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Calendar

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the details of your event, or call
(877) 248-2360, ext. 3. It will be
published in the Calendar section,
space permitting.

Providers Submit Gripes On ACOs

Comment Letters to CMS List Many Specific Issues

Hospitals and physicians have made no secret of their disappointment with the rules proposed by the **Centers for Medicare and Medicaid Services** regarding the Medicare Shared Savings Program for accountable care organizations.

On Monday, June 6, the 60-day comment period for the rules expired. Many providers have written comprehensive letters to CMS outlining where they think the rules fall short, or are impractical or impossible to meet. In many instances they have proposed amendments and changes to make the program more palatable.

Some large systems, such as **Advocate Health Care** in Chicago and **Aurora Health Care** in Milwaukee, have made clear that unless the rules are fundamentally rethought, they are unlikely to participate in the program.

Aurora CEO **Nick Turkal**, M.D., said in a statement that "without fundamental change this pilot may not be effective at achieving better value for communities."

Advocate, which is well on its way to building a commercial ACO covering 350,000 members of **Blue Cross Blue Shield of Illinois**, is worried that "some of the provisions ... will make it difficult for systems like ours – with significant experience operating a large, clinically integrated network – to consider participating in the ACO initiative," according to the comment letter by **Lee Sacks**, M.D., Advocate's chief medical officer.

Despite the hospital industry's drumbeat of negativity, some national policy experts have pushed back, pointing out that the ACO concept might not be for everybody.

"The proposed rule is a wake-up call. ... Interest in ACOs is so high that many would-be ACOs probably aren't ready for prime time," wrote **Paul Ginsburg**, president of the **Center for Studying Health System Change**, in the June 2 edition of the *New England Journal of Medicine*. And in a counterargument to Aurora and Advocate, he suggested that "CMS should place a higher priority on getting inefficient organizations into this program than on attracting ones that are already efficient."

Over the past two weeks, **Payers & Providers** spoke to several interested parties across the Midwest to gather the feedback they planned to send CMS. Those groups include:

- * **Advocate Health Care**
- * **Aurora Health Care**
- * **The Cleveland Clinic**
- * **Henry Ford Physician Network**
- * **The Rural Policy Research Institute Health Panel**

Here are some of their specific complaints and recommendations to CMS, gleaned from telephone interviews, statements, or comment letters:

Continued on Next Page



Thursday June 30th, 2011 10 AM Pacific

Medi-Cal: Preparing for the Waiver and Beyond

Please join Erica Murray, Senior Vice President, California Association of Public Hospitals and Health Systems, Mark Finucane, Managing Director, Alvarez & Marsal, former Director of Health Services, Los Angeles, Contra Costa Counties, and Dr. Bradley Gilbert, Chief Executive Officer, Inland Empire Health Plan, to discuss the Medi-Cal program, the waiver, reform and beyond: <http://www.healthwebsummit.com/2011medi-cal.htm>

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In Brief

U.S. Attorney Charges Three in Wichita with Medicare Fraud

The U.S. Attorney's Office in Wichita, Kan., indicted three people from that city for selling motorized wheelchairs to people who didn't merit that benefit.

Charged with conspiracy to defraud Medicare were **Steven J. Palacios**, 59; **Veneda Brown**, 38; and **Bonita Regina Carter**, 51. In addition, Carter was indicted for submitting false information to the Social Security Administration.

Palacios is the owner of **Advanced Medical Concepts** in Wichita. The indictment alleges that Palacios paid Brown \$48,000 and Carter \$46,000 to identify Medicare beneficiaries so that he could provide them power wheelchairs. From 2002 to 2006, Medicare paid him \$2.4 million or more. Prison terms of five to 10 years are possible if the three are convicted.

Illinois Medicaid Moves 40,000 into Managed-Care Plans

Illinois Medicaid is moving approximately 40,000 beneficiaries into two private health plans that have contracted with the state, in an effort to better coordinate their care and reduce expenses.

The recipients will be enrolled in a plan run by **Aetna Inc.** or a subsidiary of **Centene Corp.** known as **IlliniCare**. The enrollees live in suburban Cook, DuPage, Kane, Kankakee, Lake and Will counties.

"Through this innovative program we will improve outcomes and increase the quality of life for these residents while saving the taxpayers millions of dollars," said **Julie Hamos**, director of the state's **Department of Healthcare and Family Services**.

Continued on Page 3

ACO Comment Letters (Continued from Page One)

Advocate:

1. CMS has badly underestimated the real costs of setting up an ACO. Advocate estimates it is spending \$23.5 million to set up infrastructure for the BCBSIL network. It said infrastructure costs are running at around 4% of medical costs. CMS had estimated that it might cost \$1.75 million to set up an ACO.

2. The financial model doesn't give enough incentive to participate. CMS should lower the 25% withhold from the ACO's portion of shared savings to 10%, as a reward to providers. The maximum potential incentive should be raised from 17% to 25%.

3. CMS hasn't made provision for the fact that providers, especially small physician practices, will move in and out of the ACO. The list of participating physicians should be updated quarterly, if not monthly.

4. Antitrust reporting for small physicians practices is onerous.

5. ACOs should be allowed to communicate with patients without submitting their materials for CMS review first. Instead, the communications should be subject to audit by CMS.

6. The requirement that ACOs achieve 100% success at measuring 65 different quality metrics is unrealistic. A mandate of 34 metrics to be met would make more sense.

Aurora:

1. Expecting providers to take on the full risk of a defined population by the third year of the pilot won't allow patients, physicians, and hospitals enough time to adjust to the new regimen.

2. Because Aurora operates in numerous small market segments, the provision that any organization with more than 50% market share go through a Justice Department antitrust review would require a review in virtually every market.

3. Retrospective attribution of patients prevents providers from knowing their patients and their health status.

4. The expected eight to nine month delay in receiving data from CMS will undermine quality patient care.

Cleveland Clinic:

1. The application process is too burdensome and requires too much detail.

2. The number of quality metrics is overwhelming. The clinic estimates it would cost \$30,000 to develop the collection mechanism for each measure. "Multiply times 65 and you understand the enormity of the investment," said **Oliver Henkel**, chief government relations officer. "Not many

institutions will be able to incur that kind of expense in these uncertain times."

3. Most of those quality measurements are process measures, not outcomes. But a large segment of the hospital community feels it's time to move toward outcome measurements.

4. The three-year shared savings period is too short. Five years would be more satisfactory, with more of the payments front-loaded to assist providers with the heavy investments required.

5. CMS plans to hold back 25% of the shared savings. This is of no help to providers. The clinic proposes to let providers create a reserve.

6. Savings should begin with the first dollar, instead of the first dollar after the 2% benchmark is reached. (The 2% benchmark for large ACOs was established to assure that the savings were genuine and a result of changes in care management, rather than normal statistical variation.)

Henry Ford Physician Network:

1. CMS's estimate of how much investment is required to create an ACO is "a joke," said **Charles Kelly**, M.D., senior vice president of the Henry Ford doctors group. A likelier range is \$11 million to \$28 million. "You've got to put that much money in to achieve a very difficult-to-acquire financial incentive, and CMS is going to keep half of it," he said. "You spend the dollars now, and if you're lucky, a year and a half from now, you might get some of your money back."

2. Retrospective attribution is inherently unfair, since you can't control the patients you are responsible for.

3. The 50% meaningful use requirement for primary care by the end of year 2 won't work for some provider organizations. Henry Ford has an in-house IT system that is fully functional but not certified, and therefore doesn't meet meaningful use criteria.

Rural Policy Research Institute:

RUPRI, a consortium of **Iowa State University**, the **University of Missouri**, and the **University of Nebraska**, has been studying rural policy issues since 1990.

1. Physician assistants and nurse practitioners provide a lot of primary care in rural areas. Yet ACO patient attribution by CMS goes only through primary care physician services.

2. CMS proposes to deny participation to any ACO that hasn't demonstrated Medicare expenditures after three years of activity. The Physician Group Practice demonstration project showed that "cost savings are often not immediate."

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In Brief

Medicaid managed care has been available in Illinois for some time, but has only had 200,000 subscribers, out of a total of 2 million Medicaid recipients. The program is voluntary, however, and offered to beneficiaries in just a handful of areas in the state.

State officials expect the program to save \$200 million over the next five years. The state recently passed a law that will lead to half the state's 2.9 million Medicaid beneficiaries moving into coordinated care by 2015.

Contributions Pour in to Planned Parenthood of Indiana after Law

Planned Parenthood of Indiana has raised more than \$100,000 in private donations since the Indiana legislature voted to terminate public funding of the agency. The cash has allowed Planned Parenthood to continue its services of breast examinations and Pap smears for low-income women for the time being.

Opponents of the women's health and family planning organization have argued that this shows that Planned Parenthood can easily survive without taxpayer funds.

"Instead of complaining about not receiving government money, they have to go out and raise the money like other organizations," said **Mike Fichter**, president of **Indiana Right to Life**.

"What makes them any different than any other not-for-profit?" said state Sen. **Scott Schneider**, a Republican from Indianapolis. "There's no reason they can't have a capital campaign or some sort of private campaign to raise funds."

Planned Parenthood said it merits public money because it serves the public interest to offer affordable birth control that prevents unwanted pregnancies and abortions.

Betty Cockrum, president of Planned Parenthood, called the donations "a one-time thing and a temporary fix. ... This cannot be sustained." Most of the contributions have come from outside the state.

Oak Forest CON Bill Fails in Illinois

Governor Appoints Three to Bring Panel up to Nine

A bill to amend the Illinois CON statute to exclude Cook County hospitals from state oversight failed when the legislature adjourned May 31 without voting on it.

The bill had been proposed by county leaders after the CON committee on May 10 denied permission to close **Oak Forest Hospital**, which the county health system had wanted to transform into an outpatient center for budgetary and utilization reasons. (*Payers & Providers*, 31 May and 24 May). Employee unions opposed the changes.

On June 2, Gov. **Pat Quinn** named three appointees to the board, bringing it to its full complement of nine. The three vacancies had allowed the one "no" vote on the hospital

question to override the four votes in favor.

Cook County Board President **Toni Preckwinkle** said officials would go back to the CON panel in August or October and request permission to close inpatient and emergency services at Oak Forest Hospital. She blamed the county health system's executive leadership for not adequately explaining their intentions to the community, and the governor for not acting sooner to fill the empty chairs on the CON panel.

The county health system made interim adjustments to hospital operations on June 1, closing the intensive care unit and acute rehabilitation department and streamlining emergency care.

Upper Midwest Hospitals Score Well

Great Lakes States Lead Thomson Reuters List

Six of the 10 Top Health Systems in the United States are found in the states of Illinois, Michigan, Minnesota, and Ohio, according to a list published by **Thomson Reuters** last week. They were selected from 285 U.S. health systems for quality of care, efficiency, and patient satisfaction.

The six Midwestern systems are **Advocate Health Care**, based in Oak Brook, Ill.; **Kettering Health Network**, Dayton, Ohio; **Mayo Foundation**, Rochester, Minn.; **NorthShore University HealthSystem**, Evanston, Ill.; **OhioHealth**, Columbus; and **Spectrum Health**, Grand Rapids, Mich.

"Clearly the focus of leadership is raising the national bar in quality across the health system – not solely in the flagship hospital," said Jean Chenoweth, senior vice president at Thomson Reuters in Ann Arbor, Mich. "More-

over, these health systems are better aligned in achieving their goals in increasing value to the communities they serve."

The study looked at performance in eight areas: in-hospital mortality; medical complications; patient safety; severity-adjusted average length of stay; 30-day post-discharge mortality rate; 30-day post-discharge readmission rate for heart attack, heart failure, and pneumonia; adherence to clinical standards of care; and a consumer-driven patient survey score.

Data were culled from the Medicare Provider Analysis and Review dataset and the CMS Hospital Compare dataset.

In general these systems have better survival rates and fewer patient complications, and an average length of stay that is half a day shorter than their peers.

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Make EHRs a Branding Opportunity

For Small Offices, an Ad-Based System Makes Sense

The only way we will achieve a truly effective nationwide system of electronic health records connecting virtually every physician and hospital is by offering office-based physicians a free EHR. By free, I mean a reliable, easy-to-use, meaningful-use certified, web-based ambulatory EHR offered to physicians through an ad-supported model.

While a number of other industrialized countries have 90% or more of their physicians on an EHR, we are struggling to reach 50%. In the past year, thousands of U.S. physicians have moved to EHRs, but the adoption rate among small medical groups – which include 60% of practicing physicians – remains frustratingly low. Several recent surveys put it in the 20% to 30% range.

We have created a series of “digital islands” across the U.S. Many large medical groups such as **Kaiser Permanente**, **Intermountain Health Care**, and the **Cleveland Clinic** have connected large numbers of their own physicians, exchanging clinical information, and improving clinical care. They, of course, are well funded and have large IT staffs to train users and maintain their EHR systems.

In contrast, small medical groups operate on low margins, have little investment capital, and usually no IT staff. Many physicians in these practices see no reason to pay out of their own pocket for software that currently has little or no value for them.

With traditional, pay-up-front software vendors, small medical groups are at a distinct disadvantage. They simply don't have the bargaining power with a vendor that hospitals and large medical groups possess. In fact, many large EHR vendors don't even market their systems to small groups because they see no profit in it.

In contrast, a company offering a free, ad-supported EHR must supply a product that is highly reliable and easy to use for physicians. Under the free EHR model, the software company makes money from “eyeballs.” Advertisers want regular counts of page views and click throughs. If physicians aren't using

the system, ad sales will fall.

An ad-supported EHR might have seemed unorthodox five years ago, but in today's world of Gmail, Google search, and Facebook, it is not only familiar, it is highly attractive. Physicians are sophisticated consumers and most are enthusiastic consumers of other forms of ad-supported services.

In his seminal article, “Free! Why \$0.00 is the Future of Business,” which ran in the February 2008 issue of *Wired* magazine, author **Chris Anderson** noted that the “free” model of doing business has been around in various paradigms for more than 100 years. He described a number of business models now being used to deliver free services via the Web. They include ad-supported, cross-subsidized, and labor-exchange models (e.g. Wikipedia).

We believe the most appropriate free business models for EHRs is the ad-subsidized and cross-subsidy model. In the cross-subsidy model, a large integrated medical organization can license the EHR from the vendor and then provide it free to its affiliated physicians. Rather than run ads, it could display targeted clinical messages alongside the EHR. For example, anytime a physician uses the EHR to prescribe, hospital messages about drug interactions or a health plan formulary could appear. The system can also target physicians, directing certain messages to specific specialists such as cardiologists, ophthalmologists, or primary care physicians.

Google and Facebook revolutionized their markets when they launched their free, ad-supported services. The free model holds the same potential for the future EHRs. We have just taken the first step into it.

Andre Vovan, M.D., M.B.A., is a critical care physician and the founder and chairman of Mitochon Systems, based in Newport Beach, Calif.



By Andre Vovan, M.D.

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

ROUNDTABLE INTERACTIVE

PAYERS & PROVIDERS

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.

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