Healthcare Reform and Evolving Business Models
Objectives of PPACA

- Provide meaningful insurance coverage to approximately 32 million people
- Improve quality of care
- Reduce medical errors
- Create savings in federal healthcare expenditures
- “Bend” the cost curve
Health Care Reform - March 23, 2010

Expanding Coverage
- Temporary high-risk pool
- Dependent coverage
- Pre-existing condition coverage
- Prohibit lifetime limits on coverage
- Expand Medicaid to those with Incomes up to 133% FPL
- Create State-based Insurance Exchanges
- Individual and Employer Mandates

Financing
- Tanning Taxes
- Pharmaceutical Taxes
- Medicare Advantage payment restructuring
- Medicare Part A Taxes
- Medical Devices Tax
- Reducing Medicare DSH payments
- Hospital-acquired Conditions
- Health Insurance Taxes
- “Cadillac” Tax

Delivery System Reform
- Medicare and Medicaid Innovation Center
- Value Based Purchasing
- Readmissions
- Accountable Care Organizations
- Medicare Bundled Payments
- Independent Payment Advisory Board begins submitting recommendations

Source: CHW
Health Care Reform Bill Timeline (as revised by the House Reconciliation Bill)*

**SUMMARY OF SELECT REQUIREMENTS**

- State grants to establish or expand ombudsman programs are awarded
- New federal rate review process is established
- National risk-pool is created
- Temporary retiree reinsurance program is established
- Small business tax credit is established
- Prohibits lifetime benefit limits
- Allows restricted annual limits for essential benefits (as determined by HHS)
- Recissions are prohibited (except for fraud or intentional misrepresentation)
- Cost-sharing obligations for preventive services are prohibited
- Dependent coverage up to age 26 is mandated
- Internet portal to facilitate consumer and small employer shopping is created
- Coverage for emergency services at in-network cost-sharing level with no prior-authorization is mandated
- Pre-existing condition exclusions for dependent children (under 19 years of age) are prohibited
- New health plan disclosure and transparency requirements are created
- GRANDFATHERED PLANS
  - Prohibits lifetime benefit limits
  - Recissions are prohibited (except for fraud or intentional misrepresentation)
  - Dependent coverage up to age 26 is mandated
  - Pre-existing condition exclusions for dependents are prohibited
- Health insurance exchange is established
  - Guarantee issue is required
  - Rating restrictions that, among other things, limits use of age as a rating factor are imposed
  - Individual and employer responsibility requirements are established
  - Individual affordability tax credits are created and small business tax credits are expanded
  - Essential benefit plan is created
  - Pre-existing condition exclusions are prohibited
  - CO-OPs are established
  - Lifetime and annual dollar limits are prohibited for essential benefits
  - Coverage for approved clinical trials is mandated
  - Multi-state qualified health plans are created and offered through the Exchange
- Health insurance fee to fund Comparative Effectiveness is imposed
  - Uniform coverage documents and standard definitions are developed by HHS (in consultation with NAIC)
  - 85% MLR for large group (with refund) is mandated
  - 80% MLR for individual and small group (with refund) is mandated
- Health insurance provider fee imposed
  - $4 billion
  - $11.3 billion
  - $13.9 billion
  - $14.3 billion**

**IMPACT**

- Health plans develop and file new policy forms
- States approve (or disapprove) new rate filings
- HHS Secretary and states create new rate review process
- HHS Secretary establishes new national risk-pool
- HHS Secretary establishes temporary retiree reinsurance program
- 2010
- 2011
- 2012
- 2013
- 2014
- 2015
- 2016
- 2017
- 2018

*Assumes April 1, 2010 enactment  **In years following 2018, the tax amount would increase in an amount proportionally equal to overall premium growth.
Healthcare Reform Overview

- President Obama - "Everybody should have some basic security when it comes to their health"
- The bill will extend coverage to an estimated 32 million people who currently lack insurance
- Most of the major insurance reforms will take effect in 2014, but as of fall 2010:
  - Health plans will no longer be able to deny coverage to children who have pre-existing conditions
  - People who lack insurance because of illness will have access to a temporary insurance pool
  - Lifting of lifetime caps on insurance coverage and a prohibition against health plans dropping people when they get ill
  - New health plans will have to offer free preventive care
  - Young people will be able to be covered by their parents' health plan until age 26
Healthcare Change Concepts (Then & Now)

- Integrated Delivery System → Accountable Care Organization
- Primary Care Gatekeeper → Medical Home
- Global Payment → Bundled Payment
- Utilization Management → Population Management
- Universal Coverage → Universal Coverage
- Capitation → Capitation Like
Feeling Squeezed Even Before the Impact of Healthcare Reform

Reimbursement Pressures and RAC/Short Stay Issues

Physician shortages/recruitment/retention/employment

Increasingly competitive markets

Specialty hospital/ambulatory niche competition

Aging Infrastructure

Impact on operating cash flow and balance sheet stability?

Bond covenants

Investment losses

Capital access/cost and the need to fund growth strategies

Pension funding

Payor mix deterioration with rising bad debt and charity

Information technology needs

Equipment replacement/new technology

Source: CB Richard Ellis
Aggregate Total Hospital Margins, (1) Operating Margins, (2) and Patient Margins, (3) 1991 – 2008

Source: Avalere Health analysis of American Hospital Association Annual Survey data, 2008, for community hospitals.

(1) Total Hospital Margin is calculated as the difference between total net revenue and total expenses divided by total net revenue.

(2) Operating Margin is calculated as the difference between operating revenue and total expenses divided by operating revenue.

(3) Patient Margin is calculated as the difference between net patient revenue and total expenses divided by net patient revenue.
Sold Non-Profit Hospitals: Distressed Hospitals: Lessons Learned

- Usually 3 or 4 major issues:
  - Insufficient physicians or misalignment
  - Market share and revenue problem (rather than expense)
  - Not enough non operating income
  - Too long of Medicare ALOS
  - Too high charity and bad debt
  - Too little commercial insurance or too much commercial insurance with bad rates
PCP Physician Supply and Demand Observations

- Estimated 850,000 total physicians in the U.S. (78% in clinical practice)
- PCPs (FP, IM, peds) generally estimated to be between 32-37% of total physicians
- Wide regional variability across the United States
- 75% male, 25% female (but growing). Implications on physician FTE count. 1 in 3 active male physicians is age 55+, but only 1 in 7 females
- Nationally, by 2025 there will be a 37% shortage of primary care physicians and a 33% shortage of surgeons
Physician Challenges

- Struggles with cost escalation & growing administrative burdens of practice management; erosion of the solo practitioner model
- Incomes have been flat to declining for many physicians; retirements being deferred due to the economic downturn
- Quality of life/lifestyle = key for younger physicians (but lower production)
- Continuing and growing participation in JVs (desire/need for supplemental income)
- Increase in part-time practices/shared practices and use of extenders
- Increase in employment & participation in integrated models
IF I HAD MY CAREER TO DO OVER AGAIN, I WOULD...

- Choose to be a surgical/diagnostic specialist...41%
- Choose not to be a physician......................26%
- Choose to be a non-clinical physician............4%
- Choose to be a primary care doctor...........27%

Source: Merritt Hawkins
Hospitals: Picking a Physician Relationship Strategy…
Hospitals are aggressively competing for physicians utilizing a multifaceted approach including employment, network development and Clinical Co-Management opportunities.

With healthcare reform, a growing shortage of primary care physicians, and hospital competition for physicians – recruiting and retaining PCPs will become increasingly difficult. In addition, hospitals are competing for specialty physicians who generate significant revenues for the hospital.

1 Health Affairs, April 2010
2 Association of American Medical Colleges/Modern Healthcare/December 1, 2008
Percentage of Hospitals with Physician Affiliates\(^{(1)}\) by Type of Relationship, 1998 – 2008

Source: Avalere Health analysis of American Hospital Association Annual Survey data, 2008, for community hospitals.

\(^{(1)}\) A hospital is considered to have a physician relationship if the relationship exists as part of the hospital, a system or network of which the hospital is a part.

Previously Chart 2.7 in 2009 and earlier years’ Chartbooks.
Ownership Trends

Medical practice ownership trends

Source: Physician Compensation and Production Survey, Medical group Management Association 2003-2009
Kaiser Permanente Advantage

- Typically higher starting salaries; additional compensation for after hours shifts and urgent care
- Better benefits (e.g., 3 weeks vacation for new physicians, 5 weeks after 10 years of service)
- Less call burden/better lifestyle balance
- Technology/IT superiority
- Security and predictability
- Truly integrated system (hospital alignment, collegiality, resources)
On March 23, 2010 the Patient Protection and Affordable Care Act (PPACA, ACA) signed into law. Some key points were:

- Create an Innovation Center within the Centers for Medicare and Medicaid in 2011
- Provide a 10% Medicare bonus payment to PCPs and general surgeons in HPSAs for 2011-2015
- Allow providers organized as ACOs to share in cost savings starting in 2012
- National pilot of bundled payments in 2013
- Increase Medicaid payments for primary care physicians for 2013 and 2014
Dartmouth Institute for Health Policy

- Grew out of work on market variation in health cost and utilization.

- Conclusion was that Medicare spending for physician services tends to cluster around hospital service areas and based upon the availability and ownership of technologies and specialties.

- Dartmouth posited that creating “communities” responsible for managing a global payment would lead to more rational distribution of health care resources.

- Medicare Payment Advisory Committee took this idea and developed into concept of Accountable Care Organizations.

- ACO’s incorporated into Health Care Reform.
Utilization of hospital services is significantly higher for the elderly population. By 2030, this population is projected to more than double.

Theory is when you cap the total resources coming into a specific “community”, hospitals and physicians will form ACO’s to accept and manage global payments.

This new entity will be economically motivated to not expand or overuse resources.

The ACO will self police over utilizers and rationally allocate expensive resources.
Patient Centered Medical Home (PCMH)

- A model being promoted as a strategy to address health care reform goals for the future.

**PCMH Hallmarks**

- Technology driven
- Whole personal orientation
- Coordinated and/or integrated care delivery
- Value added with incentive pay-for-performance
- Enhanced access
- Primary care driven
- Personal physician
- Additional reimbursements for care coordination
- Quality outcomes and safety procedures
CMS outline of requirements

- Formal Legal Structure

- Have sufficient number of PCP’s for the number of assigned beneficiaries (5,000 minimum)

- Agree to three year participation

- Have Sufficient information regarding participating ACO health care professionals as determined by the Secretary determines necessary to support beneficiary assignment and determination of shared savings.

- Have leadership and management structure that includes clinical and administrative systems

- Have defined process to:
  - Promote evidence based medicine
  - Report the necessary data to evaluate quality and cost measures (may be based on PQRI, EHR, eRX
  - Coordinate Care

- Demonstrate it meets patient-centeredness criteria as determined by the Secretary
CMS Restriction of Beneficiaries

- Medicare beneficiaries will continue to be able to choose their health care professionals and other providers
CMS definition of who may be ACO

- Physicians and other professionals in group practices
- Physicians and other professionals in networks of practices
- Partnership or joint venture arrangements between hospitals and physicians
- Hospitals employing physicians/professionals
- Other forms that the Secretary of HHS may determine appropriate
Program is targeted to start January 1, 2012

An ACO will share in savings if program criteria are met, but will not incur a payment penalty if savings targets are not achieved.
Issues to be Addressed

- Who will take the lead?
  - Multispecialty Group Practices
  - Healthcare Systems
  - Hospitals
  - IPA
  - PHO’s
  - Foundations
  - Integrated Systems
## What might ACO’s look like?

### EXHIBIT 1

**Delivery Systems That Could Become Accountable Care Organizations**

<table>
<thead>
<tr>
<th>Model</th>
<th>Characteristics</th>
<th>Current Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integrated delivery systems</td>
<td>• Own hospitals, physician practices, perhaps insurance plan.</td>
<td>Geisinger Health System</td>
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<td>• Aligned financial incentives.</td>
<td>Group Health Cooperative of Puget Sound</td>
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<td>• E-health records, team-based care.</td>
<td>Kaiser Permanente</td>
</tr>
<tr>
<td>Multispecialty group practices</td>
<td>• Usually own or have strong affiliation with a hospital.</td>
<td>Cleveland Clinic</td>
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<td>• Contracts with multiple health plans.</td>
<td>Marshfield Clinic</td>
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<td>• History of physician leadership.</td>
<td>Mayo Clinic</td>
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<td></td>
<td>• Mechanisms for coordinated clinical care.</td>
<td>Virginia Mason Clinic</td>
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<td>Physician-hospital organizations</td>
<td>• Nonemployee medical staff.</td>
<td>Advocate Health (Chicago)</td>
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<td>• Function like multispecialty group practices.</td>
<td>Middlesex Hospital (Connecticut)</td>
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<td></td>
<td>• Reorganize care delivery for cost-effectiveness.</td>
<td>Tri-State Child Health Services (affiliated with the Cincinnati Children’s Hospital Medical Center)</td>
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<tr>
<td>Independent practice associations</td>
<td>• Independent physician practices that jointly contract with health plans.</td>
<td>Atrius Health (eastern Massachusetts)</td>
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<td>• Active in practice redesign, quality improvement.</td>
<td>Hill Physicians Group (southern California)</td>
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<td>Monarch HealthCare (southern California)</td>
</tr>
<tr>
<td>Virtual physician organizations</td>
<td>• Small, independent physician practices, often in rural areas.</td>
<td>Community Care of North Carolina</td>
</tr>
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<td>• Led by individual physicians, local medical foundation, or state Medicaid agency.</td>
<td>Grand Junction (Colorado)</td>
</tr>
<tr>
<td></td>
<td>• Structure that provides leadership, infrastructure, resources to help small practices redesign and coordinate care.</td>
<td>North Dakota Cooperative Network</td>
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</table>
Three Tiers Of Accountable Care Organizations And Possible Characteristics

**Tier 3**
- **Financial Risk:** High
- **Mode of Payment:** Full or partial capitation and extensive bundled payments.
- **Additional Incentives:** Highest level of shared savings and bonuses if per beneficiary spending is below agreed-upon target, but greatest amount of risk if spending is above agreed-upon target.

**Tier 2**
- **Financial Risk:** Moderate
- **Mode of Payment:** Fee-for-service, partial capitation, some bundled payments.
- **Additional Incentives:** More shared savings and bonuses if per beneficiary spending is below agreed-upon target, but also some risk if spending is above agreed-upon target.

**Tier 1**
- **Financial Risk:** Low
- **Mode of Payment:** Fee-for-service
- **Additional Incentives:** Some shared savings and bonuses if per beneficiary spending is below agreed-upon target.
Issues to be Addressed

- Which Payors other than Medicare will adopt approach (or will they lead?)
- How will risk be managed
- Will Capital Reserves be Required
- What New Infrastructure will be Needed
- How will the pie be split between hospital and physicians
Issues to be Addressed

- Governance & Management Structure
- Participation of Full Continuum of Providers
  - LTAC
  - Rehab
  - SNF
- Coordination of Care
- Integrated IT
- Adoption of Evidence Based Protocols across all levels of Care
- Enforcement of Standards (carrot & stick)
ACO Proposed Regulations Just Released

- Application and Acceptance
- Governance
- Medicare Beneficiaries May Opt Out/No Lock In
- CMS Will Retroactively Assign Beneficiaries Based on Primary Care Services
- Mandatory Financial Risk Sharing
- Information Technology and Quality Reporting
- Antitrust Review
Why Do an ACO?

The Optimistic View
- Coordinated care will improve quality and reduce cost overall
- The care and reimbursement model is moving in this direction
- Early adopters will gain market share and have significant advantage
- It is a precursor to capitation which will return providers (especially physicians) to control over healthcare
- Integrated delivery systems can be a winner in this model and will “bend the cost-curve”
- The alternative is a government plan

The Pessimistic View
- There is no way that CMS can implement this successfully
- There are not enough savings in bundled payments to justify the effort
- Providers failed at capitation before
- The success of integrated delivery systems has been about market power
- Commercial insurance payers are trying to off load risk
- The government plan will happen anyway
The Steps to Prepare and Implement an ACO are Necessary to be Successful In Any Scenario:

- Primary care strategy including “advanced” primary care practices (medical homes)
- Emphasis on cost effectiveness, evidence based medicine and quality measurement coordinating care
- Hospital/Physician IT connectivity
- Explore hospital/physician alignment for contracting and coordinating care
- Develop clinical protocols for key DRGs
- Plan a timely move to lower cost settings
- A managed care strategy that accounts for future payment methodologies
- Conduct an assessment of independence and/or affiliation options
- Reevaluation of Center of Excellence strategies
- Seek participation in pilots with commercial payers
- Evaluate the capital requirements needed for success
- Begin communication with staff and physicians of what’s on the horizon
Hospital Model Types

- Community based hospitals
- Market dominant stand alone hospitals
- Health systems (non integrated)
- Evolving and Integrated health systems
- Academic Medical Centers
Evolving Hospital Models: Different Strategic Focus: Community Based Hospitals

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Strategies</th>
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</thead>
<tbody>
<tr>
<td>➢ Low cost structure</td>
<td>➢ Access and flow through (ED &amp; Hospitalists)</td>
</tr>
<tr>
<td>➢ Lower health plan rates</td>
<td>➢ <strong>Primary care relationship development</strong></td>
</tr>
<tr>
<td>➢ Profitable Medicare: unprofitable commercial</td>
<td>➢ Retain physicians/ CRM</td>
</tr>
<tr>
<td>➢ High Competition for IPA and medical group relations</td>
<td>➢ Traditional Medicare/ PPO</td>
</tr>
<tr>
<td>➢ Congested emergency rooms</td>
<td>➢ Partner with IPA and Groups</td>
</tr>
<tr>
<td>➢ Lack of capital Investment and limited future access to capital</td>
<td>➢ Innovative joint ventures</td>
</tr>
<tr>
<td>➢ Aging medical staff</td>
<td>➢ Volume and revenue growth</td>
</tr>
<tr>
<td>➢ <strong>No physician integration platform</strong></td>
<td>➢ Sell excess capacity</td>
</tr>
<tr>
<td></td>
<td>➢ <strong>Evaluate partnerships, mergers or sale</strong></td>
</tr>
</tbody>
</table>
Number of Hospitals in Health Systems,\(^{(1)}\)
2000 – 2008

Source: Avalere Health analysis of American Hospital Association Annual Survey data, 2008, for community hospitals.

\(^{(1)}\) Hospitals that are part of a corporate body that may own and/or manage health provider facilities or health-related subsidiaries as well as non-health-related facilities including freestanding and/or subsidiary corporations.
### Evolving Hospital Models: Different Strategic Focus

**Health Systems (Non-Integrated)**

<table>
<thead>
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<th>Characteristics</th>
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<tr>
<td>➢ Lower cost structure</td>
<td>Access and flow through (ED &amp; Hospitalists)</td>
</tr>
<tr>
<td>➢ Profitable on Medicare</td>
<td><strong>Primary care relationship development</strong></td>
</tr>
<tr>
<td>➢ Unprofitable on Commercial insurance</td>
<td>Ensure that infrastructure keeps up with growth</td>
</tr>
<tr>
<td>➢ No physician integration platform</td>
<td>Leverage market presence and size</td>
</tr>
<tr>
<td></td>
<td>On-going consolidation and acquisition opportunities</td>
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<td></td>
<td>Look to IT as integration tool (physician connectivity)</td>
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<td></td>
<td><strong>Low cost strategy and/or develop a physician integration strategy</strong></td>
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</table>
## Evolving Hospital Models: Different Strategic Focus: Market Dominant Stand Alone Hospitals

<table>
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<tr>
<th>Characteristics</th>
<th>Strategies</th>
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<tbody>
<tr>
<td>➢ Good commercial payer rates</td>
<td>➢ Aggressive marketing &amp; branding</td>
</tr>
<tr>
<td>➢ Unprofitable Medicare business</td>
<td>➢ Centers of Excellence / bundled payments</td>
</tr>
<tr>
<td>➢ High Revenue, Cost and Profit</td>
<td>➢ Physician relations &amp; recruitment</td>
</tr>
<tr>
<td>➢ Competing to evolve existing COEs</td>
<td>➢ Primary care development strategy</td>
</tr>
<tr>
<td>➢ Current Access to Capital/concern for the future</td>
<td>➢ Expand outpatient presence</td>
</tr>
<tr>
<td>➢ High level of specialty resistance for specialist integration</td>
<td>➢ Use market position for pricing leverage</td>
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<tr>
<td>➢ Support for PCP integration</td>
<td>➢ Partnerships &amp; affiliation (network development)</td>
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<td>➢ Become IDS over time</td>
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<td>➢ Active Philanthropic Foundation (non-profit)</td>
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Evolving Hospital Models: Different Strategic Focus
Integrated Health Systems

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Strategies</th>
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<tbody>
<tr>
<td>➢ Full range of services</td>
<td>➢ Utilize size and capital to further integrate services (physician/outpatient)</td>
</tr>
<tr>
<td>➢ Risk sharing models</td>
<td>➢ Rationalize portfolio holdings (acquisition and disposition)</td>
</tr>
<tr>
<td>➢ Developed Physician Hospital integration platform</td>
<td>➢ Invest in key service line opportunities</td>
</tr>
<tr>
<td>➢ Multiple programs for independent physicians</td>
<td>➢ Leverage size and reach for pricing with payers</td>
</tr>
<tr>
<td>➢ Profitable on commercial insurance (high rates)</td>
<td>➢ Prepare for risk taking arrangements with CMS</td>
</tr>
<tr>
<td>➢ Profitable on Medicare Advantage and unprofitable on FFS Medicare</td>
<td>➢ Look to IT as integrator with physicians and patients</td>
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<td>➢ Possible health plan development/expansion</td>
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Keys to Hospital/Physician Alignment

A partnership to set and meet common goals and avoid harmful actions against each other

Key Success Factors

- Common vision and values (e.g., trust, respect, effective communication)
- Physicians are actively engaged in leadership roles
- Physicians actively participate in improving hospital efficiency (e.g., turnaround times, length of stay, resource consumption)
- Physician compensation is based on productivity and dedication to shared economic and quality goals with hospital
- Strong physician recruitment platform in which physicians do not bear undue risk
- Hospital and physicians collaborate on quality and implement best practices
- Physicians keep patient referrals within system as much as possible
- Hospital and physicians can bid for and manage bundled payments and participate in pay-for-performance
- Patients are managed seamlessly across the continuum
<table>
<thead>
<tr>
<th>Indicator</th>
<th>Measure</th>
<th>Fully Capable</th>
<th>Plan in Process</th>
<th>No Current Initiatives</th>
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<tr>
<td>Hospital and Physician Governance and Leadership</td>
<td>Knowledge Base and Strategic Vision</td>
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<td>Identifiable physician leaders</td>
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<td>Resource commitment</td>
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<td>Financial capability/Access to Capital</td>
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<td>Organizational Infrastructure and Platforms</td>
<td>Medical Foundation</td>
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<td>Physician Employment</td>
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<td>Service Line Co-Management</td>
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<td>MSO</td>
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<td>Joint Ventures</td>
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<td>Size and Depth of physician network</td>
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<td>Level of Clinical Integration</td>
<td>CMS Payment Measures Scores</td>
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<td>Surgical Care Improvement Project Scores</td>
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<td>Hospital Acquired Conditions</td>
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<td>Readmission Rates</td>
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<td>Patient Satisfaction Measures</td>
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<td>Cost per patient, discharge, DRG reduction initiatives</td>
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<td>Never Events</td>
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<td>HEDIS</td>
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<td>PQRI</td>
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<td>Transformation of PCP clinics to medical homes</td>
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<td>Technology/IT Capability</td>
<td>CPOE, EHR</td>
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<td>Meet meaningful use criteria</td>
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<td>Patient access via internet</td>
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<td>Virtual Clinic</td>
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<td>Telemedicine</td>
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<td>Experience in Alternative Payment Models</td>
<td>Bundled Payment/Episode of Care</td>
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<td>Global Capitation (Full/Partial Risk)</td>
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<td>Physician quality and cost performance incentives</td>
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<td>Legal structure to distribute gain sharing payments</td>
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<td>CMS Hospital/Physician Value Based Payment Program</td>
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<td>Other Physician Issues</td>
<td>Size and depth of PCPs</td>
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<td>CMS Minimum requirement 5,000 FFS seniors</td>
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</tbody>
</table>
Thank You

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- Email: pdalton@mdsconsulting.com