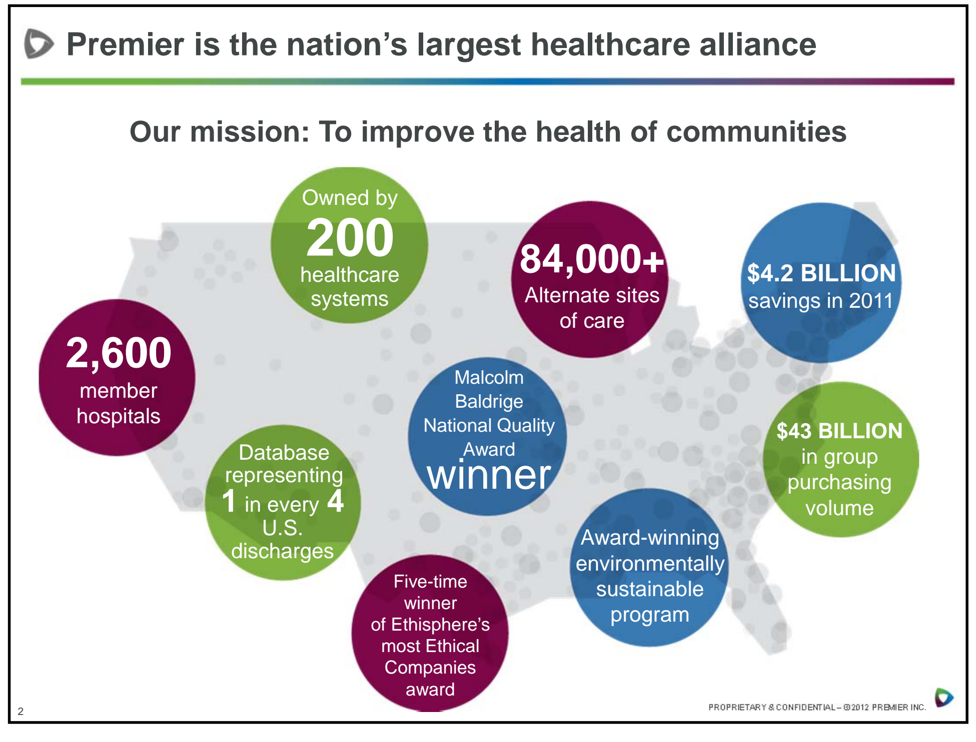
PREMIER
NCAHQ
Federal Update
April 18, 2013


Premier is the nation's largest healthcare alliance
Our mission: To improve the health of communities
Owned by 200 healthcare systems
84,000+ Alternate sites of care
$4.2 BILLION savings in 2011
2,600 member hospitals
Malcolm Baldrige National Quality Award winner
$43 BILLION in group purchasing volume
Database representing 1 in every 4 U.S. discharges
Award-winning environmentally sustainable program
Five-time winner of Ethisphere's most Ethical Companies award
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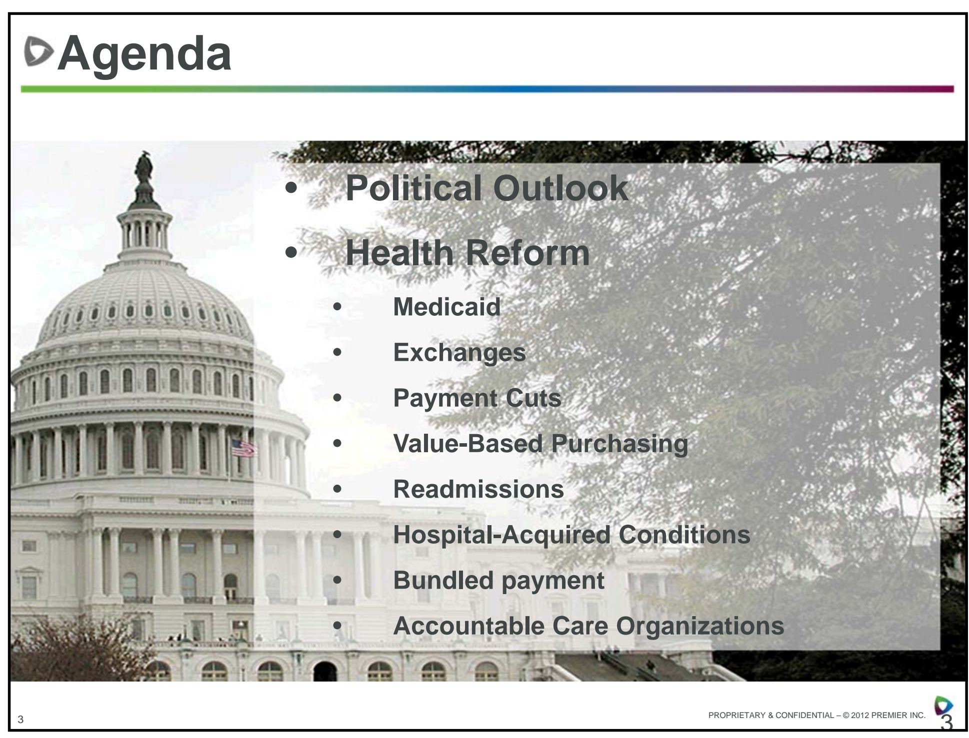
Agenda
• Political Outlook
• Health Reform
• Medicaid
• Exchanges
• Payment Cuts
• Value-Based Purchasing
• Readmissions
• Hospital-Acquired Conditions
• Bundled payment
• Accountable Care Organizations
3
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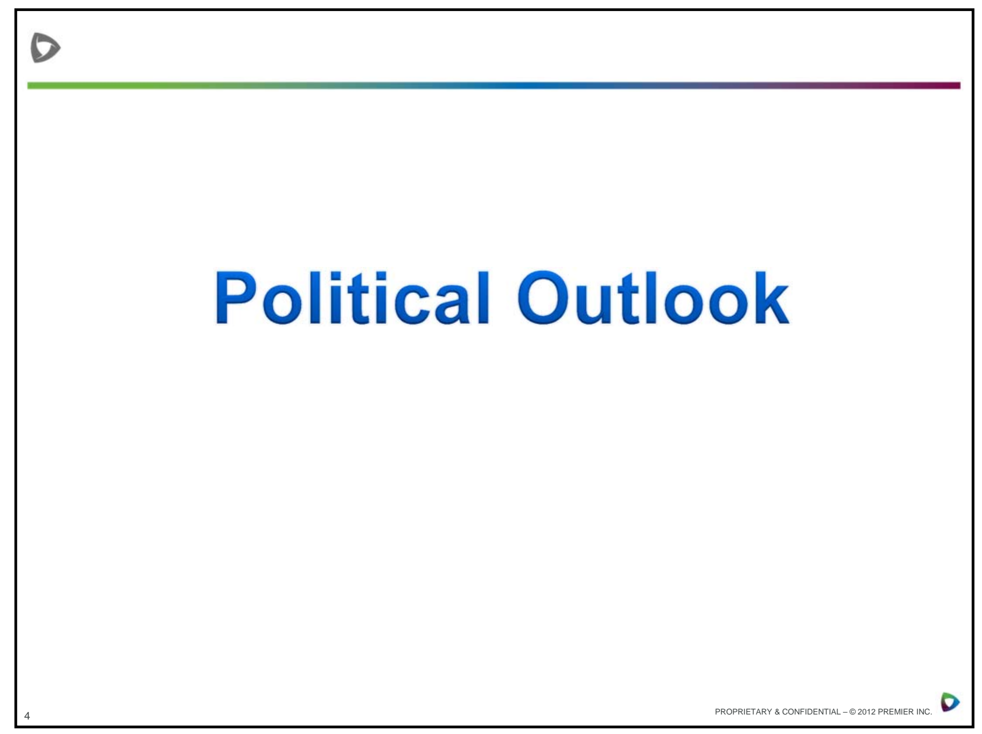
Political Outlook
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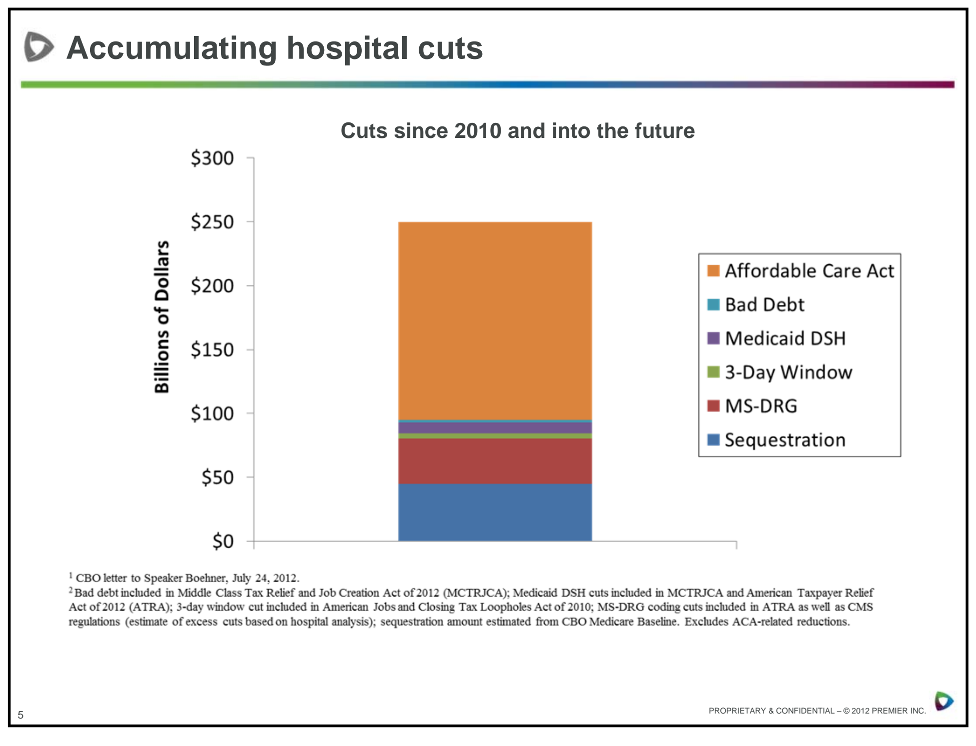
Accumulating hospital cuts
Cuts since 2010 and into the future
Billions of Dollars
$300
$250
$200
$150
$100
$50
$0
Affordable Care Act
Bad Debt
Medicaid DSH
3-Day Window
MS-DRG
Sequestration
[1] CBO letter to Speaker Boehner, July 24, 2012.
[2] Bad debt included in Middle Class Tax Relief and Job Creation Act of 2012 (MCTRJCA); Medicaid DSH cuts included in MCTRJCA and American Taxpayer Relief Act of 2012 (ATRA); 3-day window cut included in American Jobs and Closing Tax Loopholes Act of 2010; MS-DRG coding cuts included in ATRA as well as CMS regulations (estimate of excess cuts based on hospital analysis); sequestration amount estimated from CBO Medicare Baseline. Excludes ACA-related reductions.
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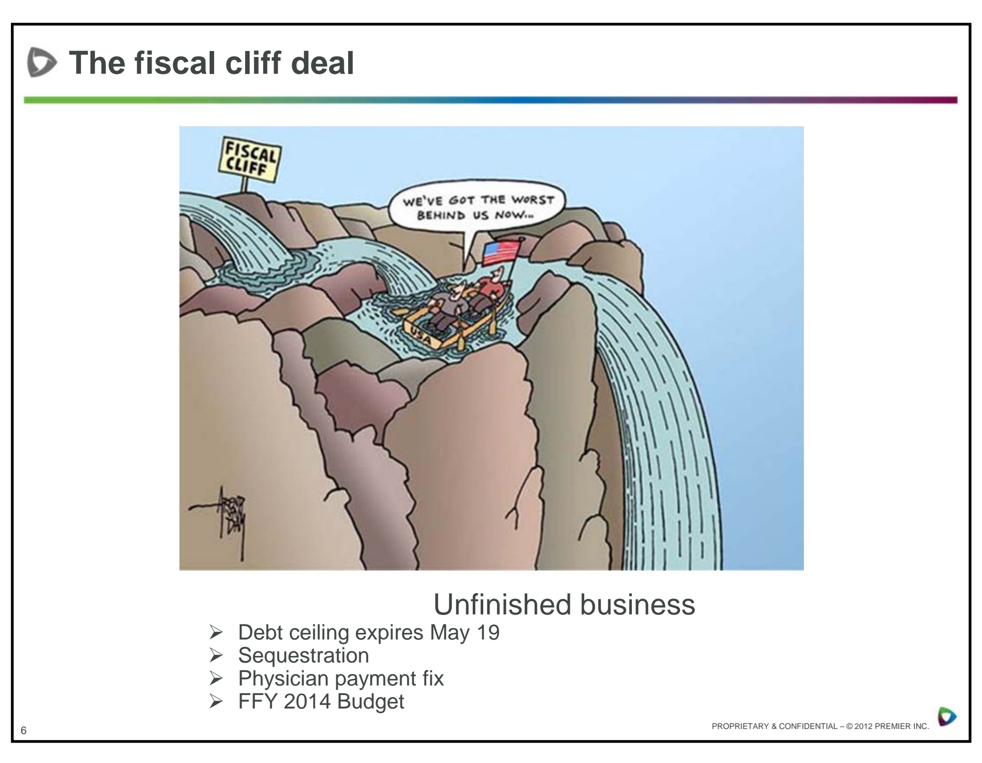
The fiscal cliff deal
FISCAL CLIFF
WE'VE GOT THE WORST BEHIND US NOW...
USA
Unfinished business
Debt ceiling expires May 19
Sequestration
Physician payment fix
FFY 2014 Budget
6
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Obama budget calls for deep cuts to Medicare providers

- April 10, President Obama released a $3.77 T (FY) 2014 budget blueprint
- $1.8 T in new savings and tax revenue over the next ten years
- Majority goes to replace sequester's $1.2 T automatic spending cuts
- Fully paid ($2 in cuts for every $1 in new revenue)
- $803.5 M for the operation of insurance exchanges
- $400 B in cuts over 10 years to Medicare and Medicaid
  - $306.6 B in provider cuts
  - $67.8 B reductions due to beneficiary cost-sharing changes
- SGR repeal and replace similar to other congressional proposals
- NIH flat funded ($31 B)
- FDA + $800 M

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Obama budget calls for deep cuts to Medicare providers

Medicare

- Reduce bad debt payments ($25.5 B)
- Reduce Graduate Medical Education payments ($11 B)
- Cuts to Critical Access Hospitals (CAHs) ($2.1 B)
- Reductions to post-acute care providers ($79 B)
- Post-acute care bundled payment ($8.2 B)
- Cut Waste, Fraud, and Abuse in Medicare ($400 M)
- Part D drug rebates ($123 B)
- Additional Independent Payment Advisory Board (IPAB) cuts
- Accelerate manufacturer drug rebates in the donut hole ($11.2 B)
- Changes to the in-office ancillary exception ($6.1 B)
- Reduce Part B drug payments ($4.5 B)
- Reduce clinical lab services payments ($9.7 B)

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Obama budget calls for deep cuts to Medicare providers

Medicaid

- Delay for one year cuts to DSH payments
- Rebases DSH for an additional year
- Apply Medicare competitive bid rates to Medicaid durable medical equipment (DME) ($4.5 billion)
- Cut Waste, Fraud, and Abuse in Medicaid ($3.7 billion)

Beneficiaries

- Increase income-related premiums ($50 billion)
- Increase Part B deductible for new beneficiaries ($ 3.3 billion)
- Introduce home health copayments for new beneficiaries ($730 MILLION)
- Introduce a surcharge for first dollar Medigap policies for new beneficiaries ($2.9 billion)

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STATE TRENDS

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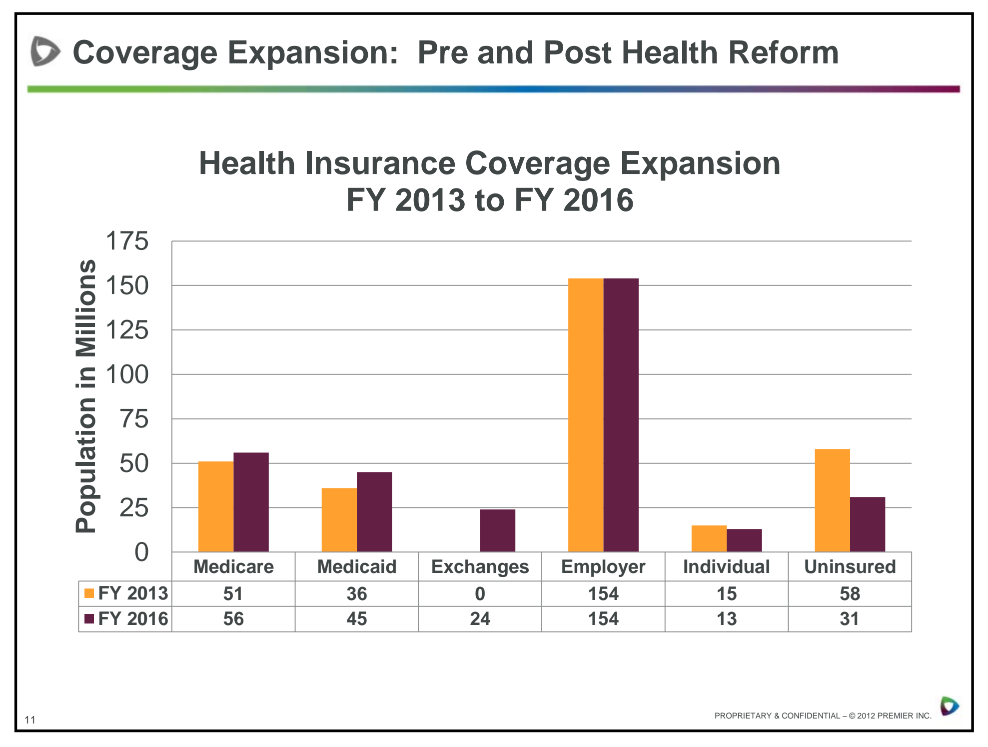
Coverage Expansion: Pre and Post Health Reform
Health Insurance Coverage Expansion
FY 2013 to FY 2016
Population in Millions
175
150
125
100
75
50
25
0
Medicare
Medicaid
Exchanges
Employer
Individual
Uninsured
FY 2013 51 36 0 154 15 58
FY 2016 56 45 24 154 13 31
11
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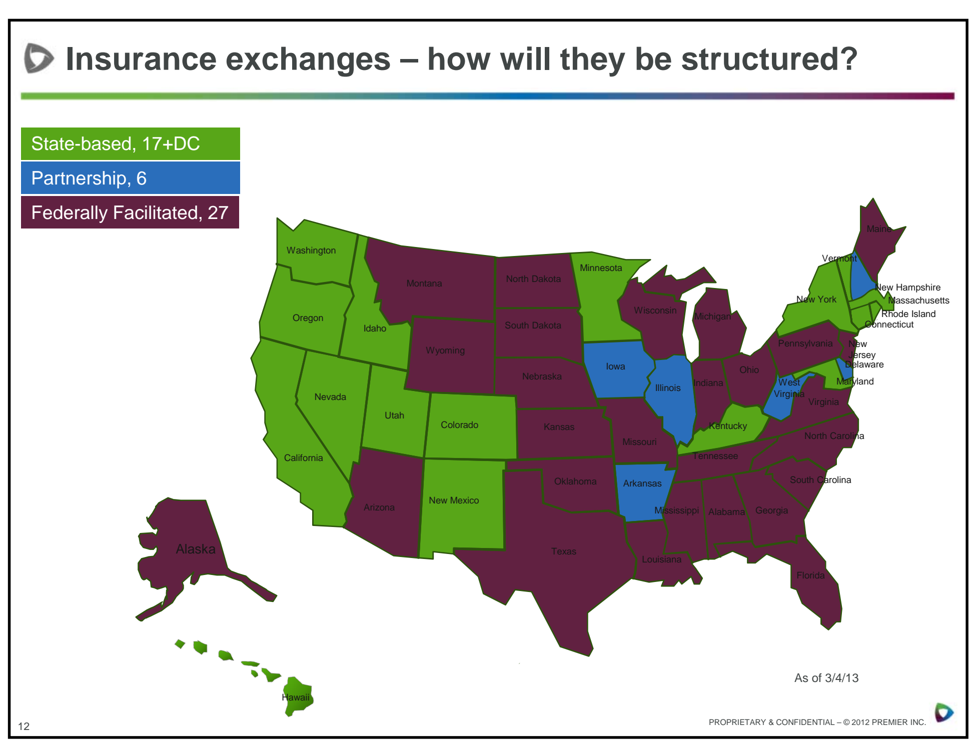
Insurance exchanges – how will they be structured?
State-based, 17+DC
Partnership, 6
Federally Facilitated, 27
Washington
Oregon
California
Nevada
Idaho
Montana
Wyoming
Utah
Arizona
Colorado
New Mexico
North Dakota
South Dakota
Nebraska
Kansas
Oklahoma
Texas
Minnesota
Iowa
Missouri
Arkansas
Louisiana
Wisconsin
Illinois
Michigan
Indiana
Ohio
Kentucky
Tennessee
Mississippi
Alabama
Georgia
Florida
South Carolina
North Carolina
Virginia
West Virginia
Pennsylvania
New York
Vermont
Maine
New Hampshire
Massachusetts
Rhode Island
Connecticut
New Jersey
Delaware
Maryland
Alaska
Hawaii
As of 3/4/13
12
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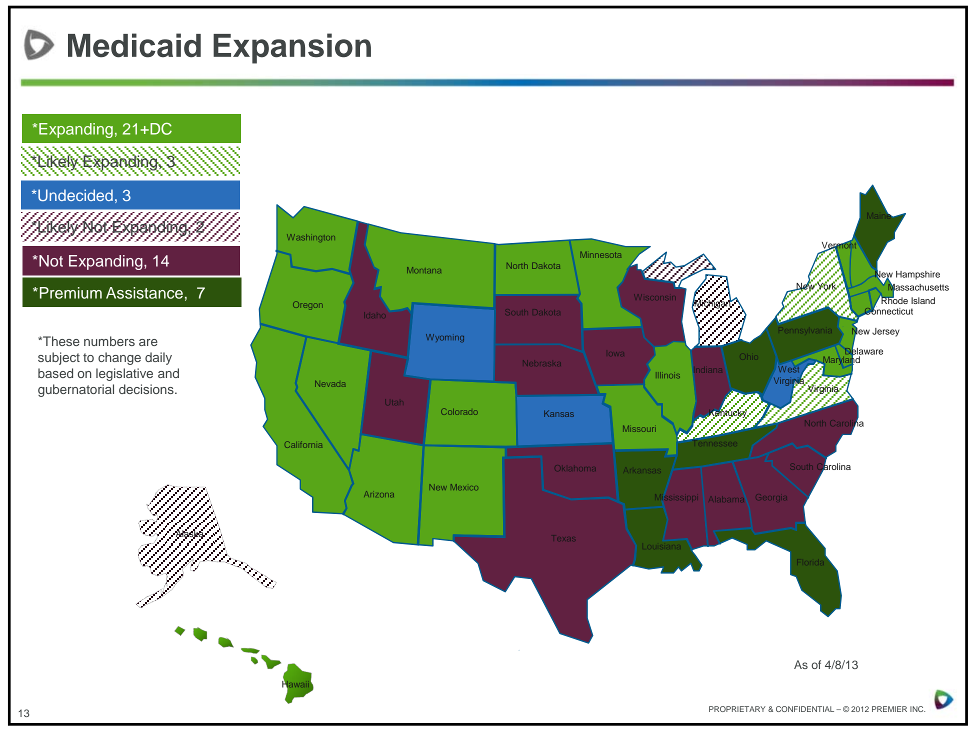

What's Next-State Insurance Exchanges?

- What percentage of the market will shift to Exchange products? How fast will it occur?
- Will smaller employers drop coverage?
- Will large employers form "private exchanges"?
- Will Medicaid coverage expand at the ACA rates?
- Will my state accept federal funding to expand Medicaid coverage?
- How quickly will DSH payments be cut?
- Should a delivery system partner with health plans for Exchange products?
- Will delivery systems provide a "deep discount" to health plans for narrow network Exchange products?

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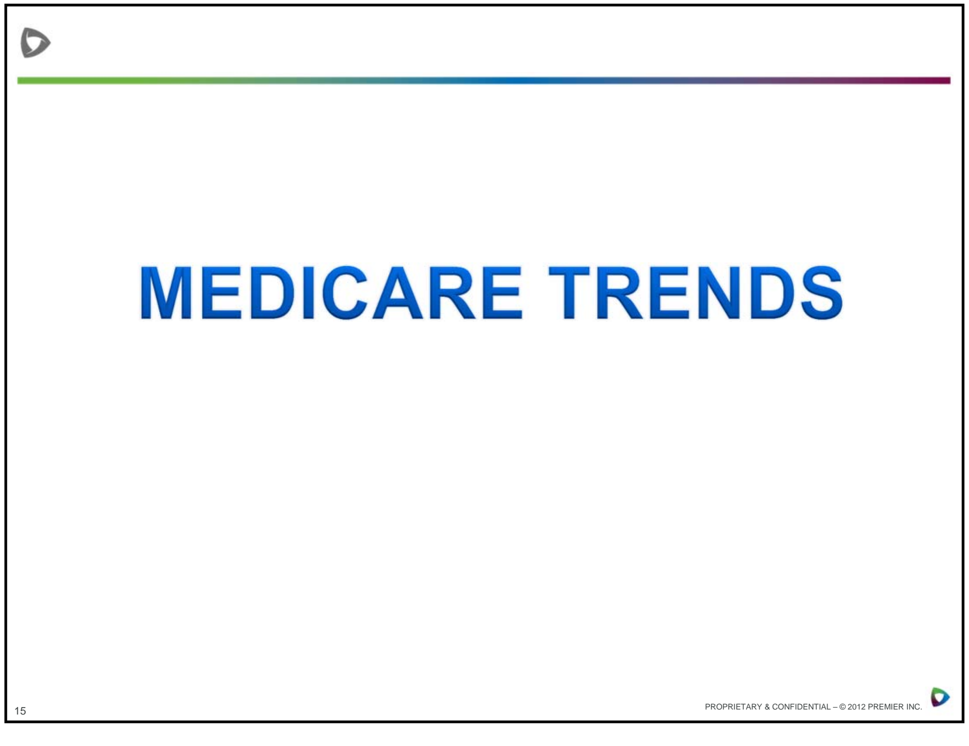

MEDICARE TRENDS
15
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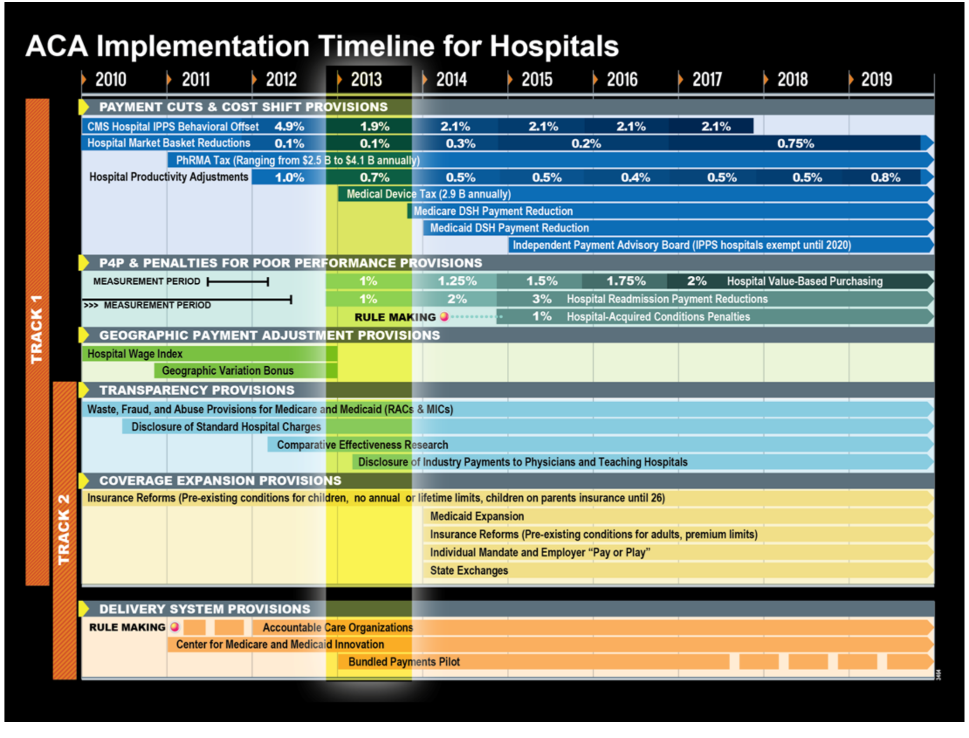
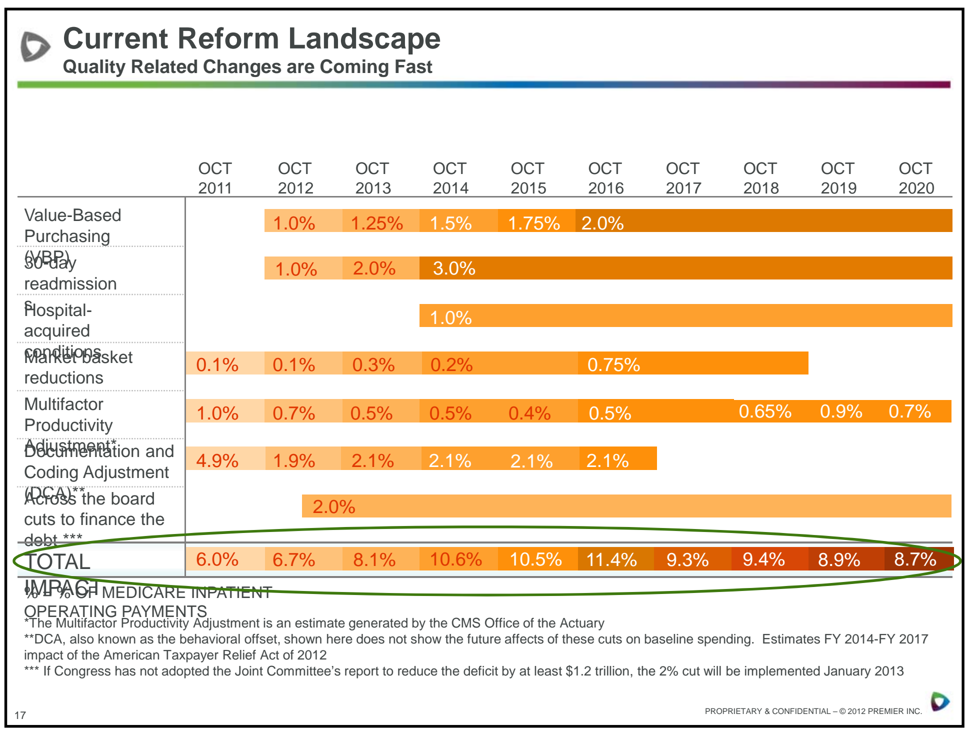


ACA Implementation Timeline for Hospitals
2010
2011
2012
2013
2014
2015
2016
2017
2018
2019
TRACK 1
TRACK 2
PAYMENT CUTS & COST SHIFT PROVISIONS
CMS Hospital IPPS Behavioral Offset 4.9% 1.9% 2.1% 2.1% 2.1% 2.1%
Hospital Market Basket Reductions 0.1% 0.1% 0.3% 0.2% 0.75%
PhRMA Tax (Ranging from $2.5 B to $4.1 B annually)
Hospital Productivity Adjustments 1.0% 0.7% 0.5% 0.5% 0.4% 0.5% 0.5% 0.8%
Medical Device Tax (2.9 B annually)
Medicare DSH Payment Reduction
Medicaid DSH Payment Reduction
Independent Payment Advisory Board (IPPS hospitals exempt until 2020)
P4P & PENALTIES FOR POOR PERFORMANCE PROVISIONS
MEASUREMENT PERIOD
>>> MEASUREMENT PERIOD
1% 1.25% 1.5% 1.75% 2% Hospital Value-Based Purchasing
1% 2% 3% Hospital Readmission Payment Reductions
RULE MAKING 1% Hospital-Acquired Conditions Penalties
GEOGRAPHIC PAYMENT ADJUSTMENT PROVISIONS
Hospital Wage Index
Geographic Variation Bonus
TRANSPARENCY PROVISIONS
Waste, Fraud, and Abuse Provisions for Medicare and Medicaid (RACs & MICs)
Disclosure of Standard Hospital Charges
Comparative Effectiveness Research
Disclosure of Industry Payments to Physicians and Teaching Hospitals
COVERAGE EXPANSION PROVISIONS
Insurance Reforms (Pre-existing conditions for children, no annual or lifetime limits, children on parents insurance until 26)
Medicaid Expansion
Insurance Reforms (Pre-existing conditions for adults, premium limits)
Individual Mandate and Employer "Pay or Play"
State Exchanges
DELIVERY SYSTEM PROVISIONS
RULE MAKING
Accountable Care Organizations
Center for Medicare and Medicaid Innovation
Bundled Payments Pilot



Current Reform Landscape

Quality Related Changes are Coming Fast

	OCT 2011	OCT 2012	OCT 2013	OCT 2014	OCT 2015	OCT 2016	OCT 2017	OCT 2018	OCT 2019	OCT 2020
Value-Based Purchasing (VBP)		1.0%	1.25%	1.5%	1.75%	2.0%				
30-day readmissions		1.0%	2.0%	3.0%						
Hospital-acquired conditions				1.0%						
Market basket reductions	0.1%	0.1%	0.3%	0.2%		0.75%				
Multifactor Productivity Adjustment*	1.0%	0.7%	0.5%	0.5%	0.4%	0.5%		0.65%	0.9%	0.7%
Documentation and Coding Adjustment (DCA)**	4.9%	1.9%	2.1%	2.1%	2.1%	2.1%				
Across the board cuts to finance the debt ***		2.0%								
TOTAL IMPACT	6.0%	6.7%	8.1%	10.6%	10.5%	11.4%	9.3%	9.4%	8.9%	8.7%

% = % OF MEDICARE INPATIENT OPERATING PAYMENTS

*The Multifactor Productivity Adjustment is an estimate generated by the CMS Office of the Actuary

**DCA, also known as the behavioral offset, shown here does not show the future affects of these cuts on baseline spending. Estimates FY 2014-FY 2017 impact of the American Taxpayer Relief Act of 2012

*** If Congress has not adopted the Joint Committee's report to reduce the deficit by at least $1.2 trillion, the 2% cut will be implemented January 2013

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Hospital Value-Based Purchasing

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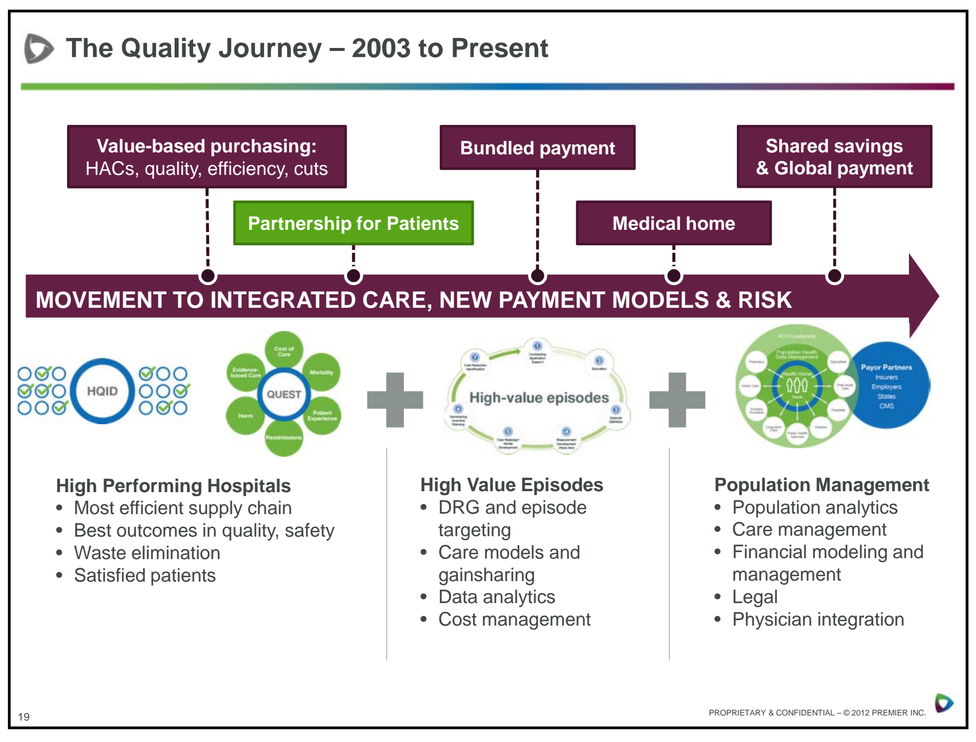
The Quality Journey – 2003 to Present
Value-based purchasing: HACs, quality, efficiency, cuts
Bundled payment
Shared savings & Global payment
Partnership for Patients
Medical home
MOVEMENT TO INTEGRATED CARE, NEW PAYMENT MODELS & RISK
HQID
QUEST
High-value episodes
Payor Partners
High Performing Hospitals
• Most efficient supply chain
• Best outcomes in quality, safety
• Waste elimination
• Satisfied patients
High Value Episodes
• DRG and episode targeting
• Care models and gainsharing
• Data analytics
• Cost management
Population Management
• Population analytics
• Care management
• Financial modeling and management
• Legal
• Physician integration
19
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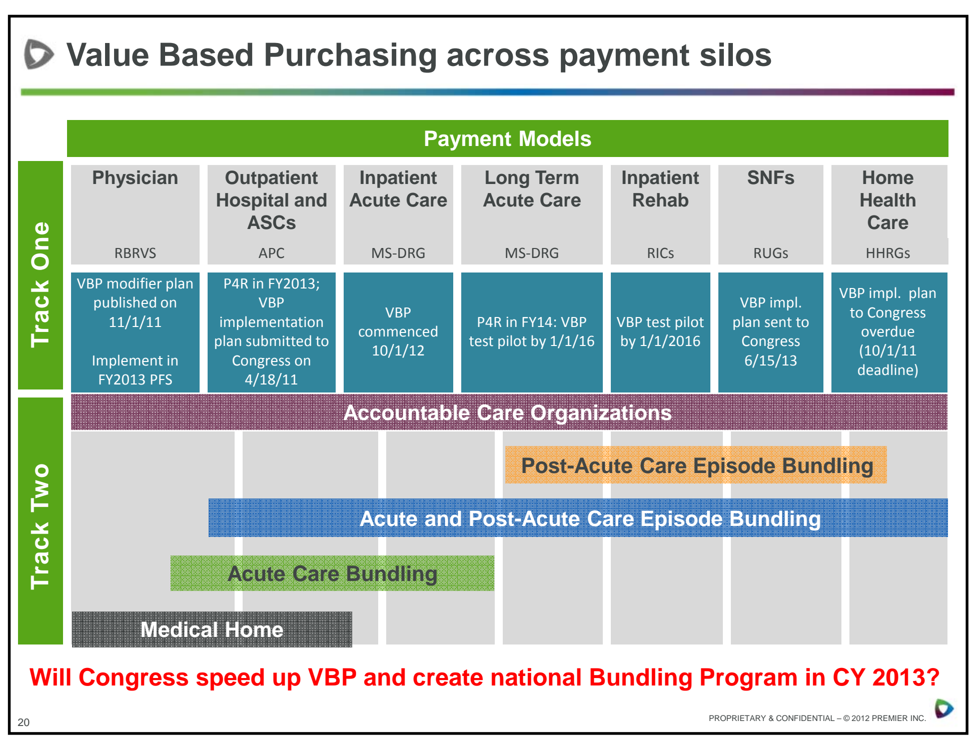
Value Based Purchasing across payment silos
Payment Models
Track One
Physician
RBRVS
VBP modifier plan published on 11/1/11
Implement in FY2013 PFS
Outpatient Hospital and ASCs
APC
P4R in FY2013; VBP implementation plan submitted to Congress on 4/18/11
Inpatient Acute Care
MS-DRG
VBP commenced 10/1/12
Long Term Acute Care
MS-DRG
P4R in FY14: VBP test pilot by 1/1/16
Inpatient Rehab
RICs
VBP test pilot by 1/1/2016
SNFs
RUGs
VBP impl. plan sent to Congress 6/15/13
Home Health Care
HHRGs
VBP impl. plan to Congress overdue (10/1/11 deadline)
Track Two
Accountable Care Organizations
Post-Acute Care Episode Bundling
Acute and Post-Acute Care Episode Bundling
Acute Care Bundling
Medical Home
Will Congress speed up VBP and create national Bundling Program in CY 2013?
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Inpatient Value-Based Purchasing

- VBP policies have been included across numerous regulation in the past 1.5 years—VBP, IPPS and OPPS.
- A percent of inpatient operating payments will be at stake depending upon quality of outcomes.

FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
1%	1.25%	1.5%	1.75%	2%

- Rewards for achievement or improvement
- While program starts October 1, 2012, payments won't be affected until January 2013 (prior claims will be reprocessed).
- AdvisorLive on April 18, 2012 www.premierinc.com/advisorlive

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VBP 2013 measures and weighting

70% Weight:
12 **clinical process** measures

- Acute myocardial infarction
- Heart failure
- Pneumonia
- Surgery
- Surgical infections

30% Weight:
8 **patient experience** measures

- Communication with nurses
- Communication with doctors
- Responsiveness of staff
- Pain management
- Communication about medicines
- Cleanliness and quietness of environment
- Discharge information
- Overall rating

Clinical Process & Patient Survey Timeline for FY 2013 Payment

- Baseline July 1, 2009 to March 31, 2010
- Performance July 1, 2011 to March 31, 2012

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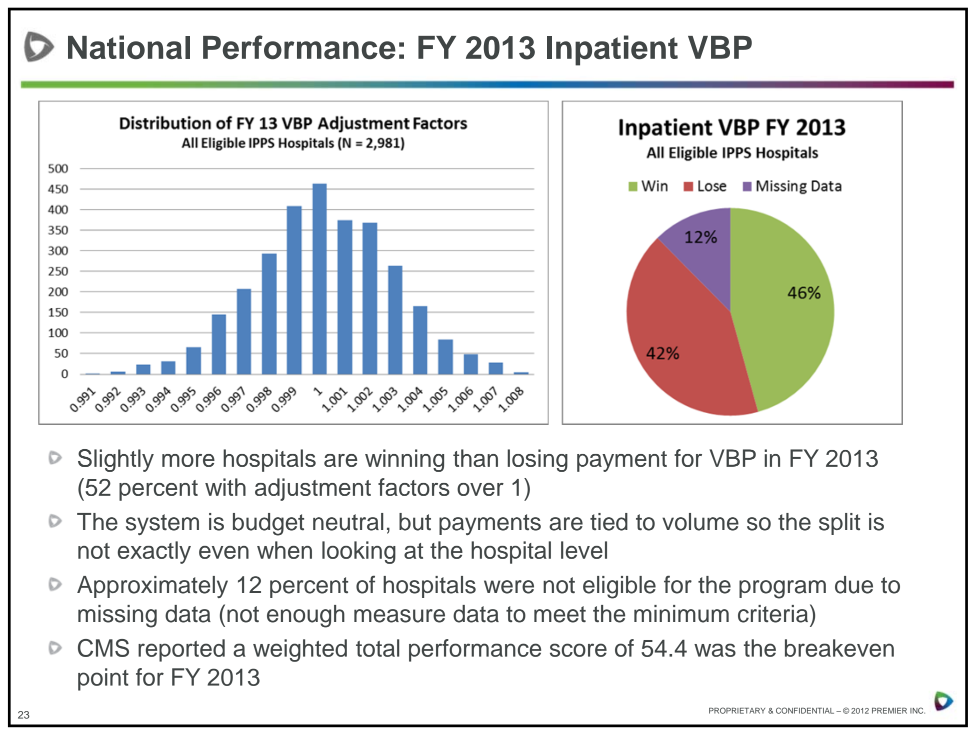
National Performance: FY 2013 Inpatient VBP
Distribution of FY 13 VBP Adjustment Factors
All Eligible IPPS Hospitals (N = 2,981)
500
450
400
350
300
250
200
150
100
50
0
0.991
0.992
0.993
0.994
0.995
0.996
0.997
0.998
0.999
1
1.001
1.002
1.003
1.004
1.005
1.006
1.007
1.008
Inpatient VBP FY 2013
All Eligible IPPS Hospitals
Win
Lose
Missing Data
12%
46%
42%
Slightly more hospitals are winning than losing payment for VBP in FY 2013 (52 percent with adjustment factors over 1)
The system is budget neutral, but payments are tied to volume so the split is not exactly even when looking at the hospital level
Approximately 12 percent of hospitals were not eligible for the program due to missing data (not enough measure data to meet the minimum criteria)
CMS reported a weighted total performance score of 54.4 was the breakeven point for FY 2013
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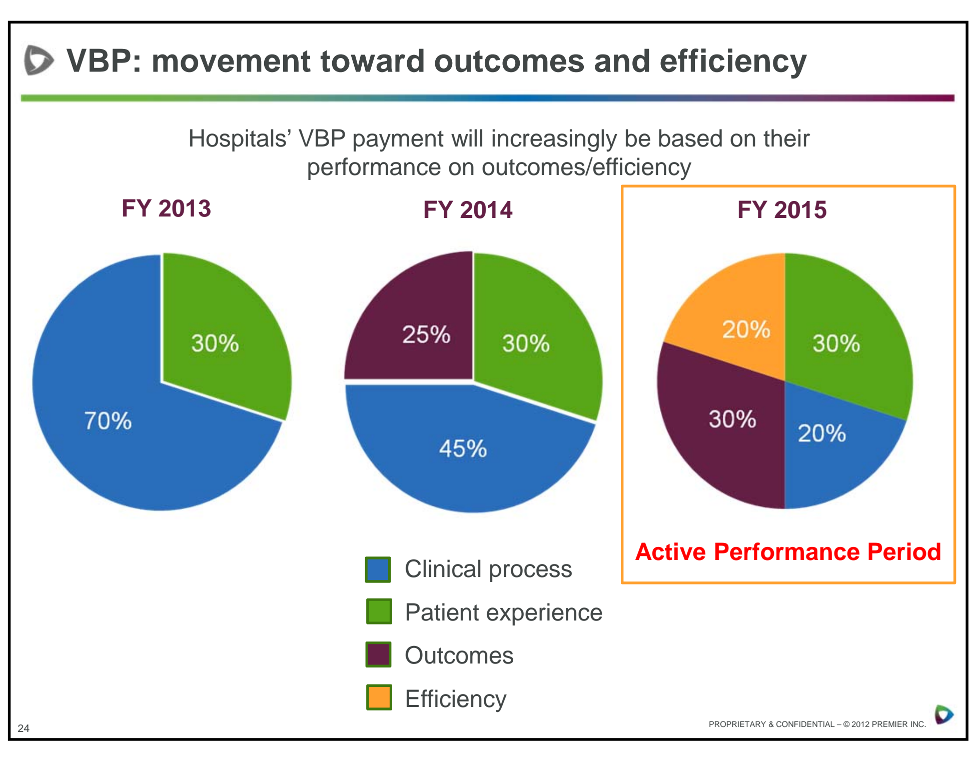
VBP: movement toward outcomes and efficiency
Hospitals' VBP payment will increasingly be based on their performance on outcomes/efficiency
FY 2013
FY 2014
FY 2015
30%
70%
25%
30%
45%
20%
30%
30%
20%
Active Performance Period
Clinical process
Patient experience
Outcomes
Efficiency
24
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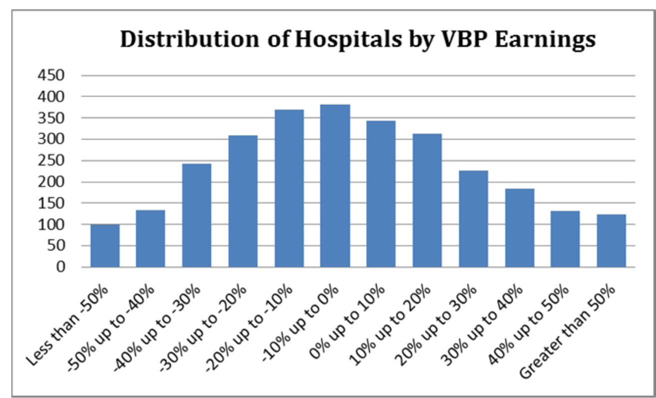
VBP FY 2014 – Distribution of Scores (Premier Model)



- For FY 2014, adds mortality and rebases benchmarks/thresholds
- Minimum back is 0.24%
- 0% means you earned back your 1.25% contribution
- Maximum back is 2.48% (almost double hospital contribution)
- Breakeven point of 40.3 (CY 10 baseline/CY 11 performance model)

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FY 2015 Final Measures

- Medicare Spending per Beneficiary – first measure in new Efficiency Domain
- Medicare Parts A and B spending per beneficiary between 3 days prior to inpatient admission and 30 days post discharge
  - Adjusted using age and severity of illness
- Calculating the ratio:

$$\frac{\text{Hospital's Medicare spending per beneficiary}}{\text{National Median Medicare spending per beneficiary}}$$

- **Implications**: Hospital must use their leverage to reduce spending *outside* the hospital akin to bundling/ACOs
  - Another incentive to reduce readmissions
  - Need to work with physicians on post-discharge plans
  - Need to strengthen relationships with post-acute care providers

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FY 2015 Final Measures

- CDC's National Health Safety Network Central-Line Blood Stream Infections measure
- AHRQ Patient Safety Indicator composite measure

PSI-90 - Composite	AHRQ	NQF Endorsed	CMS IQR & VBP
PSI 03 – Pressure Ulcer	X	X	X
PSI 06 – Iatrogenic Pneumothorax	X	X	X
PSI 07 – Central Venous Catheter-Related Bloodstream Infections	X	X	X
PSI 08 – Postoperative Hip Fracture	X	X	X
PSI 09 - Postoperative Hemorrhage or Hematoma	X		
PSI 10 - Postoperative Physiologic and Metabolic Derangement	X		
PSI 11 - Postoperative Respiratory Failure	X		
PSI 12 – Postoperative Pulmonary Embolism or DVT	X	X	X
PSI 13 – Postoperative Sepsis	X	X	X
PSI 14 – Postoperative Wound Dehiscence	X	X	X
PSI 15 – Accidental Puncture or Laceration	X	X	X

- **Implications**: Hospital-acquired conditions will heavily influence outcomes score in FFY 2015 and other penalties

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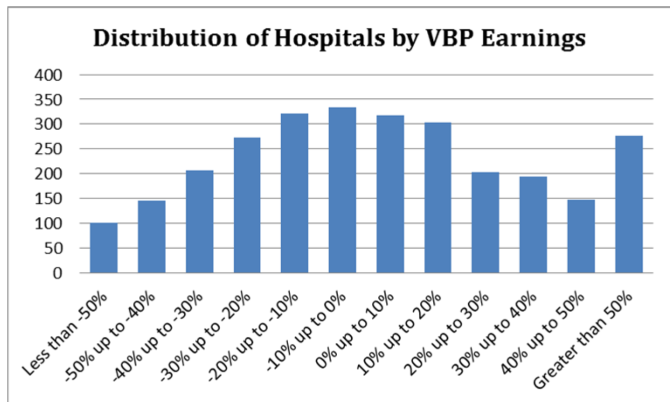
VBP FY 2015 – Distribution of Scores (Premier Model)



We calculated a weighted total performance score breakeven point to be **30.6** based on CY 2010 baseline and CY 2011 performance period measure data (mortality measures span multiple years) and FY 2015 VBP benchmark and achievement thresholds

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Performance in Inpatient VBP by Hospital Characteristic

	FY 2013	FY 2014	FY 2015
Urban/Rural			
Urban	WIN	NEUTRAL	LOSE
Rural	NEUTRAL	LOSE	WIN
Teaching			
Non-teaching	WIN	NEUTRAL	WIN
Under 100 Residents	NEUTRAL	LOSE	LOSE
Over 100 Residents	LOSE	WIN	LOSE
Disproportionate Share			
Urban DSH	LOSE	LOSE	LOSE
Rural DSH	NEUTRAL	NEUTRAL	WIN
Non DSH	WIN	WIN	WIN
Ownership			
Voluntary	WIN	WIN	WIN
Proprietary	WIN	WIN	LOSE
Government	LOSE	LOSE	LOSE
Urban, Teaching and DSH			
Urban, Teaching and DSH	LOSE	LOSE	LOSE

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Performance in VBP by Hospital Size

	FY 2013	FY 2014	FY 2015
Urban Hospital Size (Beds)			
X-Small (less than 100)	WIN	WIN	WIN
Small (100-199)	NEUTRAL	LOSE	WIN
Medium (200-299)	NEUTRAL	LOSE	LOSE
Large (300-499)	LOSE	NEUTRAL	LOSE
X-Large (more than 500)	LOSE	WIN	LOSE
Rural Hospital Size (Beds)			
X-Small (less than 50)	WIN	WIN	WIN
Small (50-99)	LOSE	NEUTRAL	WIN
Medium (100-149)	WIN	NEUTRAL	WIN
Large (150-199)	LOSE	LOSE	NEUTRAL
X-Large (more than 200)	WIN	WIN	WIN

- Very small hospitals generally win under the VBP Program
- Rural hospitals with 200 or more beds also generally win

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Hospital VBP

FY 2016 Final Baseline and Performance Periods

Measure	Baseline Period	Performance Period
Mortality Measures	October 1, 2010 – June 30, 2011	October 1, 2012 – June 30, 2014
AHRQ PSI 90	October 15, 2010 – June 30, 2011	October 15, 2012 – June 30, 2014
All other measures CLABSI? MRSA? Cdiff? Provider Flu Vaccine? Expanded HCAHPS? Stroke? VTE? Early Elective Delivery? H/K Complications? H/K Readmissions? Hospital-Wide Readmissions?	TBD	TBD

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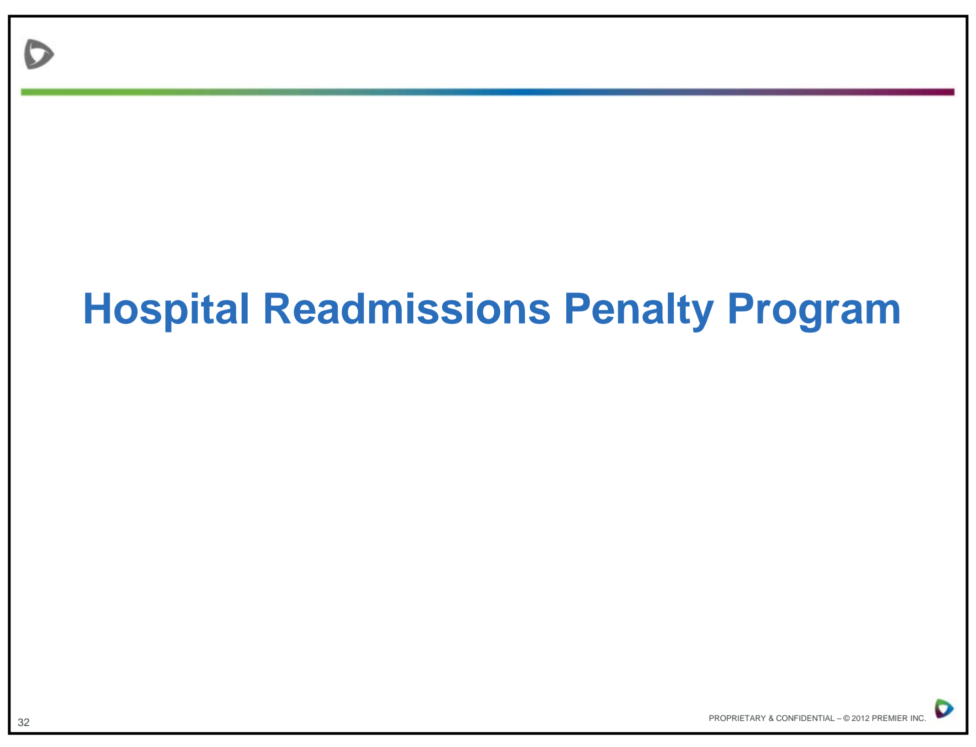

Hospital Readmissions Reduction Program

- Hospital-specific payment adjustment factor will be applied to inpatient claims beginning Oct 1, 2012.

1%	2%	3%	3%	3%
FY 2013	FY 2014	FY 2015	FY 2016	FY 2017

- Uses 30-day AMI, HF and PN measures based on 3 years of data (July 1, 2008 - June 30, 2011 for FY 2013).
- Applies to wage-adjusted base operating DRG payment amount (includes new tech add-on payment only, no adjustments for DSH, IME, outlier, or low volume).
- For SCHs the adjustment will only apply to the national portion of the rates, not the additional payment due to the hospital-specific rates.

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Readmissions into the Future

- **Expands in 2015 to include at least:**
  - Coronary Artery Bypass Graft;
  - Chronic Obstructive Pulmonary Disease;
  - Percutaneous Coronary Intervention; and
  - Other vascular Conditions.
- **Additions to the IQR program that are *likely* to be adopted in the penalty program in the future:**
  - 30-day Hip/Knee readmissions
  - Hospital-Wide All-Cause Unplanned Readmission (HWR)

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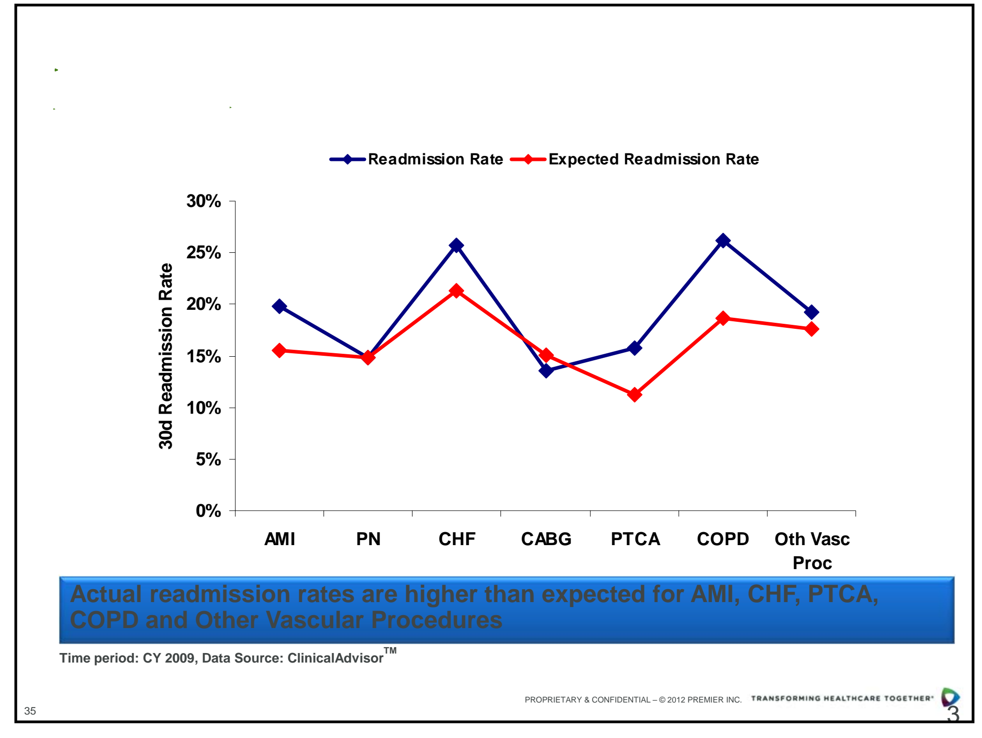
Readmission Rate
Expected Readmission Rate
30d Readmission Rate
30%
25%
20%
15%
10%
5%
0%
AMI
PN
CHF
CABG
PTCA
COPD
Oth Vasc Proc
Actual readmission rates are higher than expected for AMI, CHF, PTCA, COPD and Other Vascular Procedures
Time period: CY 2009, Data Source: ClinicalAdvisor™
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TRANSFORMING HEALTHCARE TOGETHER
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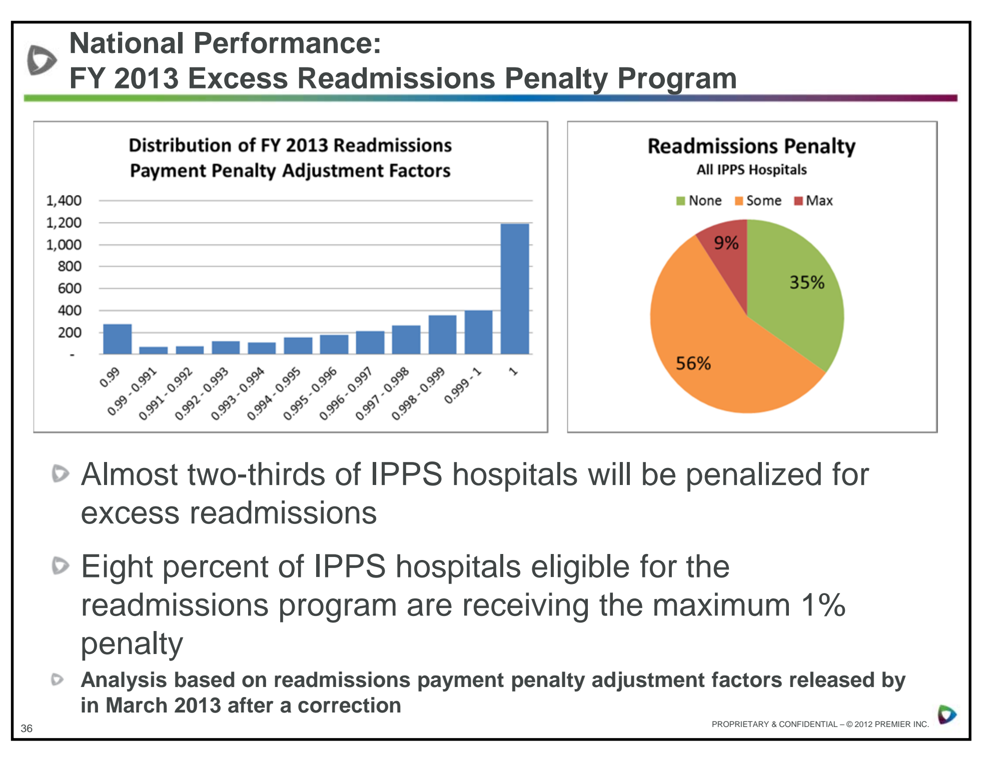
National Performance:
FY 2013 Excess Readmissions Penalty Program
Distribution of FY 2013 Readmissions
Payment Penalty Adjustment Factors
1,400
1,200
1,000
800
600
400
200
-
0.99
0.99 - 0.991
0.991 - 0.992
0.992 - 0.993
0.993 - 0.994
0.994 - 0.995
0.995 - 0.996
0.996 - 0.997
0.997 - 0.998
0.998 - 0.999
0.999 - 1
1
Readmissions Penalty
All IPPS Hospitals
None
Some
Max
9%
35%
56%
Almost two-thirds of IPPS hospitals will be penalized for excess readmissions
Eight percent of IPPS hospitals eligible for the readmissions program are receiving the maximum 1% penalty
Analysis based on readmissions payment penalty adjustment factors released by in March 2013 after a correction
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Performance in Readmissions by Hospital Characteristic

	FY 2013
Urban/Rural	
Urban	99.74%
Rural	99.70%
Teaching	
Non-teaching	99.74%
Under 100 Residents	99.74%
Over 100 Residents	99.58%
Disproportionate Share	
Urban DSH	99.72%
Rural DSH	99.68%
Non DSH	99.82%
Ownership	
Voluntary	99.72%
Proprietary	99.74%
Government	99.73%
Urban, Teaching and DSH	
Urban, Teaching and DSH	99.69%

	FY 2013
Urban Hospital Size (Beds)	
X-Small (less than 100)	99.85%
Small (100-199)	99.72%
Medium (200-299)	99.70%
Large (300-499)	99.70%
X-Large (more than 500)	99.66%
Rural Hospital Size (Beds)	
X-Small (less than 50)	99.73%
Small (50-99)	99.70%
Medium (100-149)	99.61%
Large (150-199)	99.72%
X-Large (more than 200)	99.71%

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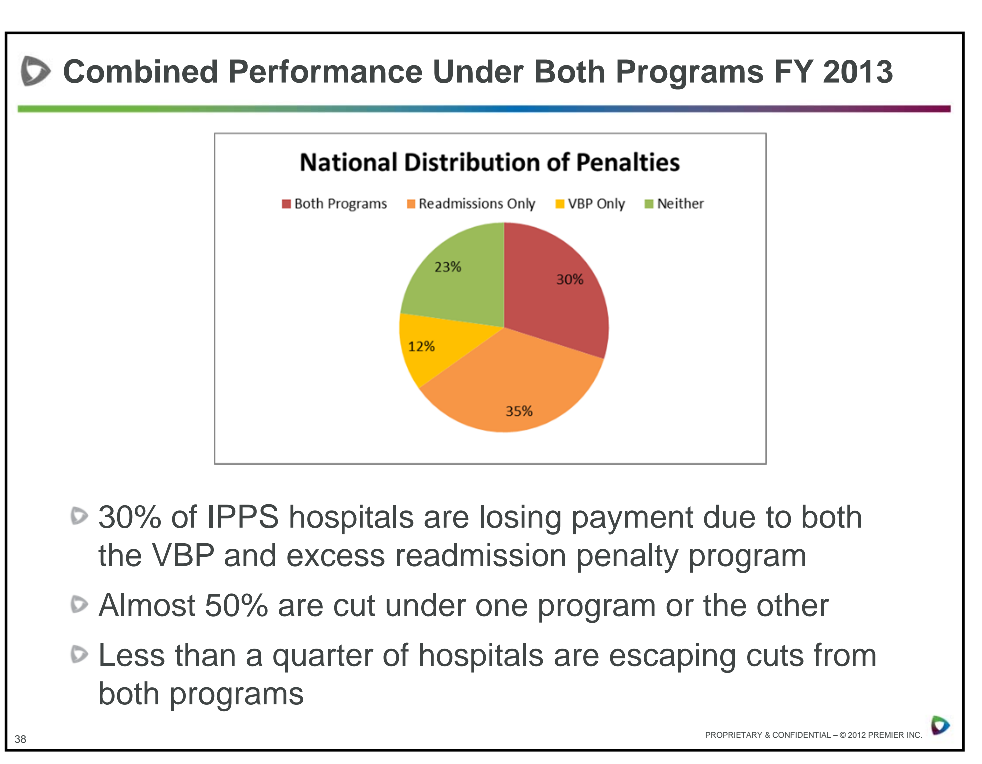
Combined Performance Under Both Programs FY 2013



- 30% of IPPS hospitals are losing payment due to both the VBP and excess readmission penalty program
- Almost 50% are cut under one program or the other
- Less than a quarter of hospitals are escaping cuts from both programs

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Hospital-Acquired Conditions Program

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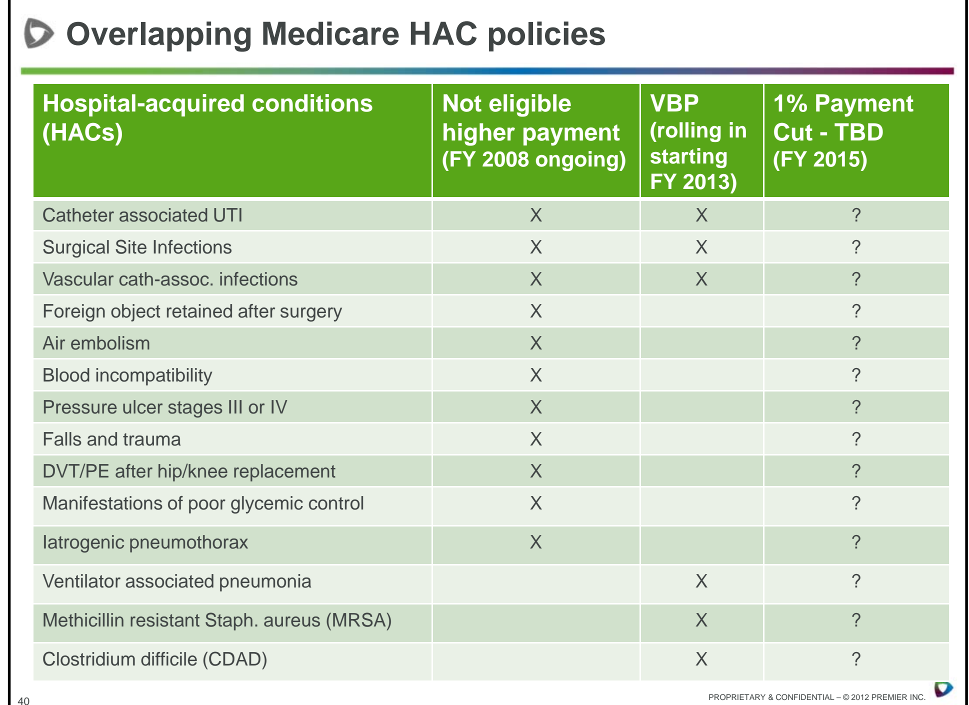
Overlapping Medicare HAC policies



Hospital-acquired conditions (HACs)	Not eligible higher payment (FY 2008 ongoing)	VBP (rolling in starting FY 2013)	1% Payment Cut - TBD (FY 2015)
Catheter associated UTI	X	X	?
Surgical Site Infections	X	X	?
Vascular cath-assoc. infections	X	X	?
Foreign object retained after surgery	X		?
Air embolism	X		?
Blood incompatibility	X		?
Pressure ulcer stages III or IV	X		?
Falls and trauma	X		?
DVT/PE after hip/knee replacement	X		?
Manifestations of poor glycemic control	X		?
Iatrogenic pneumothorax	X		?
Ventilator associated pneumonia		X	?
Methicillin resistant Staph. aureus (MRSA)		X	?
Clostridium difficile (CDAD)		X	?

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Hospital Acquired Conditions

- The top three drivers of the HAC rate based on current Hospital Compare date are:

Hospital Acquired Condition	All IPPS
Foreign Object Retained After Surgery	1.8%
Air Embolism	0.2%
Blood Incompatibility	0.1%
Pressure Ulcers Stages III and IV	8.0%
Falls and Trauma	42.2%
Vascular catheter-associated infections	21.2%
CAUTI	22.8%
Poor Glycemic Control	3.7%

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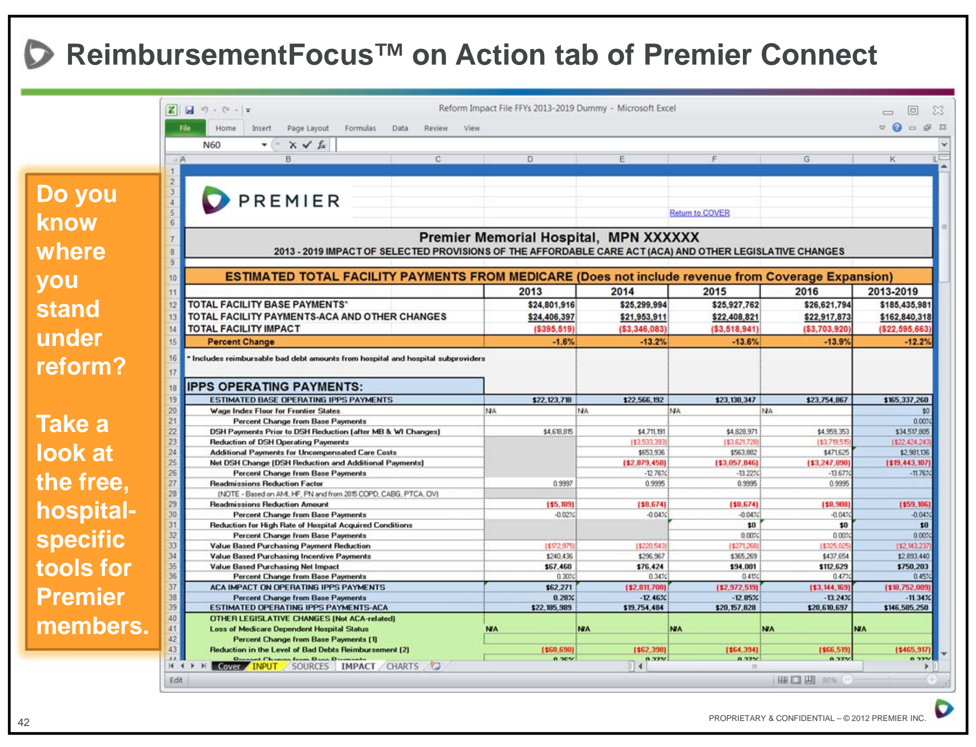

Strategies for aligning payment with outcomes
Culture of leadership and transparency
Physician coordination and buy in is key
Focus on evidence-based care
Cuts/rewards within a hospital's control
Estimate payment based on prior performance
Benchmark against peers to gauge impact
43
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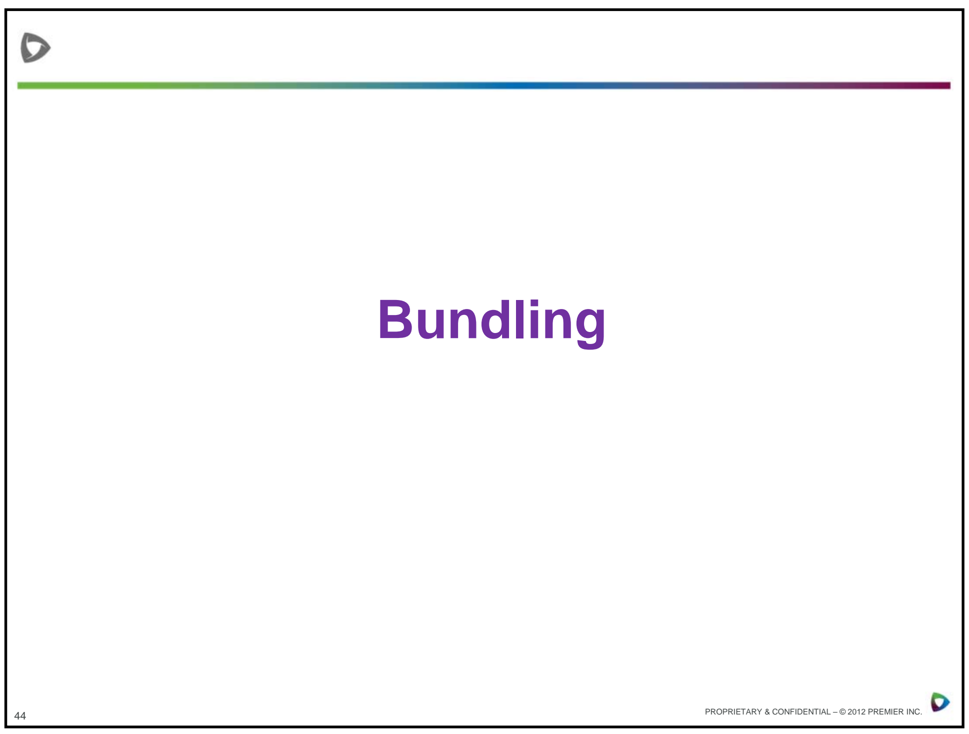
Bundling
44
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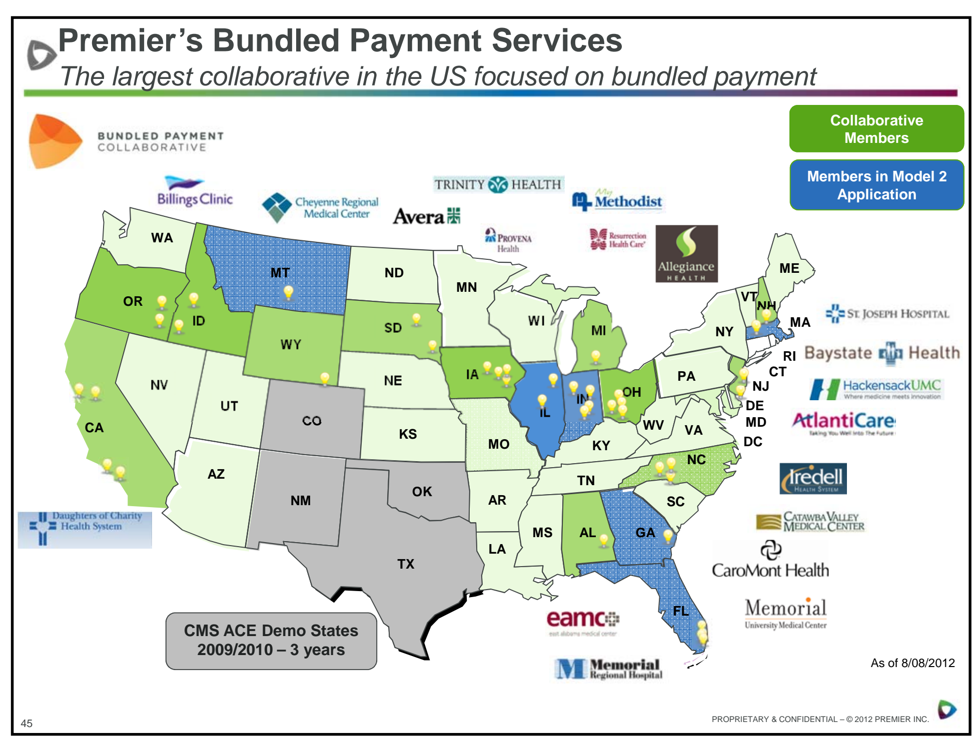
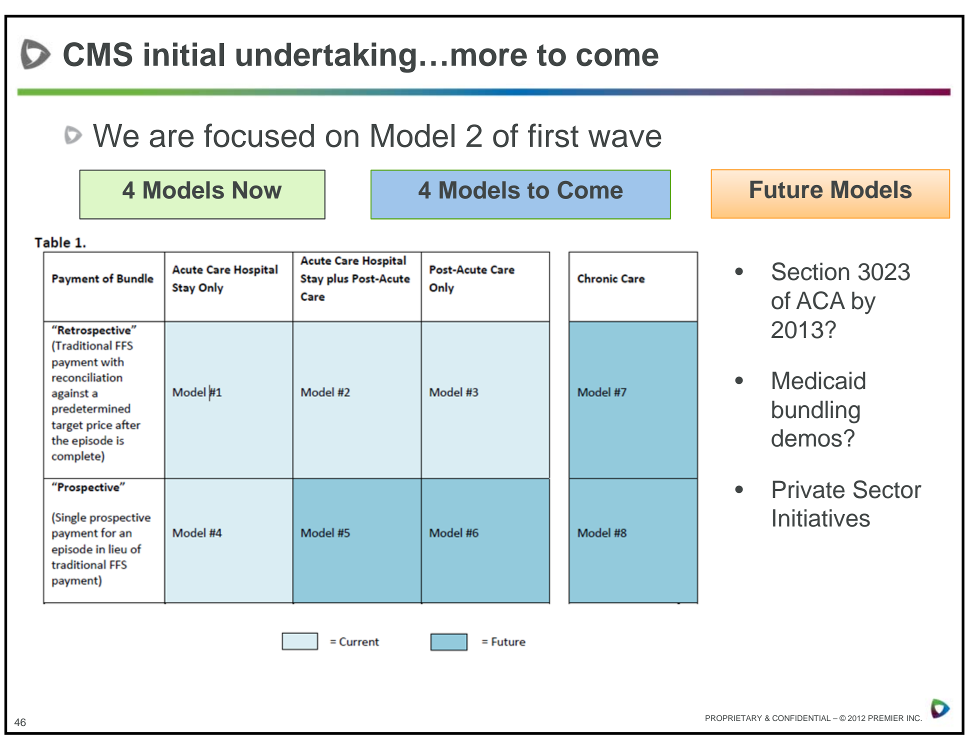
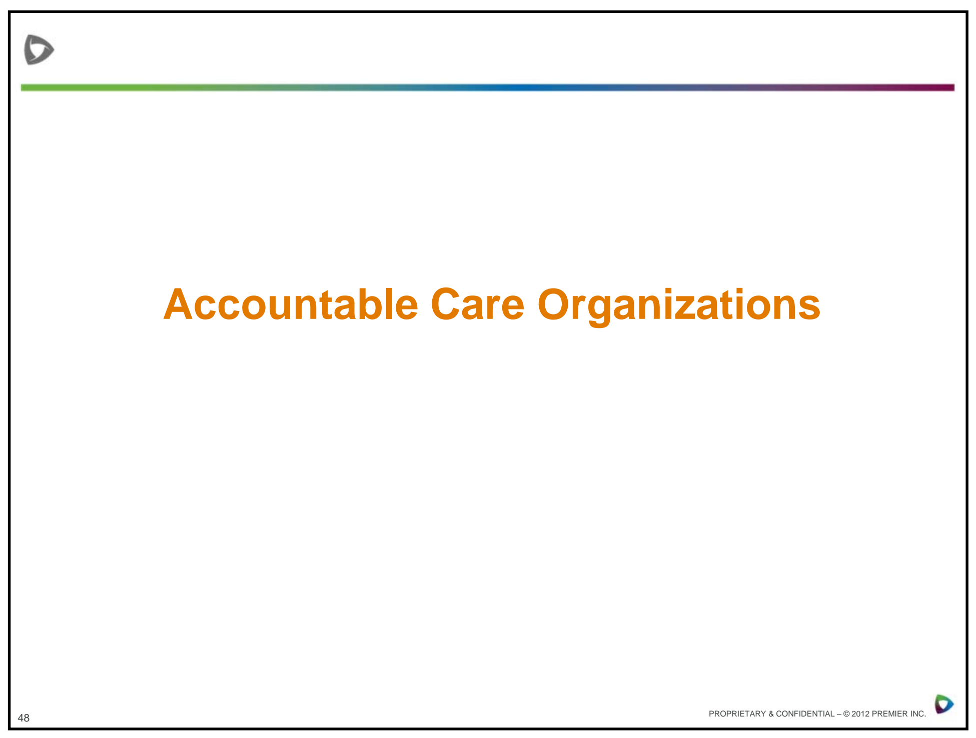




Payment of Bundle	Acute Care Hospital Stay Only	Acute Care Hospital Stay plus Post-Acute Care	Post-Acute Care Only	Chronic Care
"Retrospective" (Traditional FFS payment with reconciliation against a predetermined target price after the episode is complete)	Model #1	Model #2	Model #3	Model #7
"Prospective" (Single prospective payment for an episode in lieu of traditional FFS payment)	Model #4	Model #5	Model #6	Model #8

Enter the Employers
Lowe's: early returns on Cleveland Clinic heart deal a 'home run'
October 19, 2010 10:08 am by Brandon Glenn | 0 Comments
Walmart Employees to Receive Free Heart, Spine Services From 6 High-Profile Systems
Written by Sabrina Rodak | October 11, 2012
Walmart has expanded a Centers of Excellence program involving bundled payments that will offer heart, spine and transplant surgeries at certain high-profile health systems and hospitals at no cost to the Walmart associates,
More health systems bundling payments to cut costs
August 24, 2012 | By Alicia Caramenico
Carolinas HealthCare System now is offering bundled payments for certain heart patients and their employers, in an attempt cut cardiac care costs, reported the Charlotte Business Journal. Under the bundled payment arrangement, the Charlotte, N.C.-based health system will negotiate a flat fee for angioplasty and coronary artery bypass surgery. The new payment has been gaining popularity among other major health systems, including the Cleveland Clinic, who is in talks with defense contractor Boeing about performing heart surgeries on Boeing employees for a bundled payment. Article
47


Accountable Care Organizations
48
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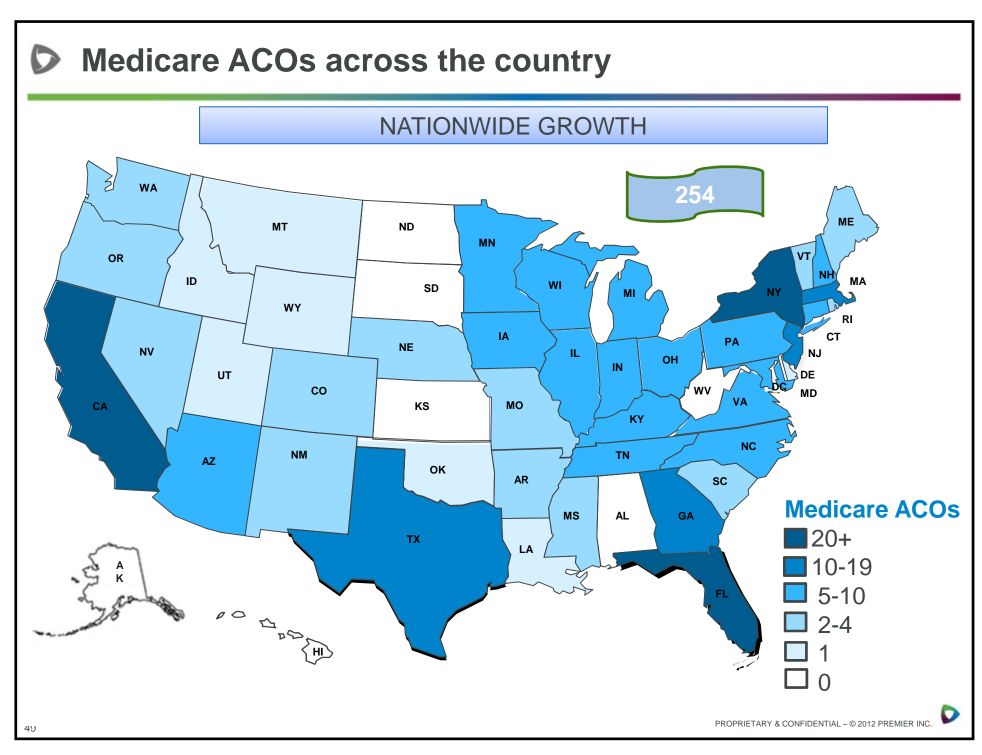

Medicare ACOs across the country
NATIONWIDE GROWTH
254
Medicare ACOs
20+
10-19
5-10
2-4
1
0
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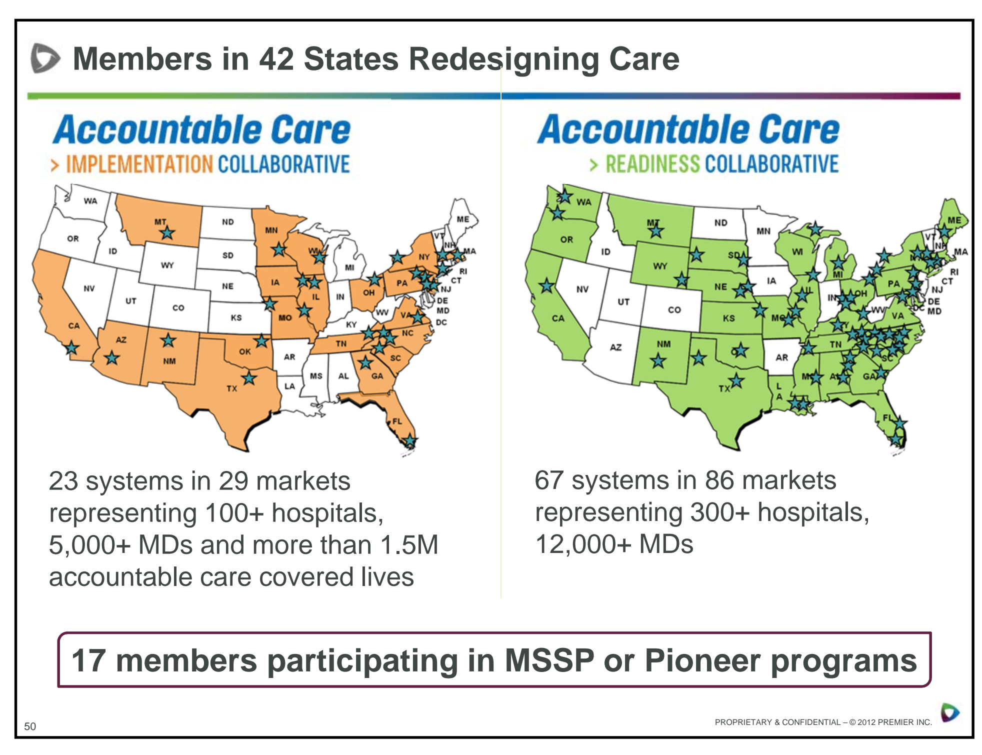

Members in 42 States Redesigning Care
Accountable Care
> IMPLEMENTATION COLLABORATIVE
23 systems in 29 markets representing 100+ hospitals, 5,000+ MDs and more than 1.5M accountable care covered lives
Accountable Care
> READINESS COLLABORATIVE
67 systems in 86 markets representing 300+ hospitals, 12,000+ MDs
17 members participating in MSSP or Pioneer programs
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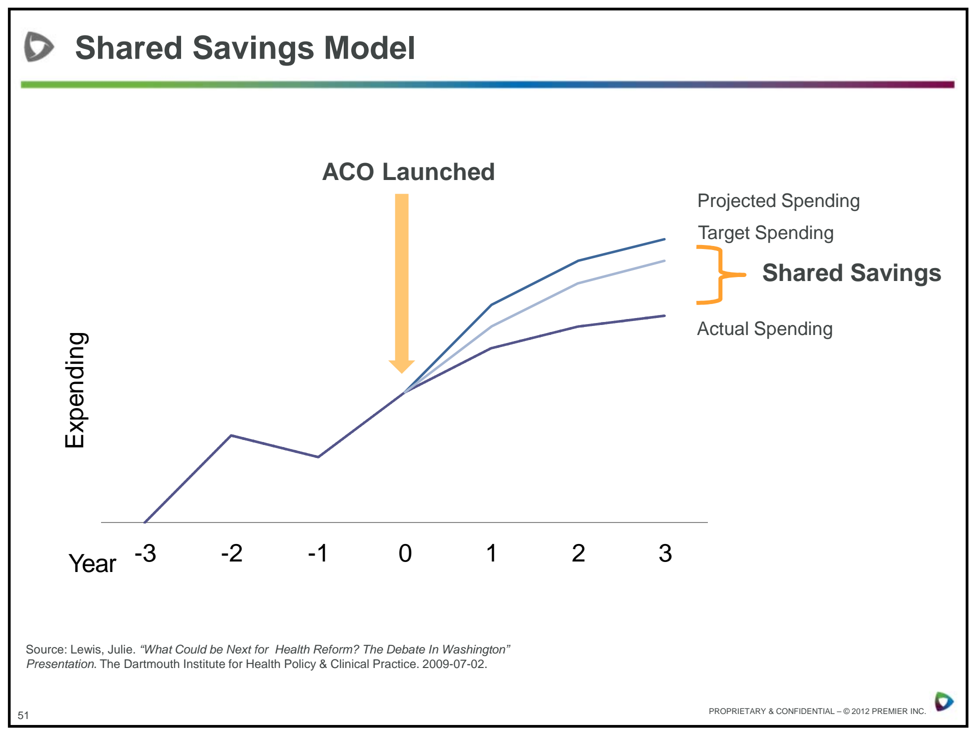

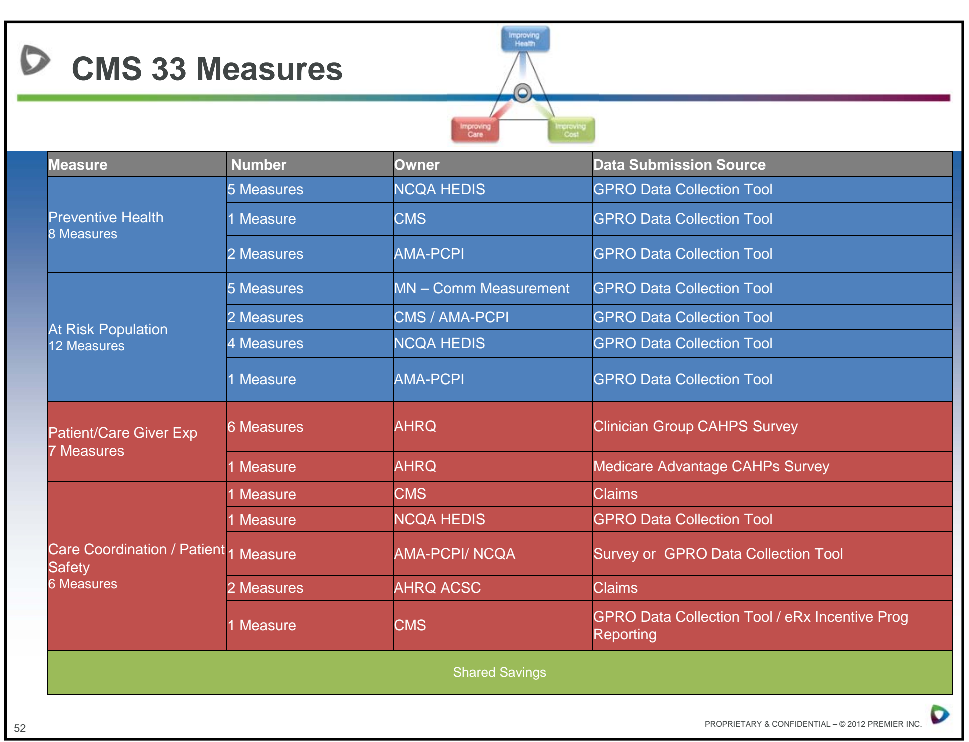
CMS 33 Measures

Measure	Number	Owner	Data Submission Source
Preventive Health 8 Measures	5 Measures	NCQA HEDIS	GPRO Data Collection Tool
	1 Measure	CMS	GPRO Data Collection Tool
	2 Measures	AMA-PCPI	GPRO Data Collection Tool
At Risk Population 12 Measures	5 Measures	MN – Comm Measurement	GPRO Data Collection Tool
	2 Measures	CMS / AMA-PCPI	GPRO Data Collection Tool
	4 Measures	NCQA HEDIS	GPRO Data Collection Tool
	1 Measure	AMA-PCPI	GPRO Data Collection Tool
Patient/Care Giver Exp 7 Measures	6 Measures	AHRQ	Clinician Group CAHPS Survey
	1 Measure	AHRQ	Medicare Advantage CAHPs Survey
Care Coordination / Patient Safety 6 Measures	1 Measure	CMS	Claims
	1 Measure	NCQA HEDIS	GPRO Data Collection Tool
	1 Measure	AMA-PCPI/ NCQA	Survey or GPRO Data Collection Tool
	2 Measures	AHRQ ACSC	Claims
	1 Measure	CMS	GPRO Data Collection Tool / eRx Incentive Prog Reporting
Shared Savings			

The Accountable Care Organization Model

A group of providers willing and capable of accepting accountability for the total cost and quality of care for a defined population.

Core Components:
- People Centered Foundation
- Health Home
- High-Value Network
- Population Health Data Management
- ACO Leadership
- Payor Partnerships

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Major market trends

- **Private Exchanges** by major employers
- **Medical Tourism**
- **Consolidation** of hospitals, health systems, and the continuum of care
- **Blending** of delivery systems, health insurance plans, and technology firms
- New **Provider Owned** Plans
- Information **technology** will enable major health care changes and drive data integration
- Development of value-based **benefit design**
- Increased patient **activation** through consumer driven health plans and other means
- Economy will continue drive payment reductions through **VBP methods**

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PACT Collaborative Learnings

- **Managing populations,** not just patients, requires fundamental change
- Significant **culture** shifts will need to occur within organizations
- **Executive leadership** within C-Suite and Board are vital
- **Transformation will be clinical,** with support from financial/payment, HIT, and legal changes
- **Physician leadership** and professional management is pivotal
- **Care models** to define evidence-based standards are critical
- Coordination across the **continuum of care** is essential
- Keys to success include a **primary care foundation,** plus **PCMH** and comprehensive informatics across the continuum
- **Variability** is a given…**flexibility** and innovation is **market driven**
- **Shared learning** collaborative is both a motivator and supportive structure
- Private payor **readiness** to alter reimbursement and share data to support ACO model varies widely
- **Unknowns** are plentiful…public and private sector have a lot to learn

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