Fourth Quarter 2015

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

As 2015 recedes gently into memory, we are presented with the eternal hope of lasting change that New Year's resolutions bring. From the smoker who wants to cease, to the sedentary who wants to start, to the overweight who wishes to lighten their load. These are all laudable resolutions that all of us would encourage patients to pursue.

Physicians can have resolutions as well. One that I hope all of us would commit to would be more engagement with the Alliance. Perhaps attending the PCP Forums or Town Hall sessions could be a start. Even better would be to develop a mindset of what can I do differently in my practice to enhance the goals of the Alliance.

Maintaining or enhancing quality will always be "Job One" for the Alliance. There are ways we can enhance quality that also lower utilization in caring for our patients. The right care at the right place at the right time should be our New Year's resolution. Changing behavior is difficult. It must start with a desire to improve and continue with a commitment to succeed. If we all acknowledge that our health care system is broken, then there must be changes we can make within to fix what is not working properly.

Where do we start? There is no simple fix of course, but perhaps these suggestions can initiate the process:

1. If each of us who practice outpatient medicine would commit to see one extra patient per day in the office who requires acute non life threatening care, as opposed to referring to an ER or urgent care, we could reduce the higher utilization expense while at the same time fostering better physician patient relationships. Yes, this would place more burdens on the physician and their staff, but the right care at the right place would be achieved.
2. Another course of action is to challenge yourself every time a trade name medicine is used in lieu of a generic alternative. Simply ask, "what am I achieving with this medicine that I cannot achieve with the generic alternative," would suffice.
3. If you are a primary care provider in the Alliance, consider taking on new, non-attributed Medicare patients to enhance our ability to succeed in the MSSP program. Performing annual wellness visits would increase revenue to the practice and MSSP enrollment.
4. Lastly, helping patients make the transition from hospital stay back to outpatient care can reduce the high costs associated with readmissions to the hospital. A very worthy goal would be to try to see patients in the office within 3 days of discharge. This is particularly true for our higher risk patients. The Alliance care coordinators can assist in letting you know when Alliance patients have been discharged and in need of office appointments.

As 2016 commences, the Alliance will be caring for 50,000 lives. This is an incredible number considering the Alliance is just completing its second year of operation. Far more important than how many lives we care for is how well we manage those lives. Shared Savings are dependent on enhancing quality, but we must also improve on utilization and lower the cost of care to share in the savings. I believe the above proposals are a good start and can help us succeed.

Have a Happy New Year,
and please take on a resolution.

Thomas A. Janus, DO

Welcome New Providers

- **Douglas Sturm, DO**
  FEMA
- **Kara Dalke, MD**
  Women's Health & Surgery Center
- **Fariah Khan, DO**
  Mark Edang, MD
  FHG
- **Selomie Kebede, MD**
  Cardiology Associates of Fredericksburg
- **Rachel McCarter, MD**
  Women's Health & Surgery Center

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Message from the Medical Director—Richard Lewis, MD

$259,643 On The Table

LET'S NOT LEAVE IT THERE

Our Aetna TCQ (Total Cost and Quality) contract went into effect on April 1, 2015. As TCQ implies, there are cost and quality components to this contract. We also receive a $2 PMPM (Per Member Per Month) payment to support our efforts to manage this population. The number of members in this plan has already grown from 10,700 at inception to almost 13,000. Thus, the payout from this PMPM alone can be substantial ($2 x 12 x 13,000 - you do the math). In addition, there is a shared savings component to this contract similar to the shared savings arrangement in MSSP. That is, if we can control costs such that the expenditures associated with taking care of this population drops below a certain threshold, we get to share the additional savings 50:50 with Aetna. We recently received our performance data from Aetna covering the first 3 months of this contract (April through June, 2015). Including our PMPM, we have earned an incentive payment of ----- $259,643.00! That's the good news. The less good news (there's always a catch, isn't there?) is that we are falling short of our quality metric performance such that if we don't improve our performance on seven quality measures by March 31, 2016, we don't get to keep the money. The remainder of this discussion will be about what the quality metrics are and how we're going to improve them.

MWHA

Clinical/Quality Measures With Claims Through 03/31/2015

Attributed Population: 10837

Measure Short Description	Measure Long Description	Eligible Population in Denominator	Numerator	Rate= Numerator divided by Eligible Population	Aetna National Adjusted Average	Relative Measure Weight	25%	50%	75%	100%
Colorectal cancer screening	This measure calculates the percentage of members age 50 to 75 who had an appropriate screening test for colorectal cancer.	1,855	[illegible]	67.71%	71.90%	[illegible]	68.00%	70.00%	71.00%	71.90%
Breast cancer screening (UPDATED)	This measure calculates the percentage of women age 50 to 74 who had a mammogram to screen for breast cancer.	941	[illegible]	71.94%	87.43%	[illegible]	74.00%	76.00%	78.00%	80.00%
Diabetes: Hemoglobin A1c testing	This measure calculates the percentage of members age 18 to 75 with diabetes receiving annual HbA1c testing.	604	528	87.42%	92.05%	12.50	88.00%	89.00%	90.00%	92.05%
Diabetes: Medical attention for nephropathy	This measure calculates the percentage of members age 18 to 75 with diabetes receiving medical attention for nephropathy.	544	471	86.58%	92.85%	12.50	88.00%	90.00%	92.00%	92.85%
Diabetes: Hemoglobin A1c poor control (>9.0%)	This measure calculates the percentage of members age 18 to 75 with diabetes that demonstrate poor glycemic control, based on a HbA1c level greater than 9%.	303	50	16.50%	16.77%	[illegible]	16.77%	16.50%	16.00%	15.50%
ACE-I/ARB: Persistent use with lab monitoring	This measure calculates the percentage of members age 18 and older who received at least a 180-day supply for ACE-I or ARB therapy and therapeutic monitoring testing: a laboratory panel or a serum potassium and either a serum creatinine or blood urea nitrogen.	687	[illegible]	87.19%	89.84%	[illegible]	88.00%	88.50%	89.00%	89.84%
Diuretics: Persistent use with lab monitoring	This measure calculates the percentage of members age 18 and older who received at least a 180-day supply of diuretics and therapeutic monitoring testing: at least a metabolic panel or a serum potassium and either a serum creatinine or blood urea nitrogen.	482	418	86.72%	89.76%	18.75	87.00%	88.00%	89.00%	89.76%
						100.00				

As you can see, we (our performance is in the fifth column) are only doing better than the national average (6th column) for the fifth measure, poorly controlled diabetics (this is the only measure for which lower is better). But, except for breast cancer screening, we're pretty close to the national average. Achieving these national averages would enable us to keep all of our shared savings. It's also good medicine/good for our patients. These are all based on well established, well recognized evidence-based measures and clinical guidelines.

So, please:

1) For those qualified patients, please schedule their colorectal and breast cancer screenings
2) For your diabetic patients, screen for nephropathy yearly with a microalbuminuria test OR have them on an ACEI or ARB OR document treatment for nephropathy (on dialysis, being treated for CKD/ESRD/ARF or being seen by a nephrologist)
3) Keep treating those diabetic patients to get their A1Cs under 9.0%. Though we're already doing well, we need to maintain this to earn 50% of our shared savings or do even better to earn a higher percentage.
4) Get yearly BMPs for your patients on ACE inhibitors, ARBs and/or diuretics.

Basic stuff, right? Just do it and document it and we'll all benefit (patients, docs, Alliance).

Rick Lewis, MD

Committee Corner...

Message from Jeffrey Frazier, MD
Chair, Finance & Contracting Committee & Board of Managers

As we wrap up 2015, we are excited to formalize shared savings contracts with two new payors. We have entered into arrangements with both CIGNA and Humana to cover an additional 6000 lives within each contract. Both of these contracts have a 1/1/2016 start date. With the addition of the two new payors, added to our current contracts with Mary Washington Healthcare, Innovations, Aetna and the Medicare Shared Savings Programs, that brings the total of covered lives within the Alliance to over 50,000. This is well ahead of business plan estimate of 17,800 covered lives to start 2016. In 2016, the Alliance will be the exclusive provider for patients who sign up for the Innovations insurance exchange product. We will continue to seek out arrangements with providers and self-funded organizations throughout 2016 to strengthen our market competitiveness with new covered lives.

In addition to the new covered lives, we have engaged along with MWHC to participate in the CMS driven Bundled Care Payment Initiative [BPCI]. This program can allow for additional revenues to the Alliance if we are able to effectively manage Medicare patient expenses before, during, and after their acute care event.

Continuing on the finance side, we are projecting that revenue will be below budgeted expectations in 2015 by about $600,000. In 2015 we ramped up care coordination and analytics within the Alliance, with their associated expenses. Despite the lessened revenues and in spite of increasing analytics and care coordination costs, through judicious management of our resources we are estimating that we will be approximately $1,150,000 below our budgeted expenses for the year. In summary, our net of anticipated revenues minus expenses is projected to be around $550,000 above our budgeted expectations. We anticipate ending 2015 with around $2,600,000 left in our initial capitalization, well ahead of our budgeted ending capital of $1,520,000 from our business plan.

I certainly appreciate all the work done by our Finance and Contracting committee members. Your physician committee members are Drs. Amory, Aaronson, Brosche, Brown, Larson, Lieser, Maurer, Muldoon, Wenger, Lewis and Janus. Sean Barden , Eric Fletcher, Tina Ervin, and Phil Brown are MWHC representatives. We would like to welcome Dr. Frederick Goodwin from FEMA to the committee.

We are excited about the Alliance's performance to date and are looking forward to a successful 2016!

Jeff Frazier, MD

Quarterly PCP Forums & Monthly Meetings

Network with your Alliance PCP colleagues. Primary Care Providers are invited to join us from 7:00—8:00 am at 2300 Fall Hill Avenue in the 5th floor conference room for a Quarterly PCP Forum beginning on Thursday, January 28. Discussions will include: performance reporting, chronic condition management guides, distribution, utilization and more.

Quarterly Forum dates include: January 28, April 28, July 28 and October 27. A free giveaway will be raffled each quarter to include an iPad Air 2, iPhone 6, Apple Watch and Microsoft Surface Pro.

In addition, a more casual PCP dialogue meeting will be held on the last Thursday of the remaining months of each quarter.

Alliance Investment Opportunity

The Alliance is pleased to inform physicians of the opportunity to join our effort to supply efficient, quality care in Fredericksburg by investing in the Company. The 2015 unit price of $5500 will be going up for 2016. The new price will be determined by an outside industry valuation firm.

Please contact **Travis Turner by December 31 at travis.turner@mwhc.com or by cell phone (607) 220-6135** and qualified physicians will be provided with access to information (Investment Information) relating to the offering of ownership interests in the Alliance.

Care Coordination Team Update

Message from Joan Snyder, RN, MS

Our Care Coordinator group identified two operational goals for 2015: to engage as many high risk patients as possible, and to develop collaborative relationships with other groups that interact with our patient populations.

Since the care coordination program was established, the nurses have made over 600 phone calls to patients or others involved in a patient's care, and documented 140 patient visits. Even though the care coordination program is still in its infancy, there have been some early successes. The nurses have been able to touch a large number of high risk patients:

- 63% of the MWHC insured patients,
- 71% of the MSSP population
- 38% of the Aetna population

Our efforts have directly prevented at least 6 readmissions and possibly prevented countless others.

Key care coordination activities included:

- helping patients to obtain all of their medications and understand the importance of taking each one correctly
- introducing palliative care at an appropriate moment
- working collaboratively with pharmacy to address chronic pain management needs
- helping patients to obtain much needed medical equipment
- assisting patients with transportation
- educating patients about their disease processes and self-management
- connecting patients to community resources

Given that the managed care population (Aetna, Innovation Health) consists of younger people who are more likely to be working, it is quite a challenge to meet this group in person and therefore more difficult to engage them. To address the needs of this group, we established a transitional care program. Key activities include making sure the patient gets to their follow up appointment, clarifying discharge instructions, reviewing medications and discussing "red flags" or symptoms that require early intervention. 112 patients have been screened with a 50% engagement rate.

We are eager to work collaboratively with a point person at the primary care practices under the new 2016 Care Coordination Agreement which provides a quarterly incentive for the practice to more actively address the following: **annual wellness visits, post discharge follow up, gaps in care, engaging high risk patients and developing patient centered medical homes.** We believe implementing care coordination interventions at the point of service in the PCP practice setting will increase patient engagement and truly strengthen our ability to meet the goals of the Alliance. We look forward to fine tuning our current efforts and tracking patient outcomes in 2016.

2015 - YEAR OF THE DRUG

Here are some representative headlines from 2015:

"PRESCRIPTION DRUG PRICES TOP HEALTHCARE ISSUES OF 2015"
"AS COMPETITION WANES, PRICES FOR GENERICS SKYROCKET"
"CEO WHO PRICED GOUGED HIV DRUG INDICTED FOR SECURITIES FRAUD"
"HOUSE COMMITTEE TO HOLD HEARING ON PRESCRIPTION DRUG PRICING"

The Fredericksburg region and the Mary Washington Health Alliance are certainly not immune from all this. New specialty medications for diseases like hepatitis C and multiple sclerosis cost between $50,000 and $100,000 annually per patient. The average price of the new injectable cholesterol lowering medications Repatha and Praluent is about $14,300 per year. So even though the average generic fill rate for a physician in the Alliance has improved to 83% this year, the PMPM (Per Member Per Month) for pharmacy costs in our self-insured/MWHC population has increased from $101.23 to $111.06 over the last 12 months. Our total yearly health care bill for our Aetna, MWHC and MSSP populations is about $242 million - $21 million (9%) of this is spent on medications. So what can we do about this (besides writing to our congressmen and women who will, in 2016, be addressing what the federal government can to do rein in these drug prices)? Well, in spite of our improving generic prescription performance, we are still prescribing millions of dollars worth of brand name drugs that have very reasonable generic alternatives. The top 3 are Nexium, Crestor and Glumetza. Therefore:

Please try to switch as many of your patients as feasible from:

- NEXIUM to OMEPRAZOLE, PANTOPRAZOLE
- CRESTOR, LIVALO to ATORVASTATIN, SIMVASTATIN
- GLUMETZA to METFORMIN

This alone will significantly decrease our healthcare bill without compromising patient care. In fact, our patients will appreciate their decreased out of pocket expenses. In addition, early in 2016, I will be mailing many of you a list of your most frequently prescribed brand name drugs for which there are good generic alternatives. We realize that there are multiple reasons why you choose to prescribe brands over generics in individual cases. We just would like you to check to make sure there is such a reason when you see that your patients are taking these medications.

What's New - Updates

Professional Liability Insurance Program

The Alliance has developed a special program to offer significantly discounted professional liability insurance (medical malpractice insurance) through Medicus a subsidiary of NORCAL Mutual. The program will help your practice significantly reduce costs and also provide benefits to the Alliance for our long term success. Furthermore, the premium discounts increase as participation increases, so it is important that as many of us as possible take advantage of this opportunity.

Some of the many benefits which are available are:

- Up front discount of 10%
- Additional discounts for Alliance physicians of up to 25% based on program participation
- Free tail for death, disability and retirement
- Prior Acts coverage
- Consent to settle held by physician
- Defense Costs outside the limit of liability
- Medicare/Medicaid Billing Error Defense Reimbursement
- State Medical Board Legal Defense Reimbursement

Please note there is **no application necessary** to receive a quote. If you credential with CAQH, simply click here and Doug Geiger, Program Manager at the Keane Group will contact you with your quote. If you credential with someone other than CAQH, call (314) 822-6939, or email him at: doug.geiger@keanegroup.com to discuss what information is needed to provide you with a quote.

We a looking forward to a good number of our Alliance physicians taking advantage of this latest benefit of being a part of MWMD.

Any changes to your practice? Contact Pam Johns at pamela.johns@mwhc.com or (540) 741-2118.
Visit both the Alliance websites at http://MWHealth Alliance.com and http://mwmd-aco.com.

MSSP Reporting Update

As a reminder, 2015 **PQRS reporting will be done on a network wide basis through the Mary Washington Health Alliance.** All eligible providers who bill under a tax ID enrolled in the MSSP will avoid the downward adjustment when our ACO has successfully reported to CMS. Throughout the year the Alliance has been taking steps to prepare the network for quality reporting. This preparation is an ongoing effort that consists of two steps:

Step 1 involves the Alliance integrating with the back-end of practice EMRs to pull clinical information. This process involves integrating the 'major' EMR vendor solutions that comprise more than 70% of our attributed lives. The process requires resource collaboration from the practice, the EMR vendor and the Alliance MSSP Reporting solution Crimson in order to make this effective. Our goal is to have several practices linked to us by the end of the year to help augment our data acquisition efforts.

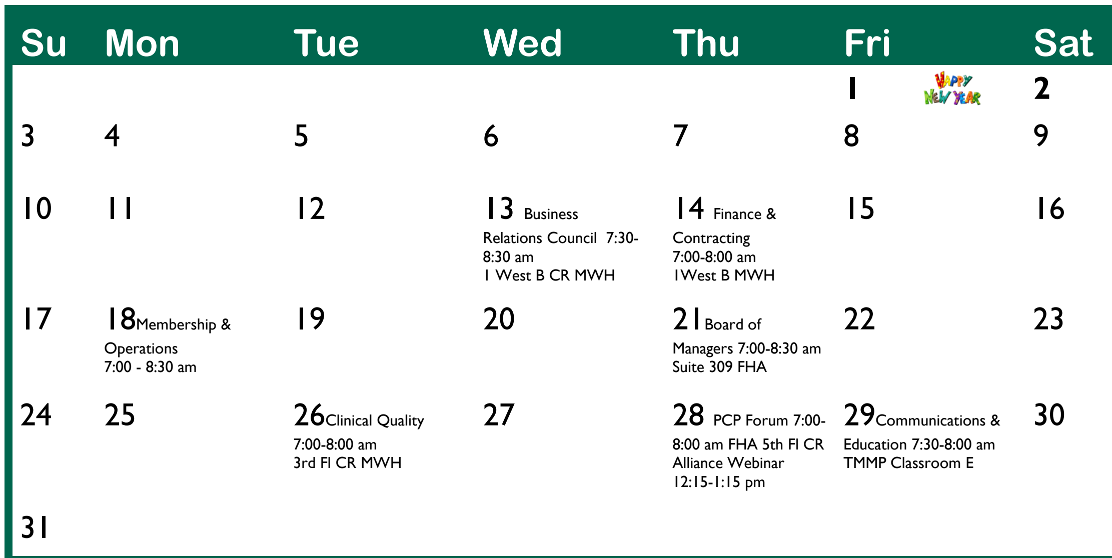
Step 2 is preparing our organization to manually abstract information that is not captured in step 1. Manual chart mining will allow us to ensure that physicians get credit for the work that they have done regardless of where, or how, it has been entered into their EMR.

Although we cannot start chart mining until we receive our patient list from CMS in January, we are already laying the groundwork to ensure the success of this operation. Once we receive our patient list from CMS we will begin our chart abstraction efforts.

We understand how important this effort is and have made it our sole priority for the coming months. We are counting on your support and cooperation throughout this effort. If you have any questions or concerns about this process please feel free to reach out to Thomas Magrino at (540) 741-3085.

ALLIANCE EVENTS

January 2016



Su	Mon	Tue	Wed	Thu	Fri	Sat
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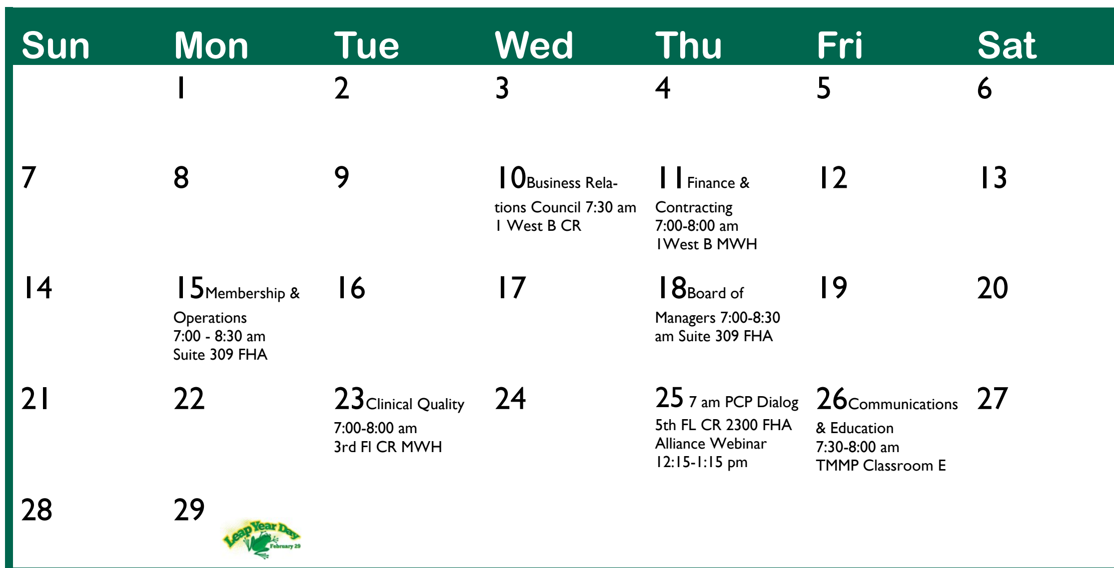
3	4	5	6	7	8	9
10	11	12	13 Business Relations Council 7:30-8:30 am 1 West B CR MWH	14 Finance & Contracting 7:00-8:00 am 1West B MWH	15	16
17	18 Membership & Operations 7:00 - 8:30 am	19	20	21 Board of Managers 7:00-8:30 am Suite 309 FHA	22	23
24	25	26 Clinical Quality 7:00-8:00 am 3rd Fl CR MWH	27	28 PCP Forum 7:00-8:00 am FHA 5th Fl CR Alliance Webinar 12:15-1:15 pm	29 Communications & Education 7:30-8:00 am TMMP Classroom E	30
31						

February 2016



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14	15 Membership & Operations 7:00 - 8:30 am Suite 309 FHA	16	17	18 Board of Managers 7:00-8:30 am Suite 309 FHA	19	20
21	22	23 Clinical Quality 7:00-8:00 am 3rd Fl CR MWH	24	25 7 am PCP Dialog 5th FL CR 2300 FHA Alliance Webinar 12:15-1:15 pm	26 Communications & Education 7:30-8:00 am TMMP Classroom E	27
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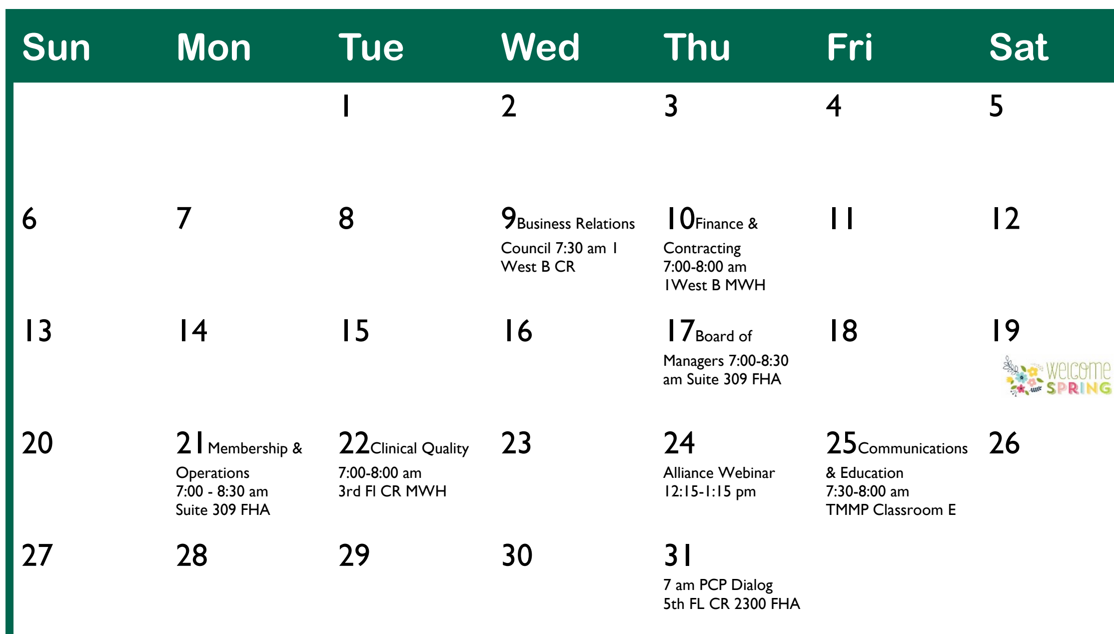
March 2016



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