Accountable Care Organizations: What They Are and Why They Are Important

Scott Fenn
Chief Integration Officer
President, BBH ACO
LEARNING OBJECTIVES

To recognize the importance of alternative payment models and their future role in US Health Care

Discuss the main issues in ACO formation and operations

Identify the key elements for ACO success
Let’s Stipulate

- Fee for Service is an unsustainable economic model for medical care
- The Medicare population is only going to grow more rapidly
- Medicare payments are spiraling out of control
- The US spends more on healthcare than any other country
- CMS has decided to emphasize alternative payment models (APMs)
- While there are a number of APMs, ACOs are going to be here for awhile
- Physician fees are going to be tied into APMs
WHAT IS AN ACO AND WHY IS IT IMPORTANT

Accountable Care Organizations (ACOs) are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their Medicare FFS patients (cms.gov)

The goal of coordinated care is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors.

It is specifically mentioned in the ACA – “to create a new type of health care entity, an ACO, that agrees to be held accountable for improving the health and experience of care for individuals and improving the health of the population while reducing the rate of growth in health care spending.”
Fundamentals of the MSSP Program

EXPLANATION OF HOW MSSP WORKS AND ARE STRUCTURED.

<table>
<thead>
<tr>
<th>DESIGN ELEMENT</th>
<th>ONE-SIDED MODEL</th>
<th>TWO-SIDED MODEL</th>
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</thead>
<tbody>
<tr>
<td>Sharing Rate</td>
<td>Up to 50% based on quality performance</td>
<td>Up to 60% based on quality performance</td>
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<tr>
<td>Minimum Savings Rate (MSR)</td>
<td>Varies by number of assigned beneficiaries</td>
<td>2%</td>
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<tr>
<td>Shared Savings Method</td>
<td>First dollar sharing once MSR is met or exceeded</td>
<td>First dollar sharing once MSR is met or exceeded</td>
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<tr>
<td>Maximum Sharing Cap</td>
<td>Total shared savings payments cannot exceed 10% of benchmark</td>
<td>Total shared savings payments cannot exceed 15% of benchmark</td>
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<tr>
<td>Minimum Loss Rate</td>
<td>None</td>
<td>ACO repays share of all losses if expenditures are more than 2% higher than benchmark</td>
</tr>
<tr>
<td>Shared Loss Rate</td>
<td>None</td>
<td>One minus final sharing rate applied once minimum loss rate is met; loss rate is capped at 60%</td>
</tr>
<tr>
<td>Maximum Loss Cap</td>
<td>None</td>
<td>Losses capped at 5%, 7.5%, 10% in years 1, 2, 3, respectively</td>
</tr>
</tbody>
</table>

SHARED SAVINGS PAYMENT CYCLE

1. **ASSIGNMENT**
   Patients assigned to ACO based on terms of contract

2. **BILLING**
   Providers bill normally, receive standard fee-for-service payments

3. **COMPARISON**
   Total cost of care for assigned population compared to risk-adjusted target expenditures

4. **BONUS**
   If total expenses less than target, portion of savings returned to ACO

5. **DISTRIBUTION**
   ACO responsible for dividing bonus payments among stakeholders

Health Care Advisory Board, 2012
BY STATUTE, ACOs MUST MEET THE FOLLOWING ELIGIBILITY CRITERIA:

- Agree to participate in the program for at least a 3-year period
- Have a sufficient number of primary care professionals for assignment of at least 5,000 beneficiaries
- Have a formal legal structure to receive and distribute payments
- Have a mechanism for shared governance and a leadership and management structure that includes clinical and administrative systems
- Shall provide information regarding the ACO professionals as the Secretary determines necessary
- Define Processes to:
  - Promote evidenced-based medicine
  - Promote patient engagement
  - Report quality and cost measures
  - Coordinate care
- Demonstrate it meets patient-centeredness criteria

Source: MLN Webinar 4/8/14 www.cms.gov/NPC
Growth of ACOs Over Time

Number of ACOs

2011 Q2: 81
2011 Q3: 97
2011 Q4: 138
2012 Q1: 148
2012 Q2: 208
2012 Q3: 334
2012 Q4: 356
2013 Q1: 458
2013 Q2: 479
2013 Q3: 489
2013 Q4: 606
2014 Q1: 627
2014 Q2: 631
2014 Q3: 645
2014 Q4: 742
2015 Q1: 738
2015 Q2: 757
2015 Q3: 761
2015 Q4: 782

Date

2011 Q2
2011 Q3
2011 Q4
2012 Q1
2012 Q2
2012 Q3
2012 Q4
2013 Q1
2013 Q2
2013 Q3
2013 Q4
2014 Q1
2014 Q2
2014 Q3
2014 Q4
2015 Q1
2015 Q2
2015 Q3
2015 Q4
Growth of Estimated ACO-covered Lives Over Time

[Line graph showing the growth of estimated ACO-covered lives from 2011 Q2 to 2015 Q4, with numbers such as 3.9, 4.1, 5.1, 7.8, 9.3, 11.3, 11.9, 14.0, 14.8, 15.0, 16.7, 17.8, 18.1, 19.3, 19.6, 22.8, 23.0, 23.1, 23.2 indicated at various points along the line.]
Accountable Care Organizations by State
Fundamentals of the MSSP Program

Relevant Fraud and Abuse Concerns

1. **Stark Law**
   - Prohibits referral to entities with which physician has a financial relationship

2. **Anti-Kickback Statute**
   - Prohibits hospital from incentivizing physician referrals

3. **Civil Monetary Penalty**
   - Prohibits both payment to Medicare beneficiaries to receive services and payment to physicians to limit services

Five (Overlapping) Waivers Within Shared Savings Program

1. **Pre-Participation Waiver**
   - Applies broadly to start-up arrangements (e.g., infrastructure subsidies) by providers taking “bona fide” steps to join program within a target year

2. **Participation Waiver**
   - Broad waiver of all three regulations for ACOs during program participation and six months after

3. **Shared Savings Distribution Waiver**
   - Specific exception to permit unrestricted distribution of savings among participants, provided payments not used to limit medically necessary care

4. **Physician Self-Referral Compliance Waiver**
   - Specific exception for arrangements that would otherwise implicate Stark law, for organizations not needing broader waivers

5. **Patient Incentive Waiver**
   - Specific exception permitting ACOs to offer “medically related” incentives to all Medicare beneficiaries to encourage prevention and compliance

Health Care Advisory Board, 2012
Statutory Requirements: Governance

- Shared governance through a governing body with representation by ACO participants and beneficiaries
  - ACO participant representation
  - ACO participants hold at least 75% control of the governing body
  - Beneficiary on the governing body
  - Flexibility for organizations to meet requirements

- Demonstrate an organizational commitment, leadership, and resources necessary to achieve the three-part aim and demonstrate clinical integration
  - Experienced leadership team
  - Medical Director
  - Qualified health professional to lead the quality assurance/improvement process

Source: MLN Webinar 4/8/14 www.cms.gov/NPC
Quality Metrics of the MSSP Program

- **33** Total number of quality measures
- **4** Domains of quality measures
- **25%** Percentage of quality score composed by each domain

**Patient, Caregiver Experience of Care**
- 7 measures
- All based on CAHPS\(^1\) scores

**Patient Safety/Care Coordination**
- 6 measures
- EHR\(^2\) capabilities weighted twice as much as other categories

**At-Risk Population**
- 12 measures
- Focused on diabetes, heart failure, hypertension, coronary artery disease

**Preventive Health**
- 8 measures
- Include a variety of screenings, measurements, immunizations

Health Care Advisory Board, 2012
Beneficiary Assignment

• Preliminary prospective assignment with final retrospective beneficiary assignment
  • An ACO needs to have at least 5,000 preliminarily assigned beneficiaries in order to be in the Shared Savings Program in each of the three years preceding the start of the agreement period (2011, 2012, 2013)
  • A beneficiary assigned in one year of the program may or may not be assigned to the same ACO in the following or preceding years

• CMS uses claims submitted to Medicare for primary care services in the assignment process

• CMS uses information you provide to us on the ACO Participant List to determine which claims to attribute to your ACO

Source: MLN Webinar 4/22/14 www.cms.gov/NPC
Beneficiary Communication

- Beneficiaries will be notified that their provider is participating in the program (ACO) via letter from the provider, or during an office visit.

- Beneficiaries will receive general notification about the program and what it means for their care.

- CMS will provide parameters around marketing materials in order to prevent beneficiary steering, inappropriate advertising and to ensure information about ACOs is consistent and accurate.

- ACOs must give beneficiaries an opportunity to decline data sharing.

Source: MLN Webinar 4/8/14 www.cms.gov/NPC
Aggregate & Patient Level Data From CMS

**Aggregate-Level Data**

- **Initial Data Provision**
  - Provided to all ACOs at start of agreement period.
  - Based on historical beneficiaries used to calculate cost benchmark.

- **Quarterly Data Reports**
  - Provided to all ACOs on quarterly basis and in conjunction with annual quality/financial reports.
  - Based on most recent 12 months of data for prospectively assigned beneficiaries.

**Includes (Where Available):**
- Financial performance
- Quality performance scores
- Aggregated metrics on assigned population
- Utilization data from historical beneficiaries (at start of agreement period)

**Individual-Level Data**

- **Benchmark Data**
  - Provided at beginning of agreement period and end of performance year as well as with each quarterly aggregate data report.
  - Information on historically assigned beneficiaries.
  - HIPAA restrictions apply

- **Beneficiary Claims Data**
  - Provided upon formal request from ACO
  - Available monthly
  - For use only in coordinating and/or improving care
  - Must publicize to patients how data will be used

**Includes:**
- Beneficiary names
- Date of birth
- Health insurance claim number
To establish the benchmark per ACO, CMS will calculate a risk adjusted average per capita of Parts A and B expenditures for Medicare FFS:

- Uses beneficiaries who would have been assigned the last 3 years and trend BY1 and BY2 to BY 3 based on national growth rates.
- BY1 is weighted at 10%, BY2 is weighted at 30% and BY3 at 60%
- Four major categories: ESRD, disabled, aged/dual eligible, aged/non dual eligible.
- Adjustments made for catastrophic claims
Formed in June 2015

Located in Jefferson, Shelby, Talladega and Walker Counties

Participated in Medicare Shared Savings Program (upside only track 1)

Wholly owned subsidiary of Brookwood Baptist Health and a division of the Brookwood Baptist Physician Alliance (an established CIN with over 650 physicians who are both clinically and financially integrated)
• Initial attributed lives approximately 16,000 but likely to grow closer to 18-20K.
• CMS attribution is based on the last 2 E&M codes paid and a host of other algorithms that help to account for mortalities, age-ins, etc.
• Expectations is for the list to change from quarter to quarter.
Completing the ACO Application to CMS

- Describe how we were going to population manage (this was in the application)
- No one knew or still knows all the “ins and outs”
- We have had 2+ years of experience with Medicare Advantage managed care through BBPA
- We have formed active Campus Medical Management Committees to support our care management structure
- ACO consists primarily of PCPs (and those few specialists associated with PCP tax IDs.
- BBPA shares clinical and claims data on covered patients leading to custom reports to share with physicians regarding quality coding and gaps in care
BPA received the initial assignment file from CMS in Jan 2016 and the subsequent Claims and Claims Line Feed (CCLF) on Feb 24, 2016.

The CCLF file also provides other key data points on our members:
- Gaps in care
- Claims for ALL providers
- Quality data

Quality Data Collection Begins: Feb 28
MSSP Renewal: Jan
Quality Data Deadline: Feb 28
# ACO Governing Board:

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
<th>ACO Eligibility</th>
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</thead>
<tbody>
<tr>
<td>Thomas Milko MD</td>
<td>Chair &amp; voting member</td>
<td>ACO Provider</td>
</tr>
<tr>
<td>Steve Boger MD</td>
<td>voting member</td>
<td>ACO Provider</td>
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<tr>
<td>John Morgan MD</td>
<td>voting member</td>
<td>ACO Provider</td>
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<tr>
<td>Joseph Wu MD</td>
<td>voting member</td>
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<tr>
<td>Tom Nolen MD</td>
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<td>Jonathan Southworth MD</td>
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<td>Jarod Speer MD</td>
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<td>Jody Gilstrap MD</td>
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<td>Larry Lee MD</td>
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<td>Stan Jett MD</td>
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<tr>
<td>Jim Lasker MD</td>
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<td>Keith Parrott</td>
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<tr>
<td>Scott Fenn</td>
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<tr>
<td>Elizabeth Ennis MD</td>
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</tr>
<tr>
<td>Andy Keith</td>
<td>voting member</td>
<td>Medicare Beneficiary representative</td>
</tr>
</tbody>
</table>
BPA ACO MSSP Leadership

Key ACO Clinical and Administrative Leadership:

ACO President: Thomas Milko MD
Chief Medical Officer: Elizabeth Ennis, MD
Compliance Officer: Michelle Castro
CMS Liaison/Operations: Greg Smith
Quality Officer: Thomas Milko, MD

Committees and Committee Leadership:

Quality Committee: Elizabeth Ennis, MD, Chair
Technology Committee: Matt Fleming, Chair
Finance Committee: Scott Hughes, Chair
Credentialing Committee: Elizabeth Ennis, MD, Chair
Compliance Committee: Michelle Castro, Chair
BPA ACO MSSP Initial Attribution

MSSP Basic data flow - CURRENT

CMS

Beneficiary Assignment File

CCLF File

Tenet ACO Database

Physician Attribution

Gap Reports by Physician
Medicare Per Capita Spending For Traditional Medicare Beneficiaries Over Age 65, By Type Of Service, 2011.
Medicare Per Capita Spending For Traditional Medicare Beneficiaries Over Age 65, By Age And Survival Status, 2011.
2016 Quality Measures

The 34 total measures fall into 4 quality domains:

<table>
<thead>
<tr>
<th>Domain</th>
<th>Number of Individual Measures</th>
<th>Total Measures for Scoring Purposes</th>
<th>Total Possible Points</th>
<th>Domain Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient/Caregiver Experience</td>
<td>8</td>
<td>8 individual survey module measures</td>
<td>16</td>
<td>25%</td>
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<tr>
<td>Care Coordination/ Patient Safety</td>
<td>10</td>
<td>10 measures, the EHR measure is double-weighted (4 points)</td>
<td>22</td>
<td>25%</td>
</tr>
<tr>
<td>Preventive Health</td>
<td>9</td>
<td>9 measures</td>
<td>18</td>
<td>25%</td>
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<tr>
<td>At-Risk Population</td>
<td>7</td>
<td>5 individual measures and a 2-component diabetes composite measure</td>
<td>12</td>
<td>25%</td>
</tr>
<tr>
<td>Total in all Domains</td>
<td>34</td>
<td>33</td>
<td>68</td>
<td>100%</td>
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</table>
Successful ACO Practices

- Bring in patients identified as high risk for early AWV
  - Large component of PCP BBPA bonus distribution methodology

- Code AWV appropriately and refer for care management
## Sample Care Gap File

<table>
<thead>
<tr>
<th>Annual Wellness Visit</th>
<th>HbA1C Test Needed</th>
<th>Mammography needed</th>
<th>NextGen Colonoscopy / FOBT / Flex Sig Date Performed</th>
<th>Colonoscopy or FOBT Needed</th>
<th>Cervical Cancer Screening Needed</th>
<th>No Recent PCP Visit</th>
<th>Diabetic Education Candidate</th>
<th>Member First Name</th>
<th>Member Last Name</th>
<th>Member DOB</th>
<th>Member Gender</th>
<th>PCP Last Name</th>
</tr>
</thead>
<tbody>
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# Health Coach Interventions

**Date Range - 01.01.2015 - 12.31.2015**

<table>
<thead>
<tr>
<th></th>
<th>Number</th>
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<tbody>
<tr>
<td>New Patients</td>
<td>2,204</td>
</tr>
<tr>
<td>Total Health Coach Encounters</td>
<td>8,855</td>
</tr>
<tr>
<td>Unique Patient Encounters</td>
<td>5,658</td>
</tr>
<tr>
<td>Currently Active Chronic Patients</td>
<td>466</td>
</tr>
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<table>
<thead>
<tr>
<th>Most Common Conditions</th>
<th>Unique Patients 01.01.2015 - 12.31.2015</th>
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</thead>
<tbody>
<tr>
<td>Atrial Fibrillation</td>
<td>388</td>
</tr>
<tr>
<td>CHF</td>
<td>790</td>
</tr>
<tr>
<td>COPD</td>
<td>893</td>
</tr>
<tr>
<td>Diabetes Mellitus</td>
<td>1,469</td>
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<tr>
<td>Dyslipidemia</td>
<td>528</td>
</tr>
<tr>
<td>Hypertension</td>
<td>2,699</td>
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</table>
Brookwood Baptist Health Physician Alliance
Health Coach Referral Form

Please fax completed form to: 205-783-7474

Patient Name: ______________________ DOB: ___ / ___ / ___ CSN: ______________________

Patient Contact No. ______________________ Date of Referral: ___ / ___ / ___

Please check the appropriate boxes indicating reason(s) for patient referral:

<table>
<thead>
<tr>
<th><strong>MEDICAL CONDITIONS/ MEDICAL ENCOUNTERS</strong></th>
<th>☑</th>
</tr>
</thead>
<tbody>
<tr>
<td>A-Fib: ≥1 related hospitalization within 6 months</td>
<td></td>
</tr>
<tr>
<td>Asthma: ≥1 ED presentation or uncontrolled per physician</td>
<td></td>
</tr>
<tr>
<td>CHF: ≥1 related hospitalization within 6 months or uncontrolled per physician</td>
<td></td>
</tr>
<tr>
<td>COPD: ≥1 related hospitalization within 6 months or uncontrolled per physician</td>
<td></td>
</tr>
<tr>
<td>Diabetes: ≥1 related hospitalization within 6 months or new DM/ poor control per physician</td>
<td></td>
</tr>
<tr>
<td>ED Visits: ≥2 non-related ED presentations within 6 months</td>
<td></td>
</tr>
<tr>
<td>Follow-up Risk: per physician</td>
<td></td>
</tr>
<tr>
<td>HTN: ≥1 related hospitalization or uncontrolled per physician</td>
<td></td>
</tr>
<tr>
<td>Hyperlipidemia: referred per physician</td>
<td></td>
</tr>
<tr>
<td>Readmission: ≥2 hospital admissions in 6 months ± medication non-adherence</td>
<td></td>
</tr>
<tr>
<td>Stroke: history of non-compliance related to amenable causes, i.e. knowledge, new CVA</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>MEDICATION MANAGEMENT</strong></th>
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<tbody>
<tr>
<td><strong>Medications</strong></td>
</tr>
<tr>
<td>Changes in the medication regimen involving the following:</td>
</tr>
<tr>
<td>• Insulin:<em><strong><strong><strong>, Other DM Therapy:</strong></strong></strong></em>, Insulin Pump:_______</td>
</tr>
<tr>
<td>• High Risk Medication Use: Warfarin_______, Digoxin_______, Antidepressants_______</td>
</tr>
<tr>
<td>• Polypharmacy (≥6 meds):_______</td>
</tr>
<tr>
<td>• Other (specify):__________________________________________________</td>
</tr>
</tbody>
</table>

Referral Orders: ________________________________________________________

________________________________________________________

Signature: ______________________________

Printed Name: ____________________ Office Phone No.: ____________________

Please FAX the completed Referral Form to the
Brookwood Baptist Physician Alliance Population Health Office
FAX: 205-783-7474
Successful ACO Practices

- Bring in patients identified as high risk for early AWV
  - Large component of PCP BBPA bonus distribution methodology

- Code AWV appropriately and refer for care management

- Identify someone in the practice to “work the list” of needed AWV and gaps in care

- Take calls from the ACO team and the health coaches

- Attend and participate in ACO meetings/data reviews
SUMMARY FOR SUCCESS

1. Choose your ACO physician participants wisely
   Be selective and exclusive
   Physician engagement is critical to your success

2. Coding is crucial to establish reasonable benchmarks
   Hire professional coders to help
SUMMARY FOR SUCCESS

3. Must have cooperation from hospitals and physicians
   • Make this a real partnership where you can both benefit

4. Need cost data – cost accounting is critical
   • You cannot show savings if you do not know cost

5. IT system must work and be timely
   • Get help analyzing the data