Advocacy Update

Blair Childs, Senior Vice President, Public Affairs
Transforming Healthcare Together

Premier is a provider-driven healthcare performance improvement company. We co-innovate solutions with our members to reduce costs, improve quality, and produce better patient outcomes.

SCALE
- Alliance of ~3,750 (78%) hospitals, ~130,000 non-acute providers and 1.2 million clinicians
- Integrated clinical, financial, operational data – insights into ~40% of U.S. health system discharges
- Approximately $50 billion in supply chain spend
- Manage ~2,000 contracts from ~1,100 suppliers

ALIGNMENT
- Members own ~74% of equity*
- 10 health system board members
- Premier field force embedded in member hospitals

COMMITMENT
- Member owner average tenure ~15 years (80% at 10+)
- Members view Premier as strategic partner

CO-INNOVATION
- Co-develop solutions with members
- Committees composed of ~163 member hospitals
- ~1,200 hospitals in performance improvement collaboratives

Note: Data as of June 30, 2015.
Transforming Healthcare Together

Analyzing, & Designing
Helping our members and staff know the opportunities, trends and implications

Improving policy
Capturing the data-driven, evidence-based insights to craft next generation policy

Testing & Scaling
Designing and scaling models that differentiates them and raises the bar for the nation

Thank you
OUTPERFORMING MATCHED HOSPITALS BY 45%

QUEST hospitals that joined the collaborative prior to 2013 performed better under the FY 2016 inpatient VBP program compared to non-QUEST hospitals with similar hospital characteristics.
2015 ACO Collaborative Performance 3X All Others

**Higher Percent of ACOS Achieving Shared Savings**

- % of PHMC Members who achieved shared savings vs. nation:
  - PHMC Members: 50%
  - Medicare ACOs (All): 31%

**Higher Rate of Shared Savings**

- PHMC Member savings as % of all Medicare ACOS:
  - PHMC Members: 6%
  - All Medicare ACOs: 94%
  - Savings: ($89.2) million

- PHMC Member savings as % of total savings:
  - PHMC Members: 78%
  - All Medicare ACOs: 22%

**Higher Average Quality Scores**

- Medicare ACO average quality scores:
  - PHMC Members: 93.81%
  - Medicare ACOs (All): 91.48%

*Savings dollars x million*
Today’s presentation

- Healthcare Reform Outlook
- Implications and Strategic Recommendations
- Post-Acute Care Reforms
- Action Points
Who Predicted Any of This?

[Cartoon showing a bracket with 'RETIRED' and 'REGROUP' outcomes, with a speech bubble saying 'I had "REPLACE"' and another saying 'I had "REPEAL"']
Republicans see this as their moment

- Unified government

- Political line of site to 2020:

  » **House:** 23 Republicans in districts carried by Clinton; 12 Democrats in districts carried by Trump. Important special elections (4R, 1D)

  » **Senate:** 8 Republicans up in 2018, 2 vulnerable; 25 Democrats, 10 vulnerable

- **Ambitious agenda:** Repeal and Replace, Tax Reform, Infrastructure

- Political base is demanding action

- **16 of 31 expansion states have Republican Governors**

- **Need to contain healthcare spending**

- **Democrat base is activated**
## Philosophical Perspectives

<table>
<thead>
<tr>
<th>Republicans</th>
<th>Democrats</th>
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<tbody>
<tr>
<td>- State insurance regulation</td>
<td>- Federal framework, regulation</td>
</tr>
<tr>
<td>- Greater state control of Medicaid</td>
<td>- Greater federal uniformity</td>
</tr>
<tr>
<td>- Control entitlements</td>
<td>- Protect entitlements</td>
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<tr>
<td>- Catastrophic coverage &amp; HSAs</td>
<td>- Comprehensive coverage</td>
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<tr>
<td>- Personal responsibility</td>
<td>- Support the poor</td>
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<td>- Lower taxes</td>
<td>- Higher taxes</td>
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<td>- Medical Malpractice Reform</td>
<td>- Oppose Medical Mal. Reform</td>
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<tr>
<td>- Lean Physician</td>
<td>- Lean Hospital</td>
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<tr>
<td>- Voluntary</td>
<td>- Mandatory</td>
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Federal Spending: Reality for the New Administration

Federal Debt Held by the Public

Percentage of Gross Domestic Product

Source: Congressional Budget Office.
National Health Spending, CBO

Total Health Care Spending: $2.9 Trillion

- Medicare: $619 Billion, 22%
- Medicaid and CHIP: $509 Billion, 18%
- Other Government Spending: $243 Billion, 8%
- Payments by Private Health Insurers: $991 Billion, 34%
- Consumers' Out-of-Pocket Spending: $330 Billion, 11%
- Other: $186 Billion, 6%

Public Spending: $1.4 Trillion, or 48 Percent

Private Spending: $1.5 Trillion, or 52 Percent
Components of Federal Spending

Percentage of Gross Domestic Product

Actual | Extended Baseline Projection

Major Health Care Programs
Other Noninterest Spending
Social Security
Net Interest

“Major health care programs” consists of spending on Medicare (net of offsetting receipts), Medicaid, and the Children’s Health Insurance Program, as well as outlays to subsidize health insurance purchased through the marketplaces established under the Affordable Care Act and related spending.
‘Trump Card?’

BY GARY VARVEL, THE INDIANAPOLIS STAR
What’s on the Table?

• Fixing the Individual Market (Health Insurance Exchanges)
• Fixing the small group market
• Insurance market Regulation (Pre-existing conditions, coverage to 26, no lifetime cap, age rating, medical loss ratio, essential health benefits)
• Employer and Individual mandates
• Medicaid Expansion
• Entitlement reform (Medicare, Medicaid, Social Security)
• Taxes
• Provider payment cuts
• Subsidies (Tax credits)
Republicans’ Healthcare Policy Goals

• Fix individual and small group market
  • Focus on achieving market competition
  • Return to state, not federal regulation

• More sustainable Medicaid payment reality
  • Entitlement reform: Block grants or per-capita caps
  • Give more control over Medicaid to states

• Reduce ACA taxes on industry

• Increase personal responsibility
  • Focus on “catastrophic coverage” with Health Savings Account
  • Use of HSAs, incentives, work requirements in Medicaid

• Most Republicans want to expand access to coverage

But How Do They Move Forward?
Healthcare Reform: What’s Next?

Bipartisan Back-Down

Use Existing Vehicles

- Stabilize exchanges, give states more control, de-regulate insurers
- Tweak Medicaid expansion
- Small changes to tax credits
- Children's Insurance program reauthorization with reforms that lead states to expand Medicaid
- FDA user fees with drug cost reforms

HHS Secretarial Authority

- More state Medicaid flexibility
- Reduce required benefits
- Tightening exchange regs: short open enrollment, dropping coverage, special enrollment…
- Continued move to APMs

Reconciliation Group

- Continued efforts to repeal & replace. Have until May 26
- House pass bill which would be reworked with more modest package crafted in Senate
- Use similar legislative provisions as AHCA but with new policies that will protect against criticisms: modest savings
- Possible 2018 option after exchange meltdown

Let It Explode…

Exchange Collapse

- Allow some state exchanges to decline and insurers lose
- Insurers continue to leave market
- Premiums and co-pays go up and consumers drop out
- Continue with subsidy case or choose not to fund subsidies

Costs Go Up

- Medicaid costs increase
- State budget cuts and problems

Blame it on Democrats and Run on it in 2018

(Medium Probability)

(Highest Short Term Probability)

(Lowest Probability)
ACA Replacement Plan: Worse Case

- **Entitlement Reforms**: Possible modest Medicare reforms. Medicaid also possible. Social Security unlikely. Support MA plans.

- **Individual Market reforms**:
  - Devolution to state regulation or option for state regulation.
  - Replace employee and individual mandate with penalty for not getting, maintaining coverage/incent states to recruit/prospective enrollment.
  - Use of high risk pools or reinsurance.
  - Maintain coverage to 26.
  - Pared down essential benefits package.
  - Expanded age rating.
  - Use of tax credits.

- **Medicaid**: Continued expansion. Per capita allocation only possible under reconciliation. Significant state flexibility to incent personal responsibility. Reduced federal funding.

- **HSAs**: Expansion in Medicaid, individual and employer plans.

- **Payment and delivery system reforms**: Continued with focus on physician models.

- **Taxes**: Eliminated or reduced.
Where are we headed?
Healthcare Implications

1. There is no new money
2. Increased strength of large physician groups
3. Continued growth of value-based payment models
4. Increased market competition for device and pharmaceuticals
5. Increased state control
6. Continued push toward consumer-driven healthcare
7. Growth in, and increased competition for, Medicare Advantage, private health plans
Pressures to take cost out of the systems continues, and now requires shifting to focus on more complex areas to find new savings

MARKET DYNAMICS

- Federal reimbursement cuts and sequestration will continue
- Entitlement reform and Block Grants mean less state funding
- Most organizations have already captured the low hanging fruit
- Growth of Value Based Payments require managing costs in a new way

2017 STRATEGIC PRIORITIES

- Increase focus on **variable costs**; Supplies, Workforce Management
- Build capabilities to tackle **clinical utilization** and physician preference
- Pursue **new revenue streams**, align providers, expand markets
- Forecast financial performance under **risk-based agreements**, penalty programs
**Increased Strength of Large Physician Groups**

**Provider engagement and alignment is a critical success factor to evolve the care deliver model and succeed in value based payment models**

**MARKET DYNAMICS**

- Increase in physician advantaged Alternative Payments Models, more focus on site neutral pay
- Growth of venture backed physician mgmt. services orgs.
- Expansion and investment in large physician groups
- Increased payer acquisition and alignment with physician organizations

**2017 STRATEGIC PRIORITIES**

- Determine **physician alignment** strategies and partnerships.
- Establish a **CIN** and use it as a vehicle to organize physicians.
- Use **MACRA** as a way to align and assist physicians.
- Develop/implement an **alternative payment model** (APM) strategy.
MACRA & Value-based Purchasing across payment silos
Track 1: P4P; losers pay winners
Hospital acquired conditions (HACs) dropped 17 percent from 2010 – 2017, reducing costs by $12 billion and saving approximately 50,000 lives.
Efficiency measure

- Total risk-adjusted spending per beneficiary between 3 prior to inpatient admission and 30 days post discharge

Hospital’s Medicare spending per beneficiary

\[
\frac{\text{Hospital’s Medicare spending per beneficiary}}{\text{National Median Medicare spending per beneficiary}} = $\]

**Physician testing** 3 days prior

**Hospital** Readmissions post-acute care 30 days post discharge

**Implication:** Hospitals must use their leverage to reduce spending outside of the hospital
MACRA reform timeline
(Medicare Access and CHIP Reauthorization Act of 2015)

Permanent repeal of SGR

Updates in physician payments


- **2015**: 0% (7/2015-2019)
- **2016**-**2019**: 0.5% (7/2015-2019)
- **2020**-**2024**: 0% (2020-2025)
- **2025**-**2026**: 0.75% update

**Track 1**

- **2018**: 4%
- **2019**-**2021**: 2% (2019-2024)
- **2022**: +2% ± 4.0%
- **2023**: +2% ± 4.0%
- **2024**: +2% ± 4.0%
- **2025**: +2% ± 4.0%
- **2026**: +2% ± 4.0%

**Track 2**

- **2017**: 3.0%
- **2018**: ± 2%
- **2019**: ± 2%
- **2020**: ± 2%
- **2021**: ± 2%
- **2022**: ± 2%
- **2023**: ± 2%
- **2024**: ± 2%
- **2025**: ± 2%
- **2026**: ± 2%

**Merit-Based Incentive Payment System (MIPS) adjustments**

- **2019**: +/−4%
- **2020**: +/−5%
- **2021**: +/−7%
- **2022**-**2026**: +/−9%

**PQRS pay for reporting**

- **2015**-**2016**: −1.5%
- **2017**-**2018**: −2.0%

**Meaningful Use Penalty (up to %)**

- **2015**: −1.0%
- **2016**: −2.0%
- **2017**: −3.0%
- **2018**: −4.0%

**Value-based Payment Modifier**

- **2015**: ± 1.0%
- **2016**: ± 2.0%
- **2017**: +2% ± 4.0%

**MIPS exceptional performance adjustment**

- **2019**-**2024**: ≤ 10% Medicare payment

**Value-based Payment Modifier**

- **2015**: ± 1.0%
- **2016**: ± 2.0%
- **2017**: ± 4.0%
- **2018**: ± 4.0%

**Value-based Payment Modifier**

- **2015**: ± 1.0%
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- **2018**: ± 4.0%

**Value-based Payment Modifier**

- **2015**: ± 1.0%
- **2016**: ± 2.0%
- **2017**: ± 4.0%
- **2018**: ± 4.0%
Population health competitive environment
New competitors will proliferate
Value Based Payments continue to expand and accelerate at a rapid pace which requires a roadmap to determine the best path forward.

MARKET DYNAMICS

- Payment models designed to shift risk, improve quality, lower costs
- P4P will continue and expand to all payment silos. Star Ratings.
- MACRA driving new public and private payment models
- Increasing measure alignment between public and private payers

2017 STRATEGIC PRIORITIES

- Understand *market competitors* and APM strategy vs. your own.
- Create a *measures management* strategy across payment programs
- Invest in *physician cost/quality* improvement tools and processes
- Develop/implement a *private payer strategy*. 
Increased Device and Pharma Competition

**Disruption in pharmacy by leveraging scale, integrating the pharmacy value chain and developing new value propositions for providers.**

**MARKET DYNAMICS**

- Reduced threat of price controls; competitive bidding processes
- Direct to patient marketing and physicians, entry to care coordination
- New at-risk models with large manufactures
- Vulnerability of 340B; Reduction/elimination of device tax

**2017 STRATEGIC PRIORITIES**

- Use *aligned incentives* in APMs for greater focus on savings
- Invest in *value-analysis* and comparative effectiveness
- **Aggressive** pharma and device cost management
- Engage in *policy* work to close drug industry loopholes and speed FDA process
Increased State Control

**MARKET DYNAMICS**

- CMS loosens constraints under 1115 and 1332 waivers.  
- Increased wellness incentives, co-pays and deductibles, and HSAs for Medicaid  
- Cost constraints will encourage states to find ways to cap spending.  
- Increased use of Medicaid private plans and Medicaid alternative payment models.

**2017 STRATEGIC PRIORITIES**

- Develop preferred *Medicaid policy* with 1115 or 1332 waivers.  
- Develop comprehensive Medicaid *care management* strategy for high cost, high need patients.  
- Consider a provider-sponsored Medicaid high *value network* or partner with insurer  
- Gain access to *Medicaid claims* for care management.

**Shifting control of Medicaid benefits and payment mechanisms to the states and shifting individual market regulation to states**
Continued Push Toward Consumer-Driven Healthcare

**HSAs, catastrophic coverage approach to health insurance to drive more consumer engagement, transparency**

**MARKET DYNAMICS**

- Market movement to catastrophic, high deductible health plans and HSAs.
- Enactment of laws requiring greater pricing transparency.
- Continued movement to high value networks that compete primarily based on price.
- Growth in lower cost, accessible outpatient/retail care settings, telehealth and applications.

**2017 STRATEGIC PRIORITIES**

- Augment acute with low-cost, accessible **outpatient** and **retail** care capabilities.
- Develop **consumer-centric**, member retention for populations served.
- Manage **bad debt collections**.
- Strengthen **brand** identity.
- Develop **pricing transparency** strategy and understanding of high volume costs.
Reduced regulation and increased reliance on private health plans will increase wealth and their impact

MARKET DYNAMICS

- Republican increased payments to Medicare Advantage (MA) plans.
- MA plans will seek to partner and contract directly with physicians, to commoditize hospitals.
- Payer consolidation could weaken health systems.
- Reduce focus on changing traditional Medicare.
- Interest in health systems owning or partnering with MA plans.

2017 STRATEGIC PRIORITIES

- Evaluate MA strategies to ensure relevancy and inclusion. First-mover opportunity where low MA share.
- Build capabilities (data sharing, payer collaboration, physician alignment) for high value network.
- Strengthen payer contracting, documentation and coding, and care management capabilities.
- Negotiate access to data and information.
Post-Acute care variation and payment reform
High Variation in Total Episode Costs

Geographic Variation in Spending, MS-DRG 291 (Heart Failure and Shock with Major Complications)

<table>
<thead>
<tr>
<th>Location</th>
<th>Ratio to U.S. Average</th>
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<td>Owensboro, KY</td>
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High Variation in Total Episode Costs, Post-Acute Care

Geographic Variation in PAC Spending, MS-DRG 291
(Heart Failure and Shock with Major Complications)

<table>
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<tr>
<th>Location</th>
<th>Ratio to U.S. Average</th>
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<td>0.60</td>
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<td>Owensboro, KY</td>
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Legend:
- Therapy
- LTC Hospital
- Inpatient Rehab.
- Home Health
- Skilled Nursing

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Congress Considering Speeding IMPACT Act Implementation

June, 30, 2016 – MedPAC report on establishing payment rates according to individual characteristics instead of the setting of care where the patient is treated and on the impact of moving to new PAC payment system.

Requires PAC providers to report standardized assessment data and HHS to align data with claims data for each patient:
- By Oct 1, 2018 – SNFs, IRFs and LTCHs
- By Jan 1, 2019 – HHAs

Deliverable: HHS provides feedback reports:
- By Oct 2017 – SNFs, IRFs and LTCHs
- By Jan 2019 – HHAs

2016 – 2022:
- By Oct 2017 – SNFs, IRFs and LTCHs
- By Jan 2019 – HHAs

Table 1: Timeline for New Quality Domains

<table>
<thead>
<tr>
<th>Quality Domains</th>
<th>HHAs</th>
<th>SNFs</th>
<th>IRFs</th>
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<td>Functional Status</td>
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<td>Skin Integrity</td>
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<td>Medication Reconciliation</td>
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<td>Major Falls</td>
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<td>Patient Preference</td>
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<td>10/1/2018</td>
<td>10/1/2018</td>
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*Displayed dates are deadlines for measure specification and data collection. Confidential feedback reporting and public reporting is required one and two years, respectively, after the dates displayed above.
5 Key Focus Areas Under New Administration and Congress

1. **Managing Costs, with Focus on Drug Spending**
   - Managing increased pharmaceutical spending
   - Managing the cost of care
   - Integrating data from disparate sources and/or investments in analytics

2. **Moving from Meaningful Use to Meaningful Insight**
   - Improving interoperability of existing health technology
   - Utilizing technology to support risk-based contracts

3. **Engaging and Satisfying Consumers**
   - Offering access to clinicians through telehealth services
   - Investing in initiatives to enhance patient engagement

<table>
<thead>
<tr>
<th>Category</th>
<th>Increase Substantially</th>
<th>Increase</th>
<th>No Change</th>
<th>Decrease</th>
<th>Decrease Substantially</th>
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<td>Managing increased pharmaceutical spending</td>
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<td>Managing the cost of care</td>
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<td>Integrating data from disparate sources</td>
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<td>Improving interoperability of existing health technology</td>
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<td>Utilizing technology to support risk-based contracts</td>
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<td>Investing in initiatives to enhance patient engagement</td>
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### 5 Key Focus Areas Under New Administration and Congress

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<th>Area</th>
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<td>Expanding post-acute care services through partnerships</td>
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<td>Implementing clinician education on population health</td>
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<td>Creating clinically integrated networks (CINs)</td>
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<td>Employing more physicians</td>
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<td>Pursuing partnerships with commercial payers in risk-based contracts</td>
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<tr>
<td>Using quality reporting systems for clinicians to commercial payers</td>
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<td>59%</td>
<td>0%</td>
<td>5%</td>
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<td>Creating registries for employed or affiliated clinicians</td>
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<td>28%</td>
<td>62%</td>
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**4. Shifting Toward Population Health, Risk and Scale**

**5. Continuing Differentiation on Clinical Quality and Costs**
Recommendations

• Cost management and clinical quality improvement
  • Physician productivity capabilities
  • Standardization of quality improvement work

• Understand the payment reform dynamics between the different payment models (MACRA, track 1 and 2)

• Understand the evolving realities of Texas Medicaid and your Delivery System Reform Improvement Program (DSRIP)

• Success requires effective Coding and documentation. Do you have strong systems in place
Final Recommendations

1. Don’t get distracted by the “sound biting” around repeal and replace. Stay focused on executing strategic responses.
   - Subscribe to my weekly update? Blair_Childs@premierinc.com

2. Be proactive and aggressive in aligning with clinicians.
   - Create and build support for your vision.
   - Implement an APM strategy, e.g., MSSP, bundles.

3. Design and execute against a MACRA roadmap.
   - Leverage to align with physicians
   - Identify your APM strategy

4. Develop a Medicaid strategy

5. Be especially active on state and federal advocacy.