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New ACO Regs Causing Dismay

Health Systems Now Unsure Whether They'll Work

The withering complexities of creating an accountable care organization under the rule proposed by Medicare are prompting leaders of major Midwestern healthcare providers to reconsider just how ardently they wish to pursue the idea.

For many providers, the "shared savings" offered by the federal government are looking more theoretical than real.

"The rewards may be a tad miserly," said **Oliver Henkel**, chief government relations officer at the **Cleveland Clinic**. "We think the rule is very prescriptive. The process will make applying for qualification very burdensome, particularly for smaller health systems. That's daunting, and will cause systems to say, I'm not going to bother."

The rule is too "complicated and laborious," in the view of **Charles E. Kelly**, M.D., senior vice president of the **Henry Ford Physicians Network** in Detroit. "If they had put the bundled payment program out there before the shared savings, it would have made more sense. That would have

whetted the appetite for people to stick their toes in the water, to see if they want to swim."

Their assessments were echoed in a handful of interviews with Midwestern institutions. Many of the best prepared, most highly integrated provider organizations are hedging their bets.

"We don't know yet," said **Craig Samitt**, CEO of **Dean Health** in Madison, Wis., which already thinks of itself as an ACO. "We are analyzing it. My sense is that people are paralyzed."

Neither the Cleveland Clinic nor Henry Ford was prepared to say whether it would file an application under the shared savings model. Both systems are preparing detailed comment letters suggesting substantial changes, and will wait to see how the final rule comes out.

While many executives laud the concept of the accountable care organization in theory, and some have already taken major steps in that direction, they say execution under the CMS rule would be difficult.



Charles E. Kelly, M.D.
Senior Vice President,
Henry Ford
Physician Network

Continued on Next Page

Thursday, June 2nd, 2011 12 PM Central

ACOs: A Midwest Perspective

This Webinar has been constructed to take the dialogue about ACOs to the next level. It will provide information on what has been accomplished to date in building ACOs in the region, relevant hospital and physician regional marketplace issues, how ACOs will function in the region, and what potential roadblocks or difficulties may be on the horizon. This session will feature national ACO expert Bill DeMarco and Dean Health System CEO Dr. Craig Samitt : <http://healthwebsummit.com/acomidwest.htm>

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In Brief

Joplin Hospital Damaged by Tornado

St. John's Regional Medical Center in Joplin, Mo., was largely destroyed by a tornado that tore through the city on Sunday.

The hospital's windows were blown out and parts of its facade were torn off, leaving its steel superstructure exposed in several places. The roof was also taken off. A ruined helicopter lay on its side, its rotors broken off, in a parking lot.

The staff had a few minutes' warning to move patients into hallways before the storm hit the nine-story building. According to news reports, the hospital started a full evacuation after it was hit by the storm. "We are not sure of the safety of the building," said **Cora Scott**, spokesperson for **St. John's Health System** in Springfield, Mo.

About 100 patients from the Joplin hospital were taken to St. John's hospitals in Springfield, about 50 miles away, and others were taken to Freeman Health System in Joplin and to other facilities.

Nearby structures were completely leveled by the storm, which killed 89 people as of Monday morning's tally. Dentist Matt Sheffer said his office across from the hospital was "totally gone." The building that his office was in "was not flimsy, he told the Associated Press. "It was 30 years old and two layers of brick. It was very sturdy and well built."

Wind from the storm carried debris as far as 60 miles. People reported finding medical records and X-rays on the ground in the next county.

Illinois CON Panel Denies Closure of Oak Forest Hospital

The **Illinois Health Facilities and Services Review Board** once again

Continued on Page 3

ACO Regulations (Continued from Page One)

That doesn't mean the ACO concept isn't valid, Samitt added. "I frankly believe the ACO destination is inevitable," he said. "Where everybody is getting caught up is, which tack we're going to take. We're in Madison, Wisconsin, and we need to get to San Diego. How do you get there? Everybody will pick a different route. But we can't all say, 'We're going to stay in Madison.'"

Nevertheless, a number of large organizations contacted for this article declined to talk about their views on the ACO transition.

* **SSM Health Care** in St. Louis begged off, saying "everyone's schedules are crazy through the next two weeks or so."

* **Spectrum Health**, parent system of **Butterworth** and **Blodgett** hospitals in Grand Rapids, Mich., said its "primary people who would decide if we wish to comment" were out of state.

* **Allina Hospitals and Clinics** in Minnesota said they were "still studying the regulations and have not made any final decisions yet."

* **Indiana University Health** didn't respond to a request for an interview.

* **St. Luke's Health System** in Kansas City, Mo., was "not ready to discuss this in the media right now," said a spokesperson.

* Across the state line, the **University of Kansas Hospital** executive team "came to the conclusion that we are still in the evaluation phase and don't have any thoughts one way or the other yet," said a spokesperson.

Several organizations that wouldn't speak to **Payers & Providers** have made their views public through other media. The **Mayo Clinic**, in Rochester, Minn., told the **Washington Post** that it was committed to the ACO model. But **Robert E. Nesse**, CEO of the Mayo system, said he didn't know whether his organization would be able to make all the decisions necessary to qualify to start the program in time. "We will engage and transform our practice," he said. "It is just a question of how we do it and who we do it with."

Aurora Health Care in Milwaukee was the most explicit in its rejection of the proposed CMS rules. In an interview with **HealthLeaders Media**, CEO **Nick Turkal**, M.D., declared flatly that his health system would not participate in the HHS shared-savings experiment unless fundamental changes were made.

"We had been very excited about the concept of ACO," Turkal said. "But the pilot as designed by CMS doesn't match with what

we expected and I don't think it matches with what a lot of providers expected across the country."

Advocate Health Care, which has been developing a commercial ACO with **Blue Cross Blue Shield of Illinois** for 15 years, already has specific targets for reducing readmissions, emergency room visits, and length of stay. "Right now we're paid for each service being rendered," said system Chief Operating Officer **William P. Santulli** in February. "Tomorrow we're going to be paid for keeping patients healthy. We're pretty bullish on what's out there on the horizon."

But Advocate, the largest hospital system in the Chicago area, is bearish on the CMS shared savings idea. "We were disappointed in the proposed rule," said **Meghan K. Clune**, vice president for government and community relations. "We are working on our comment letter and remain hopeful that CMS will make significant changes to the final rule."

On May 17, CMS released rules for another model of ACO, the Pioneer model, intended to provide "a faster path for mature ACOs that have already begun coordinating care for patients." It's designed to work with private payers. CMS is asking organizations interested in the Pioneer model to submit a letter of intent by June 18. Meanwhile, CMS will receive comment on the shared savings model until June 6.

In addition, CMS announced an "advance payments initiative," to provide upfront rewards to organizations to help them meet the financial requirements of building the ACO. CMS would prepay a portion of the anticipated savings.

Dean Health is taking a hard look at the Pioneer model, Samitt said. "It will reward organizations like Dean that have been more like an ACO for longer, that can take on a greater degree of risk, and accept a program more in alignment with commercial payers."

The **Marshfield Clinic** in Wisconsin participated in the CMS physician group practice demonstration project, which ended March 31, 2010. Marshfield earned shared savings of \$40 million in four years, more than any other of the 10 groups.

"We are seriously evaluating our options with regard to continuing with the physicians model," said **Theodore Praxel**, M.D., medical director of Marshfield's **Institute for Quality, Innovation, and Patient Safety**. The clinic couldn't participate in the shared savings model if it goes forward with the physician group model, he said.

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In Brief

stymied the plans of **Cook County** leaders by denying them permission to close **Oak Forest Hospital**.

Cook County Board President **Toni Preckwinkle** had proposed shutting down the underutilized public hospital and consolidating services at **Stroger Hospital**, which has excess capacity, for a savings of around \$40 million. The county, which encompasses Chicago and its suburbs, planned to turn the facility into an outpatient clinic and hasn't budgeted any operational funds for emergency or inpatient care past June 1. Oak Forest has 213 beds, of which only 31 inpatient beds were occupied in early May.

The state certificate of need panel rejected the county's proposal by a 4-1 vote. The one "no" vote was sufficient to derail the county's plans.

The panel has nine seats, of which three are vacant because Gov. **Pat Quinn** has not appointed new members. One of the six incumbents didn't show up for the meeting. The panel's rules require a majority of five votes to take action. Because it didn't attain that threshold, the measure failed.

Public employee unions and healthcare workers had opposed the closure, and celebrated their victory by shouting, "Vote Preckwinkle out!"

Six Minnesota Physicians Disciplined for Poor Conduct

The **Minnesota Board of Medical Practice** disciplined six physicians for improper conduct, including a botched surgery, overprescribing painkillers, and not following up on a patient's diagnostic test for cancer.

The disciplined doctors are **Sheftel Cohen**, M.D., 73; **James Eelkema**, M.D., 58; **David Gilbertson**, M.D., 71; **Todd Leonard**, M.D., 42; **Roberto Pagarigan**, M.D., 79; and **John Sander**, M.D., 79.

Insurance Regulators Get New Power

HHS Rules Allow States to Question High Rate Boosts

Starting Sept. 1, health insurance companies will be required to explain large premium increases publicly and publish that information on their own web sites as well as the federal government's Affordable Care Act web site, according to rules issued last week by the **Department of Health and Human Services**.

Rate increases of 10% or more for small group and individual policies are affected.

"Insurance companies continue to raise rates, often without justification and explanation," said **Kathleen Sebelius**, secretary of Health and Human Services. Under the Patient Protection and Affordable Care Act, the department is working with states "to review, revise, or reject unreasonable rate hikes."

The federal government does not have authority to overturn insurers' rate increases. That role falls to the insurance commissioners of the individual states, if their legislature has granted them that power.

HHS has given the states \$44 million in grants to help them fill this enhanced role. In states that decline to do so, HHS will lead the reviews itself.

The recent quarterly earnings statements of major for-profit national insurance companies showed surging profits as Americans held off getting needed medical care for economic reasons, while insurers reaped the benefits of recent premium boosts.

"Often these increases come without any explanation or justification," Sebelius said.

Kansas Insurance Commissioner **Sandy Praeger** welcomed the new authority.

"We already require companies to file their rates with us. Unless I can demonstrate that the rate is excessive or discriminatory, it is eventually approved" after a 30-day period, she said.

The new requirements will add more transparency about the rates when filed, by putting them on the department's web site.

"I think that's good. It's important for consumers to understand why rates are going up," she said. "This will bring about the necessary discipline to keep rates appropriate."

Praeger, a Republican, was elected insurance commissioner in 2002, after serving many years in the Kansas Senate, including a stint as chair of the health committee.

"States that have the ability to look at rates don't lose any of our authority," she said. "States that don't have rate authority, like Illinois, will have to get it, through legislation."

The Illinois insurance director, **Michael McRaith**, said in March that insurers in his state have pushed their prices higher, to the point of accumulating more than \$28 billion in surplus capital as of 2010.

"We are seeing in this transition period to 2014, that insurers are increasingly aggressive with their underwriting, meaning they are increasingly aggressive in denying coverage, limiting coverage, or denying or limiting any one claim," he said in an interview with **Payers & Providers**.

"They are using the absence of rate regulation to price out existing policyholders. All that is designed to lead to the accumulation of capital, so that by 2014, when insurers have to cover everyone, they'll be starting from a point of extreme financial strength."

For some small-group employers, premium increases were being reported in the 30% to 40% range, he added.

McRaith, a Democrat, will be leaving his office at the end of May to join the Obama administration as the first head of the federal office of insurance, a position created by the financial industry reform law.

Praeger said her department has worked with Kansas insurance companies to moderate rate increases.

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Let Core Principles Be Your Guide

The ACO Thicket Can Confuse Even Savvy Players

Reaction to the proposed Medicare accountable care organization shared savings program has been overwhelmingly negative, with many believing that the risk is not worth the reward. The **Center for Medicare and Medicaid Services** has already proposed, through its **Innovation Center**, enticements for ACO pioneers and a program for advance payments to help fund ACO start-ups.

Regardless of what happens with Medicare ACOs it is clear that the journey has begun. The key for any organization is identifying the right value-based payment strategy for their particular situation, which may or may not be developing an ACO. Let's reset the focus to a few core principles:

Physician Relationships:

Developing formal, collaborative relationships with physicians is essential for delivering value-based care from a market preservation and growth perspective. To realize any potential cost savings from an ACO requires physician alignment on evidence-based care protocols, physician-led quality, and self-monitoring. Also, without formal integration with physicians through either employment, financial, or clinical integration, the hospital's primary-care base is at risk of being picked off by a competitor.

Performance Quality Tracking: ACOs must have a culture of physician accountability, visibility around results, and continuous clinical quality enhancement. While arguments can be made that today's quality metrics are not the right metrics (that there is too much focus on process rather than outcome measures, that the data are wrong, or that a particular physician's patients are more complex), the reality is that physician quality tracking and performance monitoring are here to stay.

Many providers also find themselves unprepared to meet the IT requirements for exchanging and aggregating clinical data. A health information exchange, central data repository, physician portal, disease registries, clinical decision support systems, and predictive modeling are all necessary to become an ACO. These capabilities often take a year or longer to build or buy.

Outpatient Capabilities: To be successful in an ACO model, organizations must be able to manage the total cost of care for patients. Few

organizations today have the experience and resources to identify high-risk patients and ensure that they get the follow-up care needed to prevent "failures," which for an ACO would be a preventable hospital admission or readmission and emergency department visit. To be effective as an ACO, organizations will need outpatient care models to care for the sickest patients and proactive processes to manage patients with chronic disease. It takes time to build these competencies, and organizations tend to underestimate the resource and cultural requirements necessary to do so.

Other Payer Opportunities:

CMS is just one payer, and for many, starting with a hospital's self-insured employees and dependents, and then expanding to commercial payers and large employers may be a more practical and prudent approach. Some payers and large employers are more willing than others to support hospitals and physicians in pursuing value-based care. Some are eager to discuss new models that have the potential to lower costs, such as on-site clinics, medical homes, or an ACO, and may even provide capital to support the development.

The first to create an ACO in a market may reap a first-mover advantage, but it also comes with added costs and potentially more headaches. For most providers, the immediate future should focus on physician alignment strategies and developing the competencies and infrastructure to be successful. The path to becoming an ACO will be a two- to three-year journey for many. In the near term, focused efforts for primary care (e.g., medical home and clinical integration) and specialty services (e.g., co-management arrangements or bundled payments) may be more appropriate strategies.

Michael J. Randall and Gregory P. Shufelt are consultants with The Camden Group in Chicago.

Op-ed submissions of up to 600 words are welcomed. Please e-mail proposals to dmoore@payersandproviders.com.

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*New England Journal of Medicine, 2004.

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ROUNDTABLE INTERACTIVE

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Payers & Providers and MCOL present **Roundtable Interactive**. It debuts March 2011 in the Payers & Providers National edition.

Our readers always want to know what is on the minds of healthcare's c-suite executives. Conferences and trade events often only allow for crucial moments to interact with these thought leaders. With Roundtable Interactive, you'll cut through the preliminaries and immediately know what's on their mind.

Every Roundtable Interactive will feature a Q&A session conducted by Payers & Providers Publisher Ron Shinkman. His decades of experience in journalism and the healthcare industry will promise concise and revealing interviews.

Topics for upcoming Roundtable Interactives include:

- **Integrated Systems vs. Private Practice:** To what degree will physicians not already in larger medical groups or integrated health systems remain in private practice during this decade, and why. What are the advantages, disadvantages and implications in today's environment?
- **Medicaid Plans and Delivery Systems:** How much is their clout growing as Medicaid enrollment is projected to soar as part of reform? Will Medicaid increasingly be used as a vehicle for setting healthcare policy? To what degree will major health plans and systems try to increase share and concentration in this market?
- **Accountable Care Organizations:** Are they overhyped? What type of health care systems should be pursuing ACOs, and what systems should be sitting on the sidelines for now? How tied is the ACO movement to the success or failure of Medicare ACO pilots? Does the definition of ACOs need more specificity, or is it preferable to have a big tent of inclusion?

Do you want to propose or participate in a future Roundtable Interactive? Participation is entirely online, with a commitment of no more than one hour. Call Ron Shinkman at 877-248-2360, ext. 1, or e-mail him at editor@payersandproviders.com.