Second Quarter 2016

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

SOARING ABOVE THE FRAY

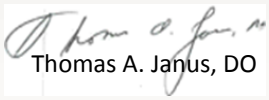
Physicians will soon encounter a transformation to their practice which will be of greater consequence than any previous change they have experienced. The complexities and intricate details of MACRA, MIPS and aAPM are far too vast to cover in this newsletter. But understand financial risk is coming to town and unlikely to leave. The upside only gain sharing programs, such as MSSP track one, which the Alliance has been participating in, will soon sunset, serving only as a transition into true financial risk.

Although potentially intimidating, this does not have to be a doom and gloom scenario. First and foremost, it is essential all members of the Alliance are well informed of the changes proposed and implemented by CMS. To that effect, the Alliance has planned three separate Town Hall meetings, each one progressively building on the previous meeting to ensure our membership is educated and enlightened with regards to our options with MACRA, MIPS and aAPM. I strongly encourage physicians to attend all three meetings. It is the preference of the MWMD board to follow the lead of the membership with regards to which track we select.

CMS is leading the charge for physicians being at financial risk for the care they provide. It is unlikely to stop there, with commercial plans following suit sooner than all of us would prefer. To date, the goals of the Alliance have been to achieve Triple Aim, and to enable physician and hospital independence. I believe we must strive to ensure our members survive the evolution of physician reimbursement exposing them to downside risk. Working independently, most groups will fail to meet the measures necessary to succeed in MACRA. Working together as a true ACO, the Alliance has the potential and resources to enhance success and financial security in these unchartered waters.

Wilbur Wright, in his quest for aviation success, once stated "no bird soars in a calm". I can assure you, CMS has removed whatever calm we were practicing within. It is the responsibility of the Alliance and its membership to negotiate these turbulent times and enable our physicians to soar to their highest levels of achievement.

I hope to see you all at the Town Hall meetings.



Thomas A. Janus, DO

Welcome New Providers & Practices

Ekram Guirguis, MD
MWMG—Reese Campus

James DeSimone, MD
Stafford Internal Medical Services

Joel Loveless, MD
Jerrold Black, MD
Doctor Express

Tedla Anbessie, MD
Yared Gebreyesus, MD
Getachew Woldeher, MD
Blue Nile Medical Group

Sanford Schaps, MD
Fredericksburg Anesthesia Services

Gayatri Vaddadi, MD
Fredericksburg Hospitalist Group

Avinash Narayana, MD
MWMG General Surgery & Trauma

Naseem Alexa Jahdi
MWMG—Rheumatology

Inside this Issue:

Message from the Medical Director—Richard Lewis, MD

"SPRINT" TO THE FINISH

I have been treating patients with hypertension in my cardiology practice for the past 32 years. I must admit that I have not been particularly aggressive in this regard. I reliably reminded my patients about the importance of treating hypertension to decrease their chances of developing one or more potential complications including heart disease, stroke and kidney failure. I was always careful to emphasize the role of lifestyle measures along with drug therapies. We discussed associated issues such as the importance of adherence to prescribed medications and avoidance of alcohol excess and certain OTC medications (especially NSAIDs). But I was generally satisfied with a recorded blood pressure of less than 140/90 even though there were many who felt that less than 120/80 was a more appropriate goal, especially in patients with certain comorbidities such as heart disease or chronic kidney disease. Now we have good clinical evidence to support those who have been pushing the more aggressive agenda: the **Systolic Blood Pressure Intervention Trial** (**SPRINT**). SPRINT randomly assigned 9361 individuals with a systolic blood pressure of 130-180 mm Hg, age of at least 50 years, and an increased cardiovascular risk to a target of less than 120 mm Hg (intensive-treatment) or a target of less than 140 mm Hg (standard-treatment). People with "difficult to control" BP as well as patients with diabetes, stroke, or polycystic kidney disease were excluded (as other studies aimed to answer the question in these patients). Data on outcomes and adverse events in the frail elderly population are to be published separately. Results of this trial were published in the NEJM 2015;373:2103-2116 + 2093-2095 (Perspective article) + 2174-78 (Editorials). During follow-up, the average systolic blood pressure in the intensive-treatment group was 13.1 mm Hg less than that in the standard-treatment group. The trial was stopped early, after a median follow-up of 3.26 years. The mean number of BP medications in the intensive-treatment group was 2.8 and in the standard-treatment group 1.8. The most common drugs prescribed were chlorthalidone, amlodipine and ACEI/ARB though beta blockers were prescribed commonly in the patients with CAD.

Participants in the intensive-treatment group had a 25% lower relative risk of major CV events. They also had a 27% lower risk of death from any cause. Rates of adverse events of hypotension, syncope, electrolyte abnormalities and acute kidney injury or failure were higher in the intensive-treatment group but injurious falls were not more frequent.

So what are the "take home messages" from SPRINT? I concur with those of the American Society of Hypertension (ASH) which I summarize here along with my comments:

- Emphasize **correct BP measurement** in the office. In the SPRINT trial, 3 readings were taken at one minute intervals with the patient seated after 5 minutes of quiet rest using an automated Omron Healthcare device. The mean of the 3 readings was recorded.
- Emphasize **lifestyle modifications** including low sodium diet such as DASH (Dietary Approaches of Stop Hypertension), regular physical activity, weight control and moderate alcohol intake
- **Individualize therapy** – the SPRINT results apply to "SPRINT-like" patients, that is, patients with established CV disease or at increased CV risk though without a history of diabetes or stroke and not considered "frail elderly".
- The intensive-treatment group in the SPRINT trial was **followed very closely.** Therefore, the patients you are treating intensively "in the real world" need close follow-up including frequent assessment of renal function, electrolytes and symptoms/potential side effects of treatment.
- The **risks and benefits** of intensive control need to be balanced in individual patients, especially considering the higher incidence of adverse events in the intensive-treatment group. **Treat the Patient, Not the Number**.

Because of the impressive outcomes in the intensive-treatment group, the SPRINT trial was stopped earlier than originally planned. Thus, further results on quality of life, cognition, long term renal function effects and experience in the frail elderly will follow over time. Also be on the lookout for changes in BP treatment guidelines such as those published by the Joint National Committee (JNC) and the American Heart Association/American College of Cardiology. For example, the JNC-8 BP goal for adults is <140/90 except for <150 mm Hg in those over age 60. The JNC-7 BP goal is less than or equal to 130/80 for patients with diabetes or chronic kidney disease. I anticipate major changes in these recommendations based on the results of SPRINT. I wouldn't be surprised if SPRINT eventually earns the designation of a "Landmark" trial.

Rick Lewis, MD

What's New - Updates

MSSP Corner *from Thomas Magrino, Business Analyst*

BMI/BP Screening

Most offices take a patient's height, weight and blood pressure readings at the start of each visit. This is because an out of range BMI or blood pressure can exacerbate conditions ranging from Asthma to Coronary Artery Disease. With this in mind, a majority of our network's physicians already provide education, medication, or a referral when they see a patient's vitals are significantly outside the normal range.

Our network can improve our current compliance, however, by encouraging providers to briefly speak to the patient if their BMI or BP is out of the normal range. A simple statement of "***I noticed your blood pressure is 121/80. That is good, but is right on the border of the pre-hypertensive range. Make sure you exercise regularly and watch out for salty foods***" is sufficient. After this write in your EMR, "***I spoke to the patient about diet and exercise because their BMI/BP was outside the normal range***" and you are compliant!

MACRA Town Halls

MACRA (**M**edicare **A**ccess and **C**HIP **R**eauthorization **A**ct 2015) replaces the flawed **SGR** (**S**ustainable **G**rowth **R**ate formula) for determining Medicare payments for health care providers' services starting in 2019.

Payments in 2019 are dependent upon provider performance in 2017 so we don't have that much time to prepare for what is a major overhaul of how providers who treat Medicare patients are compensated. Thus the Alliance is undertaking a major educational effort to inform our providers as to the ins and outs of the two main payment option arms of MACRA: **MIPS** (**M**erit-based **I**ncentive **P**ayment **S**ystem) and **aAPM** (**a**dvanced **A**lternative **P**ayment **M**odels).

Join us for this three-part educational Town Hall Series which will build upon the one before on July 26, September 27 and November 3 at the Fick Conference Center. Dinner begins at 5:30 pm with the presentation and discussion at 6:00 pm.

ADDENDUM TO "SPRINT TO THE FINISH" (Hot off the Press)

The results of the subgroup analysis for **patients aged 75 years and older** in the SPRINT trial were published in JAMA June 28, 2016 (Volume 315:24, 2637-46). As in the overall population studied, there were significant reductions in CVD events (34%) and total mortality (33%) with intensive (goal SBP < 120 mm Hg) therapy as compared with standard (goal SBP < 140 mm Hg) therapy. There were no substantial increases in major clinical adverse events in the intensive therapy group. Since the mean SBP achieved in the intensive therapy group cohort was 123 mm Hg, it might be reasonable to approach BP management in your elderly hypertensive patients as follows: Initiate treatment to achieve an SBP < 140 mm Hg. If this is well tolerated, further titrate therapy with careful monitoring to achieve an SBP of < 130 mm Hg. In general, the preferred agents should be diuretics, calcium channel blockers, ACE inhibitors and ARBs. Beta blockers should be considered in patients with CAD, CHF and arrhythmias. Since older patients with standing SBPs of < 110 mm Hg were excluded, the risk of falls and syncope may have been underestimated in SPRINT so pay particular attention to avoiding orthostatic hypotension.

PCP Forums and Informal Gatherings

The next Quarterly PCP Forum will be held at **7 am on Thursday, July 28 in the 5th Floor Conference Room in the 2300 Building** (right outside the entrance to the Alliance office suite.) The agenda includes Avoidable Admissions and how our PCP's can work with our ED physicians. We plan to have representatives from FEMA (ER physicians) and FHG (Hospitalists) at this meeting. In addition to the refreshments that are available at all of our monthly PCP gatherings, we will again be giving away a tech device. You must be present to win—just ask Drs. Lynne Clemo and Wilson "Bill" Cook who left the January and April PCP Forums respectively with a new iPad.

Also join us on the last Thursday in August, September, November and December for our informal PCP Gatherings.

Innovation Health Wellness Visits

Please be sure to communicate with your front office and appointment/ scheduling staff the requirement for a preventative office visit for Mary Washington Healthcare associates and their covered spouses. MWHC associates and spouses covered under the Innovation Health medical plan need to have an Annual Preventive Visit/ Routine Checkup completed by their PCP or OB/GYN by October 31, 2016 in order to avoid a wellness surcharge in 2017.

As a reminder, The Well Adult Care visit has a $0 copay and is covered 100%. **It is based on the calendar year allowing them to be seen anytime this year regardless of when they were seen last year.**

Revisions to PMPM Incentive Program

As you recall, the 2016 Care Coordination Agreement provided a $3 PMPM incentive paid quarterly for the PCP practice to more actively address the following five measures: **annual wellness visits, post discharge follow up, gaps in care, engaging high risk patients and developing patient centered medical homes (PCMH).**

The PMPM Quarterly Incentive Program has been revised to include just FOUR measures (the PCMH measure has been eliminated.)

The program now includes the following measures:

Measure #1: Annual Wellness Visits

Overall population is now ALL attributed MSSP patients rather than just High Risk/Rising Risk; denominator is all those eligible for an AWV this quarter. Point structure has been changed to award more points per percentage of eligible AWV's done.

Measure #2 : Discharge follow-up Visits after a Hospital Admission

Denominator remains all High risk (top 5% of risk scores) and Rising risk (top 25% of risk scores) patients attributed to practice who are eligible for this measure (ie, had an admission) Discharge follow-up interval lengthened to 5 days and now includes those discharged from any hospital (not just MWHC facilities.)

Measure #3: "Gap" Reminder contacts

Denominator remains all High risk and Rising risk patients attributed to practice who are eligible for this measure (i.e. had a gap such as out of date mammogram, colonoscopy, eye exam or A1C). Credit is given for contacting gaps each quarter until "gap" is closed by patient completing test. Point structure has been changed to award more points per percentage of contacts made.

Measure #4 : High Risk Patient contacts

Practices with less than 20 patients combined in the High Priority (top 1% of all risk scores) and High Risk categories (top 5%) can outreach patients in both categories to meet this measure. Practices with greater attribution will continue to focus on the High Priority patients to meet this measure. Point structure has been changed to award more points per percentage of contacts made.

Please contact Joan Snyder, RN, Manager Population Health, if you are interested in participating (540) 741-2119.

Committee Corner...

Message from Kurian Thott MD
Chair, Communications & Education Committee & Board of Managers

Summer is in full swing now and your Alliance is busy getting our patients access to high quality cost effective care. There have already been some communications from our committee as well as from Dr. Lewis regarding some changes that will impact everyone who practices medicine.

CMS has released their recent guidance regarding the way physicians will be paid in the future. As many of you know the SGR (Sustainable Growth Rate Formula) was replaced. We were all very happy about this…for a while. Until we realized that CMS was going to replace SGR with MACRA (Medicare Access and CHIP Reauthorization Act 2015). You have already received the FACT sheet regarding this and will be sending this same FACT sheet again in the future. It is very important for EVERY physician to read and try to understand this.

As the FACT sheet detailed, there will essentially be two different payment models; one is MIPS (Merit based Incentive Payment System) and the other is APM (alternative payment model). Each one of these is very nuanced and the board is working diligently to create the best pathway forward for our membership. In light of these new payment options, we feel it's imperative for our membership to really understand how each of these programs can impact you and your practice.

The new world of medicine, which is to move away from fee for service will be all about these type of unique payment models and the risk of how you get paid will now be on the provider or their networks' shoulders.

The Alliance is setting up 3 Town Halls over the next two quarters to address these models and educate our membership on which one will be the best option moving forward. The first one is scheduled at the Fick Center for July 26th, followed by September 27th and then November 8th.

Along the lines of enhancing communication we have been gathering cellphone numbers and carrier information from Physicians to enable us to use SMS technology to streamline our efforts in communicating with you. We will only use this to communicate meeting information and need to know urgent information.

As we continue through the mid-year your Alliance is continuing to work towards negotiating commercial payers, continuing to engage non-Alliance physicians and continue our work on population health strategies.

New Provider Website Portal

Alliance providers will soon have access to a secure portal dashboard to receive individual score cards, educational videos and practice information. All personal data will be encrypted to assure privacy. Email alerts will notify you of any new available information

To access the Provider Portal, go to "For Providers" towards the bottom of the Alliance website. Under Provider Login, click "Create an account" or click on the link http://www.mwhealthalliance.com/component/users/?view=registration and fill in the User Registration information requested. Our staff will approve your request and you will then be able to access the portal with your Username and Password.

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

July 2016

Sun	Mon	Tue	Wed	Thu	Fri	Sat
					1	2
3	4 	5	6	7	8	9
10	11	12	13	14	15	16
17	18 Membership & Operations 7:00 - 8:30 am Suite 309 FHA	19	20 Finance & Contracting 7:00-8:00 am 1West B MWH	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 **MACRA Town Hall** 5:30 pm Fick Center Aud. 1 & 2	27	28 PCP Forum 7:00 am FHA 5th Fl CR	29 Communications & Education 7:30-8:00 am TMMP Classroom E	30
31						

August 2016

Sun	Mon	Tue	Wed	Thu	Fri	Sat
	1	2	3	4	5	6
7	8	9	10	11	12	13
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 Informal PCP Gathering; 7:00 am FHA, 5th Floor CR	26Communications & Education 7:30-8:00 am TMMP Classroom E	27
28	29	30	31			

September 2016

Sun	Mon	Tue	Wed	Thu	Fri	Sat
				1	2	3
4	5 	6	7	8 Finance & Contracting 7:00-8:00 am 1West B MWH	9	10
11	12	13	14	15 Board of Managers 7:00-8:30 am Suite 309 FHA	16	17
18	19 Membership & Operations 7:00 - 8:30 am Suite 309 FHA	20	21	22	23	24
25	26	27 Clinical Quality 7:00-8:00 am 3rd Fl CR MWH **MACRA Town Hall** 5:30 pm Fick Center Aud. 1 & 2	28	29 Informal PCP Gathering; 7:00 am FHA, 5th Floor CR Alliance Webinar 12:15 pm	30 Communications & Education 7:30-8:00 am TMMP Classroom E	

ALLIANCE EVENTS