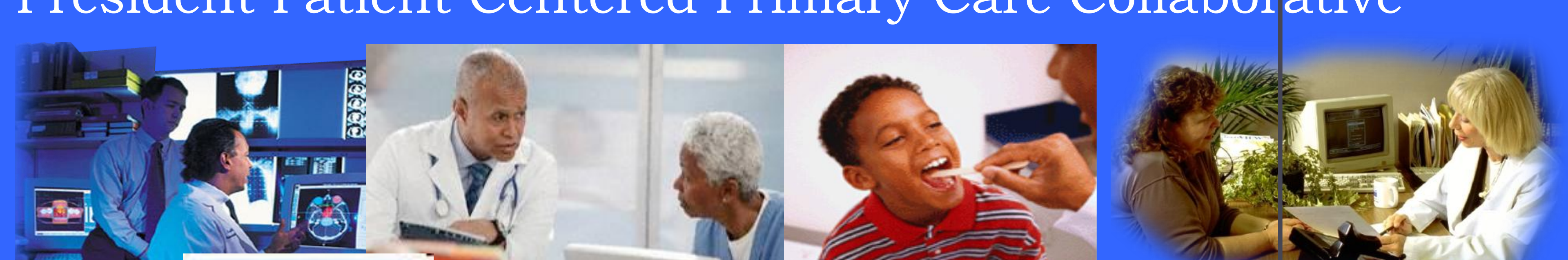
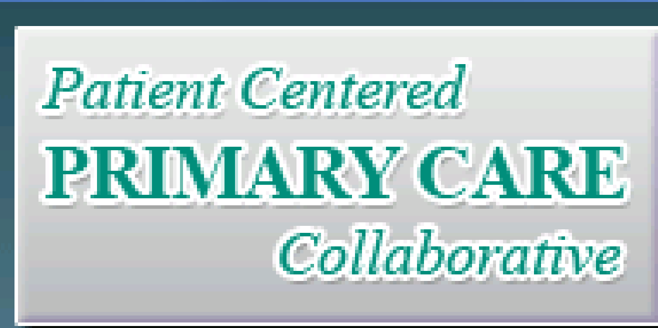
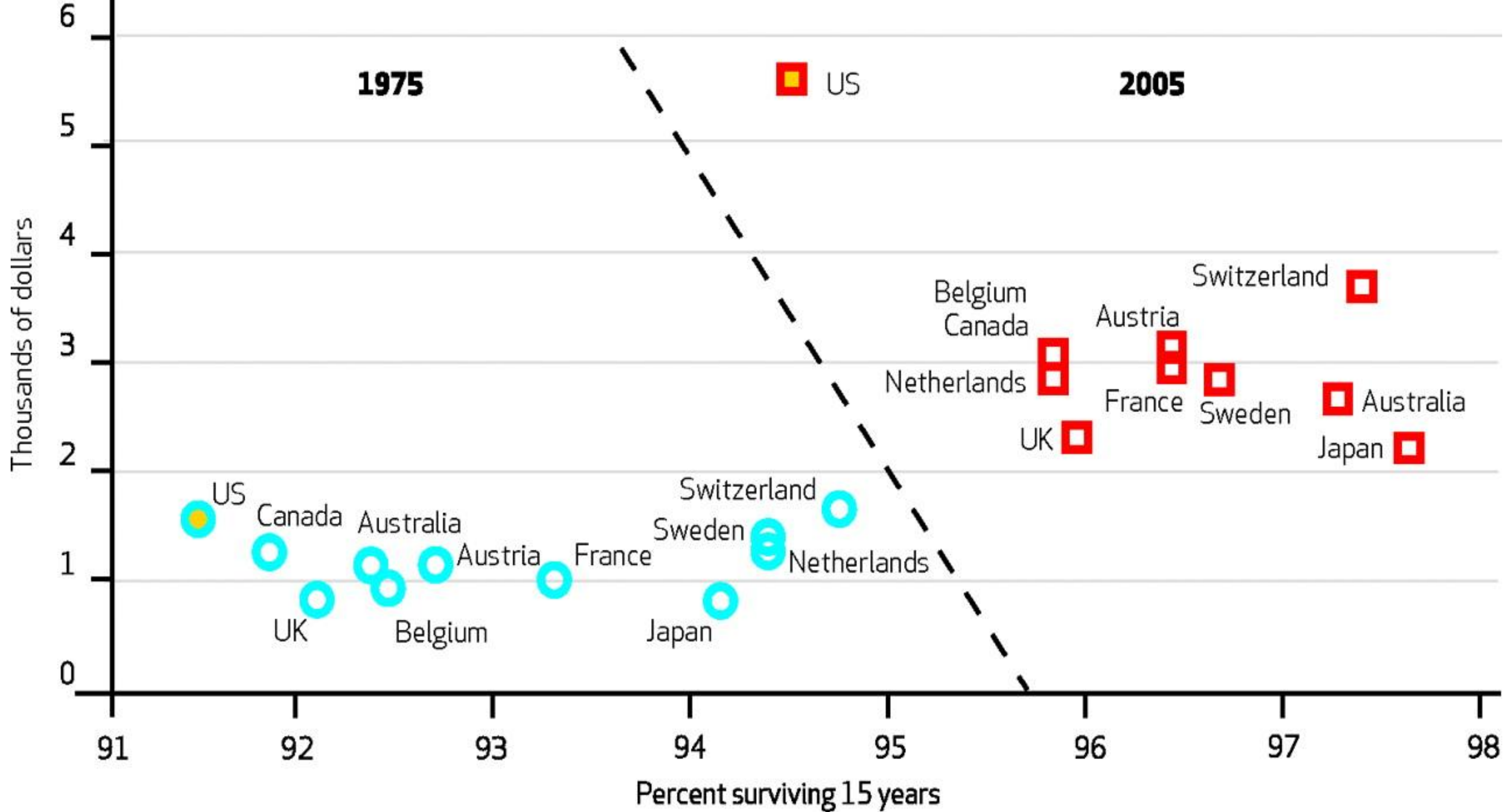
Why Employers care about Patient Centered

Paul Grundy, MD, MPH, FACOEM, FACPM
IBM Director Healthcare Transformation
President Patient Centered Primary Care Collaborative







The Cause is clear **- unregulated fee-for-service payments and an over reliance on rescue/specialty care. Lack of Comprehensive care base**

This study provides stark evidence that the U.S. health care system has been failing Americans for years,"

Commonly cited causes for the nation's poor performance are not to blame

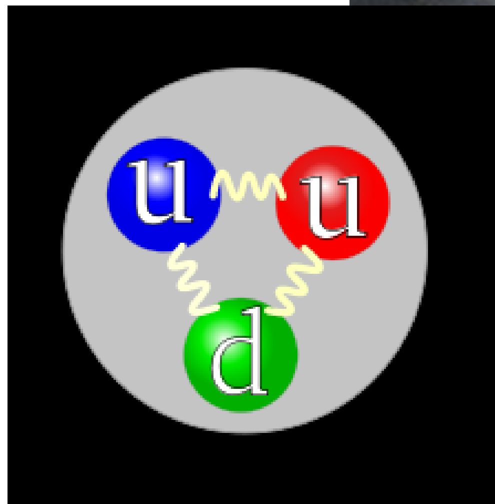
Patient Centered Medical Home/Neighborhood

Treat your Care Needs like a BAD MEDICAL NEIGHBORHOOD!! Unaccountable care, lack of organization do not go there alone -- Be wise when you go to the big City belong to PCMH !!

Product Lines DO No Harm?

(Weak force)

The $9 trillion USA Experiment has Discovered Dark Matter



Strong force = $$

How Health Insurance Design Affects Access to Care and Costs, by Income, in Eleven Countries
November 18, 2010
Authors: Cathy Schoen, M.S., Robin Osborn, M.B.A., David Squires, Michelle M. Doty, Ph.D., Roz Pierson, Ph.D., and Sandra Applebaum

An 11-country survey focusing on health care access, cost, and insurance coverage found that adults in the United States are by far the most likely to **go without care because of costs**, have trouble paying medical bills, encounter high medical bills even when insured, and have disputes with insurers or payments denied.

Her bliver de nye akutsygehuse placeret

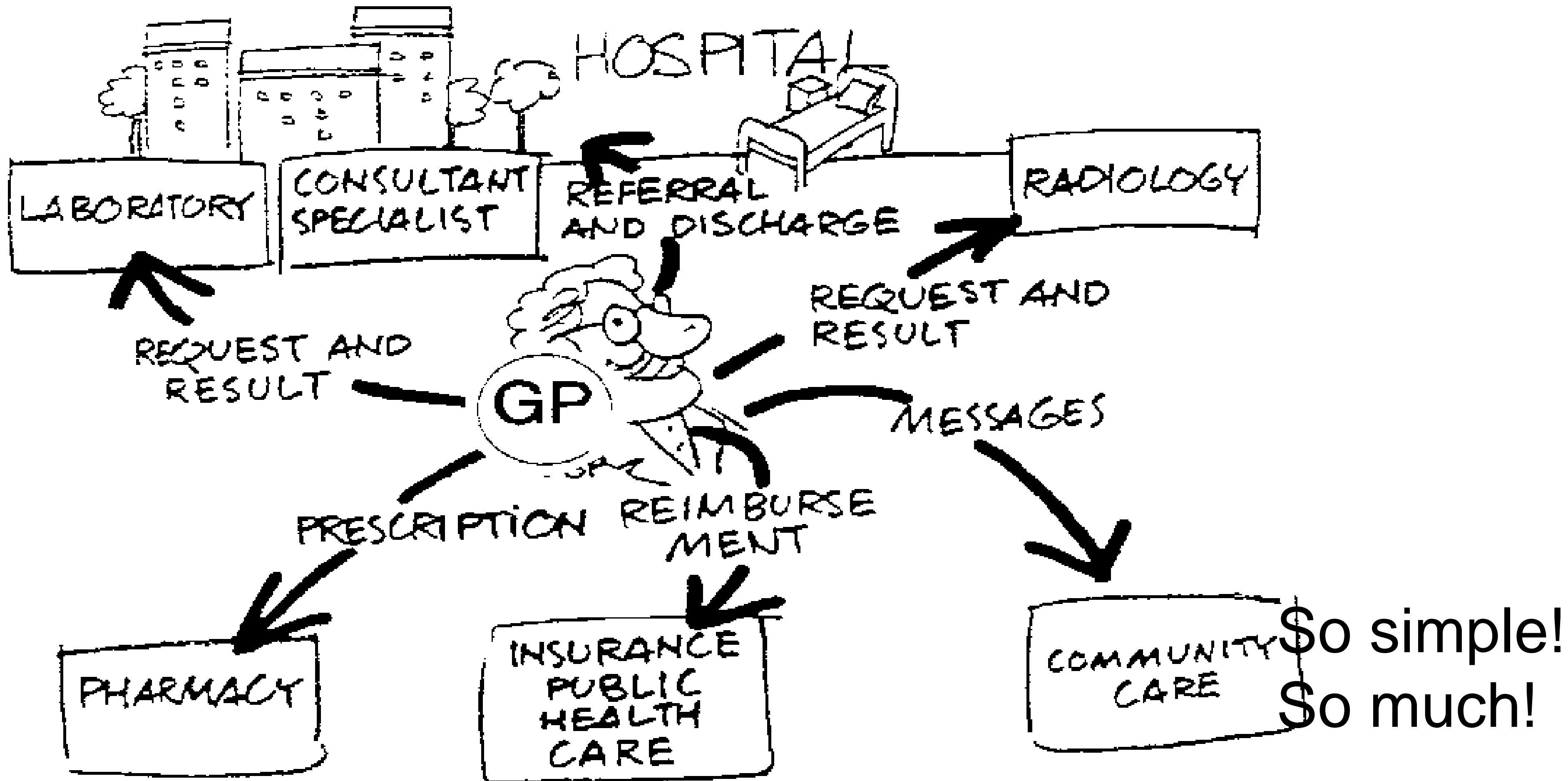
Hjørring
NORDJYLLAND
Thisted
Aalborg
Viborg
Randers
MIDTJYLLAND
Gadstrup
Århus
Horsens
Bornholm
HOVED-
STADEN
Herlev
Rigshospitalet
Bispebjerg
Hvidovre
Holbæk
Esbjerg
Kolding
Køge
Slagelse
Odense
SYDDANMARK
SJÆLLAND
Aabenraa
Nykøbing F.

Note: Placeringen af to akutsygehuse
i Region Sjælland udestår

A journey to higher quality lower cost

quality as well as efficiency

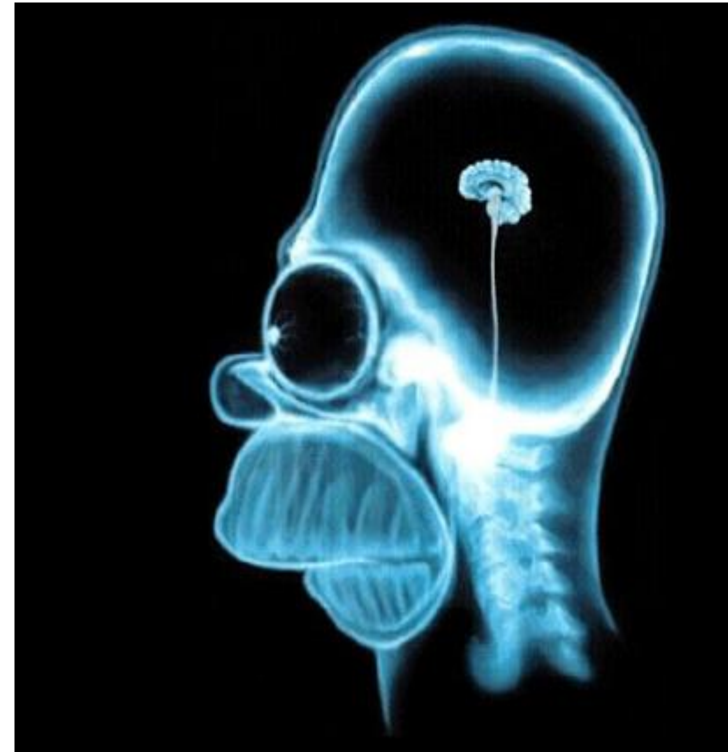
If you Scan the world and look at places that Add value you will find a common element a relationship based team with a **project manager!** A **comprehensivist**



So simple!
So much!

The Data On PCMH

- 20% reduction in Cost PCMH (Boeing Seattle Pilot)
- Group Health lowered Primary Care Burnout
- Increased Patient satisfaction
- 36.3% drop in hospital days,
- 32.2% drop in ER use.
- 9.6%, total cost
- 10.5%, Drop inpatient specialty care
- 18.9%, drop ancillary costs
- 15.0%. Drop outpatient specialty care costs



How do you fix the foundational issue: our healthcare system is so High Cost and yet so low value ??

Average health spend per capita ($US PPP)

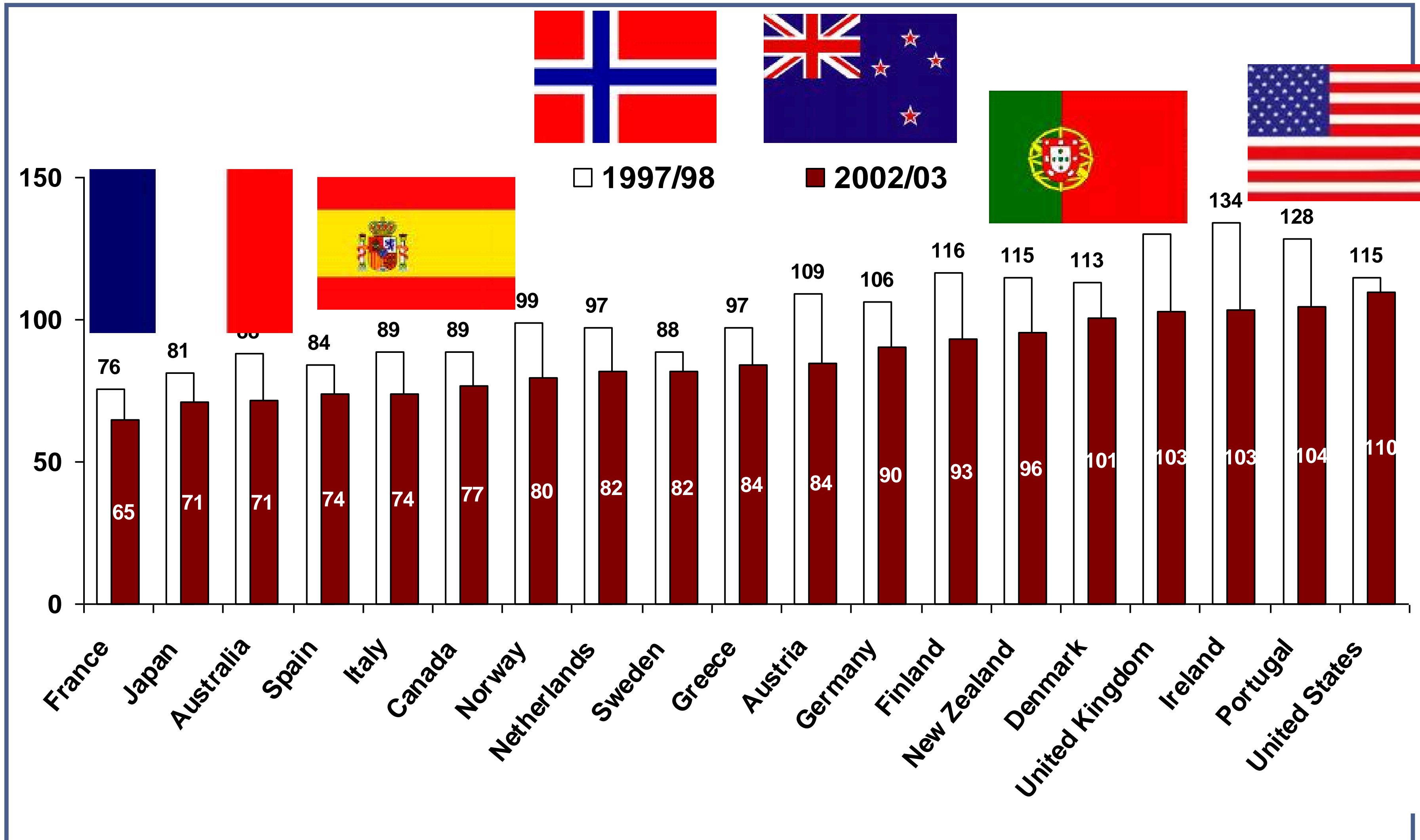
USD PPP

Public expenditure on health / Private expenditure on health

Country	Total
United States	7 29
Norway	4 763
Switzerland	4 417
Luxembourg (2006)[1]	4 162
Canada	3 895
Netherlands	3 837
Austria	3 763
France	3 601
Belgium	3 595
Germany	3 588
Denmark	3 512
Ireland	3 424
Sweden	3 323
Iceland	3 319
Australia (2006/07)	3 137
United Kingdom	2 992
OECD	2 984
Finland	2 840
Greece	2 727
Italy	2 686
Spain	2 671
Japan (2006)	2 581
New Zealand[2]	2 510
Portugal (2006)	2 150
Korea	1 688
Czech Republic	1 626
Slovak Republic	1 555
Hungary	1 388
Poland	1 035
Mexico	823
Turkey (2005)	618

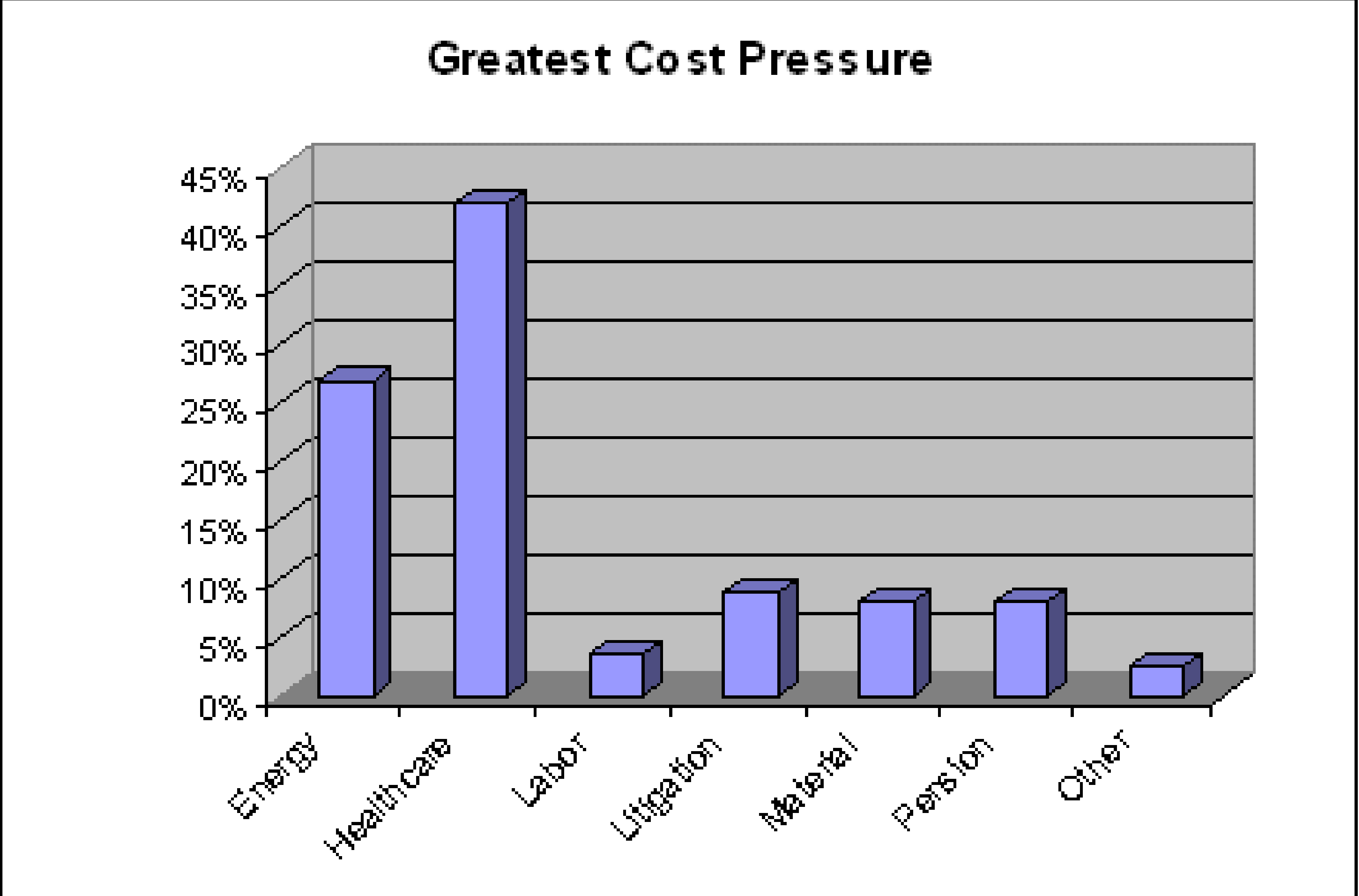
Source: K. Davis, C. Schoen, S. Guterman, T. Shih, S. C. Schoenbaum, and I. Weinbaum, Slowing the Growth of U.S. Health Care Expenditures: What Are the Options?, The Commonwealth Fund, January 2007, updated with 2009 OECD data

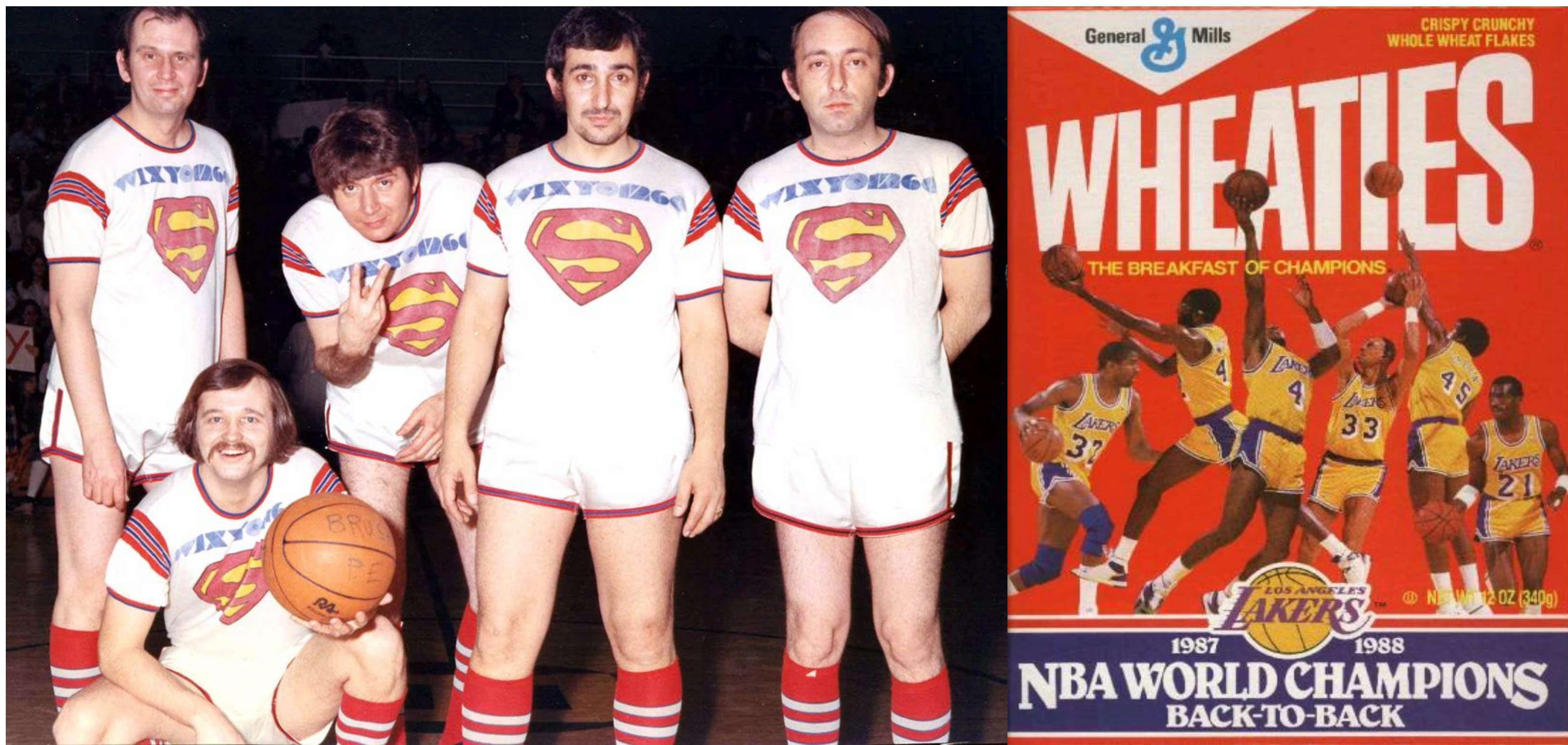
The World Health Organizations ranks the U.S. as the 37th best overall healthcare system in the world



Countries' age-standardized death rates, list of conditions considered amenable to health care Source: E. Nolte and C. M. McKee, Measuring the Health of Nations: Updating an Earlier Analysis, Health Affairs, January/February 2008, 27(1):58–71

Health care is a business issue, not a benefits issue





Coordination -- we do NOT know how to play as a team

" We don't have a healthcare delivery system in this country. We have an expensive plethora of **uncoordinated,** unlinked, economically segregated, operationally limited micro systems, each performing in ways that too often create sub-optimal performance, both for the overall health care infrastructure and for individual patients."

George Halvorson, from "*Healthcare Reform Now*

“We do heart surgery more often than anyone, **but we need to**, because patients are not given the kind of **coordinated primary care** that would prevent chronic heart disease from becoming acute.”

George Halvorson’s (CEO Kaiser) from “*Healthcare Reform Now*

Health Care Reform

The Flexner Report

"We have, indeed, in America, medical practitioners (medical communities) not inferior to the best elsewhere; but there is probably no other country in the world in which there is so great a distance and so fatal a difference between the best, the average, and the worst."

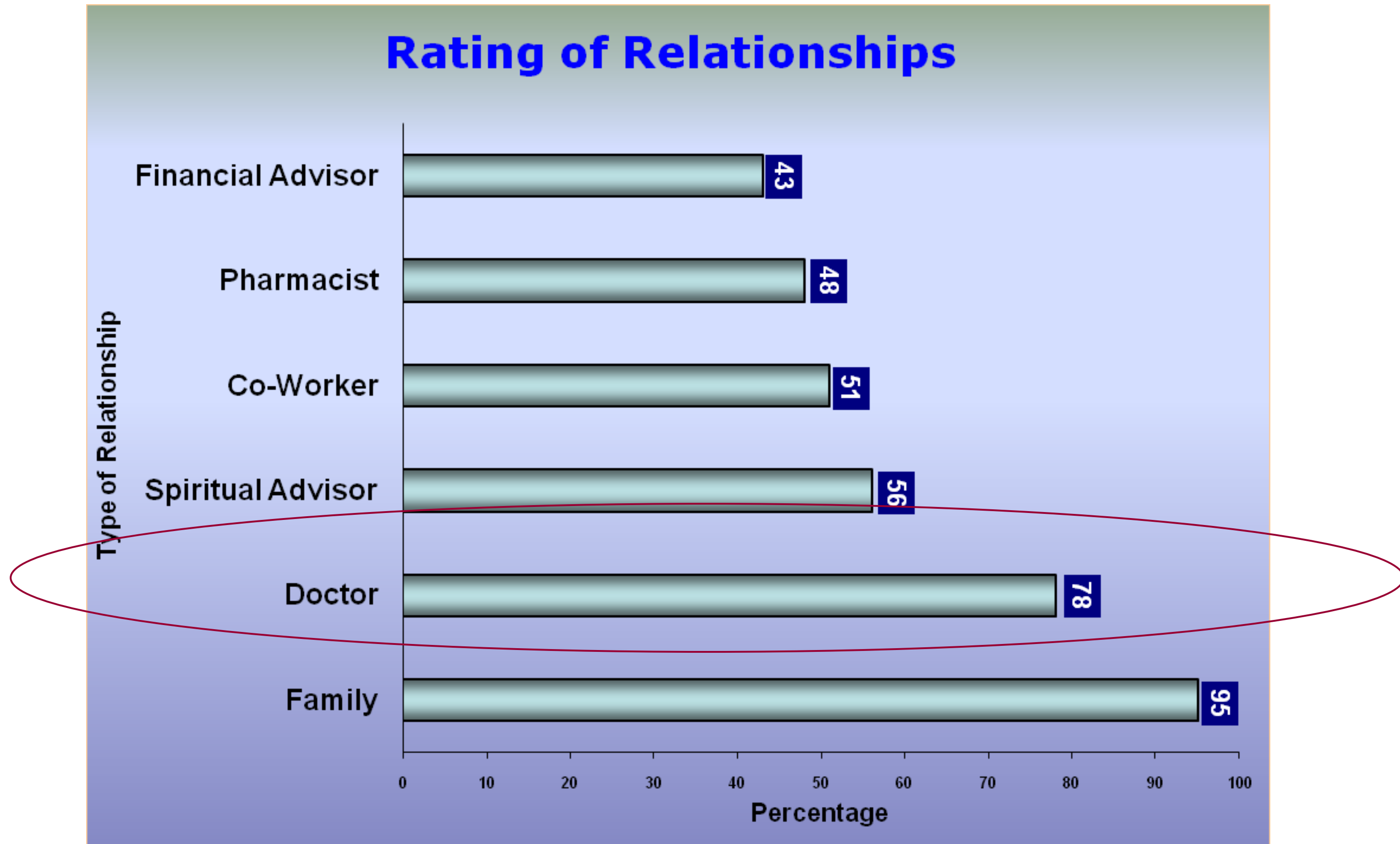
Abraham Flexner 1910

94 out of 160 medical schools were closed

Patient Centered Medical Home
The HUB President Obama 06/08/2010

A long-term **comprehensive** relationship with your Personal Physician **empowered with the right tools** and **linked** to your care team can result in better overall family health…

The Trusted Clinician Can be a Powerful Influence



Source: Magee, J., *Relationship Based health Care in the United States, United Kingdom, Canada, Germany, South Africa and Japan. 2003*

The Joint principles Patient Centered Medical Home

- **Personal physician -** each patient has an ongoing relationship with a personal physician trained to provide first contact, and continuous and comprehensive care
- **Physician directed medical practice –** the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients
- **Whole person orientation –** the personal physician is responsible for providing for all the patient's health care needs or arranging care with other qualified professionals
- **Care is coordinated and integrated across all elements of the complex healthcare community-** coordination is enabled by registries, information technology, and health information exchanges
- **Quality and safety are hallmarks of the medical home-**

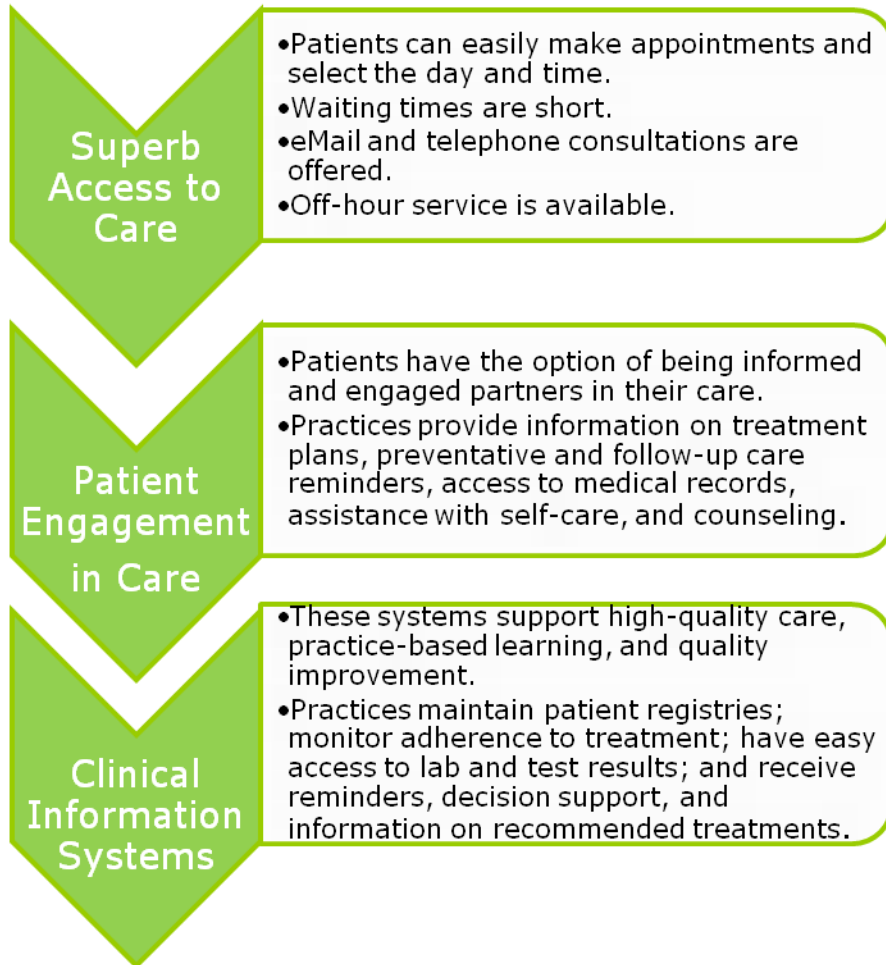
  Evidence-based medicine and clinical decision-support tools guide decision-making; Physicians in the practice accept accountability voluntary engagement in performance measurement and improvement

  Enhanced access to care is available - systems such as open scheduling, expanded hours, and new communication paths between patients, their personal physician, and practice staff are used
- **Payment appropriately recognizes the added value provided to patients who have a patient-centered medical home-** providers and employers work together to achieve payment reform

TODAY'S CARE		Comprehensive CARE
My patients are those who make appointments to see me		Our patients are the population community
Care is determined by today's problem and time available today		Care is determined by a proactive plan to meet patient needs with or without visits
Care varies by scheduled time and memory or skill of the doctor		Care is standardized according to evidence-based guidelines
I know I deliver high quality care because I'm well trained		We measure our quality and make rapid changes to improve it
Patients are responsible for coordinating their own care		A prepared team of professionals coordinates all patients' care
It's up to the patient to tell us what happened to them		We track tests & consultations, and follow-up after ED & hospital
Clinic operations center on meeting the doctor's needs		A multidisciplinary team works at the top of our licenses to serve patients

Slide from Daniel Duffy MD School of Community Medicine Tulsa Oklahoma

Defining the Care



Care Coordination

- Specialist care is coordinated, and systems are in place to prevent errors that occur when multiple physicians are involved.
- Follow-up and support is provided.

Team Care

- Integrated and coordinated team care depends on a free flow of communication among physicians, nurses, case managers and other health professionals (including BH specialists).
- Duplication of tests and procedures is avoided.

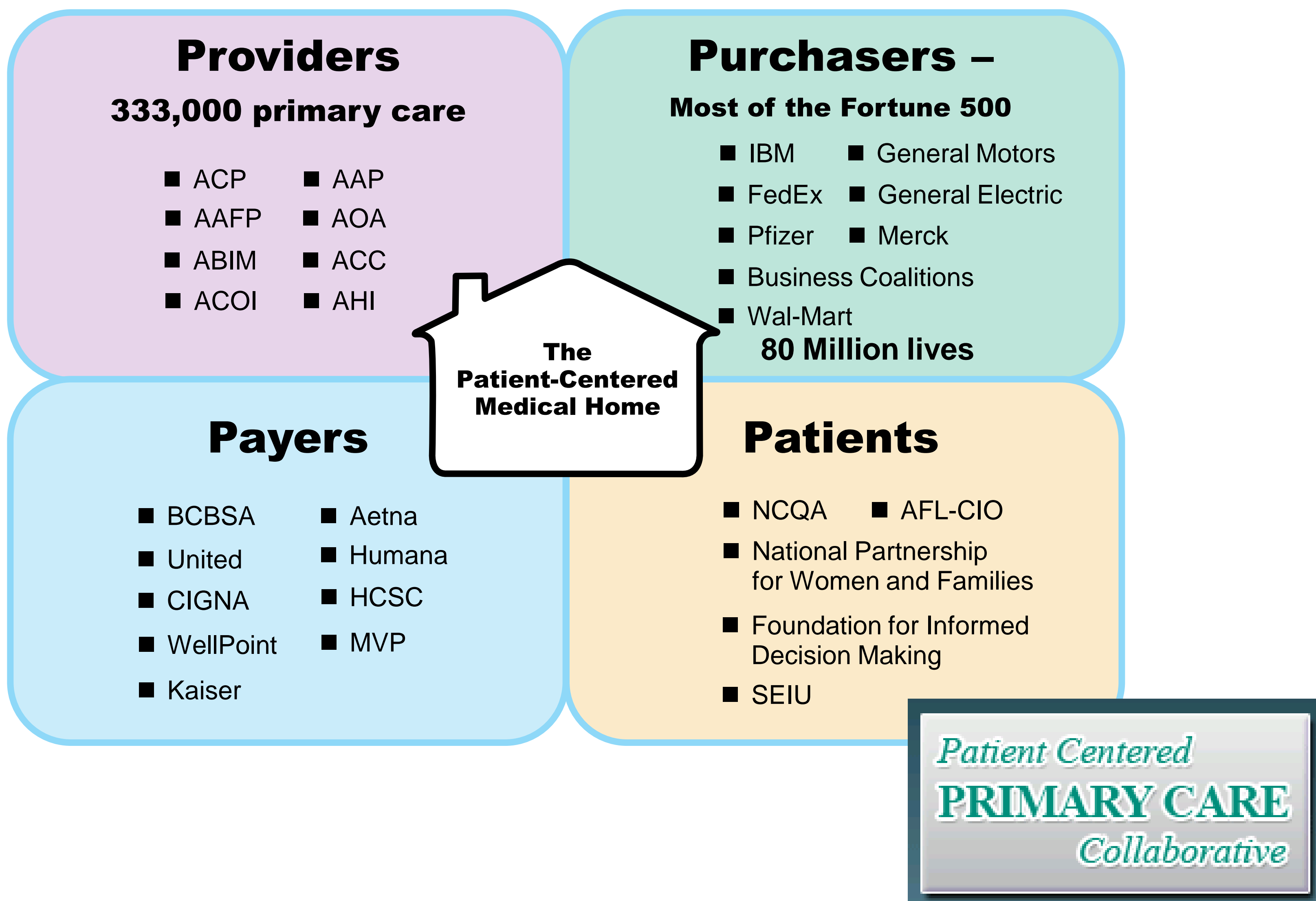
Patient Feedback

- Patients routinely provide feedback to doctors; practices take advantage of low-cost, internet-based patient surveys to learn from patients and inform treatment plans.

Publically available information

- Patients have accurate, standardized information on physicians to help them choose a practice that will meet their needs.

The Patient Centered Primary Care Collaborative: Examples of broad stakeholder support and participation



The HUB where information is action

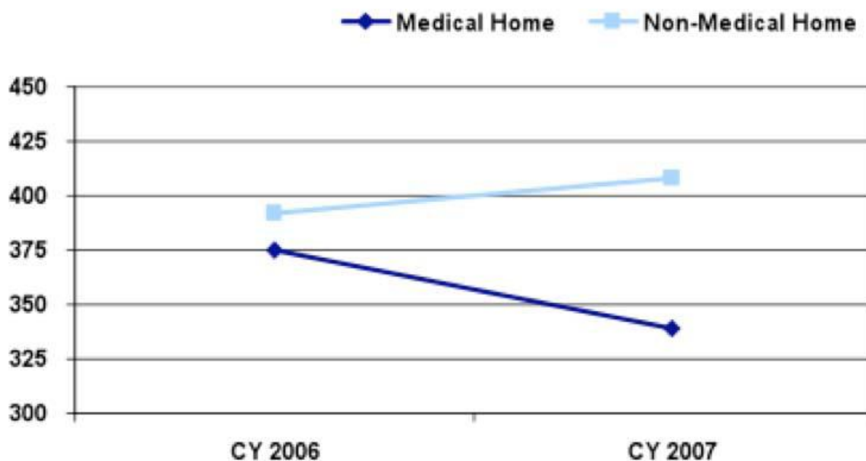
- "The first step is getting more better primary care"
- "This issue of Primary care is absolutely critical it has the potential of making such a big difference for the quality of health for everyone… how do we give **Primary care the power to be the HUB around PATIENT Centered Care**
- **June 16th 2010 $250 Million Primary care Training**
- **DOD today 1.8 Billion PCMH transformation**
- **VA 3.8 Billion PCMH transformation**
- **Kaiser Permanente**
- **CMS PCMH Roll out**

http://www.whitehouse.gov/photos-and-video/video/tele-town-hall-affordable-care-act-seniors

Aug 2010 -- American Journal of Managed Care

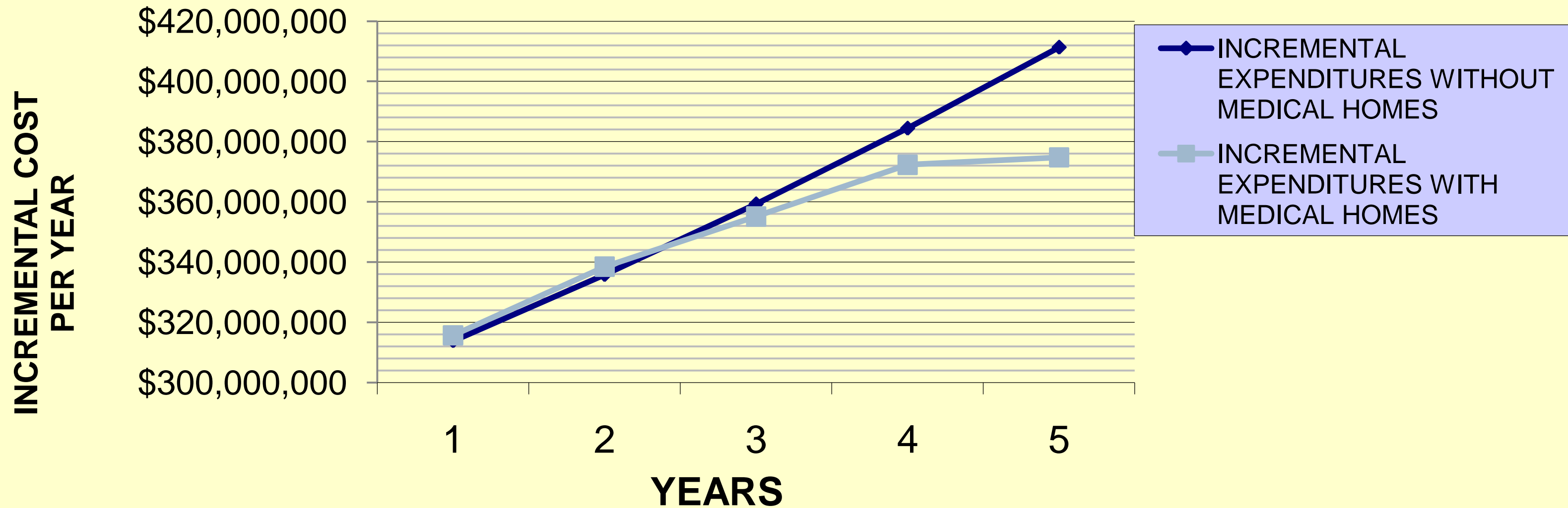
- 1st 2 years experience with ACO with PCMH base – Proven Health Navigator.
- Overall 18% reduction in admissions,
- 36% reduction in readmissions.
- The total cost of care for all patients was reduced by 9%,
- Subsequent experience 2009, 2010 has been similar - 9% reduction in cost as they rolled the model out to 35 Geisinger sites and 15 non-Geisinger sites across Central PA.

Geisinger Health System



Lewisburg Penn	Pre-Test period Jan - Oct 2006	First pilot year Jan – Oct 2007	Percent reduction
Hospital Admission	365/1000	291/1000	- 20%
Hospital re-admissions	15.2%	7.9%	- 48%
Cost			9% less

Vermont Financial Impact



	2009	2010	2011	2012	2013
Percentage of Vermont population participating	6.7%	9.8%	13.0%	20.0%	40.0%
Participating population	42,179	61,880	82,332	127,045	254,852
# Community Care Teams	2	3	4	6	13

The Results

A Summary of Medical Home Pilot Successes

Medical Home Demonstration and Pilot Project	ER Care Utilization	Hospital Care Utilization	Specialist Care Utilization	Overall Costs Savings
Group Health Cooperative of Puget Sound[1]	29%	-	-	-
Community Care of North Carolina[1]	16%	-	-	-
HealthPartners Medical Group[1]	39%	24%	-	-
Geisinger Health System[1]	-	14%	-	9%
Genessee Health Plan[1]	50%	15%	-	-
Colorado Medicaid and SCHIP[1]	-	-	-	22%
Intermountain Healthcare Medical Group[1]	-	10%	-	-
Johns Hopkins[1]	15%	24%	-	-
MDVIP *(concierge medical practices)*[2]	50%	50%	-	-
Boeing Company[3]	-	-	-	20%
Urban Medical Group[4]	-	-	-	20%
Leon Medical Centers[4]	-	-	-	20%
Caremore Medical Group[4]	-	-	-	15%
Redlands Family Practice[4]	-	-	-	15%
Average Utilization Reduction / Savings	**30%**	**25%**	**?**	**17%**

All the pilots listed above were implemented within a fee-for-service payment system - one that rewards doctors for doing more.

[1] Patient-Centered Primary Care Collaborative, *Proof in Practice, A compliation of patient centered medical home pilot and demonstration projects*, 2009
[2] MDVIP, *Hospitalization rates compared to top performing health plans by state*, 2005
[3] Health Affairs, *Are Higher-value Care Models Replicable?*, Arnold Milstein and Pranany P. Kothari, October 29, 2009
[4] Health Affairs, *American Medical Home Runs,* Arnold Milstein and Elizabeth Gilbertson, October 2009
[5] Qliance Medical Group, (non-scientific) clinician survey, 2010

Payment requires more than one method
It is not rocket science you have dials, adjust them !!!

"fee for health,"

"fee for outcome,"

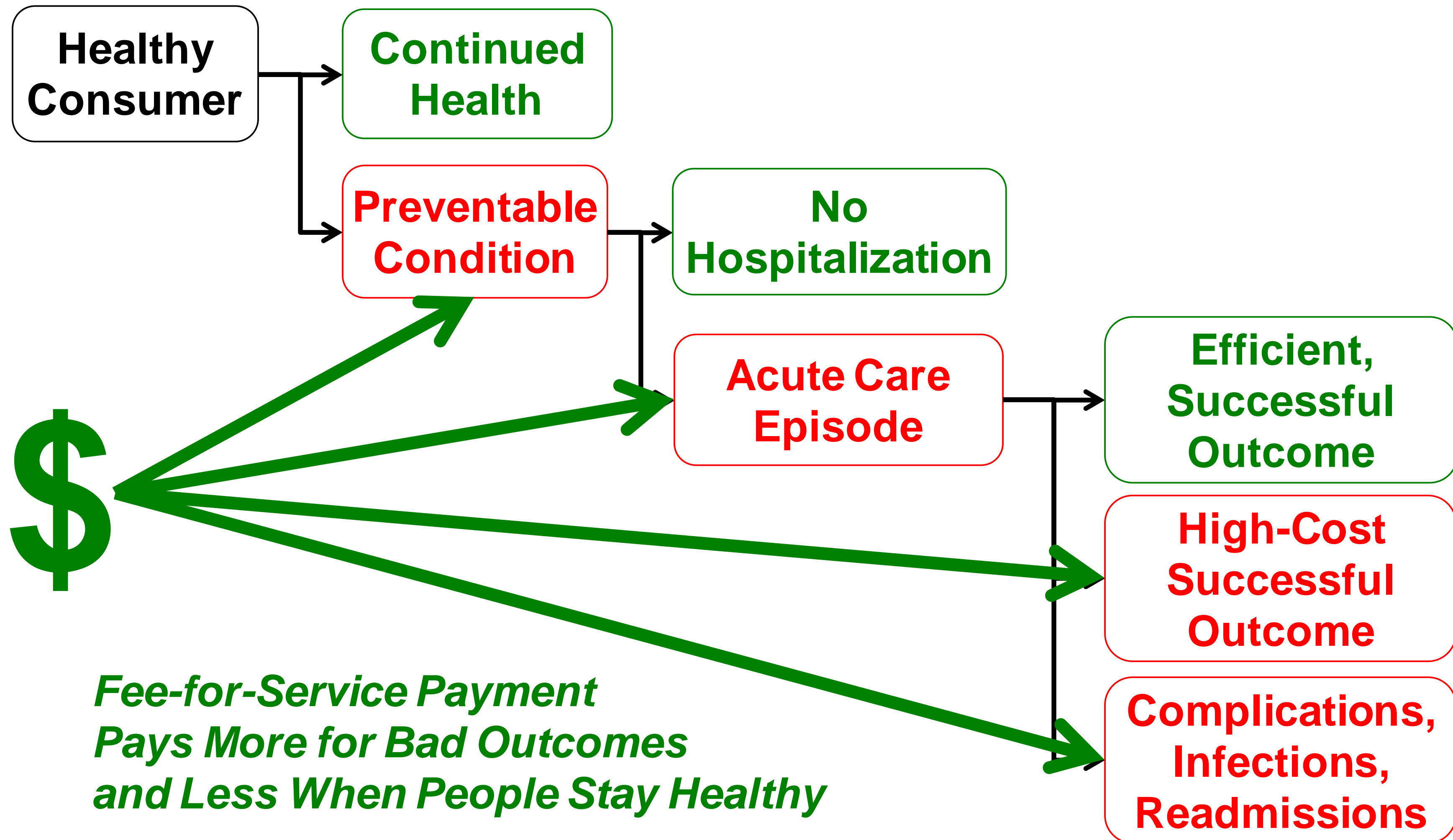
"fee for process,"

"fee for belonging/membership"

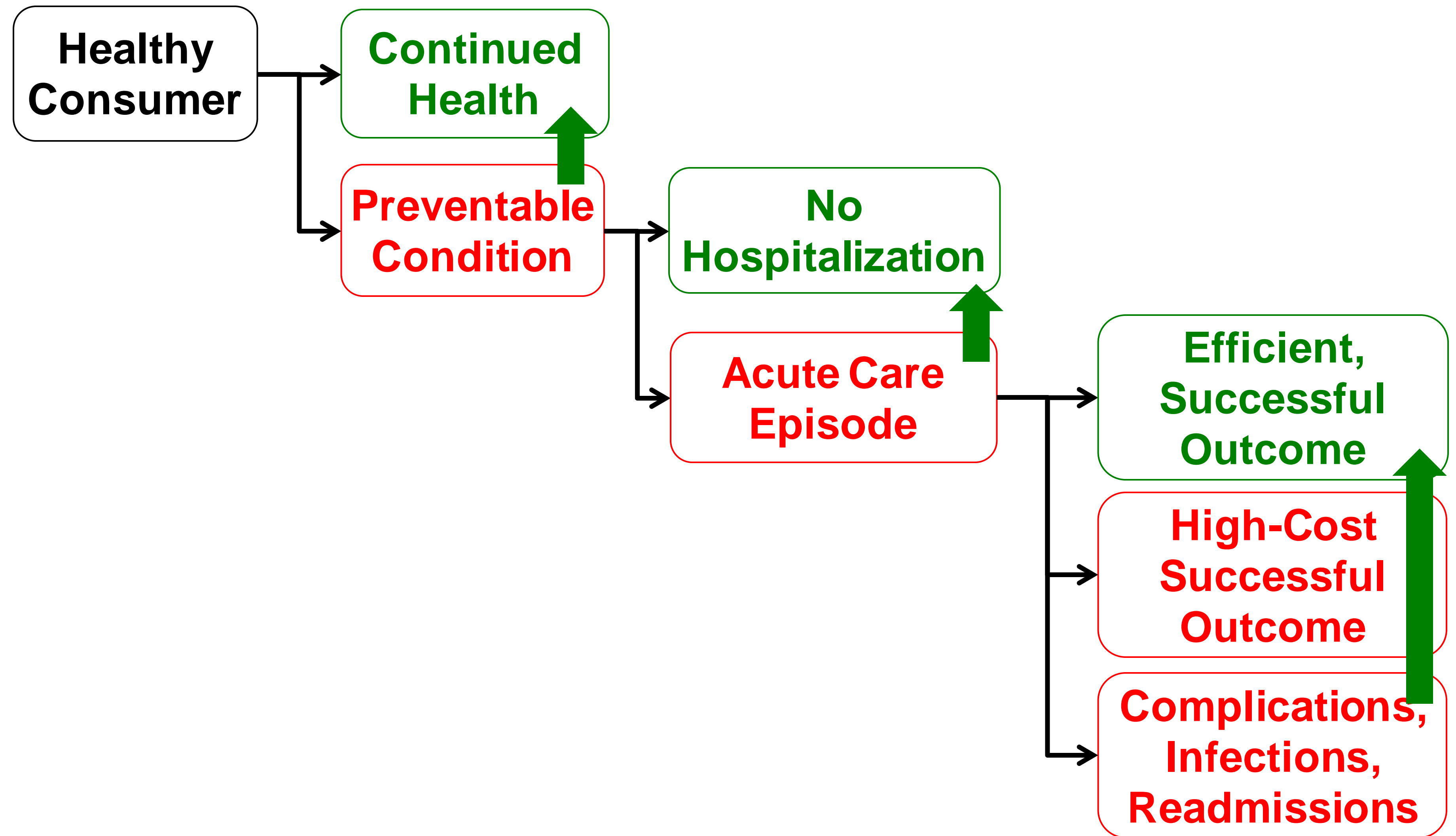
"fee for service"

Fee for satisfaction

Current Payment Systems reward Down stream cost Penalize Quality, Prevention, Primary care and Reward Volume



Healthcare Costs *Can* Be Reduced but needs to be Moved upstream to reduce downstream cost



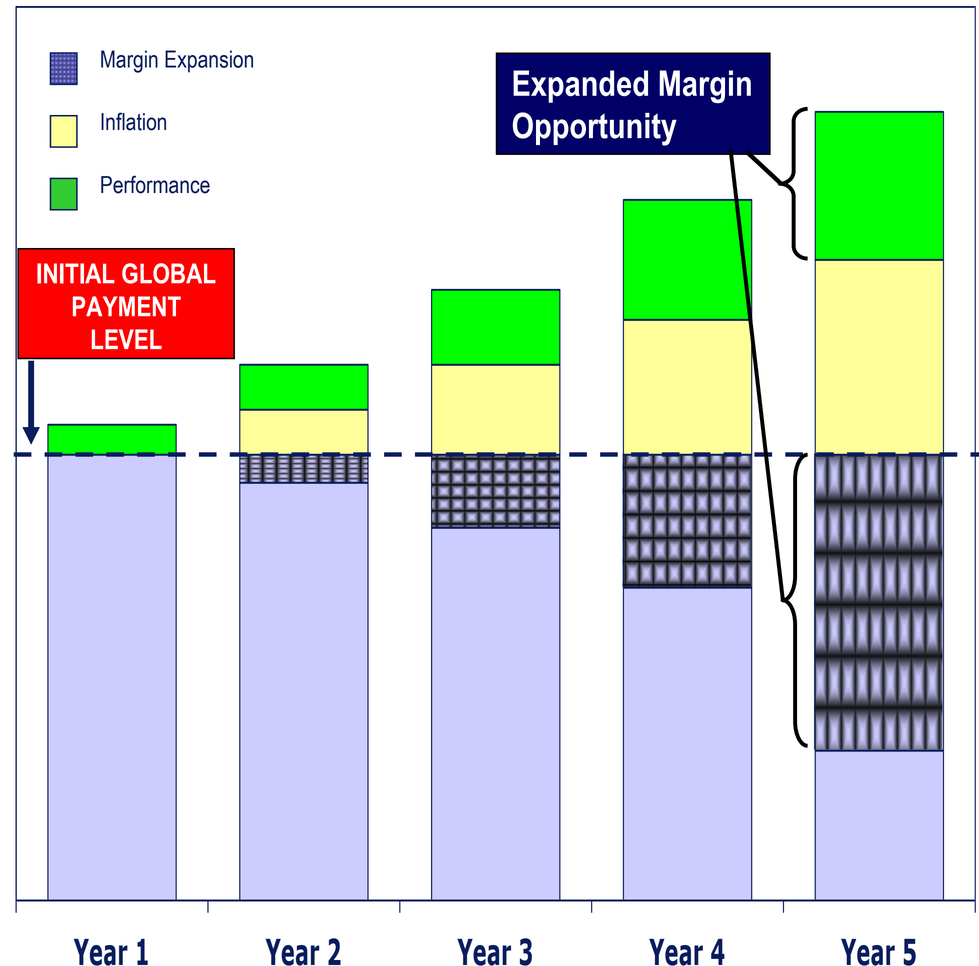
CareFirst plans to increase reimbursement to its participating physicians in three ways:

- • An immediate 12 percent hike to previously negotiated rates;
- • An additional $200 for developing new care plans for high-risk patients and another $100 for monitoring the progress of each of those patients; and,
- • Reimbursement rate increases of up to 80 percent for those doctors who show the greatest improvement in patients' well-being.
- MN $37.51 PMPM
- CMS 10 PMPM

Read more: CareFirst wins OK to reward doctors for improving care - Baltimore Business Journal

Financial Structure of the BCBS MA Alternative QUALITY Contract

- Financial Structure based on four components:
  - **Global payment**
    - Based on total medical expenses
    - Health status adjusted
  - **Margin Retention**
    - Initial Global Payment includes inefficiencies
  - **Performance Incentive**
    - Up to 10% of Total Medical Expense
  - **Inflation**
    - Set at general inflation



IBM Announces FREE Primary care to its employees

Give Employees 100% Coverage for Primary Care

This is part of our partnership with Primary care in our journey together for better healthcare

MHS Policy Memorandum: Implementation of the Patient Centered Medical Home Model of Primary Care

Sept 18 2009

OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, DC 20301-1200

SEP 1 8 2009

MEMORANDUM FOR ASSISTANT SECRETARY OF THE ARMY (M&RA)
ASSISTANT SECRETARY OF THE NAVY (M&RA)
ASSISTANT SECRETARY OF THE AIR FORCE (M&RA)

SUBJECT: Policy Memorandum Implementation of the 'Patient-Centered Medical Home' Model of Primary Care in MTFs

References: (a) Assistant Secretary of Defense (Health Affairs) (ASD (HA) Policy 99-033, Individual Assignments to Primary Care Managers by Name. (http://mhs.osd.mil/Content/docs/pdfs/policies/1999/99-033.pdf)
(b) ASD(HA) Policy 06-007 TRICARE Polic... Standard Area Standards (http://mhs.osd.... 2006/06-007.pdf)
(c) ASD (HA) Policy 07-009 Access to Prima... Treatment Facilities (http://mhs.osd.mil/C... 2007/ 07-009.pdf)

This policy, in conjunction with references (b) and ... which is hereby cancelled. References (b) and (c) outline ... are required by Title 32, Code of Federal Regulations (CF... the current standards ensure timely access to appointments ... of the patient-provider relationship in assuring continuity of care, and as a major driver of patient satisfaction and better outcomes for our TRICARE Prime beneficiaries. This policy builds on MTF current success with appointment access and provider continuity by requiring that a single primary care framework be adopted that specifically targets communication and patient-centered health care delivery.

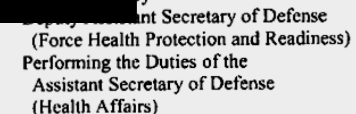
The Patient-Centered Medical Home (PCMH) is an established model of primary care that improves continuity of care and enhances access through patient-centered care and effective patient-provider communication. Consistent with longstanding MHS goals, the PCMH is associated with better ... admissions for patients with chroni... compliance with recommended car... principles of the PCMH is that pati... care provider who delivers first con...

to utilize innovative approaches that are patient-centered and access focused. Open access scheduling, online appointing and online provider/patient communication, 24-hour nurse advice and triage lines, and provider/patient telephonic consults are examples of some innovative approaches that may used to enhance patient-provider communication.

The effectiveness of PCMH policy implementation will be assessed through PCM assignment and PCM team appointment continuity. Measures of the effectiveness of PCMH outcomes will be assessed through MHS measures of access, and through measures of patient satisfaction with care, patient satisfaction with provider communication, and patient satisfaction with technical health care quality. Metrics will be reported to leaders through the MHS Strategic plan, with MHS action plans and incentive programs to reward innovation and success developed through the MHS Clinical Quality Forum, the Clinical Proponency Steering Committee, and the Senior Military Medical Advisory Committee.

A centrally supported PCMH communication plan will be developed to meet ... ing the PCMH model. The MHS ... beneficiaries and MTF personnel.

... n P. Kugler, Deputy Chief ... RICARE Management Activity. ... tma.osd.mil.



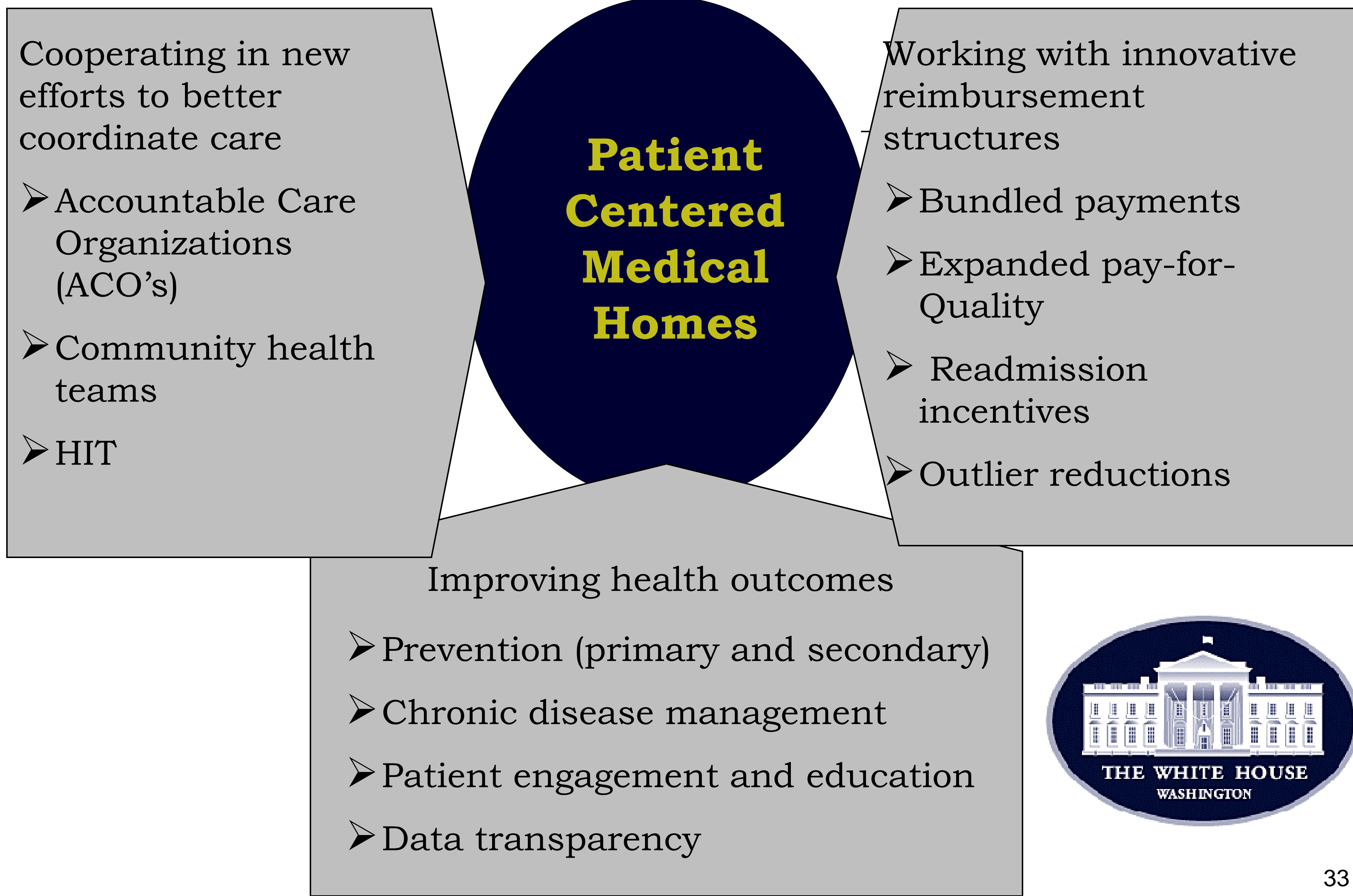
...ey
...nt Secretary of Defense
(Force Health Protection and Readiness)
Performing the Duties of the
Assistant Secretary of Defense
(Health Affairs)

cc:
Service Surgeons General

In the VA and DOD Every patient is assigned a Patient Centered Medical Home and Primary Care Manager (PCM)

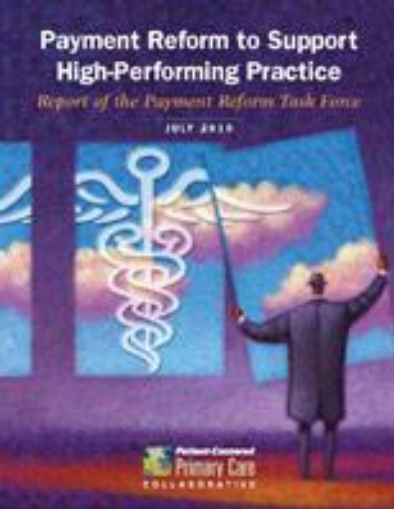
This policy is applicable to all MTFs and is effective immediately

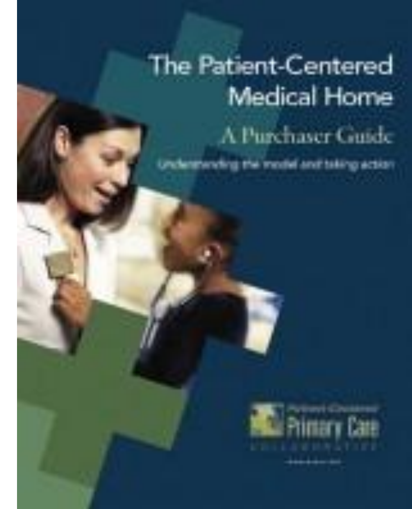
Moving towards a more accountable coordinated system



Under the new Law The Secretary of Health and Human Services (HHS) will have the authority to expand pilot programs and put them into practice—without going through Congress.

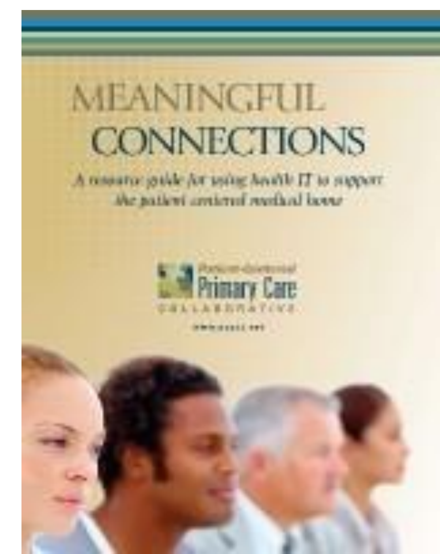
(See the law, Patient Protection and Affordable Care Act, 3021 (2009), Center for Medicare and Medicaid Innovation within CMS, p.723).





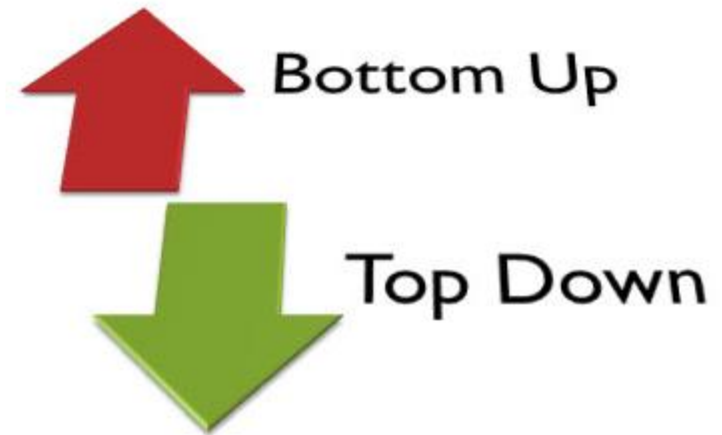
Payment Reform | Medication Management | PCPCC Brochure | Purchaser Guide

PCPCC Pilot | PCPCC Consumer | Value Based Insurance Design | Meaningful Connections



PCMH/ACO – should BE Same thing different view agreed concept by HHS, VA, DOD etc!! 08/08/2010 White House, 07/13 2010 Harvard, Dartmouth, UW working group, Bookings,

PCMH is the **patients** view from the bottom up -- The kind of care your Mother want: relationship, accessible, coordinated, comprehensive A set of principles PCMH.



From the System view it is the structure ACO

Trajectory to Value Based Purchasing: Achieving Real Care Coordination and Outcome Measurement

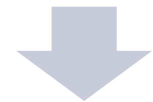
HIT Infrastructure: EHRs and Connectivity

Primary Care Capacity: Patient Centered Medical Home

Operational Care Coordination: Embedded RN Coordinator and Health Plan Care Coordination $

Value/ Outcome Measurement: Reporting of Quality, Utilization and Patient Satisfaction Measures

Value-Based Purchasing: Reimbursement Tied to Performance on Value (quality, appropriate utilization and patient satisfaction)



Achieve Supportive Base for ACOs and Bundled Payments with Outcome Measurement and Health Plan Involvement

ACO The Law --CMS

- Formal Legal Structure that allows for receiving and distributing Payments and “shared savings”

- Sufficient **Primary care** capacity to manage 5,000 Medicare Beneficiaries

- Leadership and Management Structure that includes Clinical and Administrative Systems

ACA

- Medical Home- **(Sec. 3502)** This directs the Secretary to establish **patient-centered medical homes defined as a mode of care that includes. . .safe and high-quality care through evidence-informed medicine, appropriate use of health information technology, and continuous quality improvements.**
- Centers for innovation Section 3021. Establishment of Center for Medicare and Medicaid Innovation ("CMI") within CMS
- Accountable Care Organizations (ACO)- No later than January 1, 2012, the Secretary is required to establish a shared savings program that would reward ACOs that take reasonability for the costs and quality of care received by their patient panel over time. The bill requires ACOs to define processes to promote evidence-based medicine and patient engagement, report on quality and cost measures, and coordinate care, such as through the **use of telehealth, remote patient monitoring, and other such enabling technologies. (Sec. 3022)**
- Independence at Home Demonstration Project- The bill creates a new demonstration program to begin not later than January 1, 2012, **independence at home medical practice as one that uses electronic health information systems, remote monitoring, and mobile diagnostic technology (Denmark)**. **(Sec. 3024)**
- .Insurance Exchanges OPM --

Group Health's decision to adopt the medical home model **"looks brilliant,"**

- **not just for patient care but in terms of business.**
- **Group Health added 35,000 net new members in 2009 and had already added 14,000 net new members in January 2010 alone.**
- Then there is the $40 million a year in total cost savings projected from moving to the medical home model.
- **Armstrong predicts, Group Health will end up with a significant cost advantage over rival insurers in the Washington and Oregon markets.**
- Armstrong says, Group Health 10 percent per member per month cost advantage for commercial customers.
- **Group Health is aiming for a 15 percent cost edge in the future**.
- That would translate into lower premiums or richer benefits, or both, for members.
- Now that they've moved to the medical home, most Group Health doctors like the new digs and don't want to go back. ▪"

We are Beyond the Pilot

Independence BCBS PA implemented

a new PCMH reimbursement system

10% bump in base pay Primary Care

$1.25 for Level 1

$2.00 for Level 2

$3.00 PMPM for Level 3

Doubling of the P4P dollars Quality and Cost of Care within the control of the PCP"

MISSISSIPPI PATIENT-CENTERED MEDICAL HOME ACT

HOUSE BILL NO. 1192
TO DIRECT THE STATE BOARD OF HEALTH TO ADOPT THE PRINCIPLES OF THE PATIENT-CENTERED MEDICAL HOME

- Care in a patient-centered medical home is coordinated across all elements of the health care system and the patient's community to assure that the patient receives the indicated care when and where the patient needs the care in a culturally appropriate manner;
- A patient in a patient-centered medical home actively participates in health care decision making, and feedback from the patient is sought to ensure that the expectations of the patient are being met
- patient programs that provide a whole-person orientation that includes care for all stages of life, including acute care, chronic care, **disability care**, preventive services and end-of-life care;

MEDICARE-MEDICAID PCMH ADVANCED PRIMARY CARE DEMONSTRATION INITIATIVE

On June 2nd 2010 HHS Secretary Sebelius, announced the rollout the Centers for Medicare and Medicaid Services (CMS) will establish a demonstration program that will enable Medicare to join Medicaid and private insurers in innovative state-based advanced primary care initiatives.

New Medicare Demonstration

•Design will include mechanisms to assure it generates savings for the Medicare trust funds and the federal government

•Private insurers work in cooperation with Medicaid to set uniform standards for "Advanced Primary Care (APC) models"

•Provide incentives for doctors to spend more time with their patients and offer better coordinated higher-quality medical care

States Wishing to Participate in the New Demonstration Must:

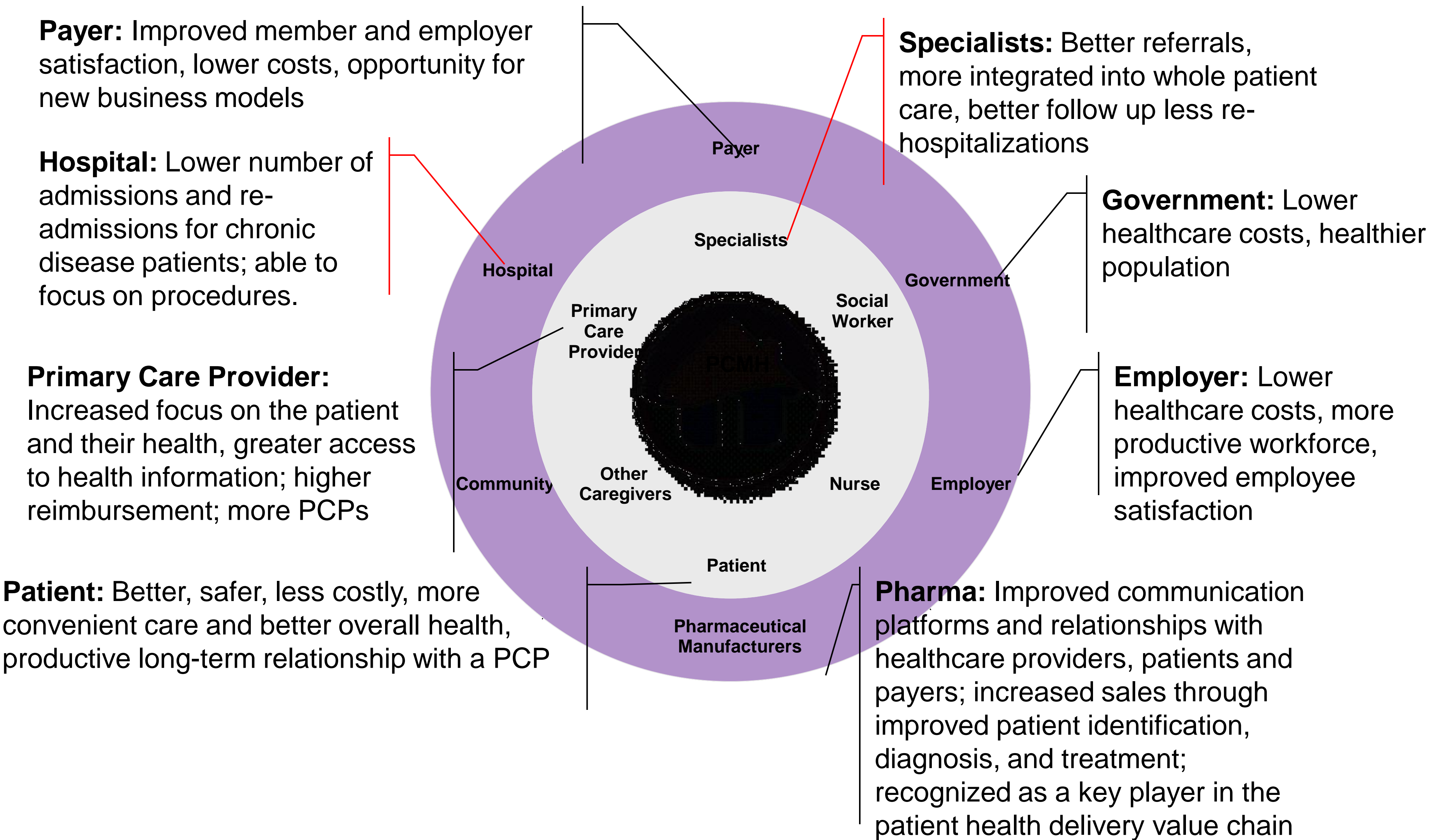
•Certify they have already established similar cooperative agreements between private payer and their Medicaid program;

•Demonstrate a commitment from a majority of their primary care doctors to join the program;

•Meet a stringent set of qualifications for doctors who participate; and

•Integrate public health services to emphasize wellness and prevention strategies.

The PCMH model impacts stakeholders across the continuum of care



Benefits of Patient Centered Medical Home

- Reduce hospital
- Better care
- Better satisfaction
- Improved health status

- Flexible provider payments
- Collaborative Provider relationship
- Reduce overall medical spend

- Reduce readmission
- Reduce inappropriate use of ED
- Improve discharge planning

- Improved PCP's reimbursement
- Practice efficiency
- Patient satisfaction

The Stalemate that blocks change

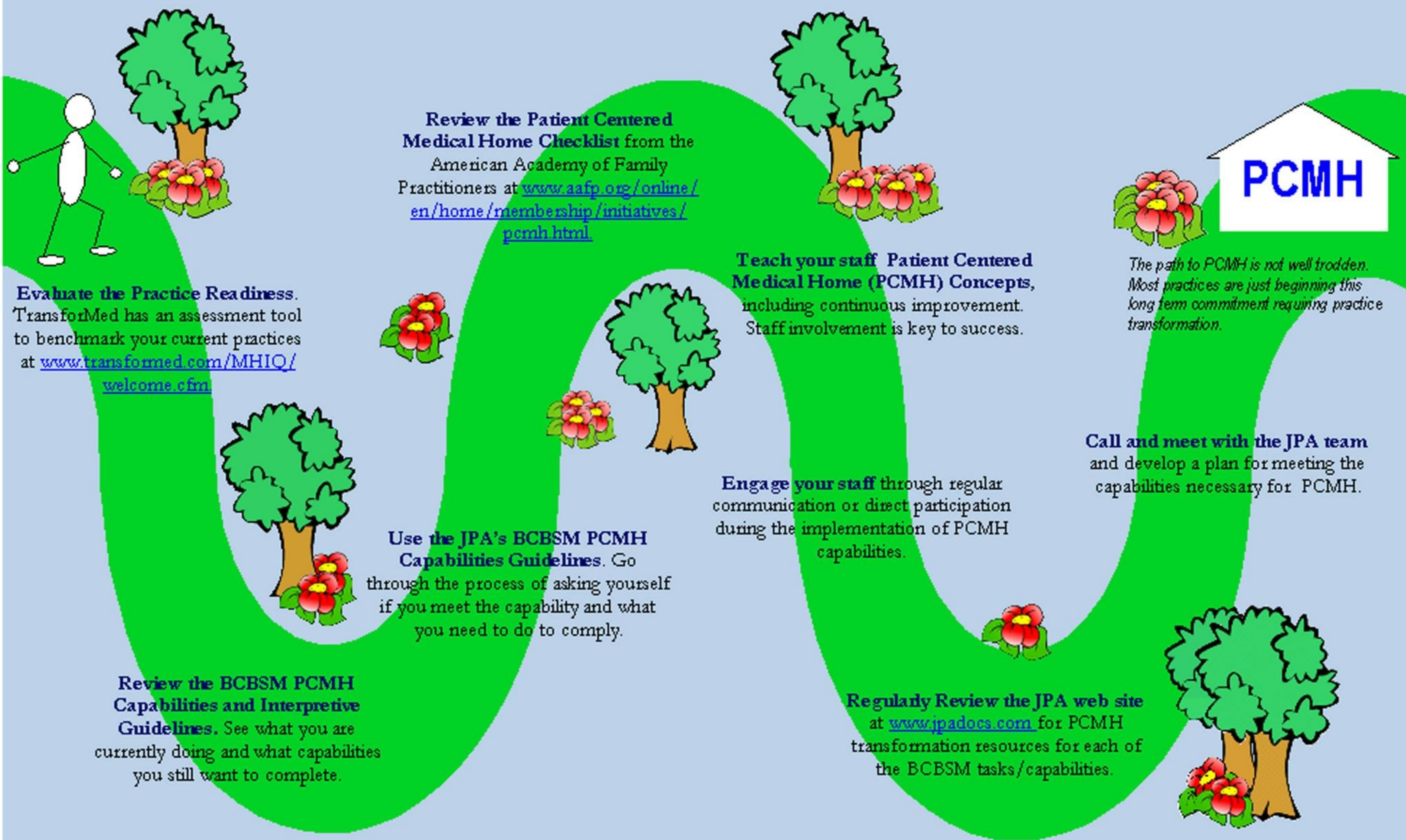
Comprehensive providers unable to transform practice without viable & sustainable payment for desired services

BUT

Employers & payers unwilling to pay for desired services unless primary care demonstrates value AND creates potential to save money

Slide courtesy of Lisa M. Letourneau MD, MPH – Maine PCMH

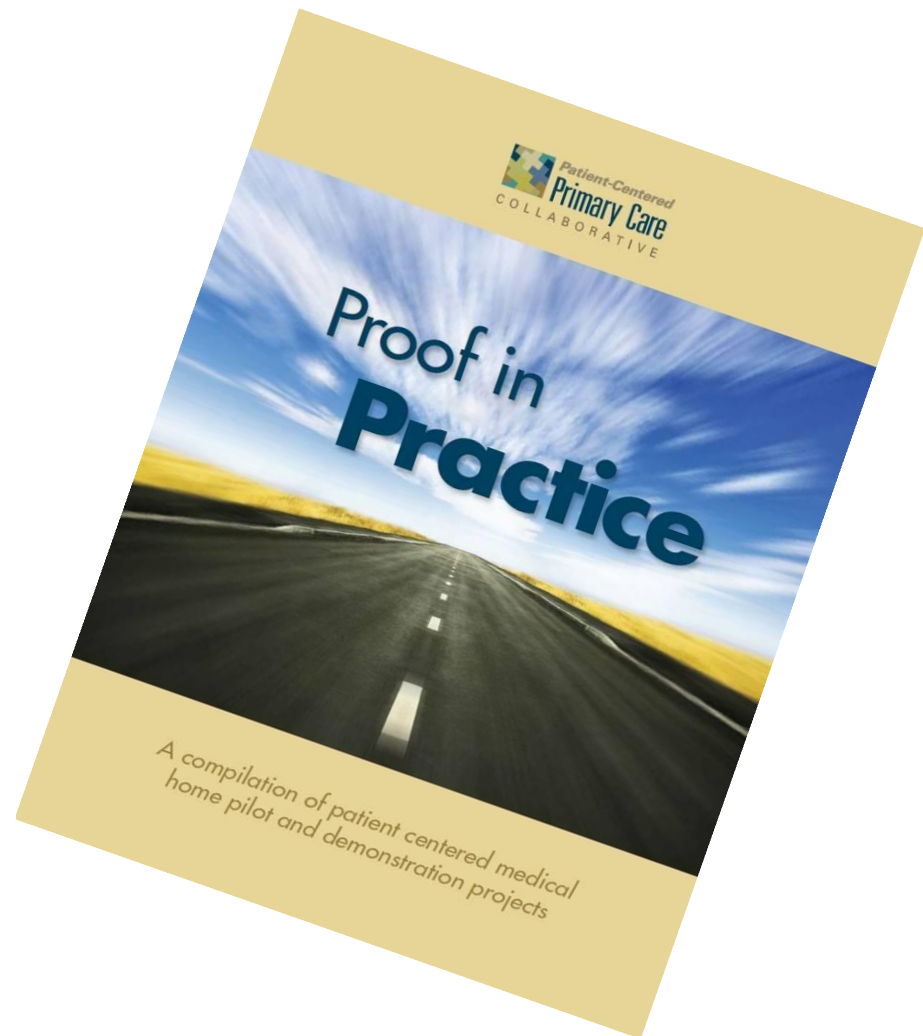
Path to PCMH with BCBS Michigan



Patient Centered Primary Care Collaborative

“Proof in Practice– A Compilation of Patient Centered Medical Home Pilot and Demonstration Projects” Released October 2009

- Developed by the PCPCC Center for Multi-stakeholder Demonstration through a grant from AAFP offering a state-by-state sample of key pilot initiatives.
- Offers key contacts, project status, participating practices and market scan of covered lives; physicians.
- Inventory of : recognition program used, practice support (technology), project evaluation, and key resources.
- Begins to establish framework for program evaluation/ market tracking.



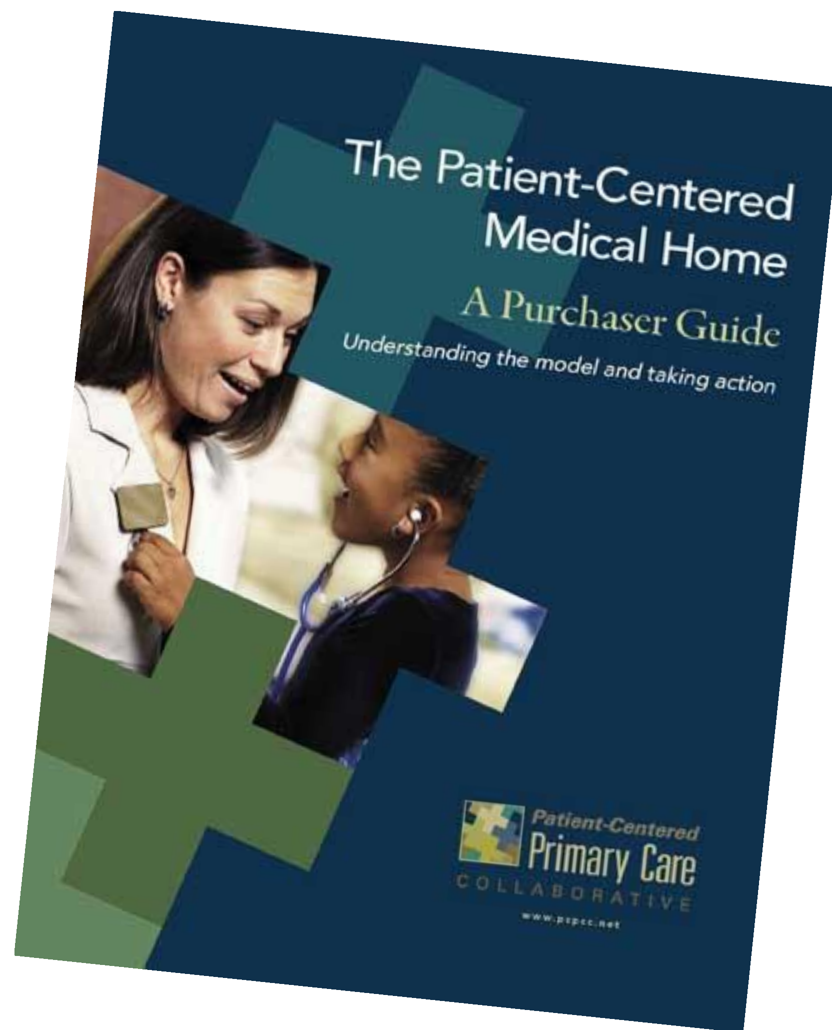
Why employers care about PCMH

- Improved coordination of healthcare
- Enhanced quality of care
- Better clinical outcomes
- Improved patient satisfaction with healthcare
- And (hopefully) lower health and lost productivity costs
  - Healthier workforce
  - Healthier families in workforce
  - Increased efficiency of care (reduces costs)
  - More valuable health benefit

Patient Centered Primary Care Collaborative

"Purchaser Guide" Released July, 2008

- Developed by the PCPCC Center for Benefit Redesign and Implementation
- Guide offers employers and buyers actionable steps as they work with health plans in local markets - over 6000 copies downloaded and/or distributed.
- Includes contract language, RFP language and overview of national pilots.
- Includes steps employers can take to involve themselves now in local market efforts.



Patient Centered Primary Care Collaborative

"A Collaborative Partnership – Resources to Help Consumers Thrive in the Medical Home" Released October 2009

Included in the Guide:

- PCPCC activities and initiatives supporting consumer engagement
- Tools for consumers and other stakeholders to assist with PCMH education, engagement and partnerships
- A catalogue of resources with descriptions of and the means to obtain potential resources for consumers, providers and purchasers seeking to better engage consumers

Resources

- Patient centered medical home: What, why and how? IBM IBV whitepaper: http://www-935.ibm.com/services/us/gbs/bus/html/gbs-medical-home.html
- Patient-Centered Primary Care Collaborative: http://pcpcc.net/content/patient-centered-medical-home
- PRISM: http://www.prism1.org
- American Academy of Family Physicians:

  www.aafp.org/online/en/home/membership/initiatives/pcmh.html
- American College of Physicians: www.acponline.org/advocacy/where_we_stand/medical_home
- American Academy of Pediatrics: www.medicalhomeinfo.org/
- TransforMED: http://www.transformed.com/transformed.cfm
- NCQA Recognition: www.ncqa.org/tabid/631/Default.aspx
- MedHomeInfo: www.medhomeinfo.org

Questions?

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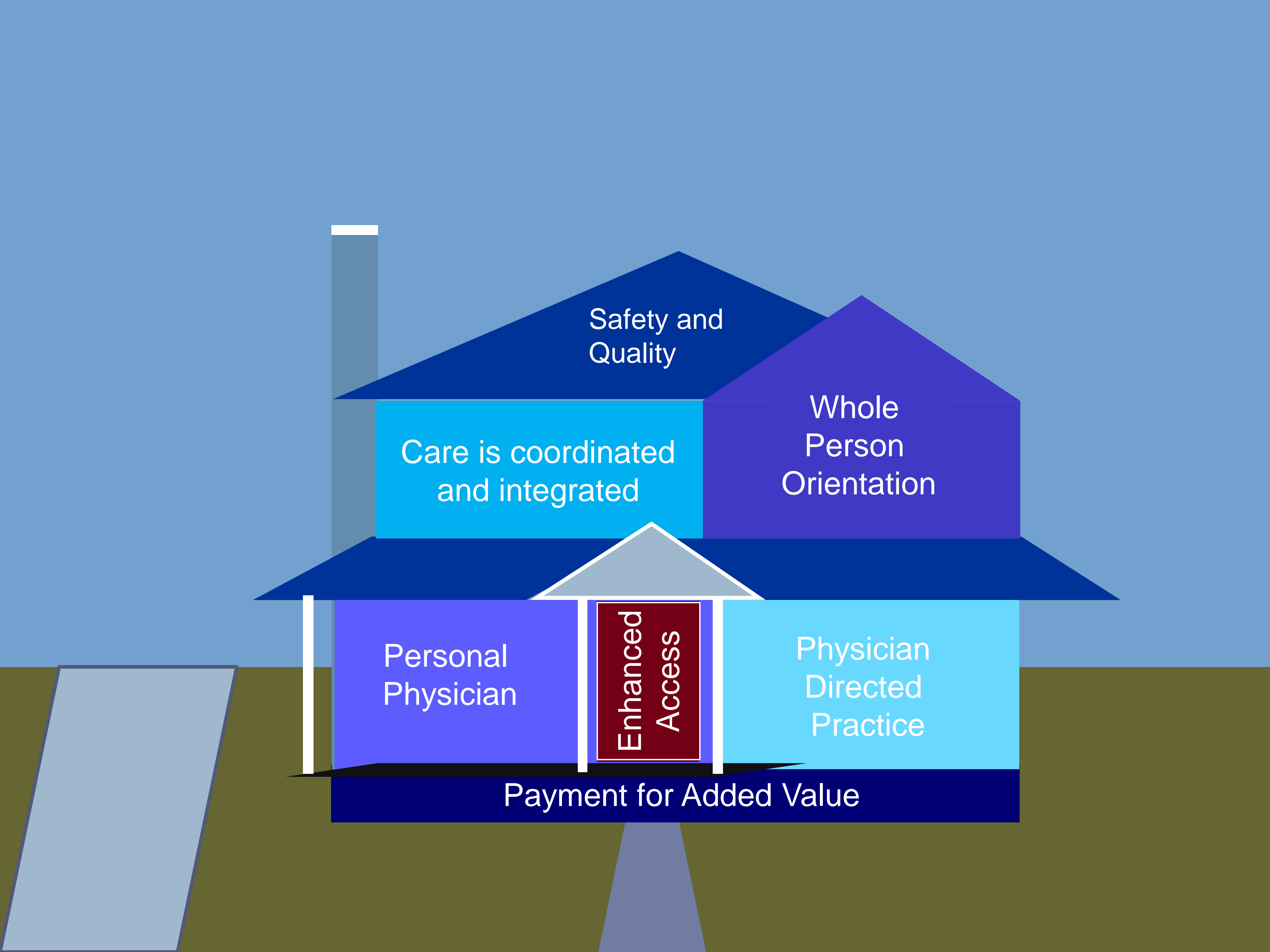
Safety and Quality
Care is coordinated and integrated
Whole Person Orientation
Personal Physician
Enhanced Access
Physician Directed Practice
Payment for Added Value

ACO and the Principles of the PCMH

Whether building a community-wide ACO or a solo primary care practice, adherence to guiding PRINCIPLES provides the foundation. Through the PCMH Joint Principles, we (the buyers and providers) have agreed to change our covenant with one another. The Joint Principles of the PCMH have been agreed on by the entire "House of Medicine." They are therefore owned by the very folks that should deliver comprehensive care (the primary care providers) and their specialist colleagues. For Accountable Care to achieve its goals, successful organizations will NEED a foundation in these principles.

As a buyer, I want to be assured that the foundation - the principles - are in place, including a personal relationship with a healer, improved access, care that is <u>coordinated</u>, <u>integrated</u>, and <u>comprehensive</u>.

Why you need to stop whining and move

- Starting in 2015, hospitals with poor quality metrics could be financially penalized by Medicare and Medicaid. For example a 300-bed hospital in the low-performing category could be penalized more than $1.3M annually. Each year, about 1,000 hospitals will fall into the bottom performance quartile, subjecting them to financial penalties. (THERE IS Teeth)
- Providers will need to improve quality substantially as government healthcare programs shift from fee-for-service to value-based reimbursement. (There is an Acton Plan)
- As Medicaid expands by 40% over the next decade, hospitals must learn how to operate on Medicaid rates, which currently do not fully cover hospitals' costs.
- Providers and payers should "unlock data" and share infrastructure to more effectively manage care (e.g., by creating accountable care organizations). WORK TOGETHER