of activity under the Collaborative Commercial Care Coordination (CCCC) program, which involves patients who have insurance coverage through Cigna, Aetna and Innovation Health. The Alliance is proud to add a new payer program as an extension to the CCCC – Anthem's Enhanced Personal Health Care Program (EPHC).

The Anthem EPHC program provides Alliance physicians with tools, resources and information that promote proactive health management and coordinated care delivery. This value based payment program provides financial incentives to Alliance providers for the clinical services they provide outside of a traditional office visit such as coordinating patient care, performing patient follow-up and closing gaps in care. The focus of the Alliance – Anthem collaboration in the EPHC program is for Alliance providers to implement and execute collaborative processes which result in high quality, patient centered care.

All Alliance participating primary care practices (adult and pediatric) will receive risk-adjusted Per Member Per Month reimbursement based on the number of attributed patients in the Alliance. The PMPM base rate is adjusted based on the prospective risk score of each patient in the Alliance attributed population to arrive at a risk-adjusted PMPM for the network.

Each participating practice will establish unique processes or programs to support population health activities such as:

- accessing the EPHC web-based portal on a regular basis
- outreach to high risk patients
- care coordination for patients with high readmission rates
- offering information around unnecessary ED avoidance opportunities
- closing active or upcoming "gaps in care" associated with clinical quality measurement standards.

The Alliance will provide training and support to the practice for accessing the Anthem web based portal, setting up processes for completing care coordination activities and interpreting performance metrics. The Alliance has a team of nurses who will work with each practice to analyze their data, identify specific patient populations for intervention and create processes to target their efforts in each key area. Participating practices will be able to share successful processes with other practices in the program. Anthem also provides a wide range of Learning Opportunities which can be LIVE webinar events or recorded ones.

The EPHC program also offers additional rewards to participating providers who are able to provide appropriate care in a cost effective manner, while maintaining or improving performance against nationally recognized quality measures. Practices are eligible to earn shared savings if the network performance during the measurement period creates "net savings" (ie, network costs in the measurement period come in lower than projected). In order to actually qualify for shared savings payments however, providers must meet a minimum performance threshold – referred to as the **"**quality gate**".**

There are over 35,000 Anthem patients currently attributed to Alliance providers as part of the EPHC program. We are excited to use data provided by Anthem to support care improvements for our patients.

Quarterly PCP Forum

Quarterly PCP Forum
Thursday, October 26
7:00 am
Suite 511 Conference Rm.
2300 Fall Hill Avenue

Topics include: Million Hearts Update, RAF Coding and Aetna RAFT Program

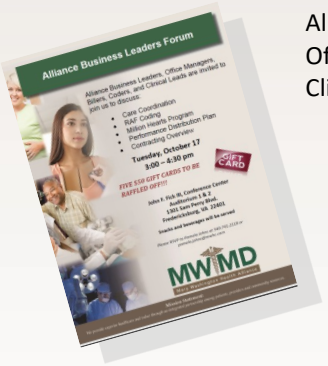
What's New - Updates

GPRO Reporting

We will begin communicating our strategy and expectations for aggregating and reporting 2017 quality data at the end of this month. As a reminder, the Alliance will cover the quality portion of MIPS through our regular annual GPRO (PQRS) reporting process. Your participation in the Alliance also earns you 100% of your Clinical Practice Improvement Activity (CPIA) score for 2017. The Resource Utilization portion has been waved for this introductory year.

If you have any questions about this process please reach out to Thomas Magrino at 540-741-3085 or Dr. Lewis at 540-741-1552.

Business Leader Forum—October 17



Alliance Practice Business Leaders, Office Managers, Billers, Coders and Clinical Leads are invited to join us

Tuesday, October 17
Fick Conference Center
3:00—4:30 pm

- Contracting Overview
- RAF Coding
- Million Hearts Program
- Care Coordination
- Performance Distribution Plan

Five $50 Gift Cards will be raffled off!!!
RSVP to Pam Johns at (540) 741-2118 or pamela.johns@mwhc.com

Welcome New Alliance Practices and Providers

Brian Josephs, MD
Advanced Care for Women

Denis Halmi, MD
Masoud Rezvani, MD
DHMR Clinics

Stephen Balleh, MD
Pearl Horng, MD
FEMA

Pascal Ngongmon, MD
MWMG Sleep Medicine

Ayinde Bourne, MD
Pulmonary Associates of Fred.

Pinky Sharma, MD
Radiologic Associates of Fred.

Dawn Alexander, MD
Rappahannock Family Phys.

William B. Johnson, MD
The Children's Clinic of Fredericksburg

Teresa Kerge, MD
VISA

Manan Mehta, MD
Virginia Oncology Care

Alliance Town Hall Panel Discussion

Providers and Practice Managers are cordially invited to an Alliance Town Hall Panel Discussion
featuring...


Dr. Mike McDermott


Dr. Tom Janus


Dr. Richard Lewis

Monday, November 6 at 6:00 pm
Jepson Alumni Executive Center
Dinner with Beer & Wine Served at 5:30 pm
1119 Hanover Street; Fredericksburg
RSVP to Pamela Johns at 741-2118 or pamela.johns@mwhc.com

October 2017

Sun	Mon	Tue	Wed	Thu	Fri	Sat
1	2	3	4	5	6	7
8	9	10	11	12 IT Committee 11:30 am FHA Rm 340	13 Communica-tions & Education 7:30 am 1W A	14
15	16	17 Business Leaders Forum Fick Ctr. 3 pm	18	19 Board of Managers 7 am MWH 1W Exec. BR	20	21
22	23	24 Clinical Quality MWH 1 West A 7 am	25	26 PCP Forum 7 am FHA 5th fl CR	27	28
29	30 Finance & Contracting Committee Fick Center 7 am	31 				

November 2017

Sun	Mon	Tue	Wed	Thu	Fri	Sat
			1	2	3	4
5	6 Alliance Town Hall Jepson Ctr. 6 pm	7	8	9	10Communica-tions & Education 7:30 am 1 West A	11
12	13	14	15	16 Board of Managers 7 am MWH 1W Exec. BR	17	18
19	20	21	22	23 	24	25
26	27	28Clinical Quality MWH 1 West A 7 am	29	30		

December 2017

Sun	Mon	Tue	Wed	Thu	Fri	Sat
					1	2
3	4	5	6	7	8 Communica-tions & Education 7:30 am 1 West A	9
10	11	12 	13	14	15	16
17	18	19	20	21Board of Managers 7 am MWH 1W Exec. BR	22	23
24	25 	26Clinical Quality MWH 1 West A 7 am	27	28	29	30
31						

UPCOMING ALLIANCE EVENTS