Improving Quality and Reducing Total Cost of Care in the PGP Demo and Pioneer ACO

Daniel Trajano, MD, MBA

Park Nicollet Pioneer ACO

HealthPartners

Daniel Trajano has no relevant financial or personal relationships with commercial interests to disclose.

DISCLOSURES

Question 1. What is an ACO?

a) "A unicorn, a fantastic creature that is vested with mythical powers. But no one has actually seen one"
b) A network of doctors and hospitals shares responsibility for providing coordinated care to patients in hopes of limiting unnecessary spending.
c) Another Consulting Opportunity
d) The American Cornhole Organization

Accountable Care Organization

http://ihealthtran.com/wordpress/2012/11/key-questions-for-physicians-to-ask-before-joining-an-aco/

Another Consulting Opportunity

http://siliconbayounews.com/2013/03/11/himss-2013-new-orleans-and-health-it-advancements-highlighted-at-conference/

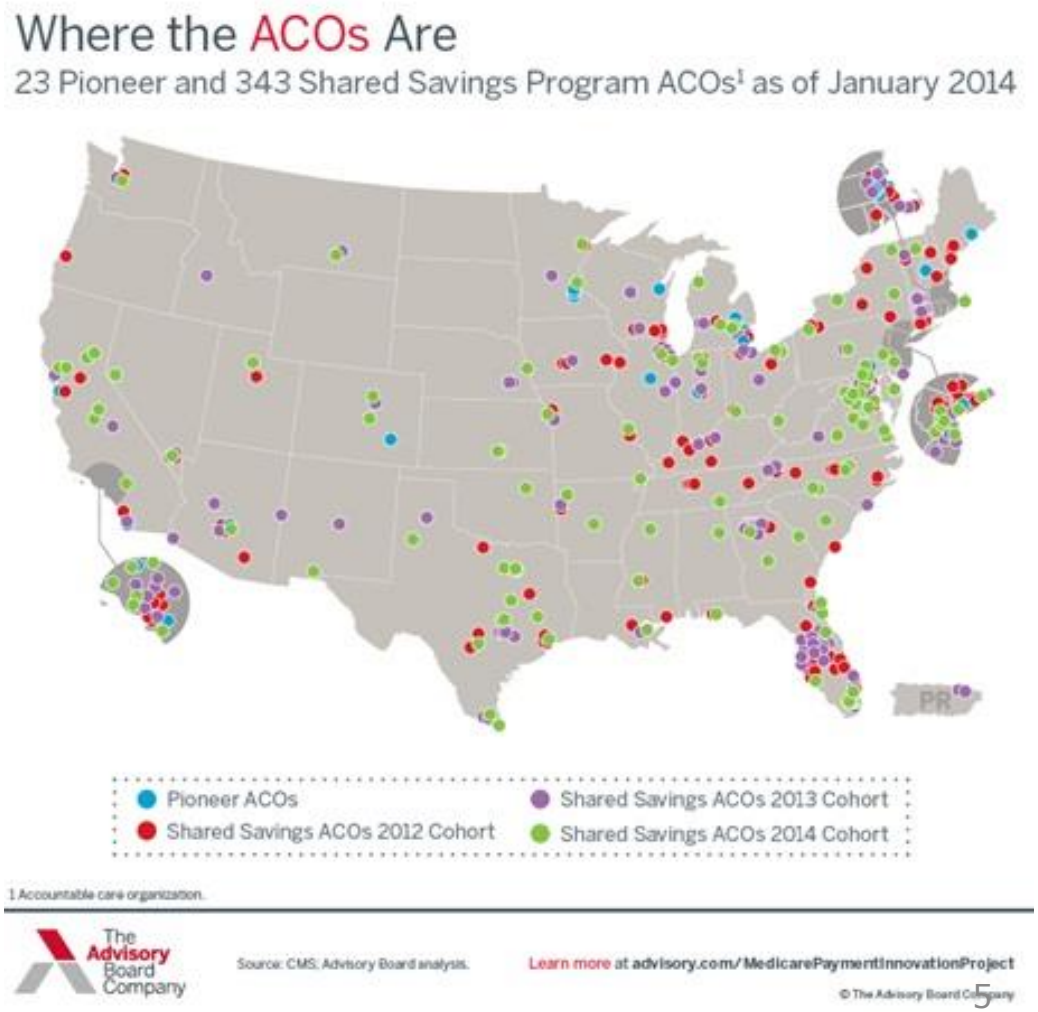
American Cornhole Organization

http://www.americancornhole.com/

Unicorn

Question 2. Is your organization a ACO (Medicare, Medicaid, or Commercial)?

a) Yes
b) No
c) I don't know




Park Nicollet
Pioneer ACO

Park Nicollet Shared Savings and Quality Pay For Performance Programs

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Pioneer ACO

MEDICA.

UCare

Question 3. Have you ever completed a Triathlon?

a) Yes
b) No
c) Are you crazy?

IRONMAN

http://au.lifestyle.yahoo.com/banzai/triathlon/feature/-/11318340/most-dramatic-finishes/

http://www.youtube.com/watch?v=MTn1v5TGK_w

Agenda

- Affordable Care Act and ACOs
- Park Nicollet's PGP Experience
- Park Nicollet's Pioneer ACO Experience
- ACO Model Challenges and Successes
- Future Value Driven Payment Models

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- **Affordable Care Act and ACOs**
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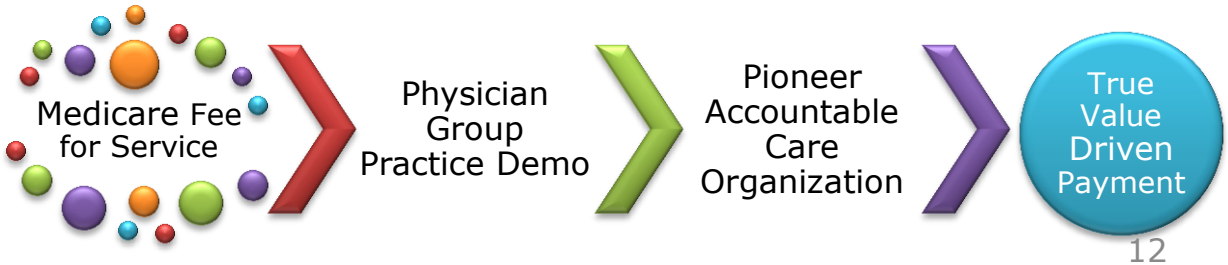
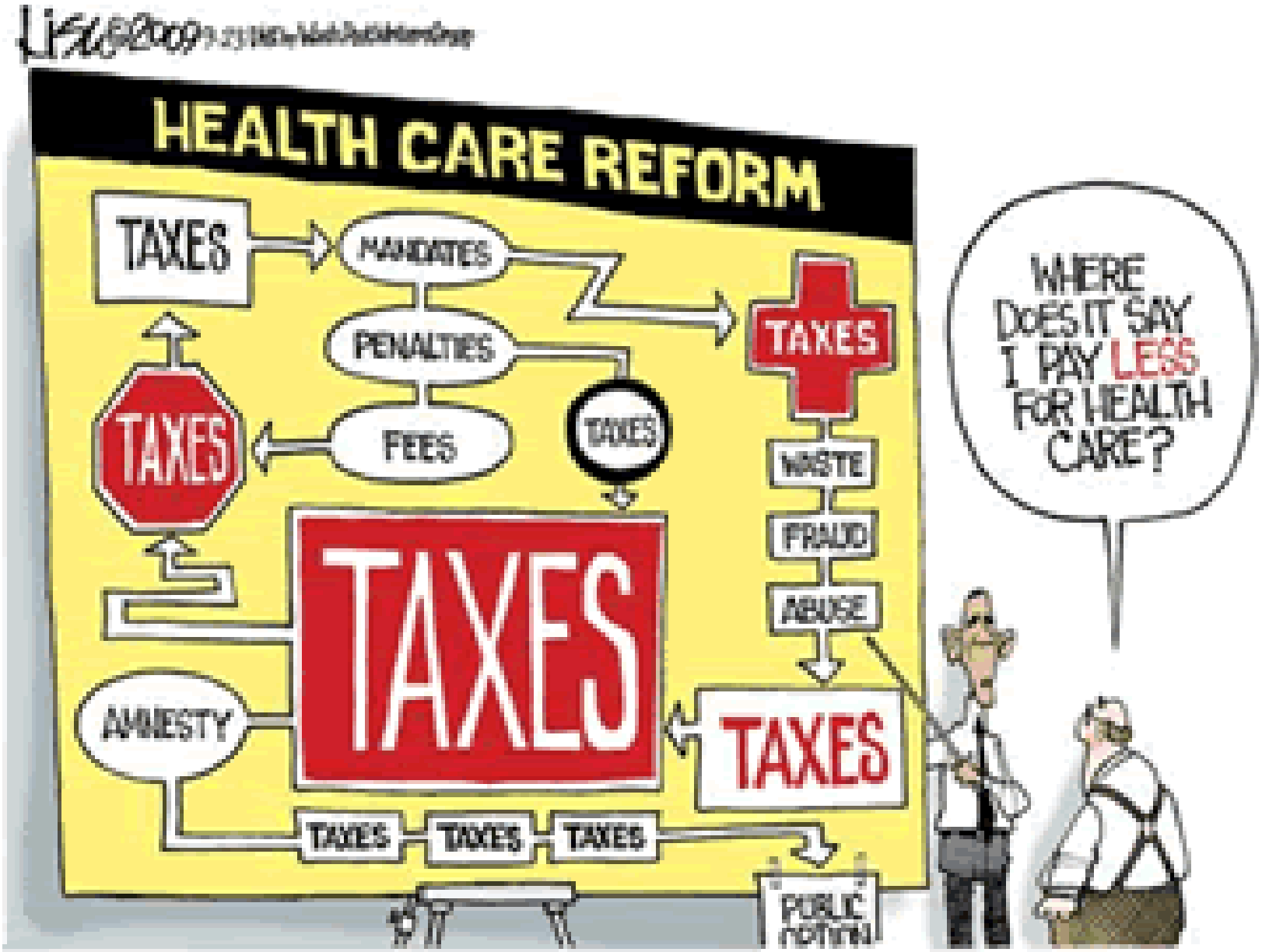


"If all we're doing is adding more people to a **broken system** then costs will continue to skyrocket, and eventually somebody is going to be bankrupt, whether it's the federal government, state governments, businesses or individual families." ~Barack Obama

NBC News 2010/
Emphasis Added

Wikipedia

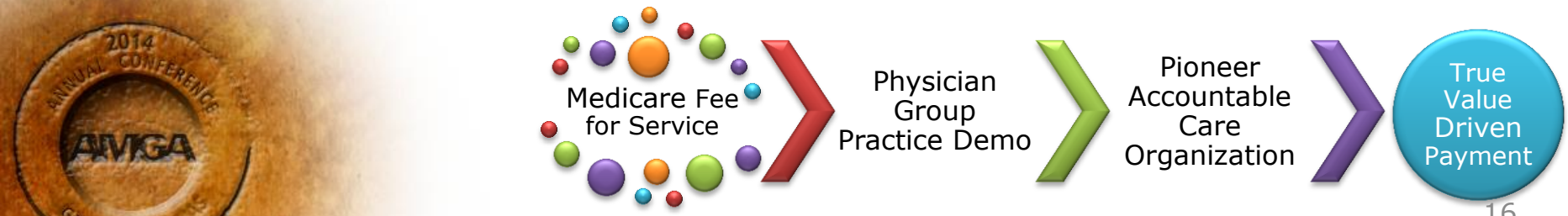
http://standupforamerica.wordpress.com/2009/09/08/health-care-part-1-making-the-case-for-reform/uninsured-cartoon/

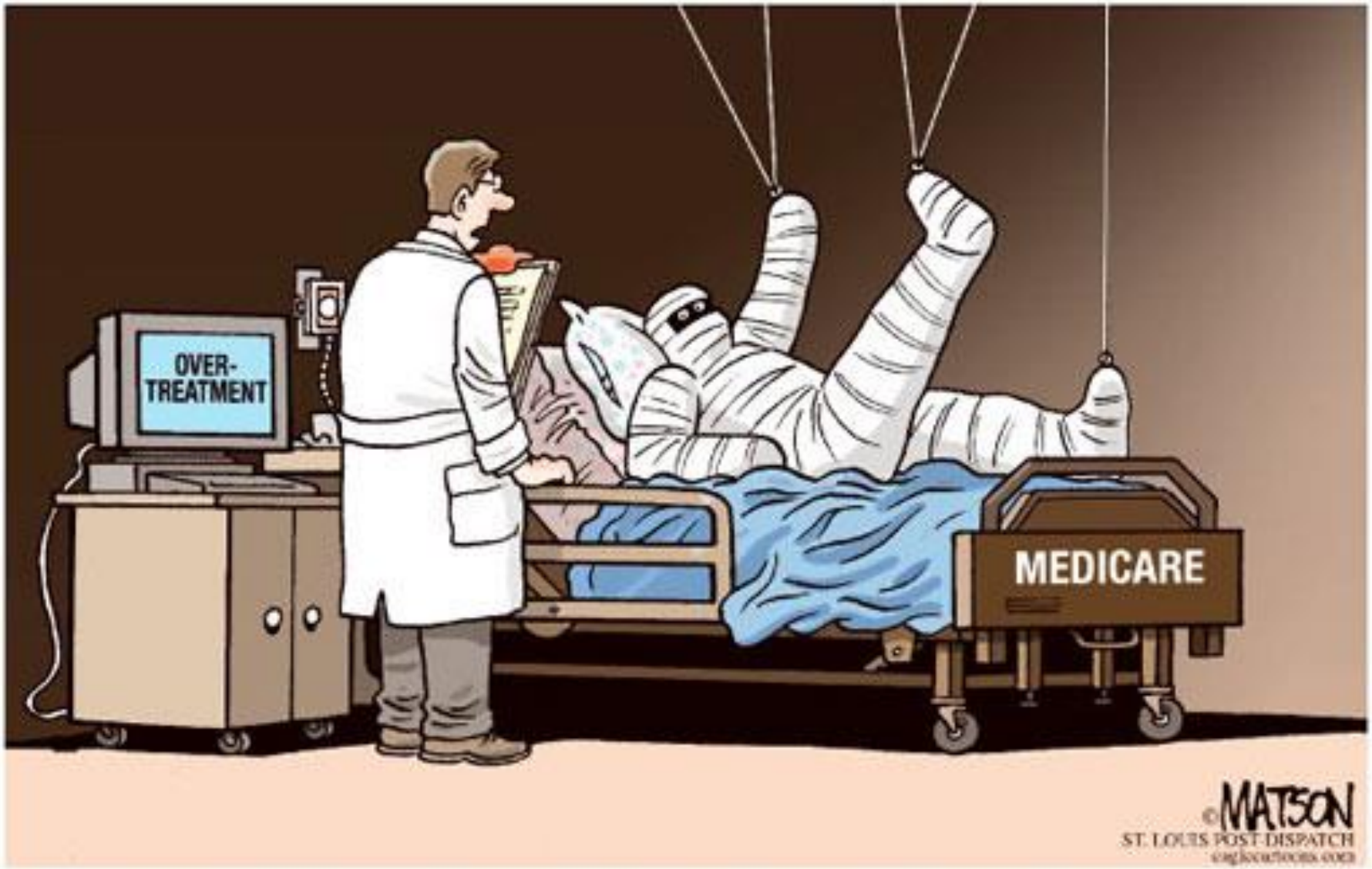


http://blog.ericlbachcpa.com/wp-content/uploads/2010/04/HealthCareReformChart.gif

"How can the best medical care in the world cost twice as much as the best medical care in the world?"

~Peter Orszag



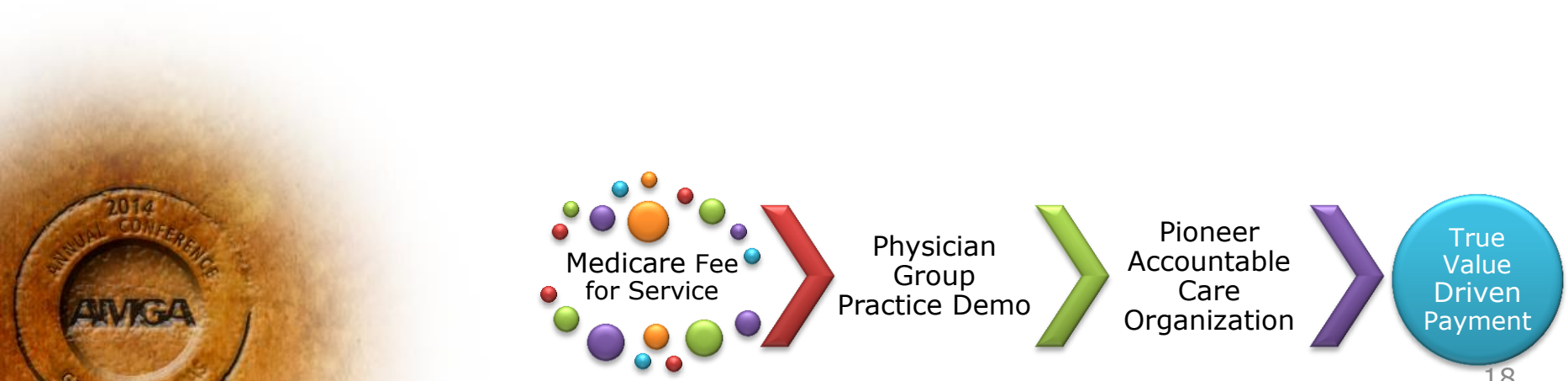


"YOU CAN NEVER BE TOO CAREFUL WITH HANGNAILS AT YOUR AGE."

http://www.kaiserhealthnews.org/Cartoons/Hangnail.aspx

“…one man’s $200 billion in waste is another man’s $200 billion profit stream.”

~Newt Gingrich



http://rphanusha.blogspot.com/2012/02/accountable-care-organizations.html


Do you have
QUESTIONS
about the
AFFORDABLE CARE ACT?

Agenda

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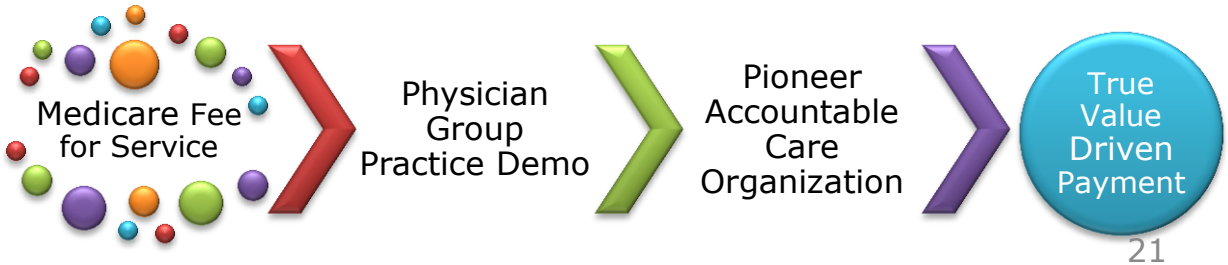
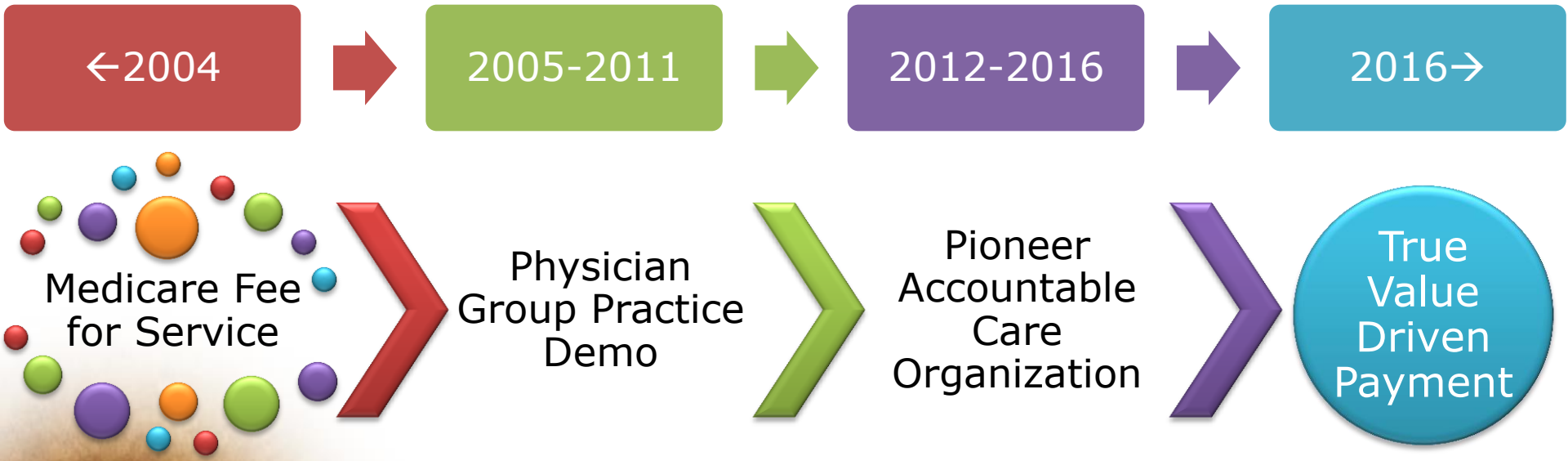
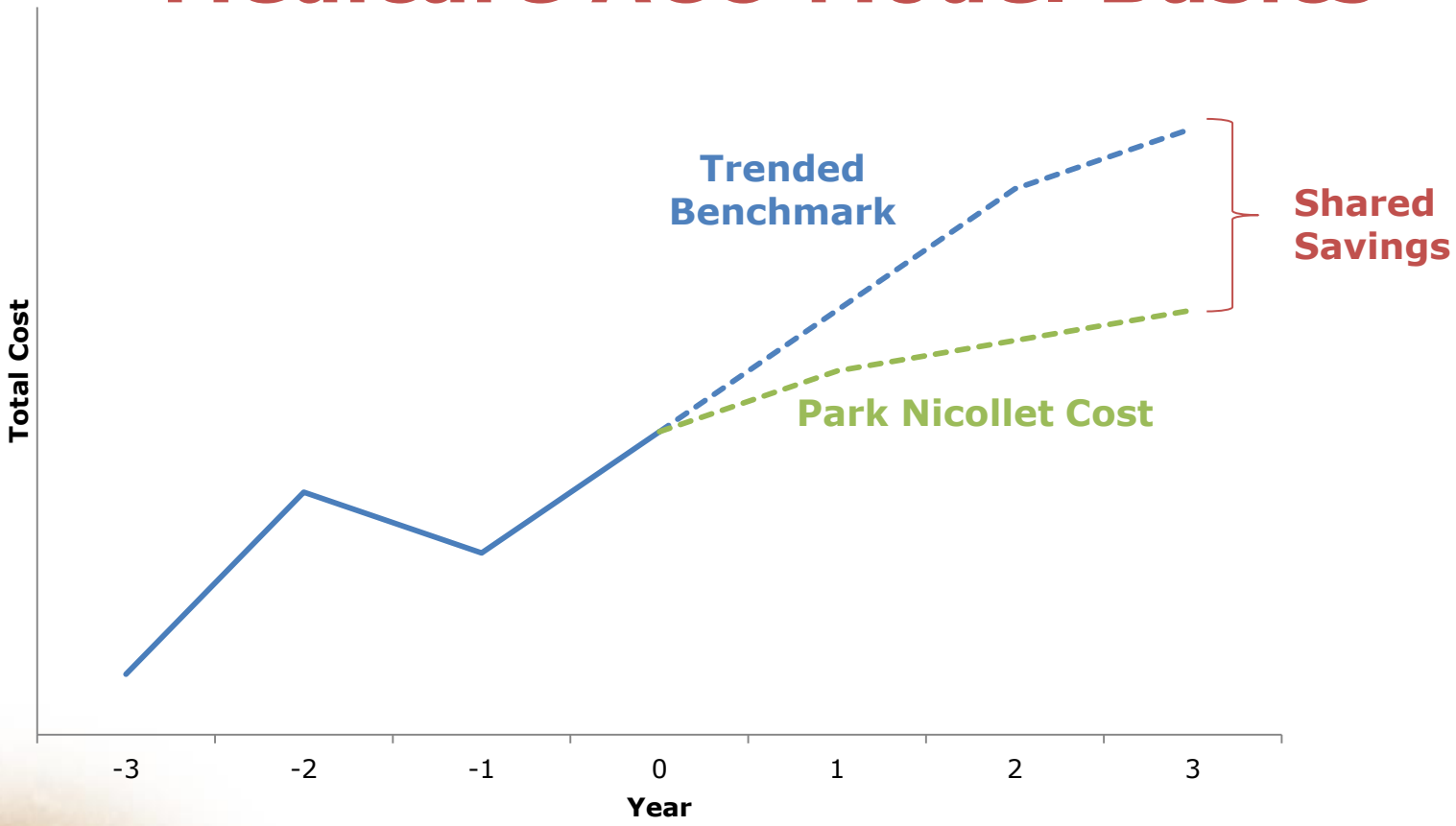
- **Park Nicollet's PGP Experience**
- **Park Nicollet's Pioneer ACO Experience**
- ACO Model Challenges and Successes
- Future Value Driven Payment Models



Park Nicollet's Medicare Payment Reform Journey



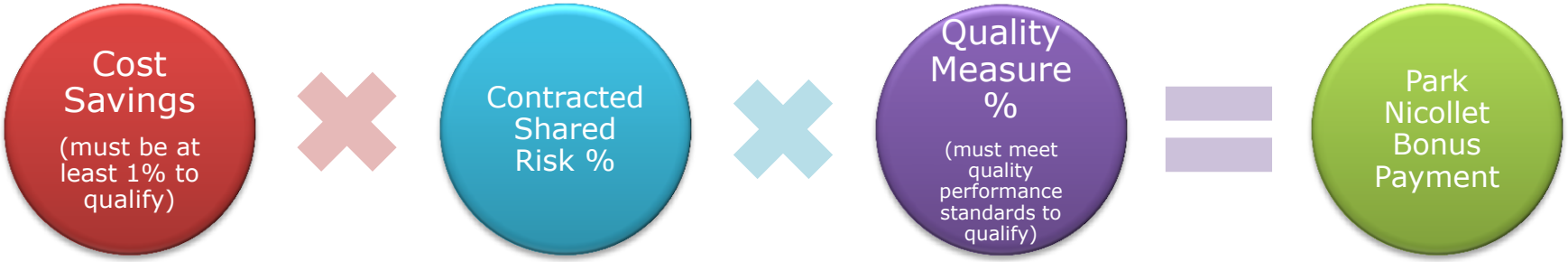
Medicare ACO Model Basics



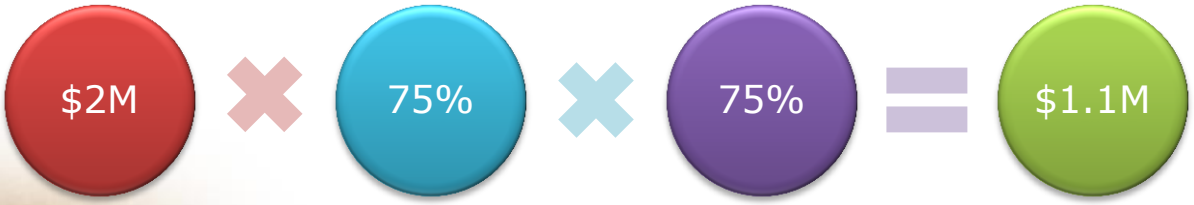
- The trended benchmark will be based on trends in national, not local, expenditures
- To earn the shared savings bonus payments, Park Nicollet's per-capita expenditures (for assigned beneficiaries) must be less than the yearly target by at least 1%

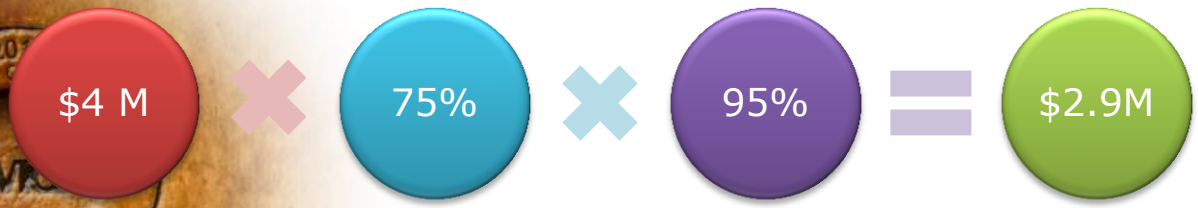
Medicare ACO Bonus Payment Overview
How Do We Get Paid?

Model Overview



Hypothetical Scenarios:





StarTribune

Feds reward Park Nicollet for healthy patients

Article by: JACKIE CROSBY Star Tribune August 9, 2011 - 2:49 PM

The St. Louis Park-based hospital received a **$5.7 million performance bonus** for its work in a five-year federal demonstration project that included physician groups at nine other hospitals and clinics around the country.

"We improved their health, we kept them out of the hospital," said Park Nicollet's Chief Medical Officer Steven Connelly. **"But because we kept them away from admissions in the emergency room, we actually lost revenue on those patients. It's not a tenable business model.** But if you transition into reimbursing for the quality of care delivered, then you have the benefit both to the organization and to the patient."

"It's not for the faint of heart," said Mark Skubic, Park Nicollet's main contact with the federal government program. **"It's an awful lot of work, but we learned a lot."**

http://www.startribune.com/business/127283643.html

Emphasis Added

PGP Model and Summary

- Park Nicollet Performed Well on Quality and Received Bonuses in 2010 (PY5) and 2011 (TD PY1)
- Initial Focus Chronic Disease Management (e.g. CHF) For All Patients
- Later Years Added Focus on HCC Coding Accuracy

Pioneer ACO vs. PGP Decision Guide

Positives

- Lower Minimum Savings Rate
  - 1% vs. 2.5% in PGP
- Higher Shared Savings Percentage
  - 70-75% vs. 50-60% in PGP
- Benchmark Based on National Comparison
- Extends Participation with CMS 3-5 years
- Anticipate Pioneer ACO Participants Will Have Influence In Future Medicare Payment Models
- Collaborate/Compete with 32 National Health Systems
  - Including Fairview and Allina
- Fewer Quality Measures
  - 33 vs. 41 in PGP
- Prospective Attribution

Negatives

- Downside Risk vs. Upside Only in PGP
  - Potentially -$5M in Poor Performance Year (Very Unlikely)
- New, Poorly Understood, and Untested Financial Model
  - Eliminates Risk Adjustment
  - Based on Historic Costs, Age, Sex, Disability Only
  - Possibly an Advantage to Park Nicollet
- Must Leave High Profile PGP Group to Join Pioneer ACO
- Required to Attend Pioneer ACO Collaborative Meetings (Possibly a Positive)

Comparison of payment arrangements in the Pioneer ACO Model

	Pioneer Core	Pioneer Option A	Pioneer Option B	Pioneer Alternative 1	Pioneer Alternative 2
Yr 1*	60% 2-sided, 10% sharing cap 10% loss cap 1% MSR	50% 2-sided 5% sharing cap 5% loss cap 1% MSR	70% 2-sided, 15% sharing cap 15% loss cap 1% MSR	50% 1-sided 5% sharing cap 2% to 2.7% MSR (depending on number of aligned beneficiaries)[1]	60% 2-sided, 10% sharing cap 10% loss cap 1% MSR
Yr 2	70% 2-sided 15% sharing cap 15% loss cap 1% MSR	60% 2-sided, 10% sharing cap 10% loss cap 1% MSR	75% 2-sided, 15% sharing cap 15% loss cap 1% MSR	70% 2-sided, 15% sharing cap 15% loss cap 1% MSR	70% 2-sided, 15% sharing cap 15% loss cap 1% MSR
Yr 3[2]	**Payment:** Population-based payment of up to50% of ACO's expected part A & B revenue **Risk**: 70% 2-sided, 15% sharing cap 15% loss cap 1% MSR	**Payment:** Population-based payment of up to 50% of ACO's expected part A & B revenue **Risk**: 70% 2-sided, 15% sharing cap 15% loss cap 1% MSR	**Payment:** Population-based payment of up to 50% of ACO's expected part A & B revenue **Risk**: 75% 2-sided, 15% sharing cap 15% loss cap 1% MSR	**Payment:** Population based payment of up to 100% of ACO's own expected part B revenue, less 3% discount. **Risk**: Full risk for all part B with a discount of 3% to 6% (depending on quality scores[3]) and shared risk for Part A (70% sharing rate, 15% sharing and loss cap).	**Payment:** Population based payment of up to 100% of ACO's own expected part A & B revenue, less 3% discount. **Risk**: Full risk for all part A & B revenue with a discount of 3% to 6% (depending on quality scores[4]).

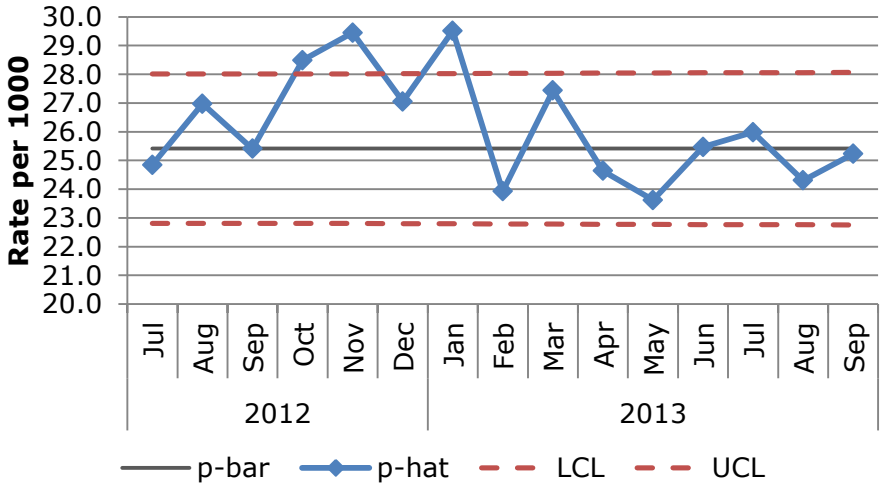
http://innovation.cms.gov/Files/x/Pioneer-ACO-Model-Alternative-Payment-Arrangements-document.pdf

Pioneer Performance

- PY1 and PY2 Summary
- Dashboard
- New Initiatives and Population Health Focus Specific to Pioneer Patients
  - SNF Geriatrician-NP Team
  - Care Conferences
  - RN Care Consultant Program

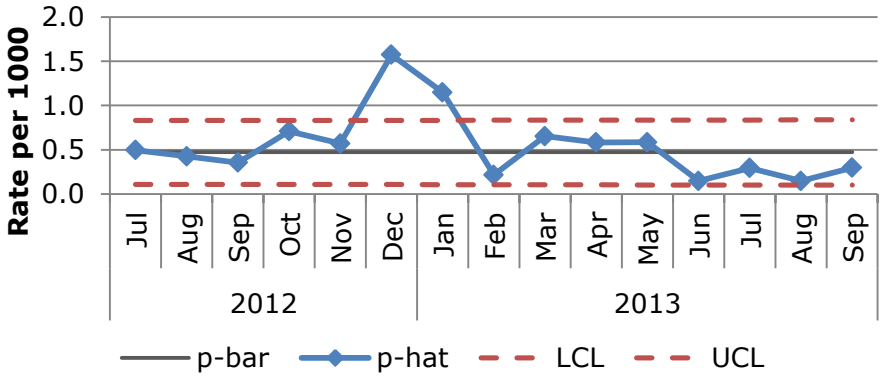
Pioneer ACO Dashboard

Admission Rate



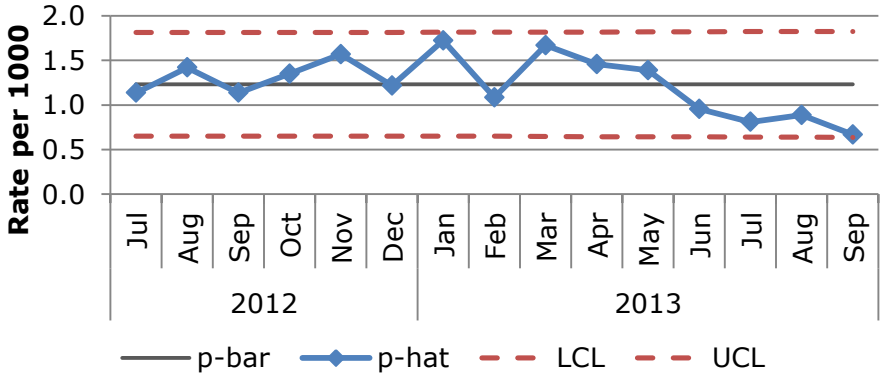
COPD/ASTHMA Admission Rate

(based on Ambulatory Sensitive Conditions Admissions: COPD/Asthma definition)

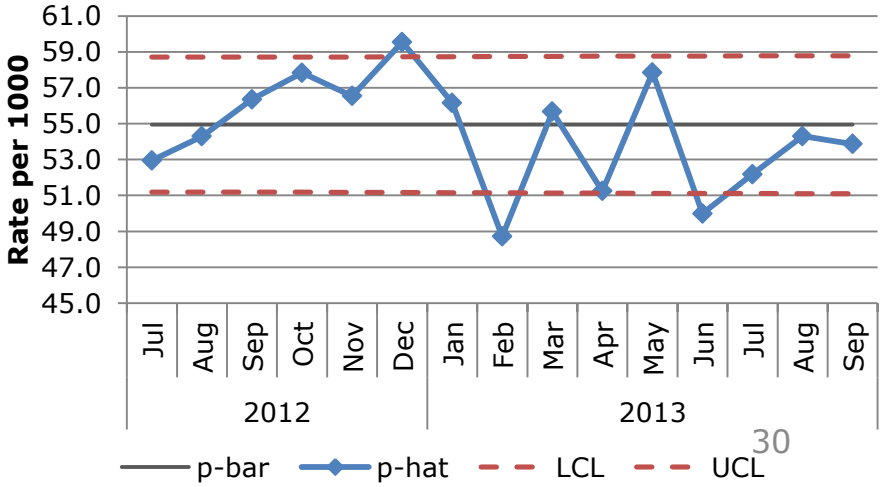


Heart Failure Admission Rate

(based on Ambulatory Sensitive Conditions Admissions: Congestive Heart Failure definition)

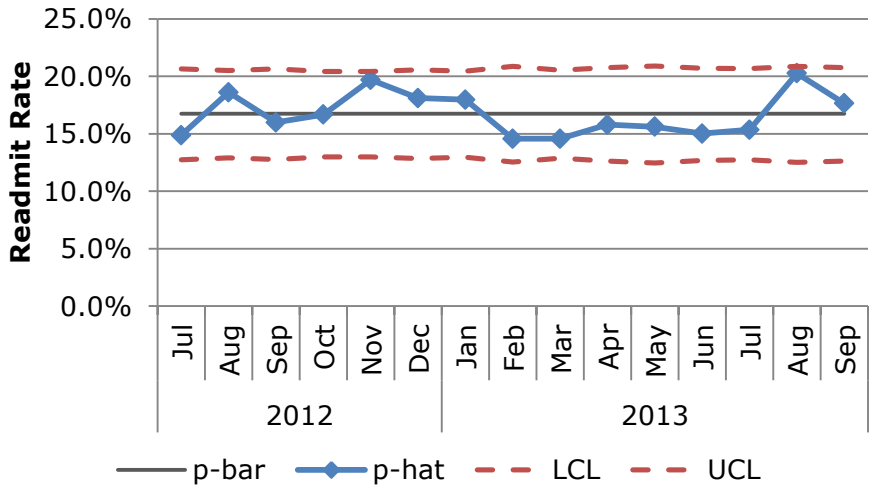


EC Visits per 1,000

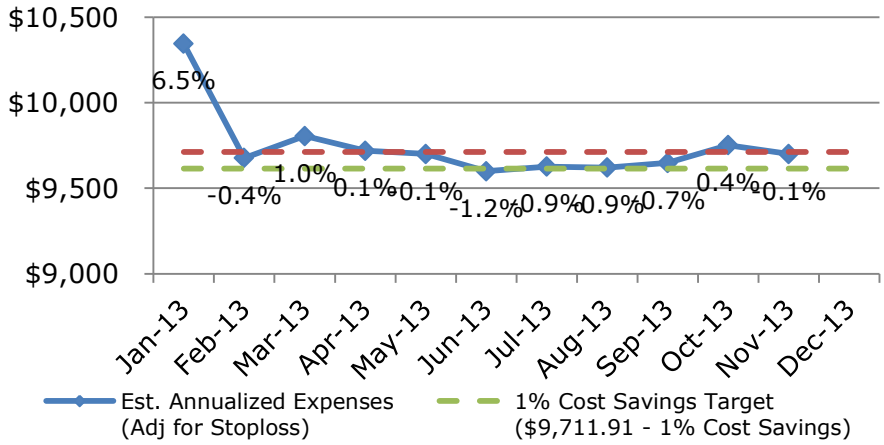


Pioneer ACO Dashboard

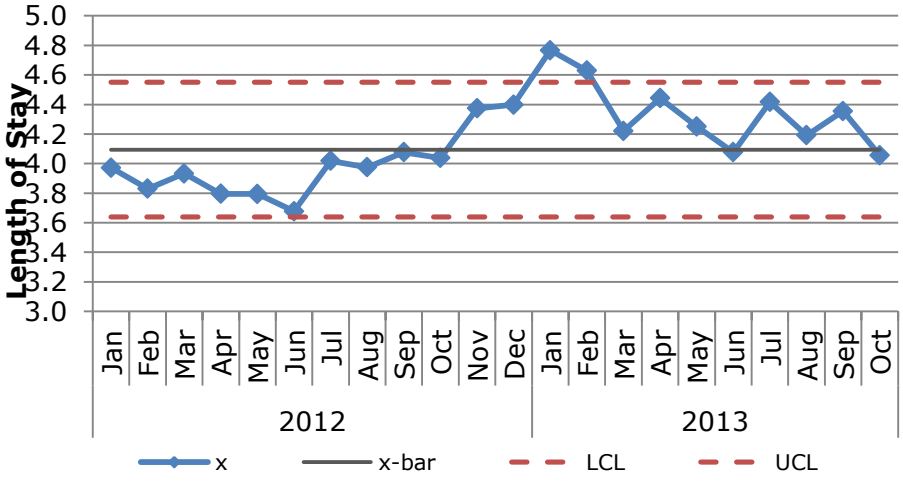
Readmission Rate



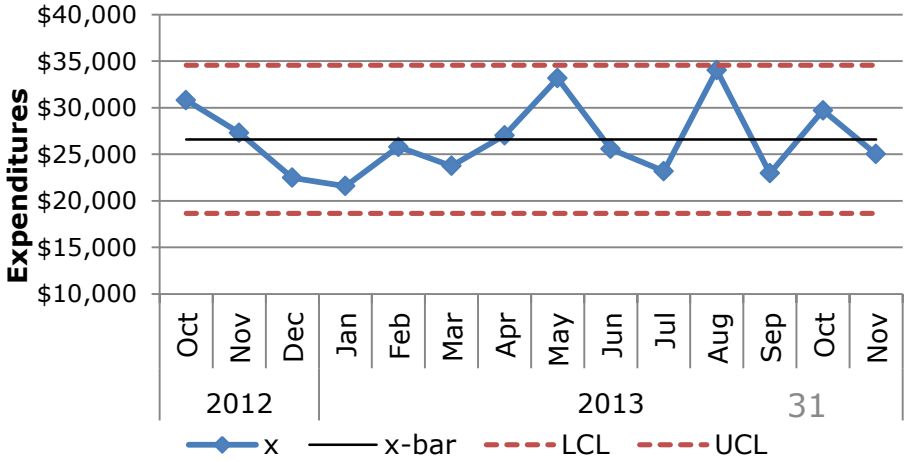
Annualized PBPM Expenditures



Length Of Stay



Average Decedent Patient Costs During The Last 6 Months Of Life

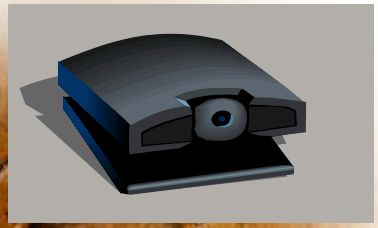


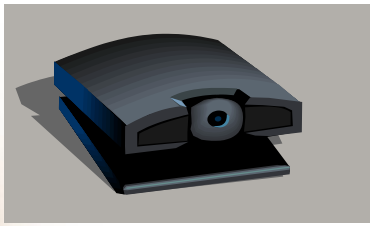
Population Health Executive Summary Dashboard

Effort #	Effort Name	2013 Pop Health Targets
#1	**Transitions** Judy Ryan/Jeanine Rosner, Linda Bauermeister	Reduce the rate of preventable readmissions or other acute care visits by transitioning patients effectively from one level of care to the next.
#2	**Care Conferences** Jeanine Rosner, Kris Kopski	All 22 Primary Care Clinics to conduct at least 2 care conferences in 2013, addressing all clinicians within the site.
#3	**Senior Services Redesign** Jennifer Olson MD, Deb Rustad NP, Linda Bauermeister RN	Understand the impact of ER Transfers after the implementation of an After Hours Call Program
#4	**Mental Health Strategy** Josh Zimmerman, John McGreevy	Improve inpatient metnal health transfer rate to Regions Hospital
#5	**Care Team Attribution** Jeanine Rosner, Kris Kopski, (PM: Greg Fedio)	Develop a care team attribution standard, vetted across the enterprise by Q1 2013. Train all staff and implement standrads by Q3, 2013.
#6	**Advanced Directives** Patti Betlach, Dawne Sipe	Increase the % of Pioneer ACO patients with an advnaced care directive on file from 25% to 34% by 12/31/13.
#7	**Care Consultant Program** Linda Bauermeister	Offer to enroll the top 4% of high risk Pioneer ACO patients and at least 3% of other PN high risk patients by 12/31/13.
#8	**Congestive Heart Failure** Dan Trajano, Cynthia Toher Steering Team: Misa/Sandstrom, Homans/Klugherz, Gapstur, Kasi Aten-Freese(PM)	Improve the rate of avoidable Heart Failure admissions

Geriatric NP and Geriatrician Team Skilled Nursing Facility Coverage

Team Care Conferences





RN Care Consultant Program

Karen Ackerman, RN

Sara Dingle, RN

Nicole Nee, RN

Char Zielin, RN

High Touch Care for the Top 4% of Pioneer ACO Patients

David's Goals

"I want to be able to go up North at least one more time, get in my boat & go fishing"

http://www.piperreport.com/archives/2010/09/accountable_care_organizations_primer_on_acos_and_medicare_shared_savings_p.html

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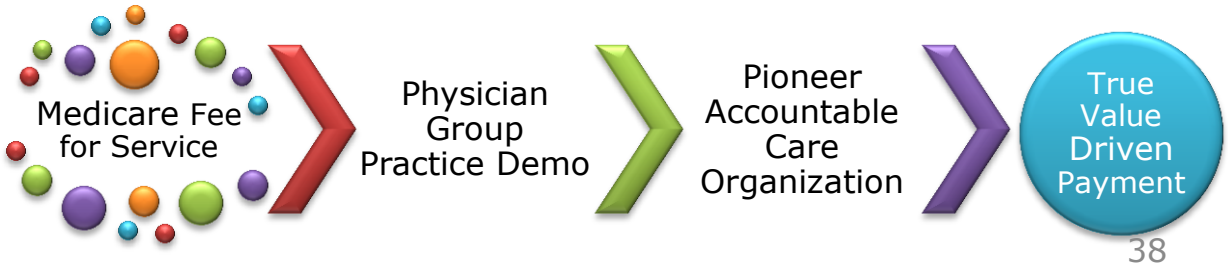


ACO Model Concerns

- Minnesota Compared to National
  - Low Baseline Cost
- Financial Model Calculations
  - Risk Adjustment Methodology
- Quality Measures
  - Benchmark Methodology
- Lack of Financial ROI in Shared Savings Models

ACO Expenditure Variation

Performance Data	Minimum	Median	Maximum
Benchmark 2012 Starts (2011 dollars at risk. MSSP only)	$7,256	$9,785	$17,236
Benchmark 2013 Starts (2012 dollars at risk. MSSP only)	$4,981	$10,030	$20,522
Baseline (decedent adjusted, capped. Pioneer only)	$7,905	$11,114	$17,817

Source: Department of Health and Human Services
http://managedhealthcareexecutive.modernmedicine.com/print/376955

http://healthaffairs.org

HEALTH POLICY BRIEF WWW.HEALTHAFFAIRS.ORG 1

HealthAffairs | Robert Wood Johnson Foundation

Health Policy Brief

AUGUST 30, 2012

Risk Adjustment In Health Insurance. When coverage is broadened in 2014, new arrangements will be needed to make sure that the market works appropriately.

WHAT'S THE ISSUE?

Insurance market reforms under the Affordable Care Act are designed to increase the number of Americans with insurance—and to shed the current system in which health plans have an incentive to enroll healthier people while avoiding the sick. One of the arrangements that will make the new system workable is risk adjustment—a process by which health insurance plans will be compensated based on the underlying health status of the people they enroll, and therefore protected against losing money by covering people with high-cost conditions.

But implementing risk adjustment could prove challenging. The statistical methods used in risk adjustment are technically complex. There are questions about the ability of the states, which have to carry out the risk adjustment, to collect accurate data and implement methodologies that result in fair

offers Medicare benefits. Payments to such private plans have always been adjusted to reflect differences in the health risks of their enrollees, initially by adjusting payments by demographic characteristics, including age, sex, and Medicaid eligibility.

Since 2000, risk-adjusted payments to MedicareAdvantage plans have used data on patient diagnoses obtained from hospital admissions. Medicare's risk-adjustment techniques have also been refined by incorporating diagnostic information from beneficiaries' use of outpatient care and prescription drugs. Risk adjustment is also being used by many state Medicaid programs and by the Massachusetts health insurance "Connector," a type of insurance exchange that distributes both publicly subsidized and private health coverage.

RISK ASSESSMENT AND RISK SCORE: In risk adjustment, a third party, such as the federal government or a state, collects and organizes data from insurance claims and clinical di-

http://www.medpac.gov/transcripts/RiskAdj_Sep_2013.pdf

Advising the Congress on Medicare issues

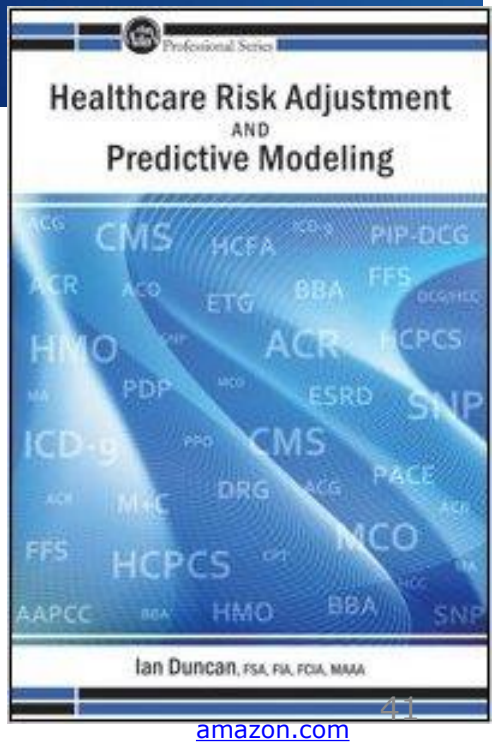
Issues for risk adjustment in Medicare

Dan Zabinski

September 12, 2013

MEDPAC

ISSN 2155-3718

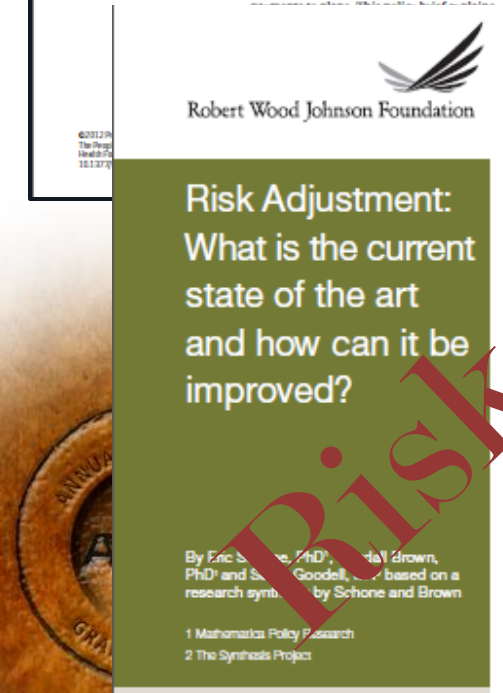


Professional Series

Healthcare Risk Adjustment AND Predictive Modeling

Ian Duncan, FSA, FIA, FCIA, MAAA

amazon.com



Robert Wood Johnson Foundation

Risk Adjustment: What is the current state of the art and how can it be improved?

By Eric S[illegible], PhD[1], [illegible] Brown, PhD[1] and S[illegible] Goodell, [illegible] based on a research synth[illegible] by Schone and Brown

1 Mathematica Policy Research
2 The Synthesis Project

THE SYNTHESIS PROJECT
NEW INSIGHTS FROM RESEARCH RESULTS

POLICY BRIEF NO. 25 | JUNE 2013

Also see comp[illegible]n report [illegible] at www.policysynthesis.org

Why is this important to policy-makers?

- All major public programs providing health coverage under capitation arrangements, including Medicare Advantage, Medicare Part D, and Medicaid, use risk adjustment to set payment rates that reflect expected costs.
- Without risk adjustment, health plans have an incentive to enroll healthier members and avoid sick members, especially when they cannot vary premiums by health status or other known factors likely to affect health care costs.
- The Affordable Care Act (ACA) moves risk adjustment beyond public programs to the private insurance market. The ACA requires risk adjustment for all insurers in the individual and small group market to reduce the incentive for plans to target their marketing toward healthy people, make insurance market reforms viable, and compensate insurers that enroll high-needs patients.

Risk adjustment has a variety of uses, but this policy brief focuses on using risk adjustment for payment purposes.

http://www.rwjf.org

Capsules THE KHN BLOG

http://capsules.kaiserhealthnews.org/?p=17632

A Bump In The Road To Accountable Care?

By Jenny Gold

MARCH 8TH, 2013, 5:41 AM

The Pioneer accountable care organizations have long been the shining stars of the Affordable Care Act's strategy to rein in the country's out-of-control spending on health care...

For the first year of the program, everything seemed like smooth sailing. But the pioneers appear to have hit their first pothole—and the administration is scrambling to make sure the project goes forward.

The problem: That pesky little part about accountability...

But then, last week, 30 of the pioneers **sent a letter to CMMI complaining that at least 19 of the quality targets had too little data behind them and were therefore unfair, unreasonable and even arbitrary**. In light of the flawed metrics, the pioneers requested that CMMI wait until 2014, when CMMI would have another year of good data collection to set benchmarks, to start basing Pioneer pay on quality, the hallmark of the program...

What the spat perhaps best reveals is that measuring quality is a difficult task, even for organizations like the pioneers who do it best...

Appendix A: ACO Quality Measure Benchmarks

Domain	Measure	Description	30th perc.	40th perc.	50th perc.	60th perc.	70th perc.	80th perc.	90th perc.
Patient/Caregiver Experience	ACO #1	Getting Timely Care, Appointments, and Information	30.00	40.00	50.00	60.00	70.00	80.00	90.00
Patient/Caregiver Experience	ACO #2	How Well Your Doctors Communicate	30.00	40.00	50.00	60.00	70.00	80.00	90.00
Patient/Caregiver Experience	ACO #3	Patients' Rating of Doctor	30.00	40.00	50.00	60.00	70.00	80.00	90.00
Patient/Caregiver Experience	ACO #4	Access to Specialists	30.00	40.00	50.00	60.00	70.00	80.00	90.00
Patient/Caregiver Experience	ACO #5	Health Promotion and Education	54.71	55.59	56.45	57.63	58.22	59.09	60.71
Patient/Caregiver Experience	ACO #6	Shared Decision Making	72.87	73.37	73.91	74.51	75.25	75.82	76.71
Patient/Caregiver Experience	ACO #7	Health Status/Functional Status	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Care Coordination/Patient Safety	ACO #8	Risk Standardized, All Condition Readmissions	16.62	16.41	16.24	16.08	15.91	15.72	15.45
Care Coordination/Patient Safety	ACO #9	ASC Admissions: COPD or Asthma in Older Adults	1.24	1.02	0.84	0.66	0.52	0.36	0.00
Care Coordination/Patient Safety	ACO #10	ASC Admission: Heart Failure	1.22	1.03	0.88	0.72	0.55	0.40	0.18
Care Coordination/Patient Safety	ACO #11	Percent of PCPs who Qualified for EHR Incentive Payment	51.35	59.70	65.38	70.20	76.15	84.85	90.91
Care Coordination/Patient Safety	ACO #12	Medication Reconciliation	30.00	40.00	50.00	60.00	70.00	80.00	90.00
Care Coordination/Patient Safety	ACO #13	Falls: Screening for Fall Risk	17.12	22.35	27.86	35.55	42.32	51.87	73.38
Preventive Health	ACO #14	Influenza Immunization	29.41	39.04	48.29	58.60	75.93	97.30	100.00
Preventive Health	ACO #15	Pneumococcal Vaccination	23.78	39.94	54.62	70.66	84.55	96.64	100.00
Preventive Health	ACO #16	Adult Weight Screening and Follow-up	40.79	44.73	49.93	66.35	91.34	99.09	100.00
Preventive Health	ACO #17	Tobacco Use Assessment and Cessation Intervention	30.00	40.00	50.00	60.00	70.00	80.00	90.00
Preventive Health	ACO #18	Depression Screening	5.31	10.26	16.84	23.08	31.43	39.97	51.81
Preventive Health	ACO #19	Colorectal Cancer Screening	19.81	33.93	48.49	63.29	78.13	94.73	100.00
Preventive Health	ACO #20	Mammography Screening	28.59	42.86	54.64	65.66	76.43	88.31	99.56
Preventive Health	ACO #21	Proportion of Adults who had blood pressure screened in past 2 years	30.00	40.00	50.00	60.00	70.00	80.00	90.00
At-Risk Population Diabetes	Diabetes Composite ACO #22 – 26	ACO #22. Hemoglobin A1c Control (HbA1c) (<8 percent) ACO #23. Low Density Lipoprotein (LDL) (<100 mg/dL) ACO #24. Blood Pressure (BP) < 140/90 ACO #25. Tobacco Non Use ACO #26. Aspirin Use	17.39	21.20	23.48	25.78	28.17	31.37	36.50
At-Risk Population Diabetes	ACO #27	Percent of beneficiaries with diabetes whose HbA1c in poor control (>9 percent)	70.00	60.00	50.00	40.00	30.00	20.00	10.00
At-Risk Population Hypertension	ACO #28	Percent of beneficiaries with hypertension whose BP < 140/90	60.00	63.16	65.69	68.03	70.89	74.07	79.65
At-Risk Population IVD	ACO #29	Percent of beneficiaries with IVD with complete lipid profile and LDL control < 100mg/dl	35.00	42.86	51.41	57.14	61.60	67.29	78.81
At-Risk Population IVD	ACO #30	Percent of beneficiaries with IVD who use Aspirin or other antithrombotic	45.44	56.88	68.25	78.77	85.00	91.48	97.91
At-Risk Population HF	ACO #31	Beta-Blocker Therapy for LVSD	30.00	40.00	50.00	60.00	70.00	80.00	90.00
At-Risk Population CAD	CAD Composite ACO #32 – 33	ACO #32. Drug Therapy for Lowering LDL Cholesterol ACO #33. ACE Inhibitor or ARB Therapy for Patients with CAD and Diabetes and/or LVSD	54.08	61.44	66.11	69.96	72.32	76.40	79.84

Care Coordination/Patient Safety	ACO #11	Percent of PCPs who Qualified for EHR Incentive Payment	51.35	59.70	65.38	70.20	76.15	84.85	90.91
Care Coordination/Patient Safety	ACO #12	Medication Reconciliation	30.00	40.00	50.00	60.00	70.00	80.00	90.00
Care Coordination/Patient Safety	ACO #13	Falls: Screening for Fall Risk	17.12	22.35	27.86	35.55	42.32	51.87	73.38
Preventive Health	ACO #14	Influenza Immunization	29.41	39.04	48.29	58.60	75.93	97.30	100.00
Preventive Health	ACO #15	Pneumococcal Vaccination	23.78	39.94	54.62	70.66	84.55	96.64	100.00
Preventive Health	ACO #16	Adult Weight Screening and Follow-up	40.79	44.73	49.93	66.35	91.34	99.09	100.00
Preventive Health	ACO #17	Tobacco Use Assessment and Cessation Intervention	30.00	40.00	50.00	60.00	70.00	80.00	90.00
Preventive Health	ACO #18	Depression Screening	5.31	10.26	16.84	23.08	31.43	39.97	51.81
Preventive Health	ACO #19	Colorectal Cancer Screening	19.81	33.93	48.49	63.29	78.13	94.73	100.00
Preventive Health	ACO #20	Mammography Screening	28.59	42.86	54.64	65.66	76.43	88.31	99.56
Preventive Health	ACO #21	Proportion of Adults who had blood pressure screened in past 2 years	30.00	40.00	50.00	60.00	70.00	80.00	90.00
At-Risk Population Diabetes	Diabetes Composite ACO #22 – 26	ACO #22. Hemoglobin A1c Control (HbA1c) (<8 percent) ACO #23. Low Density Lipoprotein (LDL) (<100 mg/dL) ACO #24. Blood Pressure (BP) < 140/90 ACO #25. Tobacco Non Use ACO #26. Aspirin Use	17.39	21.20	23.48	25.78	28.17	31.37	36.50
At-Risk Population Diabetes	ACO #27	Percent of beneficiaries with diabetes whose HbA1c in poor control (>9 percent)	70.00	60.00	50.00	40.00	30.00	20.00	10.00
At-Risk Population Hypertension	ACO #28	Percent of beneficiaries with hypertension whose BP < 140/90	60.00	63.16	65.69	68.03	70.89	74.07	79.65
At-Risk Population IVD	ACO #29	Percent of beneficiaries with IVD with complete lipid profile and LDL control < 100mg/dl	35.00	42.86	51.41	57.14	61.60	67.29	78.81
At-Risk Population IVD	ACO #30	antithrombotic	45.47	56.88	68.25	78.77	85.00	91.48	97.91
At-Risk Population HF	ACO #31	Beta-Blocker Therapy for LVSD	30.00	40.00	50.00	60.00	70.00	80.00	90.00
At-Risk Population CAD	ACO #32 – 33	ACO #32. Drug Therapy for Lowering LDL Cholesterol ACO #33. ACE Inhibitor or ARB Therapy for Patients with	54.08	61.44	66.11	69.96	72.32	76.40	79.84

Virtually Impossible to Attain Specific Quality Benchmarks:

Influenza Immunizations	**100%**
Pneumococcal Immunizations	**100%**
Adult Weight Screening and Follow-up	**100%**
Colorectal Cancer Screening	**100%**
Mammography Screening	**99.56%**

StarTribune

Lower health care costs elude hospitals

Article by: Jackie Crosby and Jim Spencer
Star Tribune staff writers
August 15, 2013

Hitting the bull's-eye on a "triple aim" of improvements under the federal health law promises to be a major challenge for the nation's hospitals.

Initial results from a federal pilot program released Tuesday showed that ***hospitals excelled at improving the quality of medical care and in getting high marks from patients. But a majority struggled with the third goal — lowering the cost of care.***

After the first year of the program, just 13 of the 32 participating health systems were able to lower health care costs for such conditions as diabetes and high blood pressure. Two hospitals lost money…

Still, federal officials heralded the program's first year, saying it saved nearly $33 million in the Medicare program primarily by reducing hospital admissions and readmissions…

None of the Minnesota hospitals — Allina, Fairview and Park Nicollet — succeeded in lowering costs, which would have rewarded them with additional federal money. *But officials with the three Twin Cities organizations said they had slowed the pace of cost increases or otherwise "controlled" the total cost of care for their patients covered by Medicare…*

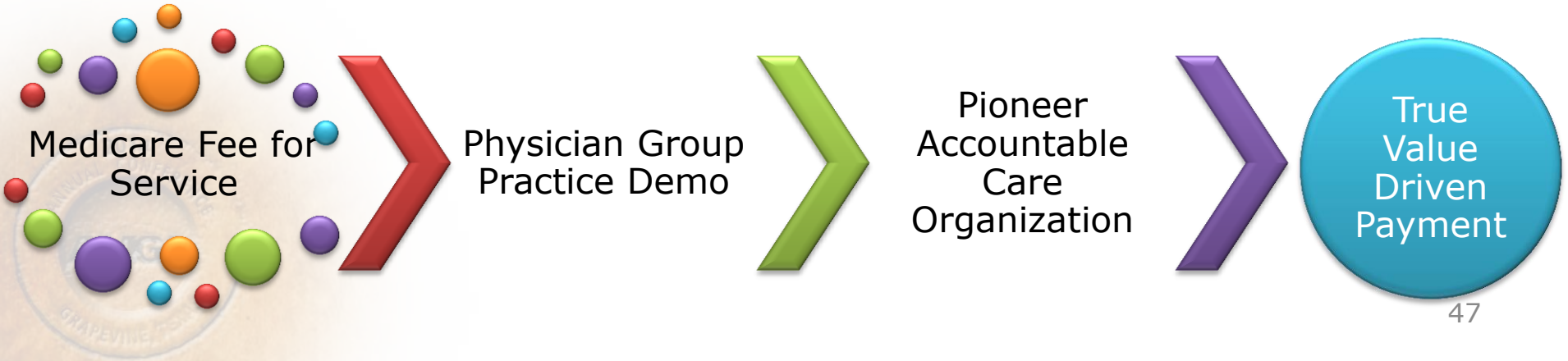
http://www.startribune.com/lifestyle/health/215761941.html

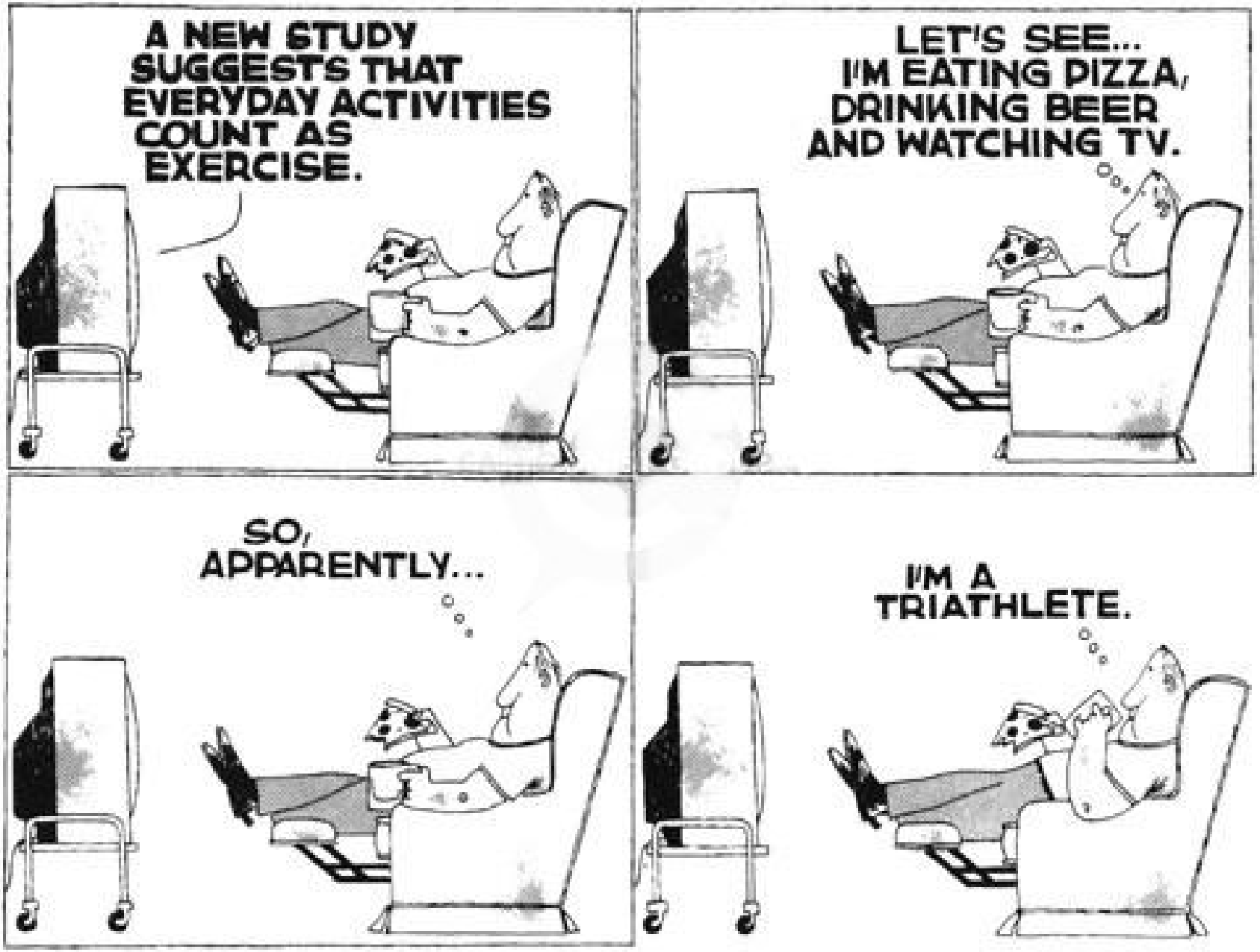
Pioneer ACO Success?

	YES	NO	MAYBE
FINANCIAL WIN FOR PARK NICOLLET?		√	
QUALITY IMPROVEMENT?			√
IMPROVE PATIENT EXPERIENCE?			√
VOLUME→VALUE CULTURE CHANGE?	√		
UNDERSTAND AND INFLUENCE MEDICARE PAYMENT REFORM?	√		
COLLABORATE WITH OTHER HIGH PERORMANCE HEALTH SYSTEMS?	√		

The Future

- Leverage HealthPartners Combination
- Influence CMS/CMMI on ACO Model Enhancements
- Expand Aligned Payment and Risk Contracts
- Stay in Pioneer, Move to MSSP, Bundled Payment, Medicare Advantage???



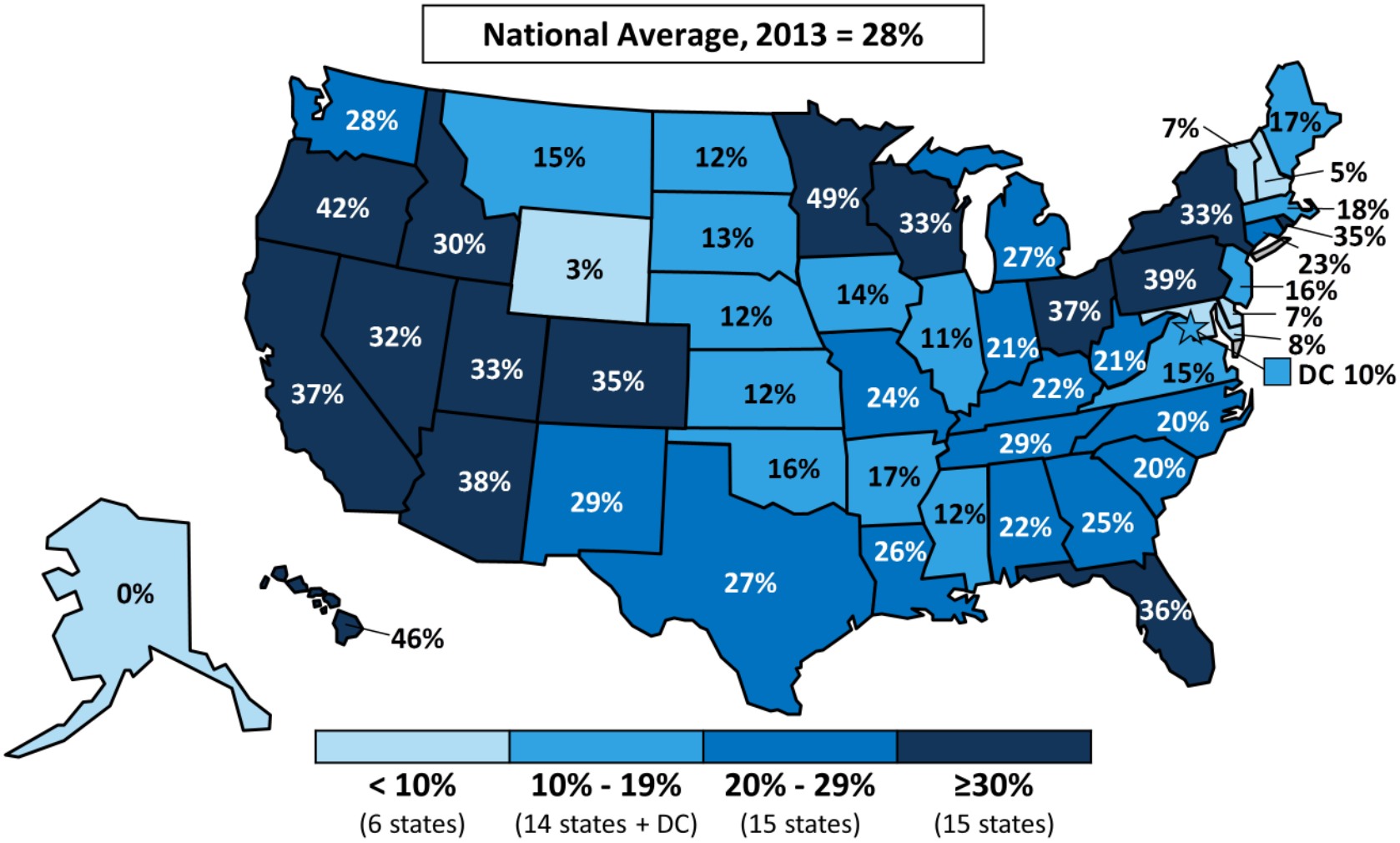


http://www.kaiserhealthnews.org/Cartoons/2014/January/Stupor-Bowl.aspx

APPENDIX

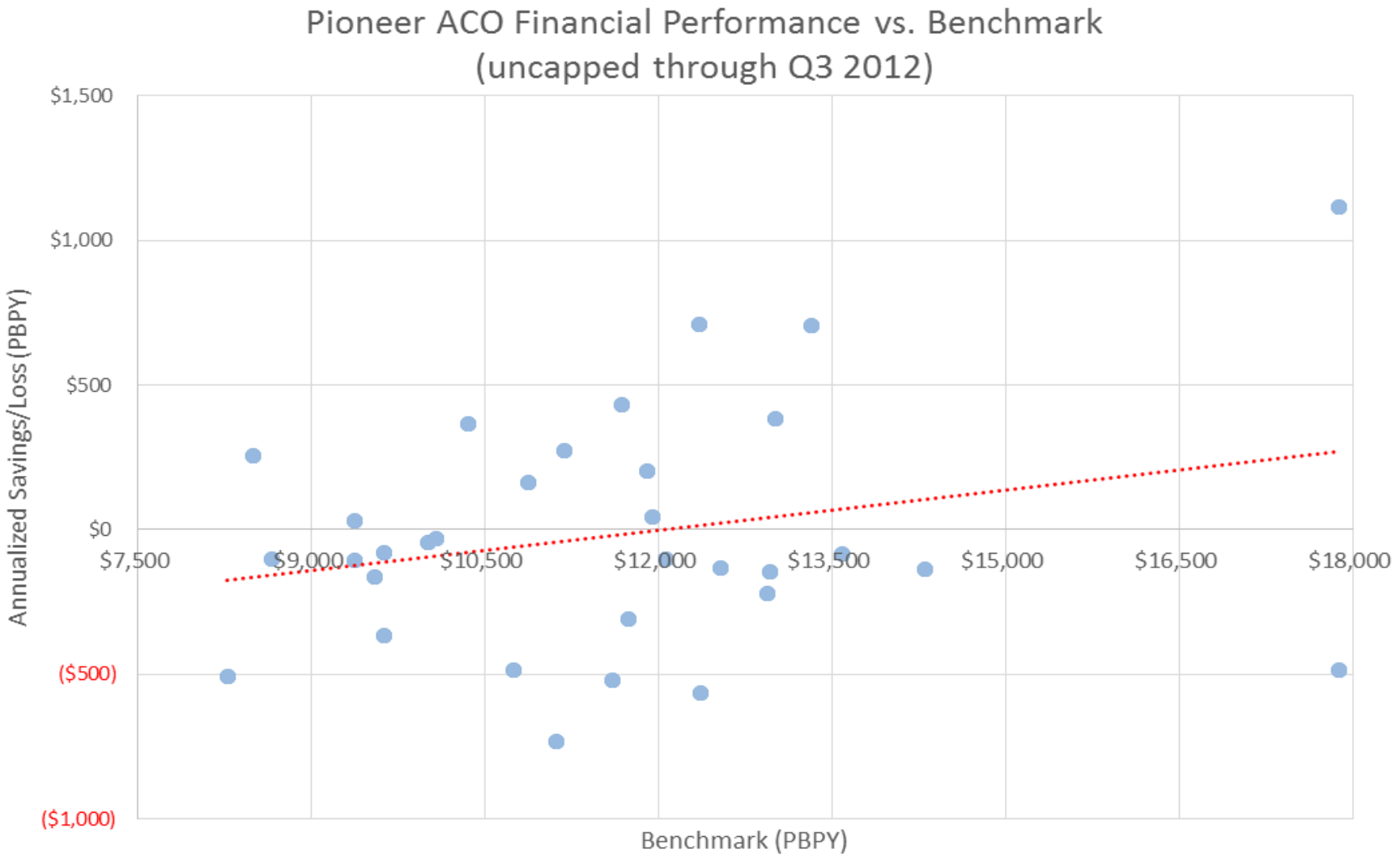
Exhibit 2

Share of Medicare Beneficiaries Enrolled in Medicare Advantage Plans, by State, 2013



NOTE: Includes MSAs, cost plans and demonstrations. Includes Special Needs Plans as well as other Medicare Advantage plans.
SOURCE: MPR/Kaiser Family Foundation analysis of CMS State/County Market Penetration Files, 2013.

ACO Expenditure Variation



Source: Pioneer ACO Dashboard, April 2013
Specifications: Benchmark and Savings/Loss % (Uncapped)

THE NEW YORKER

http://www.newyorker.com/online/blogs/newsdesk/2012/06/atul-gawande-failure-and-rescue.html

Failure and Rescue

Posted by *Atul Gawande*
June 4, 2012

The following was delivered as the commencement address at Williams College on Sunday, June 3rd.

We had a patient at my hospital this winter whose story has stuck with me. Mrs. C. was eighty-seven years old, a Holocaust survivor from Germany, and she'd come to the emergency room because she'd suddenly lost the vision in her left eye. It tells you something about her that she was at work when it happened—in the finance department at Sears.

She'd worked her entire life. When her family left Nazi Germany, they narrowly avoided the concentration camps but ended up among twenty thousand Jewish refugees relocated to the Shanghai ghetto in Japanese-