

INSIDE

80 ACOs to Know:

View the Comprehensive List p. 10

Confused About How to Divvy Up ACO Funds?

7 Steps to Navigate Payment Allocation Under ACOs p. 31

CFO Panel:

CFOs Carl Biber, Denis Conroy, Dan Fromm and Mark Krieger Discuss Their Organizations' Financial Strategy and Biggest Challenges p. 36

Chuck Lauer:

What We Need to Do if the Supreme Court Strikes Down the Healthcare Law p. 53

INDEX

Special Compensation Section p. 20**Physician-Hospital Relationships & ACOs** p. 30**Finance & Revenue Cycle Issues** p. 41**Transaction & Valuation Issues** p. 43**Legal & Regulatory Issues** p. 45**Executive Briefing: OR Efficiency** p. 48**Hospital and Health System Executive Moves** p. 55

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BUSINESS & LEGAL ISSUES FOR HEALTH SYSTEM LEADERSHIP

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11 Hospital, Health System Executive Compensation Trends

By Sabrina Rodak

Hospital and health system executive compensation is affected by several factors in the healthcare industry, including a greater focus on quality and patient satisfaction, as well as consumers' increasing involvement in their healthcare. As healthcare organizations face the uncertainty of the healthcare reform law's constitutionality and changing regulatory requirements, the need to recruit and retain strong leaders may be more important than ever. Here are 11 hospital and health system executive compensation trends experts are seeing in the current market.

continued on page 21

The Future of the American Hospital: Role and Relevancy in the Next Decade

By Molly Gamble

If predictions ever hold weight, they certainly don't in the healthcare industry. Too much is prone to change — like the Patient Protection and Affordable Care Act, which awaits its summer Supreme Court ruling. When components of an industry as large as its entire reform law aren't even certain, it's tough to say what is.

continued on page 8

8 Biggest Mistakes an ACO Can Make

By Bob Spoerl

Given the recent announcement of the first 27 CMS Medicare Shared Savings Program accountable care organizations, and with health insurance giants such as Cigna, UnitedHealth Group and Blue Cross Blue Shield touting accountable care models, it's safe to say the phenomenon is both public and private. And regardless of how the Supreme Court rules on the Patient Protection and Affordable Care Act, most healthcare leaders agree that accountable care in one form or another is here to stay.

As more hospitals, physicians and payors nationwide enter into integrated care models, the time is ripe for hospital leaders to consider issues ACOs will face during formation, in order to address the biggest mistakes they might make on the path to starting one. In the coming months, as more ACOs develop, there will likely be a clearer picture of all the issues an ACO could run up against. For now though, here's a list of some mistakes that could spell serious trouble for an up-and-coming ACO.

continued on page 30

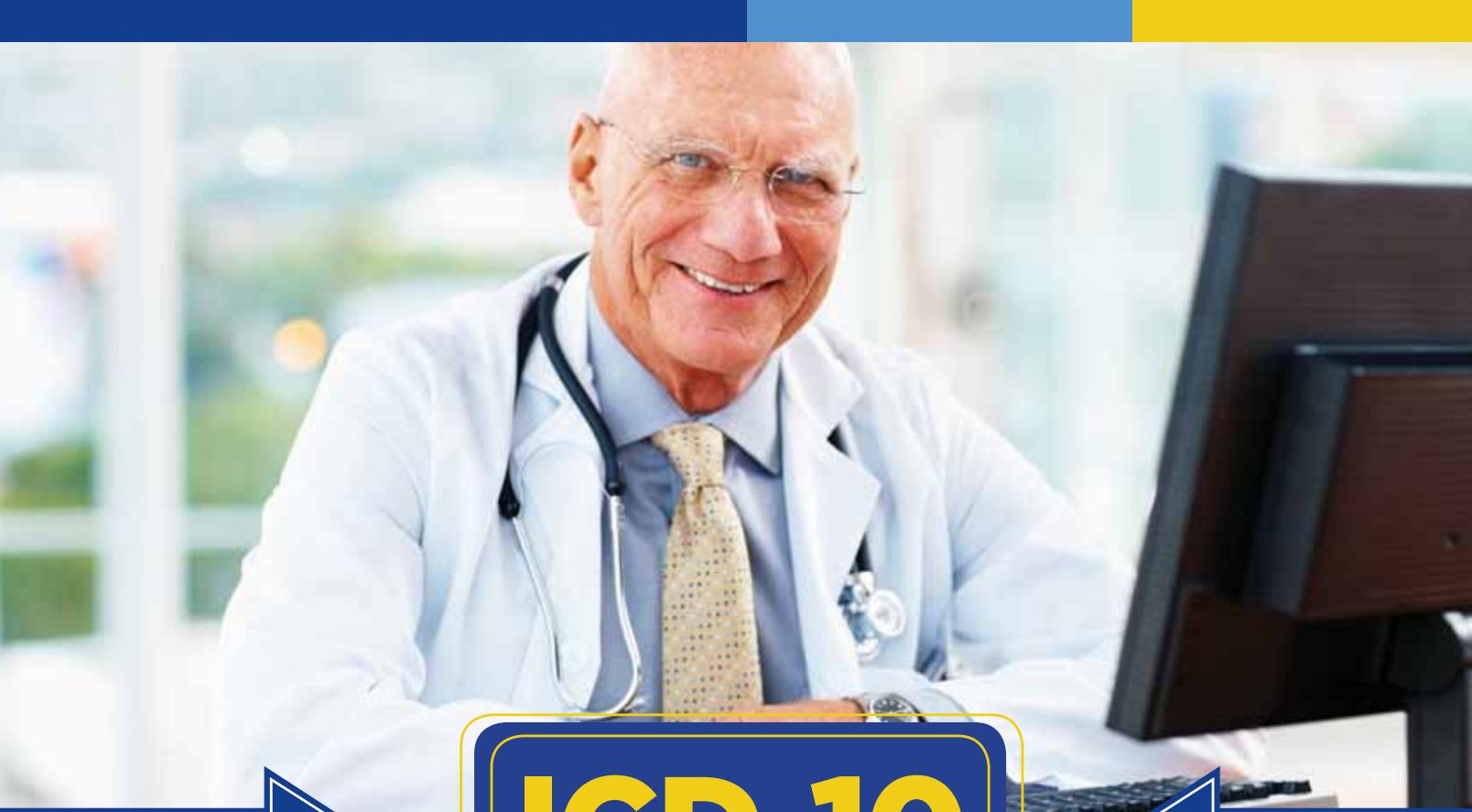
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FEATURES

7 Publisher's Letter

10 80 Accountable Care Organizations to Know

16 A "Lean" Vision Drives Stanford Hospital & Clinics' Performance: Q&A With CEO Amir Dan Rubin

17 Surgically Remodeling a Hospital: Q&A With Dr. Jeffrey Steinberg, CEO of Vanguard's Weiss Memorial Hospital

Special Compensation Section

23 Compensation Manifesto: 11 Steps for Hospital CEOs and Compensation Committees to "Get it Right"

25 200 Statistics on Physician Compensation — 2012 Edition

28 Physician-Generated Hospital Revenue vs. Salary: 48 Statistics

29 28 Statistics on Highest On-Call Coverage Per Diem Payments

Physician-Hospital Relationships & ACOs

31 7 Steps to Navigate Payment Allocation Under ACOs

34 Physician Strategy as the Foundation to Improving Community Health

CFO Roundtable

36 Hospital CFO Panel: How Are You Approaching Your Fiscal Strategy Right Now?

Finance & Revenue Cycle Issues

41 CMS Releases FY 2013 IPPS Proposed Rule: 12 Points to Know

42 Moody's: 2012 Shows Even Mix of Hospital Upgrades, Downgrades

42 Fitch: Patient Admissions, Pricing Trends Mixed at For-Profit Hospitals

Transaction & Valuation Issues

43 An Overview of Recent Challenges to Hospital Transactions: Is the FTC Really More Aggressive?

Legal & Regulatory Issues

45 Community Health Needs Assessment: 5 Phases to Compliance

46 OIG Claims Georgetown University Hospital Overbilled Medicare by 659K

Executive Briefing: OR Efficiency

48 The OR Efficiency Game Plan: Using Daily Huddles to Streamline Care

52 The Next Iteration of Hospital-Physician Alignment: Making Medicare Profitable

Chuck Lauer

53 What We Need to Do if the Supreme Court Strikes Down the Healthcare Law

54 Hospital & Health System Transactions

55 Hospital & Health System Executive Moves

55 Advertising Index



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Becker's Hospital Review

Publisher's Letter

Becker's Hospital Review Special Compensation Issue; Accountable Care Organizations; Upcoming Becker's Healthcare Events

June Issue. We are pleased to share with you the June special issue of *Becker's Hospital Review*. This "Special Compensation Issue" features more than 300 statistics and benchmarks on hospital executive and physician compensation. It also includes two of our most popular annual lists, "100 Great Places to Work in Healthcare" and "100 Great Hospitals" featuring outstanding healthcare organizations across the country of all sizes and types that have demonstrated excellence. Also included in this issue are Q&As with two leading hospital executives: Amir Rubin, CEO of Stanford Hospital & Clinics and Dr. Jeffrey Steinberg, CEO of Weiss Memorial Hospital in Chicago, part of Vanguard Health Systems. Both share their insight on challenges facing their organizations and opportunities ahead for healthcare delivery.

ACOs. CMS recently announced the names of 27 organizations which will be the first to participate in the agency's Medicare Shared Savings Program. These organizations join 32 Pioneer Accountable Care Organizations and other commercial ACOs currently in operation across the country. CMS is continuing to accept applications for the MSSP. While the future success of the ACO model is one that is still hotly debated, there are certainly a number of health systems that have not been afraid to embark on testing the model. In this issue, you'll find a handful of stories directly related to effective ACO operations including: "8 Biggest Mistakes an ACO Can Make" and "7 Steps to Navigate Payment Allocation Under ACOs."

Upcoming events. If your hospital or health system operates or has joint ventured on an ambulatory surgery center or is considering doing so, please save the date for our 19th Annual Ambulatory Surgery Centers Conference, October 25-27, 2012, at the Swissotel Chicago. The conference is the premier event for ASC business and legal issues and brings together hundreds of surgery center owners and operators. More information is available at www.BeckersASC.com.

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The Future of the American Hospital: Role and Relevancy in the Next Decade (continued from page 1)

Short of forecasting, healthcare and economic experts have some sophisticated thoughts on how American hospitals could transform in the next decade. Will hospitals remain the cornerstone of community healthcare? Could hospital beds become void of certain diseases as medical discoveries either cure them or drive their treatment into alternative care settings? Will mediocre hospitals drop like flies in the next 10 years, while others behave like other consumer-oriented American industries, such as banks?

The questions vary but share this common theme: The role of the American hospital is about to undergo some serious change.

Fewer heads in beds

The growth of outpatient service utilization is going to present the largest change to hospitals' strategic plans in the next decade. Care delivery in the outpatient setting is expected to grow exponentially by 2022, redefining hospitals' reliance on some of the most lucrative service lines. Sg2, a healthcare analytics firm based in Skokie, Ill., estimates a 27 percent growth in outpatient cancer care within the next 10 years. Other specialties expected to boom in this environment include general surgery (23 percent), neurosciences (22 percent) and cardiovascular (19 percent).

A simultaneous decline in hospital inpatient services is expected, affecting a range of specialties. Cardiovascular care will take the largest hit, according to Sg2, experiencing a 27 percent drop in inpatient volume by 2022. Recent studies and reports have already shown a dramatic shift in treatment locations for some of the country's most prevalent and serious conditions. From 1998 through 2008, heart failure-related hospitalizations declined by roughly 30 percent.¹ In 1987, the share of total cancer costs resulting from inpatient admissions stood at 64 percent. Between 2001 and 2005, that figure plummeted to 27 percent, according to a 2010 study² published in *Cancer*.

These developments and forecasts have left hospital leaders re-examining their business strategies and how they plan to respond to changes in patient volume. In an interview last year, Kevin Tabb, MD, CEO of Beth Israel Deaconess Medical Center, said his organization is turning away from the heads-in-beds business model. "In the past we thought about, 'How do we get more referrals here downtown?' That's not the model for the future," he said in a recent report by Boston's NPR news station. Instead of focusing acutely on referrals and patient volume, Dr. Tabb said he sees his hospital becoming part of a larger ecosystem.

Craig Rhyne, MD, CMO of Lubbock, Texas-based Covenant Health System, also anticipates a decline in the relevance of inpatient volume. "As cost containment efforts continue in healthcare, there must be a greater emphasis placed on keeping patients healthy and out of the hospital. This will probably come in some form of community wellness model where physicians and hospitals are rewarded for treating conditions on outpatient basis before they become so severe that they actually require hospitalization," he says.

Finding new niches in the healthcare ecosystem

These clinical changes raise questions over whether wellness maintenance — opposed to treating the acutely-ill — is a viable business strategy for hospitals. The country's top-tier hospitals have tailored their specialty programs to incorporate survivorship services, health education and therapy. These multidisciplinary elements may have been deemed somewhat uncommon only a few years ago in traditional hospital-based treatment but have become staples in patient-centered disease management. "Cancer used to be about surgery. Now treatment is increasingly focused on survivorship," says Eric Louie, MD, CMO with Sg2. "All of it is moving to a wellness focus."

There is a distinct need for wellness services, particularly in the framework of today's healthcare continuum that aims for seamless care delivery. Hospitals are responding to declined inpatient volumes by finding other ways to add value to the healthcare continuum — and it's more than a gym. "I don't think providing a gym for people is a business strategy, necessarily," says Steve Lefar, president of Sg2. "But, providing the kind of care that keeps people well and has the right incentives — that will be a strategy. This is an issue of value. Those [hospitals] delivering that kind of value will have more patients sent to them."

For example, one of the survivorship programs offered at Johns Hopkins' Sidney Kimmel Comprehensive Cancer Center is specifically designed for breast cancer patients. The program's website³ says "living through treatment is only half the story," and emphasizes the need for hospital-based survivorship services, as "there is no organized system in place to ensure communication between a woman's cancer specialist and primary care provider once treatment is completed."

Groundbreaking advancements in genetic counseling services will help providers make enormous strides in preventive care and are likely to signal a sea change in healthcare. "The advent of modern genomics and the ability to understand what drives illness at a personal level will have an extraordinary impact," says Mr. Lefar. "We'll have a much better understanding of what people need to do to stay well," he says.

Dr. Rhyne also anticipates fewer people dying in hospitals within the next few years. He also expects a change in public perception — people will no longer expect patients with fatal diagnoses to die in a hospital bed. "The custom of dying only in a hospital is a fairly recent event," says Dr. Rhyne. "Prior to 50 or 60 years ago, most patients actually died in their home." Dr. Rhyne says that when hospital services or treatment no longer offer substantial hope for recovery or improvement, more patients may choose to die in their homes.

The partnering phenomenon

The odds of a hospital surviving on its own — without being part of this healthcare ecosystem — are low, leaving many partnering, forming clinical affiliations, merging or selling. The current wave of hospital consolidation has involved unlikely suitors, such as for-profit corporations, private equity firms and insurance companies. Religiously-affiliated institutions are also pairing with public, secular ones — the *New York Times*⁴ recently reported 20 such transactions within the past three years.

Fewer independent hospitals will make it to 2022 without striking some type of deal with a larger healthcare system, but there is a new facet to the pending consolidation. With more options available today than 10 years ago, the million-dollar question has been extended beyond *whether* a hospital will merge or partner, to *what* it will merge or partner with, and how it will work as a local system.

Whether under the Medicare Shared Savings Program or a private, commercial model, accountable care organizations are a significant driver in healthcare consolidation. ACOs incentivize providers to control costs within the continuum of care, such as primary care, home healthcare, outpatient clinics and preventive services. This incentive makes integrated delivery systems the best option. "ACOs offer a model in which hospitals may be integrated, though perhaps on a limited basis, into a wellness delivery paradigm," says John Romley, PhD, an economist with the Leonard D. Schaeffer Center for Health Policy and Economics at University of Southern California. "Watching the rollout of ACOs will be fascinating."

While short of a strict merger or acquisition, providers are likely to collaborate for clinical purposes as well, especially in the age of personalized medicine. Medicine based on individual risk assessments or genetic coding is still novel, and a recent PwC report said hospitals that make long-term investments in genetic medicine and partner — with organizations either inside or outside the healthcare industry — are most likely to succeed in

competitive environments. "Personalized medicine is a highly complex field, and no one organization or industry has all the resources, knowledge and tools needed to implement personalized medicine," the report read.

No more flying under the radar

America's hospitals are likely to be fewer in number albeit better quality by 2022, and financial performance won't be the only factor driving some hospitals' fallout. Increased transparency around hospital quality and the Value Based Purchasing Program, slated to go into effect in October 2012, have refined accountability in healthcare. The VBP Program is based on measures used in the Hospital Inpatient Quality Reporting program, including patient experience measures as indicated by CMS' HCAHPS survey.

Patient experience ratings will determine 30 percent of the total VBP bonus payments. The HCAHPS survey asks patients a variety of questions, including one in which they must rank their hospital stay on a scale from one through 10. Aside from government regulation, marketplace competition is also propelling hospitals to vie for patients by posting the prices of their most common procedures online — a practice that has traditionally been unheard of.

"Up until now, we haven't had appropriate transparency around performance and quality," says Dr. Louie. "In transparency's absence, a lot of hospitals flew under the radar. Now, low-performers are falling by the wayside." As hospitals publish infection rates online for patients to view, or choose to post prices, they are beginning to resemble other industries that have been sharing similar information for years.

Modeling other industries in the face of increased competition

Hospitals are finding themselves in a game of consumerism catch-up, according to Mr. Lefar. Business innovation in the hospital industry mildly resembles that which banks experienced. The emergence of convenient, transparent and customer-centered strategies like ATMs and online banking bears resemblance to telemedicine, for example. But hospitals still have a ways to go, according to Mr. Lefar.

"The demands from consumers are for this industry to behave more like other industries," he says. Although people can deposit checks from home and sign mortgages online — and have been able to do so for years — making an appointment with a physician online from the comforts of home is still considered novel.

American hospitals are likely to face a larger pool of competitors as well, including some entities that may have been less of a concern in the past. For example, even the country's most reputable and financially sound hospitals haven't been immune to the competition of retail walk-in clinics in neighborhood CVS and Wal-Mart stores.

Many physicians are quick to deem these care settings "as cheap, unworthy competitors," according to a 2009 *New York Times*⁵ report, but more recently hospital systems have joined their ranks in a move to own one more piece of the care continuum. In 2009, Cleveland Clinic partnered with CVS stores in northeastern Ohio and took over nine of the stores' MinuteClinics, assigning a physician to each one. Mayo Clinic did the same thing in 2008 when it began opening retail clinics in grocery stores within the Rochester, Minn.-area.

Will a change in role mean a change in relevance?

Role and relevance are entwined in any industry, begging the question of whether the American hospital will hold the same relevance in 2022 that it does today. Hospitals as many Americans know them today are likely to evolve into integrated, multidimensional institutions — much more than a building to visit when you're sick. "In a broader sense, as a convener of human activities and resources to deliver wellness care, [the hospital] will flourish. That will expand beyond the four walls of the traditional hospital," says Dr. Louie. "That's the role the hospital of the old will fulfill in the new world." ■

Footnotes:

1 Jersey Chen, Sharon-Lise T. Normand, Yun Wang, Harlan M. Krumholz, "National and Regional Trends in Heart Failure Hospitalization and Mortality Rates for Medicare Beneficiaries, 1998-2008," *Journal of the American Medical Association* 306 (2011): 1669-1678.

2 Tangka, F.K., Trogdon, J.G., Richardson, L.C., Howard, D., Sabatino, S.A., Finkelstein, E.A., "Cancer treatment cost in the United States: Has the burden shifted over time?" *Cancer*, 116 (2010): 3477-3484.

3 "Survivorship," accessed April 25, 2012, http://www.hopkinsmedicine.org/kimmel_cancer_center/centers/breast_cancer_program/survivorship.html.

4 Reed Abelson, "Catholic Hospitals Expand, Religious Strings Attached," *New York Times*, February 20, 2012.

5 Milt Freudenheim, "Hospitals Begin to Move Into Supermarkets," *New York Times*, May 11, 2009.

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80 Accountable Care Organizations to Know

By Molly Gamble

Accountable Care Organizations to Know

Accountable care organizations have proliferated in the past three years. The increase has been spurred by private payors' interest in coordinated care management and the Patient Protection and Affordable Care Act, which introduced the Medicare Shared Savings Program. There has been a significant amount of ACO development within the past year specifically, as CMS revealed the first 32 Pioneer ACOs and, more recently, the first 27 Medicare ACOs. Commercial health insurers are also revealing extensive plans for ACO development. Major payors like Cigna, UnitedHealth Group, Blue Cross Blue Shield and Aetna continue to pursue performance-based contracts with providers across the country.

The following list includes 80 commercial and Medicare ACOs. They are presented alphabetically, either by the ACO's formal name or the name of the ACO's main provider.

Accountable Care Coalition of Caldwell County (Lenoir, N.C.). The ACC of Caldwell County was named by CMS as one of the first 27 participants in the Medicare Shared Savings Program. It is comprised of a partnership between Caldwell Memorial Hospital and Collaborative Health Systems. Of the 27 Medicare ACOs announced in April, nine of them are working with Collaborative Health Systems, which is a subsidiary of Medicare Advantage. The hospital, which opened in 1951, includes more than 50 providers. The ACO will serve more than 5,000 Medicare beneficiaries.

Accountable Care Coalition of Coastal Georgia (Savannah). Named in April as one of the first 27 ACOs within the Medicare Shared Savings Program, the ACC of Coastal Georgia consists of South Coast Medical Group and Collaborative Health Systems. Approximately 8,000 Medicare beneficiaries are covered by this ACO.

Accountable Care Coalition of Eastern North Carolina (New Bern). The Atlantic Integrated Health Network partnered with Collaborative Health Systems to form the ACC of Eastern North Carolina, which is participating in the Medicare Shared Savings Program. Atlantic Integrated Health Network includes more than 6,400 providers, and founded in 1994, it is one of the oldest physician-led networks in the state. The ACO will serve about 10,000 Medicare beneficiaries.

Accountable Care Coalition of Greater Athens Georgia. The Coalition of Athens Area Physicians partnered with Collaborative Health Systems to form the ACC of Greater Athens Georgia, which is participating in the Medicare Shared Savings Program. The Coalition was founded in 1994 and includes more than 230 independent physicians. Approximately 8,500 Medicare beneficiaries are covered by this ACO.

Accountable Care Coalition of Mount Kisco (N.Y.). A participant in the Medicare Shared Savings Program, the ACC of Mount Kisco consists of a partnership between Mount Kisco Medical Group and Collaborative Health Systems. The medical group, founded in 1946, includes more than 270 physicians in 40 medical specialties at 25 locations.

Accountable Care Coalition of the Mississippi Gulf Coast. Formed by a partnership between Mississippi Coast Physicians and Collaborative Health Systems, the ACC of the Mississippi Gulf Coast is expected to serve about 7,000 Medicare beneficiaries. It is participating in the Medicare Shared Savings Program.

Accountable Care Coalition of the North Country (Canton, N.Y.). The ACC of the North Country is an ACO formed between North Country Physicians Organization and Collaborative Health Systems. North Country PO is a multi-specialty medical group that includes more than 170 physicians in 30 medical specialties. The ACO, which was recently selected by CMS to participate in the Medicare Shared Savings Program, is expected to serve about 5,300 beneficiaries.

Accountable Care Coalition of Southeast Wisconsin (Milwaukee). This ACO is comprised of a partnership between Independent Physician Network and Collaborative Health Networks. Established in 1984, IPN includes more than 900 affiliated physicians who care for more than 130,000 patients in southeastern Wisconsin. CMS recently named the ACO as one of the first 27 participants in the Medicare Shared Savings Program, and it is expected to cover about 10,000 beneficiaries.

Accountable Care Coalition of Texas (Houston). The ACC of Texas is comprised of independent physician associations, medical groups and health systems in the Houston and Beaumont areas of Texas, along with Collaborative Health Systems. The ACO is participating in the Medicare Shared Savings Program and is expected to serve approximately 70,000 beneficiaries.

Advocate Health Care (Oakbrook, Ill.). Advocate — a 10-hospital system — partnered with Blue Cross and Blue Shield of Illinois in October 2010 to form a three-year ACO called AdvocateCare. Advocate agreed to limit annual increases in return for the opportunity to share in savings resulting from clinical integration programs. BCBS of Illinois is the largest health insurer in the state, with nearly 7 million members. AdvocateCare most recently included approximately 375,000 members.

Allina Hospitals & Clinics (Minneapolis). Allina Hospitals & Clinics was selected as one of the first 32 ACOs to participate in CMS' Pioneer ACO

program. The non-profit, 11-hospital system provides care for nearly a third of the population in Minnesota and western Wisconsin, and approximately 15,000 Medicare patients are covered by its ACO.

AppleCare Medical ACO (Artesia, Calif.). AppleCare Medical ACO is affiliated with AppleCare Group and includes partnerships with more than 800 physicians in the region, as well as major hospitals across Southern California. The ACO, which was selected to participate in the Medicare Shared Savings Program, is expected to serve nearly 8,000 people in Southern Los Angeles and Orange County.

Arizona Connected Care (Tucson). Arizona Connected Care is a collaboration of independent healthcare providers in Southern Arizona, including Tucson Medical Center, three federally qualified health centers and more than 150 physicians. The ACO will focus on care transitions and access to team-based primary care services. A participant in the Medicare Shared Savings Program, ACC is expected to cover about 7,500 beneficiaries.

AtlantiCare (Egg Harbor Township, N.J.). AtlantiCare launched an ACO in October 2011. The ACO, which is operated through AtlantiCare Health Solutions, a non-profit corporation in New Jersey, includes participation from partner payors and independent and employed physicians. The AtlantiCare system includes more than 600 physicians and AtlantiCare Regional Medical Center, a 567-bed teaching hospital.

Atlantic Health System ACO (Morristown, N.J.). Non-profit, four-hospital Atlantic Health formed a commercial ACO in December 2010. In April, CMS selected the ACO to participate in the Medicare Shared Savings Program. Operating as the AHS ACO, about 50,000 Medicare beneficiaries will be covered by the model. The ACO includes a partnership with Valley Hospital in Ridgewood, N.J., and participation from more than 1,300 physicians, including more than 200 primary care providers.

Atrius Health (Boston). Atrius is the largest independent, non-profit physician group in Massachusetts, comprised of approximately 1,000 physicians. In late 2011, it was selected by CMS to participate in the Pioneer ACO model. Five of Atrius Health's six medical groups are participating in the ACO: Dedham Medical Associates, Granite Medical Group, Harvard Vanguard Medical Associates, South Shore Medical Center and Southboro Medical Group. Reliant Medical Group is considering participation in the ACO, as it recently joined Atrius in October 2011.

Banner Health (Phoenix). The Banner Health Network was the first organization accepted by CMS into the agency's Pioneer ACO program in late 2011. The network includes Banner Health-affiliated physicians, 13 Banner

hospitals — with 12 in the metropolitan Phoenix area — and other Banner services throughout Arizona. The ACO is a partnership between Arizona Integrated Physicians, Banner Medical Group and Banner Physician Hospital Organization. In total, it includes more than 2,600 primary care and specialty physicians.

Bellin-ThedaCare Healthcare Partners (Green Bay, Wis.). Bellin Health, ThedaCare and independent physicians were selected to work together as a Pioneer ACO by CMS in late 2011. The two health systems have a history of collaboration. They formed the Northeast Wisconsin Health Value Network in 2008, which was recently renamed as Bellin Health-ThedaCare Healthcare Partners. It includes eight major healthcare facilities between the two systems along with roughly 700 affiliated physicians.

Beth Israel Deaconess Physician Organization (Boston). The Beth Israel Deaconess Physician Organization was selected to participate in CMS' Pioneer ACO program in late 2011. The group has more than 1,600 physicians, including upwards of 350 primary care providers. It is affiliated with Beth Israel Deaconess Medical Center, a teaching hospital of Harvard Medical School, as well as several community hospitals in the region.

Bon Secours Medical Group (Richmond, Va.). Bon Secours Medical Group, the physician practice of Bon Secours Virginia Health System, launched an ACO with Cigna in April 2012. The model is based on the patient-centered medical home model of care, under which primary care physicians are rewarded for improved outcomes and lowered medical costs. The initiative covers approximately 8,000 Cigna beneficiaries.

Bronx Accountable Healthcare Network (New York City). Bronx Accountable Healthcare Network is affiliated with Montefiore Medical Center and was named to participate in the Pioneer ACO program in late 2011. CMS has estimated that roughly 24,000 Medicare beneficiaries will be served by the Montefiore ACO due to their current or past visits with one or more of the system's 2,400 employed and community-based physicians. This ACO is the only Pioneer ACO in New York state.

Brown & Toland Physicians (San Francisco). Brown & Toland Physicians was named as a Pioneer ACO in late 2011 by CMS. The independent practice association is comprised of more than 1,500 physicians and is affiliated with six hospitals in the San Francisco Bay Area.

Carilion Clinic (Roanoke, Va.). Carilion announced the formation of its ACO with Hartford, Conn.-based Aetna in March. The ACO will result in co-branded commercial healthcare plans for businesses and individuals, new payment models, shared cost savings, and joint opportunities to personalize care needs of patients,

including Virginia's Medicaid beneficiaries. Aetna serves roughly 35.3 million people, and Carilion serves nearly 1 million through its hospitals, outpatient specialty centers and advanced primary care practices.

Catholic Healthcare West (San Francisco). Along with San Ramon, Calif.-based Hill Physicians and Blue Shield of California, CHW launched a program to manage the care of more than 40,000 members of the California Public Employees' Retirement System. The collaboration, which was announced in April 2009 and went live in January 2010, essentially operates as an ACO. CalPERS members who already had a primary care physician affiliated with Hill were automatically enrolled in the program, which aims to improve what the providers considered a disjointed delivery system.

Chinese Community Accountable Care Organization (New York City). The Chinese Community ACO, a participant in the Medicare Shared Savings Program, will operate in the Chinese community of New York City. Through physician collaborations, the ACO is focused on providing culturally competent care to patients in an underserved, minority population. New York hospitals involved in the collaboration include Beth Israel Medical Center, New York Hospital Queens, Lutheran Medical Center and Flushing Hospital. The ACO is expected to cover about 12,000 Medicare beneficiaries.

CIPA Western New York IPA (Buffalo, N.Y.). This ACO will do business as Catholic Medical Partners, which is a Buffalo, N.Y.-based partnership between Catholic Health, St. Mary's Hospital and a network of more than 900 independent physicians. A participant in the Medicare Shared Savings Program, the ACO will serve roughly 31,000 beneficiaries.

Coastal Carolina Quality Care (New Bern, N.C.). Coastal Carolina Health Care — a physician-owned, multispecialty group with more than 50 providers — is the sole participant in this ACO. Recently named to participate in the Medicare Shared Savings Program, CCQC is expected to serve about 11,000 Medicare beneficiaries. Care for Medicare patients accounts for more than half of the medical group's care delivery.

Crystal Run Healthcare ACO (Middletown, N.Y.). A multispecialty group with more than 200 providers, Crystal Run Healthcare spans more than 40 medical specialties and includes 15 practice locations. Its ACO, which is participating in the Medicare Shared Savings Program, is expected to cover approximately 10,000 beneficiaries in New York and Pennsylvania.

Dartmouth-Hitchcock (Lebanon, N.H.). Dartmouth-Hitchcock was selected to participate in CMS' Pioneer ACO program in late 2011. Previously, Dartmouth-Hitchcock has also participated in CMS' Physician Group Practice

Demonstration and Transition Demonstration Projects, as well as other ACO models with three major insurers: Anthem, Cigna and Harvard Pilgrim Health Care. The Dartmouth-Hitchcock Clinic includes more than 1,200 primary and specialty care physicians throughout New Hampshire and Vermont.

Doctors Medical Center (Modesto, Calif.). In June 2011, Doctors Medical Center announced the launch of a three-year ACO with San Francisco-based Blue Shield of California and Modesto-based AllCare Independent Physician Association. The program covers approximately 8,000 HMO members. The healthcare entities share clinical and case management information to coordinate services, and incentives are aligned to improve quality and patient service while reducing costs.

Eastern Maine Healthcare Systems (Brewer, Maine). Eastern Maine was one of the first 32 Pioneer ACOs in the country, a CMS program that went into effect in January 2012. Its ACO includes approximately 8,000 Medicare beneficiaries who see providers based at three hospitals within the EMHS system — Aroostook Medical Center in Presque Isle, Eastern Maine Medical Center in Bangor, and Inland Hospital in Waterville. The system — which includes nursing homes, integrated physician groups and home health organizations — has said more than 60 percent of its revenue comes from Medicare and MaineCare.

Fairview Health Services (Minneapolis). Fairview, a 10-hospital system, was selected to participate in the CMS Pioneer ACO program in late December 2011. Fairview has pursued the ACO model through its Fairview Health Network for the past few years. In July 2009, the system signed performance-based contracts with Medica and continued to pursue similar deals with other major payors. Approximately 363 providers from 46 Fairview Health sites are participating in the Pioneer ACO, which includes more than 19,000 Medicare beneficiaries.

Florida Physicians Trust (Winter Park). This ACO includes a diverse group of independent physicians, including doctors of medicine and doctors of osteopathic medicine. The physicians will focus on care coordination, team-based care and improved provider-patient communication. The ACO, which was named as one of the first 27 ACOs to participate in the Medicare Shared Savings Program, is expected to serve about 16,500 beneficiaries.

Franciscan Alliance (Mishawaka, Ind.). The 13-hospital system formed an ACO in February 2010 and was named one of the first 32 Pioneer ACOs by CMS in late December 2011. The Pioneer ACO covers 22,000 Medicare patients in central Indiana and includes more than 700 physicians, 180 of whom are employed. The others are independent physi-

cians who agreed to coordinate care as part of the ACO. Franciscan Alliance took its first step toward ACO formation in late 2010 when it forged an agreement with Anthem Blue Cross and Blue Shield to provide patients enrolled in Hoosier Healthwise and the Healthy Indiana Plan with access to a more integrated system.

Genesys Physician Hospital Organization (Flint, Mich.). Genesys PHO is a collaboration between Genesys Health System and Genesys Physicians Group Practice. In late 2011, CMS named the PHO to participate in the CMS Pioneer ACO program. Genesys Health System, which includes Genesys Regional Medical Center at Health Park, is part of Ascension Health, the country's largest Catholic health system.

Hackensack (N.J.) Physician-Hospital Alliance ACO. HackensackUMC, the non-profit, 775-bed teaching hospital, is the anchor of this ACO. The Physician-Hospital Alliance ACO includes 735 physicians and advanced practice nurses. The integrated Hackensack system includes a cancer center, children's hospital, women's hospital and heart hospital. Named to participate in the Medicare Shared Savings Program, the Hackensack ACO will cover approximately 11,000 beneficiaries.

Health Choice (Memphis). A physician hospital organization affiliated with Memphis, Tenn.-based Methodist Le Bonheur Healthcare, Health Choice launched a collaborative accountable care initiative with Cigna in September 2011. The ACO covers approximately 17,000 Cigna health plan members who receive care from 29 Health Choice physicians at seven participating practice locations. The program was the first patient-centered ACO in the Memphis area between independent medical practices and a health plan.

Healthcare Partners Medical Group (Torrance, Calif.). CMS named Healthcare Partners Medical Group to participate in the Pioneer ACO program in late 2011. The group includes more than 1,200 employed and affiliated primary care physicians and more than 30,000 employed and contracted specialists. Prior to its participation in the Pioneer ACO program, the medical group also announced its participation in a commercial ACO with Irvine, Calif.-based Monarch Healthcare and Anthem Blue Cross.

HealthCare Partners of Nevada (Las Vegas). HealthCare Partners of Nevada is a multispecialty medical group and independent physician association that includes more than 203 primary care physicians and more than 1,700 specialists. In late 2011, CMS named the group to participate in the Pioneer ACO program to reduce costs and enhance care coordination for Medicare beneficiaries.

Heritage California ACO (Northridge, Calif.). Heritage California ACO is operated by the Heritage Provider Network, which is a collaboration of 10 affiliated medical groups and independent physician associations. The Heritage Provider Network contracts 2,300 primary care physicians, 30,000 specialists and more than 100 hospitals. The ACO's service area spans eight counties in North, Central and Coastal California.

Hoag Memorial Hospital Presbyterian (Newport, Calif.). Hoag Memorial formed a three-year ACO with Blue Shield of California and Greater Newport Physicians Medical Group. GNP Medical Group includes more than 500 physicians, who mainly deliver care at Hoag. Under the initiative, the organizations will share clinical and case management information, coordinate healthcare services and align incentives to reduce costs and improve quality. The ACO will officially go into effect July 1, 2012.

Jackson Purchase Medical Associates (Paducah, Ky.). This ACO is comprised of six medical groups throughout the Jackson Purchase region of Kentucky, including walk-in centers and specialists in endocrinology, rheumatology and renal care. Recently named to participate in the Medicare Shared Savings Program, the Jackson Purchase ACO is expected to cover roughly 6,000 Medicare beneficiaries.

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Jordan Community ACO (Plymouth, Mass.). The Jordan Community ACO is a non-profit organization consisting of more than 100 physicians from Plymouth Bay Medical Associates, Jordan Physician Associates and specialists from Jordan Hospital, also located in Plymouth. Together, the physicians will coordinate care for more than 6,000 Medicare beneficiaries, since CMS named the ACO as one of the first 27 participants in the Medicare Shared Savings Program.

JSA Medical Group (Saint Petersburg, Fla.). JSA Medical Group includes 34 primary care practices in the greater Tampa Bay and Orlando areas, along with affiliations with more than 50 primary care practices. The group includes 184 primary care physicians and roughly 1,800 specialists. In late 2011, CMS named JSA Medical Group as one of the first 32 Pioneer ACOs in the country.

Kaleida Health (Buffalo, N.Y.). In April, Kaleida Health announced its participation in a commercial accountable care initiative with BlueCross BlueShield of Western New York. The model, which is the first of its kind in the Buffalo region, includes a network of Western New York physicians who will contract with Kaleida and BCBS to create a physician-led organization.

Methodist Health System (Dallas). In May 2011, Methodist partnered with Texas Health Resources, based in Arlington, to develop a multi-provider ACO. Doug Hawthorne, CEO of Texas Health Resources, said the non-profit health systems both have strong faith-based foundations and are anchored in complementary locations. Prior to the announcement, the organizations participated in ACO preparatory projects with Premier, a national healthcare performance improvement alliance.

Michigan Pioneer ACO (Detroit). The Michigan Pioneer ACO is anchored by Detroit Medical Center and includes more than 200 employed and affiliated primary care and specialist physicians who provide services to Medicare patients through the hospital. DMC was one of the first hospitals in the country to successfully go entirely "paperless" with an electronic medical record in 2008. Late last year, CMS named the Michigan Pioneer ACO as one of the first 32 Pioneer ACOs in the country.

Monarch Healthcare (Irvine, Calif.). Monarch Healthcare, an independent practice association, was named one of the first 32 Pioneer ACOs by CMS in late 2011. Monarch is the largest physician organization in Orange County with more than 2,300 private practice physicians who care for roughly 176,000 people. In May 2010, Monarch also announced its participation in an ACO pilot project led by The Dartmouth Institute for Health Policy and Clinical Practice. That pilot was a partnership between Monarch, Anthem Blue Cross and HealthCare Partners, an IPA based in Torrance, Calif.

Mount Auburn Cambridge Independent Practice Association (Brighton, Mass.). Mount Auburn Cambridge IPA was named one of the first 32 Pioneer ACOs by CMS in late 2011. The ACO includes the IPA as well as Mount Auburn Hospital, a teaching hospital in Cambridge, Mass. The IPA includes more than 500 physicians. Mount Auburn Hospital has also formed risk-based contracts with Blue Cross Blue Shield of Massachusetts, Tufts Health Plan and Harvard Pilgrim Health Care.

North Country ACO (Littleton, N.H.). Participants in the North Country ACO include Ammonoosuc Community Health Services, Coos County Family Health Services, Indian Stream Health Center and Mid-State Health Center. All ACO participants are members of the rural health network North Country Health Consortium, which was founded in 1997. The ACO, which was selected to participate in the Medicare Shared Savings Program, is expected to cover about 6,000 beneficiaries.

Norton Healthcare (Louisville, Ky.). In November 2010, Norton partnered with insurer Humana to create the first ACO in the Louisville area. Non-profit Norton is comprised of five Louisville hospitals with approximately 2,300 total physicians on its medical staff. The ACO was launched as part of the Brookings-Dartmouth ACO Pilot Project.

North Texas ACO (Fort Worth and Arlington). North Texas Specialty Physicians and Texas Health Resources were selected by CMS to participate in the Pioneer ACO program in late 2011. NTSP is an independent physician association including more than 600 primary care and specialty physicians caring for patients in four Texas counties. THR is one of the largest faith-based, non-profit health systems in the country with 24 hospitals.

OhioHealth (Columbus, Ohio). In June 2011, OhioHealth announced its collaboration with Ohio-based health insurer Medical Mutual and the Medical Group of Ohio to form the Health4 program, which functions as an ACO. The 18-hospital system first formed Health4 with MGO in 2009. The partnership focused on a clinically integrated pay-for-quality approach to healthcare. The payor's recent addition to the partnership allows Health4 physicians and hospitals to be financially rewarded when quality measures are met and savings are realized.

Optimus Healthcare Partners (Summit, N.J.). This physician-led ACO includes more than 500 primary and specialty physicians. Named a participant in the Medicare Shared Savings Program by CMS, Optimus Healthcare Partners will serve beneficiaries in 11 New Jersey counties. In an April news report from *NJ Spotlight*, Optimus Healthcare CEO Thomas Kloos, MD, has said he expects to start with 27,000 Medicare patients and hopes to enroll commercial payors and increase the patient population to about 100,000 by the end of 2012.

OSF Healthcare System (Peoria, Ill.). OSF Healthcare was selected in December 2011 to participate in CMS' Medicare Pioneer ACO program. The health system uses care managers to help coordinate patient care from service points within the healthcare continuum. OSF Healthcare has a primary care physician network consisting of more than 600 PCPs, specialists

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and advanced practitioners. It also includes an extensive network of home health services, known as OSF Home Care Services, for patients' post-acute care needs.

Park Nicollet Health Services (St. Louis Park, Minn.). Park Nicollet was named one of the first 32 Pioneer ACOs by CMS late last year. The system has more than 1,000 physicians on staff and includes the 426-bed Park Nicollet Methodist Hospital, 29 multi-specialty clinics, a research foundation and an international diabetes center. The system previously participated in CMS' five-year Physician Group Practice Demonstration. In its fifth year, Park Nicollet achieved benchmark performance on all 32 quality measures.

Partners HealthCare (Boston). Partners was one of the first 32 organizations to participate in CMS' Pioneer ACO model. The system's background with care coordination stems back to 2006, when the system's Massachusetts General Hospital in Boston launched the Care Management Program, one of six CMS demonstration projects in the country. The program was found to be so successful — for every dollar spent, the program saved \$2.65 in healthcare costs — that in 2009, CMS renewed it for another three years and expanded it to two more Partners hospitals: Brigham and Women's Hospital in Boston and North Shore Medical Center in Salem, Mass.

Physician Health Partners (Denver). Physician Health Partners is a medical management company, and it was named to participate as a Pioneer ACO by CMS along with three of its strategic partner independent practice associations. Those IPAs are Primary Physician Partners, South Metro Primary Care and KEY Primary Care Physicians. The model focuses on medical homes and consists of more than 260 primary care physicians.

Physicians of Cape Cod ACO (Hyannis, Mass.). The Physicians of Cape Cod ACO has been pursuing care coordination for beneficiaries through its managed care program since 2002. The ACO was recently approved by CMS to participate in the Medicare Shared Savings Program — the first of 27 ACOs to do so. It is expected to cover about 5,000 Medicare beneficiaries in the Cape Code area.

Piedmont Physicians Group (Atlanta). Part of non-profit Piedmont Healthcare, Piedmont Physicians Group launched a pilot ACO with Cigna in July 2010. The ACO covers about 10,000 people in Cigna health plans. Under the pilot, Cigna pays the providers of Piedmont Physicians Group — which includes more than 100 primary care physicians — as usual for medical services, along with an additional fee for care coordination and medical home services. Physicians also get bonus payments if they meet targets for better quality and lower costs.

Premier ACO Physician Network (Calif.). The Premier ACO Physician Network is a subsidiary of Lakewood IPA, which has served patients in the Long Beach and Orange County areas for 25 years. Premier ACO Physician Network was recently selected by CMS to participate in the Medicare Shared Savings Program. It is expected to cover approximately 12,500 beneficiaries.

Presbyterian Healthcare System (Albuquerque, N.M.). Presbyterian was named one of the first 32 Pioneer ACOs by CMS in late 2011. The non-profit, eight-hospital system is also the largest managed care organization in the state, providing commercial health insurance along with Medicare and Medicaid products. It employs more than 500 physicians and practitioners, and its medical group has more than 30 locations throughout the state.

Primary Partners (Fla.). Primary Partners includes participating physicians from four Florida counties: Lake, Orange, Osceola and Polk. The ACO will offer clinically integrated patient-centered care while primary care physicians continue operating their independent practices. In April, CMS named Primary Partners as one of the first 27 ACOs to participate in the Medicare Shared Savings Program. The ACO is expected to serve about 7,500 beneficiaries.

Primecare Medical Network (San Bernardino, Calif.). Primecare Medical Network consists of 12 independent practice associations and two medical groups with more than 200 primary care physicians and 1,000 specialists. The network has participated in multiple health plan pay-for-performance quality programs and was named as one of the first 32 Pioneer ACOs by CMS in late 2011. The network operates in California's Riverside, San Bernardino and San Diego counties.

ProHealth Care (Waukesha, Wis.). In October 2010, ProHealth partnered with Waukesha Elmbrook Health Care, a local independent physician association, to form the first ACO in southeast Wisconsin. The ACO, called ProHealth Solutions, includes more than 475 physicians. Other participants in the model include Waukesha Memorial Hospital, Oconomowoc Memorial Hospital and ProHealth's behavioral health, home care and hospice facilities.

ProMed Alliance (Dade County, Fla.). ProMed Alliance, a subsidiary of Peer Review Mediation & Arbitration, a medical services business development company, formed an accountable care organization in March 2012. The ACO will include 10 to 15 primary care physicians, 15 to 20 specialists, and an advanced diagnostic and surgery center. The ACO is the first of 50 PRMA and ProMed plan to develop across the country over the next five years.

RGV ACO Health Providers (Donna, Texas.). Comprised of six primary care group practices, the RGV ACO serves patients from six Texas counties and their surrounding communities. This ACO is designed to provide patients with 24-hour access to providers at 10 clinic locations through the implementation of medical home concepts. Recently named by CMS as a participant in the Medicare Shared Savings Program, the ACO is expected to serve more than 6,000 beneficiaries.

Renaissance Medical Management Company (Wayne, Pa.). Founded in 1998, RMMC is an independent practice association owned and managed by primary care physicians in Southeastern Pennsylvania. In late 2011, the IPA was selected by CMS to participate in the Pioneer ACO program. The IPA includes more than 200 primary care physicians across five counties.

Santa Clara County Individual Practice Association (San Mateo, Calif.). SCCIPA and Anthem Blue Cross of California formed an ACO in August 2011 to provide care for Anthem PPO members in the Silicon Valley. The medical group includes 284 primary care physicians, 550 specialists and 10 acute-care facilities throughout Santa Clara County. The clinic has been said to "operate like a clinic without walls," in that it coordinates patients and health plans through an established network of medical services and providers.

Seton Health Alliance (Austin, Texas). Seton Health Alliance is an open network of providers currently made up of Seton Healthcare Family, an 11-hospital system, and Austin Regional Clinic. The ACO serves an 11-county region in Central Texas that includes 13 hospitals. In late 2011, Seton Health Alliance was named a participant in the Pioneer ACO program by CMS.

Sharp Healthcare System (San Diego). Sharp HealthCare was selected by CMS as one of the first 32 Pioneer ACOs, effective in 2012. The ACO includes 836 physicians and 52 mid-level providers and covers approximately 32,000 beneficiaries. A key goal of the ACO is the reduction of preventable readmissions across seven Sharp hospitals, an initiative addressed through care transitions programs, skilled nursing programs and end-of-life care services.

St. John Providence Health System (Warren, Mich.). In October 2011, St. John Providence formed a physician-led ACO in a 50-50 partnership with The Physician Alliance, which is comprised of six independent physician groups — or more than 2,300 physicians — in Michigan. The ACO is called St. John Providence Partners in Care and is expected to cover approximately one million patients in five counties.

St. John's Mercy Medical Group (St. Louis). St. John's Mercy Medical Group, a physician-led practice including 165 primary care physicians affiliated with St. John's Mercy Health Care, launched an accountable care pilot program with Cigna in July 2010. The ACO uses registered nurse case managers to serve as clinical care coordinators for Cigna beneficiaries, and physicians are rewarded through pay for performance structures if they meet metrics for quality and medical costs.

St. Joseph Health System (Orange, Calif.). St. Joseph Health System and Blue Shield of California launched a one-year accountable care initiative in January 2012. The model, which functions as an ACO, covers approximately 30,000 Blue Shield HMO members in Orange County. It involves St. Joseph Hospital in Orange, St. Jude Medical Center in Fullerton, Mission Hospital in Mission Viejo and Laguna Beach, a home health ministry, three medical groups and three affiliated physician networks.

Steward Health Care System (Boston). Steward Health Care System includes 10 community hospitals and serves more than one million patients across 85 Massachusetts communities. The system also includes a medical group and hospice and home care services. It was named a Pioneer ACO by CMS in late 2011.

TriHealth (Fort Dodge, Iowa). TriHealth's ACO is anchored by Trinity Regional Medical Center, Berryhill Center for Mental Health, Trimark Physicians Group and Iowa Health Home Care. TriHealth has an eight-county service area in a predominantly rural area of northwest central Iowa. In late 2011, CMS named TriHealth a participant in the Pioneer ACO program.

University of Michigan Health System (Ann Arbor). The University of Michigan Health System was named to participate as one

of the first 32 Pioneer ACOs in late 2011. The ACO is a partnership with IHA Health Services Corporation, a multi-specialty group practice based in Ann Arbor with roughly 175 physicians. The three-hospital system has previously found success in the Medicare Physician Group Practice Demonstration, a five-year project in which U-M's Faculty Group Practice saved Medicare upwards of \$22 million through medical cost reductions.

Weill Cornell Physician Organization (New York City). Weill Cornell, which includes approximately 71 physicians, launched an accountable care initiative with Cigna in January 2011. The initiative is essentially an accountable care organization since it shares the model's population health goals. It is the first patient-centered accountable care initiative in New York City involving a health plan and physician organization.

West Florida ACO (Trinity, Fla.). CMS named West Florida ACO as one of the first 27 participants in the Medicare Shared Savings Program this April. The ACO is made up of more than 30 primary care physicians and specialists who focus on care coordination for geriatric patients. Internist Jayadeva Chowdappa, MD, heads the ACO, which is expected to serve more than 10,000 Medicare beneficiaries.

Westmed Medical Group (Purchase, N.Y.). Westmed — a multi-specialty practice including more than 220 physicians — launched an ACO with UnitedHealthcare and Optum in March 2012. Participating physicians are measured and rewarded based on quality outcomes, patient satisfaction and cost reduction compared to medical costs in the local market. Westmed has also received level-3 recognition for its patient-centered medical home from the National Committee for Quality Assurance. ■

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A “Lean” Vision Drives Stanford Hospital & Clinics’ Performance: Q&A With CEO Amir Dan Rubin

By Kathleen Roney

Stanford (Calif.) Hospital & Clinics is known worldwide for advanced treatment of complex disorders in areas such as cardiovascular care, cancer treatment, neurosciences, surgery and organ transplants. It is currently ranked No. 17 on the *U.S. News & World Report’s* “America’s Best Hospitals” list and No. 1 in the San Jose metropolitan area.

Stanford Hospital is also internationally recognized for translating medical breakthroughs into the care of patients. For instance, Stanford Hospital recently became the first hospital in Northern California to have the Solitaire FR, a new FDA-approved device to remove blood clots, available for use.

Amir Dan Rubin leads Stanford Hospital as president and CEO. Previously he served as COO of the 832-bed UCLA Health System in Los Angeles, where he oversaw an operating budget of \$1.6 billion. Since his appointment in 2011, Mr. Rubin has maintained Stanford’s reputation as a leading healthcare provider.

Here he discusses how focusing on the organization’s vision rather than finances, transparency and a “Lean” approach to performance improvement help him guide Stanford into a future that is better than its past 50 years.

Question: You became CEO of Stanford Hospital & Clinics in January 2011 during what could certainly be called an uncertain time in healthcare with reform and payment issues. How have you approached your role as CEO in light of those issues?

Mr. Rubin: Fundamentally as CEO, I focus on our core mission and vision. Our mission is to care, educate and discover. Our vision is to heal humanity through science and compassion one patient at a time. While we must be thoughtful with what’s going on in the regulatory and payment environment, our core focus needs to always be on providing outstanding care to each and every patient we serve. We constantly focus on that ideal.

Stanford’s mission and vision guide how I approach my CEO role as well, and all other factors are seen as contributing criteria or factors which we need to address. However, these factors need to be secondary issues to our goal of healing humanity, one patient at a time. While in my role, it is important to be thoughtful and mindful about what’s changing in the environment around us, it doesn’t fundamentally change who we are or what we do.

Q: You mentioned Stanford’s longtime mission and vision of healing humanity one patient at a time. Does Stanford have any other current goals driving its outcomes and care?

ADR: Stanford has enjoyed great success. Over the last 50 years, we have had five Nobel prizes, carried out the first heart-lung transplant in the world, and were the first in the world to use a linear accelerator for cancer treatment, among other notable accomplishments. Our big vision now is trying to have as great of an impact on the world of healthcare, if not a greater one, over next 50 years. We are working on sequencing human genomes, conducting innovative stem cell research, and we were one of the earliest adopters of electronic health records in the country. Overall, we are focusing on how to visualize and advance improved, evidence-based healthcare.

Q: I imagine that working to produce outcomes to rival the great accomplishments Stanford has had in the past can be challenging. How do you encourage an environment conducive to improvement and advancement in healthcare treatment, research and technology?

ADR: I have learned to try to understand the core operations and processes beneath things, to not just accept them at face value and move on. Often when you do that, you find there isn’t a lot of logic to why things are the way they are. So why not change it for the better? Here at Stanford we use the “Lean” process improvement approach or methodology. It derives from the Toyota Production System. It engages people to improve their performance and the performance of the hospital. You look at the hospital processes and identify which area is adding value, which area is delivering great value and which area is a waste of time. The Lean Process follows the idea that by systematically and continuously improving processes, and by engaging the team, we can develop an organization that is focused, every day, on being better than it was before.

Q: Stanford is currently building a \$2 billion hospital facility. A project of that scale must require a lot of hard work and dedication from you, administration and employees. How have you approached your leadership through such a large project?



ADR: The administration and I approach the project in a very collaborative and transparent way, with great rigor and discipline. From the beginning, it has been transparent. We welcomed all the necessary constituents to be involved in the design. We had teams of physicians, nurses, staff and community members thinking about the design, workflow and how to make the facility a safe and healing environment. Our project approval process was also very transparent. We probably had 100 open community meetings that presented the design of the new hospital and the key components. We had great participation from all types of constituents. As we move forward and operationalize the design, we are still thinking about the team members, the patients and the families.

We also have had a lot of engagement with Silicon Valley organizations such as Oracle, Hewlett Packard, Apple, Cisco and others. As we think of the future with the new hospital, we wanted it to be a test bed and innovation center. It has been incredible to leverage the expertise and capabilities here in California’s Silicon Valley.

Q: I imagine with all the involvement of constituents and stakeholders that you received lots of perspectives and varying feedback. How do you work through all those opinions and suggestions?

ADR: First, we sorted and grouped the feedback based on the different constituent voices. We learned many great things from staff and physicians. Then we tried to incorporate the ideas into the design itself — how the facility will flow and how patients and families will interact with the facility. We took the feedback, and at the end of the day, it is memorialized in

We seek to deliver both leading edge and coordinated care — we seek to deliver the Stanford Edge as we call it. Our focus is on delivering the absolute best care possible in quality and patient satisfaction. We make sure we are delivering the most effective treatments and incorporating the latest insights to ensure the patient's best chance for surgical healing. We consider what the pa-

the ball. We have to focus on care and then we are thoughtful about our financial management.

I have learned to try to understand the core operations and processes beneath things, to not just accept them at face value and move on. Often when you do that, you find there isn't a lot of logic to why things are the way they are. So why not change it for the better?

— Amir Dan Rubin, CEO, Stanford Hospitals & Clinics

the bricks, in the mortar, in the processes and in the information technology of the new hospital.

Q: Stanford has been able to maintain very positive revenues despite a challenging healthcare environment and while building a large new hospital facility. What has helped Stanford to maintain such positive financial management?

ADR: We think primarily about patient care.

tient's access is like and what our delivery to meet their needs is like. We question whether we are delivering value in demonstrable performance.

That is where it all starts. If one doesn't focus on outstanding care, innovative treatments, coordinating care for patients and delivering a good care experience, then you are not going to do well financially. If we focused on financial management, I think we wouldn't have our eye on

Q: What advice would you give other executives who are looking to lead their hospitals and health systems to the standards of care that Stanford has achieved?

ADR: I think being a leader in healthcare starts with a love and passion for what you do. Take the opportunity to meet with people — talk to patients, talk to staff. Understand the world through other people's eyes. Ask questions. Why are things the way they are? How are things from another's perspective? Understand the underlying processes and try to be of help and do so with great respect for others and their work. Ultimately, it is important to have a passion for what you do. Respect people and be here to serve humanity.

Additionally, being a leader of a successful healthcare organization means focusing on a vision. The organization and all of its leaders must then model values and approaches that are in line with that vision. It is about setting clear objectives and engaging team members in those efforts. For instance, for us at Stanford, it is about having big visions, big aspirations and having significant impact in the world. Meeting healthcare demands today means engaging team members, defining best practices, developing those best practices, training team members on them, redesigning processes around them, recognizing performance and then continuously improving. That approach has been effective in my career. ■

Surgically Remodeling a Hospital: Q&A With Dr. Jeffrey Steinberg, CEO of Vanguard's Weiss Memorial Hospital

By Bob Herman

This past September, Weiss Memorial Hospital brought in the East Coast-based Jeffrey Steinberg, MD, to lead the Chicago-based facility. Dr. Steinberg, a urological surgeon, came to Weiss Memorial — which is part of Nashville, Tenn.-based Vanguard Health Systems — from Saint Francis Hospital and Medical Center in Hartford, Conn., where he was the senior vice president for health policy and disparity and chairman and director of surgery. Prior to that, he was the chief of surgery at Saint Vincent Hospital in Worcester, Mass., which is the flagship hospital of Vanguard's New England market.

During his tenure with those two hospitals, Dr. Steinberg boosted their surgical profiles. At Saint

Francis, he recruited 14 employed surgeons that generated \$20 million in net patient revenue, and upon leaving, the surgery department had more than 220 active surgeons. While at Saint Vincent Hospital, he helped establish the first da Vinci Surgical System program in Central Massachusetts.

Surgery — and the management of it — is Dr. Steinberg's forte, and he says there are many ways hospitals can help this department improve. Here, he talks about how he plans to lead Weiss Memorial, how hospitals can improve their surgical volume and how a strong primary care base and surgical specialists are irrevocably linked to success.

Question: What are your visions for the new-look of Weiss Memorial Hospital?



Dr. Steinberg: Weiss has a rich tradition of serving the Uptown community in Chicago. It's really been serving the diverse community for the past 60 years, and it's a wonderful, caring community hospital with an academic affiliation with the University of Chicago Medical Center.

As for initiatives, I was the first physician who has been actively recruited within Vanguard Health Systems, and they recruited me because Weiss is a surgical hospital and a physician-friendly hospital. We want to grow the primary care base as well as the medical and surgical specialists, and we want to create additional centers of excellence in all of the clinical areas. Having practiced and benefited from major academic centers in Boston and Worcester, Mass., I'm trying to build on my experience in creating centers of excellence at Weiss for physician alignment, physician recruitment and collaborative building programs. We are one of four Vanguard hospitals in the Chicago market, so this is a market-wide strategy. We have to compete in this very competitive Chicago healthcare market.

Q: You are a urological surgeon leading a hospital with a lot of prior executive experience. How will your previous experience help you and help to improve the hospital both financially and clinically?

JS: I'm a product of the Harvard medical program in general surgery and urology. I practiced at the Cambridge Health Alliance to be chief of surgery. I went to St. Vincent's in Worcester to be chief of surgery, as well as at St. Francis in Hartford. Along the way, my major initiatives were recruiting additional physicians and building centers of excellence. I had many experiences in partnering with physicians and also in retaining practices of physicians who were already on the medical staff. To bring them into active management of these entities through co-management agreements — creating models that add value to the hospital — improves outcomes and encourages physician loyalty while further developing programmatic excellence.

As I was building these programs, I was practicing alongside with these physicians. I was right next door to these surgeons. It's very important for hospital leaders to have credibility and to see at a granular level what barriers and opportunities there are for physicians to succeed and grow into something larger than themselves.

Q: How do you plan to work with CFO Jeff Wright and the entire financial team?

JS: Jeff is a wonderful colleague. He was the acting CEO here at Weiss, and he has a wealth of experience as well. We've worked with some of the same folks. He worked at Geisinger Health System — Geisinger is a very progressive system in Pennsylvania, and it rolled out new models of care that President Barack Obama noted in a previous State of the Union Address. [Jeff] has been a fabulous partner to help me grow at Weiss, and I've recruited additional executives to help Weiss grow and develop programs of excellence. Our new executive team is positioned for growth.

Q: What are some of the short- and long-term financial and clinical objectives?

JS: Clinical: recruitment, recruitment, recruitment. We're looking at additional primary care physicians both in internal medicine and family practice, and we're recruiting additional surgical specialties, particularly in otolaryngology, urology, general surgery and gynecology. For medical specialties, we want to recruit additional cardiologists and gastroenterologists.

It's not just recruiting, but also creating programs of excellence in each of those areas. It's not just plopping down those physicians in those areas. It's all part of a coordinated growth initiative by the Vanguard Chicago market. That's my number one imperative. We're there already in orthopedics, and we're going to expand that to sister hospitals, too.

Financially, we want to be healthier, and we are. Our volume is growing. We want to reinvest in facilities so we can continue to provide top-notch care. Our medical office buildings are underutilized, so we have plans to provide new ambulatory services there and bring on additional physicians who would like to have ambulatory practices there. Our new facilities master plan will position us for growth to make the hospital comfortable, confidential and technologically advanced for all patients — inpatient or ambulatory. Ambulatory is really important because that's where healthcare reform is headed.

Q: What are the most effective ways for hospitals to increase their surgical volume?

JS: You need to have a strong primary care physician base to feed to your specialists is number one. You need to take care of the primary care physicians and provide a full range and spectrum of things they need for their patients.

Number two: How do you increase and make your processes more efficient and easier for patients to navigate? You want to make sure every patient has exceptional service because they are your best ambassadors. Word of mouth still plays a very important role in attracting new patients, and my goal is to delight patients so they tell their neighbors, friends and others. It's making sure existing patients are delighted because they are your best salespeople.

We also want to make it easy for patients to physically navigate the hospital. They should know where services are, where they go to get prepared for surgery, where to follow up after surgery, nurses calling and giving postoperative directions, primary care physicians knowing what the ongoing care needs are. It's not just episodic care but also aggregating into the complete continuum of care.

Other ways are having the latest equipment, operating room availability and having excellent staff who are actively engaged in their service. Co-management agreements — where the orthopedic surgeons are running the program and have skin in the game to make sure there are good outcomes — are also a very effective mechanism for engaging physicians in hospital operations because they are the content experts of providing the best care. That's one of our ways we align interests of physicians with the hospital and ultimately gives the patients the best care. ■

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11 Hospital, Health System Executive Compensation Trends
(continued from page 1)

1. Total compensation is increasing slightly. One trend is that hospital executive compensation is increasing by approximately 3 percent per year, according to David A. Bjork, PhD, senior vice president and senior advisor of the executive compensation and governance practice at Integrated Healthcare Strategies. IHS' Spring 2012 Salary Increase, Incentive and Benefit Updates Survey found that the average budgeted salary increases for hospital and health system executives in 2012 are 2.5 percent.

Some healthcare executives, however, are choosing to forgo compensation increases or bonuses. "Despite the odds against many of the C-suite executives and the fact that they are leading their organizations through unparalleled economic times, we are seeing more and more of these executives take a voluntary pay cut," says David Gillan, vice president of purchased services at Novation. "These executives want to lessen the burden on the organizations they are leading and realize the cuts are being felt by all staff."

In 2011, median and average base salaries for independent hospital CEOs were \$467,500 and \$482,300, bringing their median and average total annual cash compensation to \$496,400 and \$539,200, respectively. Independent health system CEOs had a median base salary of \$649,900 and an average

base salary of \$687,900, which brought their median and average total annual cash compensation to \$790,100 and \$861,500, respectively, according to IHS' 2011 National Healthcare Leadership Compensation Survey.

2. Compensation increases are higher at standalone hospitals.

Standalone hospitals tend to give higher increases in compensation for their executives than hospitals under a system, according to Paul Esselman, executive vice president and managing principal at Cejka Search. "One of the reasons is standalone hospitals are up against the market and have to perform in order to stay independent. There is so much more pressure on leadership to perform, to deliver quality and safety scores and implement initiatives," he says. In comparison, hospitals under a large system have more resources and support at their disposal to meet quality and cost goals.

In 2011, total cash compensation for integrated health system CEOs and independent hospital CEOs differed by roughly 3 percentage points: Integrated health system CEOs had a 3.1 percent increase while independent hospital CEOs had a 6 percent increase from the previous year, according to Hay Group's 2011 Hospital Prevalence and Planning Report.

3. Boards are more conservative. One new trend in hospital and health system compensation is that the organizations' boards are being more conser-

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vative and more cautious, Dr. Bjork says. Their caution is motivated by several reasons, including lower reimbursements, pressure to reduce costs and the public's perception of executive compensation. "Boards are also nervous about the future because of healthcare reform," Dr. Bjork says. "They're concerned about the effects of accountable care on the financial health of their institutions and the kind of transformation the organizations need to go through in order to thrive in the future. They know that healthcare organizations are going to need to change a lot, and they're in part wondering how those changes will affect the way they deliver pay to the organizations' leaders."

4. Boards' focus on reducing costs affects compensation. The pressure to reduce costs in healthcare has caused many hospital and health system boards to be more conservative in adding new components to an executive's compensation package, Dr. Bjork says. "They are really focused on trimming costs and becoming cost-effective, and it's starting to affect the way they look at executive pay," he says.

This focus on reducing costs has triggered some boards to raise the threshold for awarding executives bonuses for financial improvement. For example, executives at Chattanooga, Tenn.-based Erlanger Health System did not receive bonuses despite the system's fiscal year 2011 profit because the board of trustees instituted stricter bonus criteria. In FY 2010, Erlanger had an \$8.6 million profit and gave \$1.9 million in bonuses. In FY 2011, the system made a profit of \$5.4 million. Under the new bonus system, Erlanger must have an operating margin of 30 percent, a total profit of \$12 million and a 25 percent increase in admissions, among other requirements.

5. Boards' awareness of public perception yields fewer bonuses. Hospital and health system boards are also less apt to hand out large bonuses to the organization's leaders because the public tends to portray executive compensation increases negatively. "They know they're

going to have to defend their decision, so they're finding it difficult to be generous even when they are very impressed with the performance they're getting out of their leaders," Dr. Bjork says. Boards are awarding bonuses less not due to poor performance, but due to concerns about the public's perception. "Very few boards really believe that executive pay is too high. But they're acutely attuned to all the criticism they hear and see in print that executive pay is too high. They're really responding to the public relations risk more than they are to their own sense that pay is too high," he says.

The public's attack on hospital leaders' compensation increases can be particularly harsh when the increases follow layoffs at the organization. For instance, there was backlash against Jackson Health System in Miami when it was found that CEO Carlos Migoya earns roughly \$850,000 per year while the system made more than 1,100 layoffs.

However, if cutting staff is the best solution to poor financial performance, leaders are only being rewarded for doing their job, Dr. Bjork says. Some boards are delaying bonuses to executives until months or a year after the layoffs occurred to avoid the public's perception that the executives are benefiting at the employees' expense.

Mr. Esselman suggests consumers' greater awareness of healthcare executives' compensation will force hospitals and health systems to be more transparent with the community and communicate more effectively. Delivering high quality care may also reduce the public's negative viewpoint of healthcare leaders' compensation. "When patients in the hospital feel like they're getting the best care, the compensation of their executives becomes less of an issue," he says.

6. Pay increases for new leaders. One trend that has continued from previous years is that new executives recruited from other organizations are often compensated more than their predecessors. Experienced executives are usually paid well, and it typically takes a good increase to

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Compensation

Position	2011 median base salary	2011 average base salary	2011 median total annual cash	2011 average total annual cash
Independent hospital				
CEO	\$467,500	\$482,300	\$496,400	\$539,200
CFO	\$263,600	\$279,800	\$275,700	\$312,100
COO	\$265,000	\$283,800	\$287,900	\$319,900
Independent health system				
CEO	\$649,900	\$687,900	\$790,100	\$861,500
CFO	\$371,100	\$381,900	\$427,800	\$454,800
COO	\$389,000	\$414,400	\$430,900	\$491,900

Source: IHS

persuade an experienced executive to change jobs, according to Dr. Bjork. This trend may become more important as more hospital and health system executives reach retirement age, the stresses of healthcare reform spur some executives to retire early and hospitals search for new leaders to transform an organization struggling with healthcare reform regulations.

Hospitals increase pay for new executive leaders in part to attract the strongest leaders to the organization. “Committees are very divided,” Dr. Bjork says. “They’re cautious as they are making their decisions, but they understand that they need first rate talent, so they are willing to pay enough to get really good talent and hold onto them.”

7. Boards are becoming more involved in compensation plans. As boards are becoming more attuned to efforts to reduce the cost of care and more sensitive to the public’s view of compensation, they are beginning to take a larger role in developing goals for executives’ incentive plans, according to Dr. Bjork. “In the past, they used to be more willing to let management take the lead in deciding what the measures should be. Boards are now exerting more control over deciding what the measures are, how to weight the measures and what the goals should be,” he says.

The Center for Healthcare Governance noted in a monograph that the Patient Protection and Affordable Care Act’s provisions for rewarding high quality and penalizing low quality partly motivated hospital compensation committees to take more responsibility for goal-setting in executive pay. By becoming more involved in establishing targets for incentive payments, boards can ensure the hospital or health system is incentivizing the correct behavior to reach quality and safety goals. Boards are focusing on quality, physician alignment and patient satisfaction metrics, among others.

8. Compensation is based on quality metrics. Hospital and health system executives’ bonuses are increasingly based partly on quality and safety performance. This shift is due in part to healthcare reform’s emphasis on quality and safety and their relationship to financial rewards or penalties. Regardless of whether the law is deemed unconstitutional or

not in June, this trend is likely to continue due to greater transparency, which allows patients to be more selective in choosing healthcare providers, and the benefits of saved costs and saved lives that come with higher quality. “I believe we’re going to continue to see compensation and bonus compensation for healthcare executives not be solely based on financial performance of the organization but on things like quality, safety and service,” Mr. Esselman says.

9. Compensation is based on the ability to align physicians. In addition to rewarding healthcare leaders for quality, hospitals and health systems are also rewarding their leaders for

success in aligning physicians, as it is also encouraged under the healthcare reform law. “The leaders that are able to achieve collaboration are highly sought after,” Mr. Esselman says. “Those highly sought after leaders, when they’re successful in achieving some of these [physician alignment] initiatives, will be rewarded.” Leadership’s engagement of the community and collaboration with payors and local physician groups can help drive greater quality and cost savings and will be rewarded in leaders’ compensation packages. “Physician alignment strategies will become an increasing piece to a hospital executive’s compensation because every hospital wants to have a strong medical staff, and it really falls on the leadership of that hospital to create that environment where physicians want to come to their hospital and admit their patients,” Mr. Esselman says.

In fact, nearly 38 percent of hospitals and health systems will use some type of physician alignment criteria in their incentive plans in 2012, according to IHS’ Spring 2012 Salary Increase, Incentive and Benefit Updates Survey.

10. Compensation is based on patient satisfaction. Patient satisfaction is also becoming more common in hospital and health system executives’ compensation. “Senior leaders will increasingly be rewarded for overall patient satisfaction with their organization, because each leader has a hand in shaping a patient’s experience,” Mr. Esselman says. “For example, a CFO who improves the accuracy and efficiency of the patient billing process has a positive impact on patient satisfaction.” The 2011 Hay Group Healthcare Compensation Study found that 79 percent of providers use patient satisfaction as the primary measure for annual incentives across all executive employee groups of the organization.

Compensation increases

Position	Median base salary increase 2010-2011	Median total cash increase 2010-2011
Integrated health system CEO	4%	3.1%
Independent hospital CEO	5%	6%

Source: Hay Group

Long-term incentive plans

Year	Large non-profit health systems using long-term incentive plans for CEOs	Median long-term incentive opportunities for non-profit health system CEOs
2001	39%	20% of salary
2011	45%	28% of salary

Source: IHS

11. Long-term incentives are becoming more prevalent. More hospitals and health systems are including long-term incentives in their executives' compensation packages as healthcare reform requires changes that will affect the entire system of delivery over time. "By and large it's an effort to put into place a program that focuses on transformation. They're recognizing that if they focus only on this year's performance, they're not focused on the need to transform how healthcare is delivered," Dr. Bjork says. He says long-term incentives, which usually look ahead three years, are also a way to retain leaders because they must wait three years to receive their bonus.

In 2001, 39 percent of large non-profit health systems used long-term incentive plans for CEOs. By 2011, this number reached 45 percent, according to an IHS report. In that same time span, the median long-term incentive opportunities for non-profit health system CEOs increased from 20 percent of salary to 28 percent of salary per year, according to IHS.

The 2011 Hay Group Healthcare Compensation Study found that only 14 percent of non-profit integrated health systems offered long-term incentive plans in 2006, but 25 percent offered these plans in 2011. Similarly, 14 percent of non-profit secular integrated health systems had long-term incentive plans in 2006 and 23 percent had them in 2011. Non-profit religious integrated health systems showed the most change, going from 8 percent offering long-term incentive plans in 2006 to 31 percent offering the plans in 2011.

Overall, hospital and health system executive compensation trends reflect trends in the industry as a whole: there is a greater focus on transparency, quality, physician alignment, patient satisfaction and long-term change. As the challenges in healthcare today demand strong leadership, hospital and health system executives may continue to see increases in compensation to attract and reward high talent. However, there is likely to also be some restraint in bonuses from the board as the market increases pressure on organizations to reduce costs. ■

Compensation Manifesto: 11 Steps for Hospital CEOs and Compensation Committees to "Get it Right"

By Bob Herman

Compensation of hospital CEOs and other top hospital executives, especially at non-profit organizations, is undergoing mass amounts of scrutiny, thanks in part to the new federal standards that require transparency of all tax-exempt organizations.

Kenneth Ackerman, chairman of Integrated Healthcare Strategies and former president of Geisinger Medical Center in Danville, Pa., spoke at the American College of Healthcare Executives 2012 Congress on Healthcare Leadership in Chicago on March 19. He said that hospital executives and the compensation committee within the board of directors must be on the same page if community members, media and all other interested parties are to understand the methodology behind the salary figures. He explained 11 checklist points for hospital executives and hospital compensation committees to follow in order to reach that level of understanding.

1. Have a dedicated compensation committee. A compensation committee is typically composed of five board members tasked with setting the compensation of the hospital CEO and other high-paid executives. That committee wields an extraordinary amount of power when it comes to setting the pay standards for the hospital, so it must be a dedicated group of independent directors who possess the necessary skill sets. Mr. Ackerman emphasized that setting compensation is more than just an accounting task — it needs to come from a group of people who are willing to show the time commitment and will not have any conflicts of interest.

2. Prepare a compensation committee charter. Mr. Ackerman has seen compensation committee charters at hospitals that are three to four sentences, but a charter that is that short will not have much of an impact or detail as to how things are run. "That's not a charter," Mr. Ackerman said of a three- to four-sentence compensation charter. "You have to spell out in some detail what has been delegated and how the compensation committee is going to govern."

3. Adopt a board-approved compensation philosophy. Similar to the charter, a compensation committee must put forth a board-approved philosophy on how compensation is viewed in the hospital. Mr. Ackerman said the philosophy is the bedrock of any good compensation plan, and it helps keep the board and CEO on the same wavelength.

4. Focus on total compensation. A compensation committee cannot only focus on the cash compensation, which includes salary, benefits and other immediate cash incentives. The federal government is looking at the entire spectrum of compensation, which includes deferred compensation and retirement plans, and therefore that must be reflected on the Form 990. "That's what the IRS expects of your organization," Mr. Ackerman added.

5. Establish the Rebuttable Presumption Reasonableness. Internal Revenue Code 4958 established many provisions for tax-exempt organizations, including hospitals. Under IRC 4958, a tax-exempt organization can establish RPR, which more or less validates why an executive was paid a certain amount. Mr. Ackerman said every hospital CEO and compensation committee should establish the RPR because it is a safe harbor and provides protection as to the compensation rationale. He said every compensation committee and board meeting should include in their minutes how compensation was determined with supporting documentation, such as providing comparability data of other healthcare executive compensation trends.

6. Hold regularly scheduled meetings. Speaking of meetings, executives and compensation committees should meet at least two or three times per year as a minimum. "Holding meetings only once a year is not doing the job," Mr. Ackerman said. "Things are moving too fast. To have [the committee] making informed decisions, doing it in one or even two meetings won't do it justice."

7. Ensure adequate time to deliberate and conduct CEO appraisal. Because there are so many different factors that affect hospital executive compensation, such as comparability data and hospital revenue size to name a few, Mr. Ackerman said hospitals should allow for enough time to set the right compensation. This is especially true as boards and committees set the compensation for the hospital CEO, which usually receives the most scrutiny.

8. Hold executive sessions. Executive sessions are meeting agenda discussions in which board and compensation committee members debate

and question the CEO and other executives on performance and other issues that are pertinent to setting their pay. Mr. Ackerman said after board members conduct their inquiries, the executives can be excused for further debate. "This may take five minutes, or this could take 20 minutes," Mr. Ackerman says. "But it's good governance, and it sets the tone."

9. Instill an environment of continuous quality. "If the board isn't committed to [self-evaluation], who is?" Mr. Ackerman asked. He said CEO self-evaluation and committee self-evaluations will ensure that compensation is justified while also ensuring the right people are being retained for the jobs.

10. Prepare to address media inquiries. Every hospital executive, especially the CEO, should know who the hospital's media spokesperson is and what the simple statement will be regarding his or her salary and benefits. Any comments on compensation should be directly attributed to the statement, yet thoughtful enough to answer any potential questions from deadline-pressured reporters.

11. Practice full disclosure to the board using tally sheets. In 2002, the U.S. Securities and Exchange Commission required that for-profit entities use tally sheets, which describe an executive's current and potential total compensation, retirement income and severance benefits, and what a lump sum severance benefit could be if the executive were let go without cause. These types of compensation sheets are not required of non-profit hospitals, but Mr. Ackerman said it is certainly a best practice. "The best practices in corporate America should occur in the not-for-profit sector," he said. ■

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200 Statistics on Physician Compensation — 2012 Edition

By Bob Herman

For hospitals and health systems, physician compensation will always be a hot-button issue. Branching out and attracting physicians is a core goal of any health organization, especially with the advent of accountable care organizations, but because physicians go through thorough and rigorous medical training to deliver the highest possible care to patients, they must be compensated appropriately.

The same certainly applies to nurses, frontline staff and all other members of the health-care delivery system. However, as hospitals continue to purchase physician practices and physician reimbursement hangs in the balance, physician pay rises to the top of the bucket. The same holds true for independent practice physicians, as their declining revenue streams directly impact how much bread they take back to their table.

Highest-paid specialties

Surgical specialties again lead the pack in highest salaries and compensation packages. Cardiac and thoracic surgeons, orthopedic surgeons, noninvasive and invasive cardiologists, urologists, gastroenterologists, ophthalmologists and many others all had pay figures above \$350,000 and as high as \$532,000 (cardiac and thoracic surgeons).¹ Neurosurgeons are also among the highest-paid physicians, as their compensation routinely tops \$700,000, depending on the employment setting.²

The highest-earning physicians are most likely to be found in the North Central region of the United States, which comprises Iowa, Missouri, Kansas, Nebraska, South Dakota and North Dakota.³ This could partially be attributed to less competition in smaller communities and sparsely-populated rural areas, which generally have to pay more to attract physicians.

Lowest-paid specialties

It's no surprise the lowest-paid physician specialties are all branches of primary care, as has been the trend for many years. Family medicine physicians, internists, pediatricians and hospitalists had some of the lowest median salaries.⁴ Family medicine physicians had the lowest overall compensation at a tick over \$208,000, a 1 percent decrease from 2010.

The Northeast part of the United States, which mostly includes New England, was the geographic locale most likely to pay physicians least.⁵ Although the costs of living are higher on the upper East Coast than many other places, the heavy competition and condensed populations have driven down the compensation levels.

Other trends

Compensation for men and women across all physician specialties continues to be one of the biggest discrepancies in the healthcare sector. In each of the 21 specialties that were examined, men made more than women. On average, men make 40 percent more than women across all the specialties, although that gap is smaller within the primary care groups and OB/GYN.⁶

Physicians that saw the biggest pay bumps between 2010 and 2011 include cardiologists, emergency medicine physicians, endocrinologists and hospitalists — all of whom saw at least a 5 percent spike in median salary.⁷

When asked if they considered themselves to be “rich,” radiologists, oncologists and gastroenterologists were most likely to respond “yes.” Internists, pediatricians, obstetricians and gynecologists had the lowest percentage of respondents who thought they were rich. Fifty-four percent of primary care physicians do not think they are fairly compensated, and across all specialties, it's almost a 50/50 split of those who think are and are not fairly compensated.⁸

Physician statistics — 2012

Here are 200 statistics on the latest physician compensation figures and trends across 21 specialties, based on the most recent data available from several physician compensation reports and surveys. The main physician compensation statistics covered in the following 21 specialties include median salary, median gross charges, median work relative value units, regional compensation, hospital versus multispecialty group practice salary and salary offers.

Note: Some of the statistics may seem higher or lower compared with others in each specialty. A collection of physician surveys were used to compile information. In addition, every specialty does not contain the same number of statistics, as some data was not available for each specialty. Please read the following to understand where the statistics came from:

Median salary, median work RVUs, median gross charges are from the American Medical Group Association's 2011 Medical Group Compensation and Financial Survey, a 2011 report based on 2010 data. The survey collected responses from 239 medical groups that represent more than 51,700 physicians during the first quarter of 2011.

Mean salary for men, mean salary for women, highest-paying region, lowest-paying region, hospital-employed salary, multispecialty group practice salary are from Medscape's 2012 Physician Compensation Report. The report collected responses from 24,216 U.S. physicians across 25 specialty areas from Feb. 1, 2012, to Feb. 17, 2012.

Highest offered base salary and lowest offered base salary are from Merritt Hawkins' 2011 Review of Physician Recruiting Incentives. The report is based on 2,667 permanent physician search assignments that Merritt Hawkins engaged in from April 2010 to March 2011.

Anesthesiologists

Median salary: \$372,750
(0.61 percent increase from 2010)
Median gross charges: \$1,190,600
Mean salary for men: \$324,000
Mean salary for women: \$260,000
Highest-paying region: South Central (\$331,000)
Lowest-paying region: West (\$283,000)
Hospital-employed salary: \$325,000
Multispecialty group practice salary: \$396,000
Highest offered base salary (not including bonuses): \$475,000
Lowest offered base salary (not including bonuses): \$290,000

Cardiac and thoracic surgeons

Median salary: \$532,567
(0.1 percent decrease from 2010)
Median work RVUs: 9,612
Median gross charges: \$1,708,258

Cardiologists

Median salary: \$422,921
(5.20 percent increase from 2010)
Median work RVUs: 7,126
Median gross charges: \$1,433,771
Mean salary for men: \$325,000
Mean salary for women: \$246,000
Highest-paying region: North Central (\$379,000)
Lowest-paying region: West (\$270,000)
Hospital-employed salary: \$254,000
Multispecialty group practice salary: \$327,000
Highest offered base salary (not including bonuses): \$525,000
Lowest offered base salary (not including bonuses): \$270,000

Dermatologists

Median salary: \$386,068
(2.9 percent increase from 2010)
Median work RVUs: 7,440
Median gross charges: \$1,586,069
Mean salary for men: \$313,000
Mean salary for women: \$252,000
Highest-paying region: West (\$355,000)
Lowest-paying region: South Central (\$192,000)
Hospital-employed salary: \$157,000
Multispecialty group practice salary: \$382,000
Highest offered base salary (not including bonuses): \$500,000
Lowest offered base salary (not including bonuses): \$245,000

Diagnostic radiologists

Median salary: \$492,102
(2.95 percent increase from 2010)
Median work RVUs: 7,597
Median gross charges: \$2,307,260

Emergency medicine physicians

Median salary: \$285,910
(6.37 percent increase from 2010)
Median work RVUs: 6,933
Median gross charges: \$883,878
Mean salary for men: \$253,000
Mean salary for women: \$192,000
Highest-paying region: North Central (\$282,000)
Lowest-paying region: Northeast (\$211,000)
Hospital-employed salary: \$247,000
Multispecialty group practice salary: \$223,000
Highest offered base salary (not including bonuses): \$380,000
Lowest offered base salary (not including bonuses): \$160,000

Endocrinologists

Median salary: \$233,000
(6.46 percent increase from 2010)
Median work RVUs: 4,446
Median gross charges: \$739,001
Highest offered base salary (not including bonuses): \$270,000
Lowest offered base salary (not including bonuses): \$180,000

Family medicine physicians

Median salary: \$208,658
(0.1 percent decrease from 2010)
Median work RVUs: 4,977
Median gross charges: \$695,191
Mean salary for men: \$174,000
Mean salary for women: \$134,000
Highest-paying region: North Central (\$185,000)
Lowest-paying region: Mid-Atlantic (\$142,000)
Hospital-employed salary: \$169,000
Multispecialty group practice salary: \$177,000
Highest offered base salary (not including bonuses): \$290,000
Lowest offered base salary (not including bonuses): \$130,000

Gastroenterologists

Median salary: \$415,872
(2.68 percent increase from 2010)
Median work RVUs: 8,073
Median gross charges: \$1,911,359
Mean salary for men: \$315,000
Mean salary for women: \$249,000
Highest-paying region: Northwest (\$372,000)
Lowest-paying region: Mid-Atlantic (\$278,000)
Hospital-employed salary: \$205,000
Multispecialty group practice salary: \$311,000
Highest offered base salary (not including bonuses): \$505,000
Lowest offered base salary (not including bonuses): \$300,000

General surgeons

Median salary: \$367,315
(2.86 percent increase from 2010)
Median work RVUs: 7,081
Median gross charges: \$1,348,560
Mean salary for men: \$276,000
Mean salary for women: \$223,000
Highest-paying region: Great Lakes (\$297,000)
Lowest-paying region: Northwest (\$233,000)
Hospital-employed salary: \$226,000
Multispecialty group practice salary: \$324,000
Highest offered base salary (not including bonuses): \$450,000
Lowest offered base salary (not including bonuses): \$205,000

Hematologists/medical oncologists

Median salary: \$325,000
(1.28 percent increase from 2010)
Median work RVUs: 4,318
Median gross charges: \$661,792
Mean salary for men: \$276,000
Mean salary for women: \$224,000
Highest-paying region: Southwest (\$342,000)
Lowest-paying region: Northeast (\$207,000)
Hospital-employed salary: \$190,000
Multispecialty group practice salary: \$347,000
Highest offered base salary (not including bonuses): \$550,000
Lowest offered base salary (not including bonuses): \$250,000

Hospitalists (internal medicine)

Median salary: \$229,294
(6.29 percent increase from 2010)
Median work RVUs: 3,914
Median gross charges: \$430,581
Median salary for men: \$335,000
Median salary for women: \$275,000
Highest-paying region: Southern (\$247,000)
Lowest-paying region: Eastern (\$212,000)
Hospital-employed salary: \$221,928
Partner private practice salary: \$218,154
Highest offered base salary (not including bonuses): \$305,000
Lowest offered base salary (not including bonuses): \$160,000

Internal medicine physicians

Median salary: \$219,500
(2.42 percent increase from 2010)
Median work RVUs: 4,838
Median gross charges: \$716,181
Mean salary for men: \$175,000
Mean salary for women: \$149,000
Highest-paying region: South Central (\$189,000)
Lowest-paying region: Northeast (\$151,000)
Hospital-employed salary: \$163,000
Multispecialty group practice salary: \$194,000
Highest offered base salary (not including bonuses): \$285,000
Lowest offered base salary (not including bonuses): \$130,000

Neurologists

Median salary: \$246,500
(4.23 percent increase from 2010)
Median work RVUs: 4,868
Median gross charges: \$790,046
Mean salary for men: \$198,000
Mean salary for women: \$160,000
Highest-paying region: Southeast (\$209,000)
Lowest-paying region: Southwest (\$155,000)
Hospital-employed salary: \$150,000
Multispecialty group practice salary: \$227,000
Highest offered base salary (not including bonuses): \$345,000
Lowest offered base salary (not including bonuses): \$160,000

Obstetricians/gynecologists (general)

Median salary: \$302,638
(2.33 percent increase from 2010)
Median work RVUs: 6,639
Median gross charges: \$1,196,029
Mean salary for men: \$234,000
Mean salary for women: \$206,000
Highest-paying region: Great Lakes (\$245,000)
Lowest-paying region: Northeast (\$205,000)
Hospital-employed salary: \$194,000
Multispecialty group practice salary: \$233,000
Highest offered base salary (not including bonuses): \$360,000
Lowest offered base salary (not including bonuses): \$220,000

Ophthalmologists

Median salary: \$356,339
(3.6 percent increase from 2010)
Median work RVUs: 8,821
Median gross charges: \$1,687,537
Mean salary for men: \$295,000
Mean salary for women: \$216,000
Highest-paying region: West (\$315,000)
Lowest-paying region: Southeast (\$253,000)
Hospital-employed salary: \$147,000
Multispecialty group practice salary: \$289,000

Orthopedic surgeons

Median salary: \$501,808
(0.23 percent increase from 2010)
Median work RVUs: 8,026
Median gross charges: \$1,841,857
Mean salary for men: \$326,000
Mean salary for women: \$240,000
Highest-paying region: West (\$350,000)
Lowest-paying region: Northeast (\$303,000)
Hospital-employed salary: \$251,000
Multispecialty group practice salary: \$340,000
Highest offered base salary (not including bonuses): \$700,000
Lowest offered base salary (not including bonuses): \$300,000

Otolaryngologists

Median salary: \$377,430
 (2.35 percent increase from 2010)
 Median work RVUs: 6,926
 Median gross charges: \$1,518,509
 Highest offered base salary (not including bonuses): \$500,000
 Lowest offered base salary (not including bonuses): \$230,000

Pediatricians (general)

Median salary: \$213,379
 (1.67 percent increase from 2010)
 Median work RVUs: 5,089
 Median gross charges: \$807,449
 Mean salary for men: \$180,000
 Mean salary for women: \$137,000
 Highest-paying region: North Central (\$183,000)
 Lowest-paying region: Northeast/West (\$146,000)
 Hospital-employed salary: \$150,000
 Multispecialty group practice salary: \$166,000
 Highest offered base salary (not including bonuses): \$250,000
 Lowest offered base salary (not including bonuses): \$120,000

Pulmonologists

Median salary: \$303,125
 (1.21 percent decrease from 2010)
 Median work RVUs: 6,014
 Median gross charges: \$876,283
 Mean salary for men: \$248,000
 Mean salary for women: \$221,000
 Highest-paying region: South Central (\$328,000)
 Lowest-paying region: Northeast (\$212,000)
 Hospital-employed salary: \$174,000
 Multispecialty group practice salary: \$284,000
 Highest offered base salary (not including bonuses): \$430,000
 Lowest offered base salary (not including bonuses): \$200,000

Urologists

Median salary: \$413,746
 (0.05 percent decrease from 2010)
 Median work RVUs: 7,503
 Median gross charges: \$1,751,208
 Mean salary for men: \$313,000
 Mean salary for women: \$253,000
 Highest-paying region: West (\$343,000)
 Lowest-paying region: Mid-Atlantic (\$272,000)
 Hospital-employed salary: \$192,000

Multispecialty group practice salary: \$397,000
 Highest offered base salary (not including bonuses): \$550,000
 Lowest offered base salary (not including bonuses): \$320,000 ■

Footnotes:

- ¹ American Medical Group Association's 2011 Medical Group Compensation and Financial Survey.
- ² Medical Group Management Association's Physician Compensation and Production Survey: 2011 Report Based on 2010 Data.
- ³ Medscape's 2012 Physician Compensation Report.
- ⁴ American Medical Group Association's 2011 Medical Group Compensation and Financial Survey.
- ⁵ Medscape's 2012 Physician Compensation Report.
- ⁶ Ibid.
- ⁷ American Medical Group Association's 2011 Medical Group Compensation and Financial Survey.
- ⁸ Medscape's 2012 Physician Compensation Report.

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Physician-Generated Hospital Revenue vs. Salary: 48 Statistics

By Bob Herman

Newly recruited physicians offer a lot of potential for hospitals, especially as the scramble for physician practices ensues. Physicians are able to support the hospital's mission of providing quality care across a broad spectrum of specialties, and they are able to engender financial benefits by creating downward revenue that helps keep service lines profitable while covering any of their practices' losses, if applicable.

One of the key cogs that links physicians to hospital revenue is compensation: If a physician brings in more business and enhances the scope of the hospital's care, how are they getting paid?

Merritt Hawkins, a physician search and consulting firm, conducted a survey in 2010 that showed the net annual revenue generated by physicians in several specialties on behalf of their affiliated hospitals. The *2010 Physician Inpatient/Outpatient Revenue Survey* has been a leading benchmark for hospitals to see how physicians impact the revenue of different service lines, and Phil Miller, media associate at Merritt Hawkins, says the firm will be conducting a 2012 survey of physician-generated revenue, due out this fall.

For the 2010 survey, Merritt Hawkins received responses from 114 hospital and health system CFOs. The CFOs indicated the combined net inpatient and outpatient revenue generated annually for their facilities by a single, full-time equivalent physician across several specialties. Revenue was represented by procedures per-

formed at the hospital, tests and treatments ordered and other factors. (For primary care physicians, hospital CFOs were asked to determine revenue generated from direct admissions, procedures performed, lab tests, etc., but not from indirect revenue primary care physicians may have generated from patient referrals to specialists utilizing the hospital.)

Looking at the physician-generated revenue by specialty and the related salaries for those physicians can reveal patterns insight on where emphasis is being placed on different hospital physician specialties.

Out of the 17 specialties in the survey, neurosurgeons were far ahead in revenue generated, salary and revenue-to-compensation ratio. The median 2010 generated hospital revenue for neurosurgeons was nearly \$2.82 million, and they were paid on average \$571,000. That means for every \$1 neurosurgeons received in compensation, they brought in \$4.93 of revenue into the hospital.

Orthopedic surgeons and general surgeons were the next group of physicians that generated the most revenue for hospitals. Orthopedic surgeons brought in an average of \$2.12 million in revenue, while general surgeons were not far behind at \$2.11 million. However, their compensation levels varied drastically. Orthopedic surgeons made \$481,000 in salary, while general surgeons earned \$321,000. For every \$1 of compensation, orthopedic surgeons generated \$4.40 in hospital rev-

enue. General surgeons, on the other hand, were compensated \$1 for every \$6.58 of generated revenue, roughly 1.5 times the amount of both neurosurgeons and orthopedic surgeons.

General surgeons were not the only set of physicians that had revenue-to-compensation ratios higher than 6.5 to 1. Family practice physicians and internal medicine physicians had ratios of 9.38 to 1 and 9.02 to 1, respectively. Primary care physicians have traditionally been compensated less than surgical specialties, and the data reinforces this trend even though they bring in a lot of money (each generated more than \$1.6 million on average).

Nephrologists and ophthalmologists had the lowest amounts of average generated revenue at an annual average of \$696,888 and \$842,711, respectively. Nephrology is a very specialized field, and ophthalmology is more commonly found in ambulatory surgery centers than hospitals. Because of their low revenue totals, both specialties saw more personal income per dollar of revenue generated (\$1 of compensation for every \$2.90 in revenue for nephrology and \$1 of compensation for every \$2.99 for ophthalmology).

Here are all 48 statistics across 16 specialties on physician-generated hospital revenue, hospital salaries for physician and their corresponding revenue-to-compensation ratios based on data from Merritt Hawkins' *2010 Physician Inpatient/Outpatient Revenue Survey*.

Cardiologists (invasive)

Median 2010 revenue: \$2,240,366

Median 2010 hospital compensation: \$475,000

Revenue-to-compensation ratio: 4.72:1

Cardiologists (noninvasive)

Median 2010 revenue: \$1,319,658

Median 2010 hospital compensation: \$419,000

Revenue-to-compensation ratio: 3.15:1

Family practice physicians

Median 2010 revenue: \$1,622,832

Median 2010 hospital compensation: \$173,000

Revenue-to-compensation ratio: 9.38:1

Gastroenterologists

Median 2010 revenue: \$1,450,540

Median 2010 hospital compensation: \$393,000

Revenue-to-compensation ratio: 3.69:1

General surgeons

Median 2010 revenue: \$2,112,492

Median 2010 hospital compensation: \$321,000

Revenue-to-compensation ratio: 6.58:1

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Hematologists/medical oncologists

Median 2010 revenue: \$1,485,627
 Median 2010 hospital compensation: \$335,000
 Revenue-to-compensation ratio: 4.43:1

Internal medicine physicians

Median 2010 revenue: \$1,678,341
 Median 2010 hospital compensation: \$186,000
 Revenue-to-compensation ratio: 9.02:1

Nephrologists

Median 2010 revenue: \$696,888
 Median 2010 hospital compensation: \$240,000
 Revenue-to-compensation ratio: 2.9:1

Neurologists

Median 2010 revenue: \$907,317
 Median 2010 hospital compensation: \$258,000
 Revenue-to-compensation ratio: 3.52:1

Neurosurgeons

Median 2010 revenue: \$2,815,650
 Median 2010 hospital compensation: \$571,000
 Revenue-to-compensation ratio: 4.93:1

Obstetricians/gynecologists

Median 2010 revenue: \$1,364,131
 Median 2010 hospital compensation: \$266,000
 Revenue-to-compensation ratio: 5.13:1

Ophthalmologists

Median 2010 revenue: \$842,711
 Median 2010 hospital compensation: \$282,000
 Revenue-to-compensation ratio: 2.99:1

Orthopedic surgeons

Median 2010 revenue: \$2,117,764
 Median 2010 hospital compensation: \$481,000
 Revenue-to-compensation ratio: 4.4:1

Pediatricians

Median 2010 revenue: \$856,154
 Median 2010 hospital compensation: \$171,000
 Revenue-to-compensation ratio: 5.01:1

Pulmonologists

Median 2010 revenue: \$1,204,919
 Median 2010 hospital compensation: \$293,000
 Revenue-to-compensation ratio: 4.11:1

Urologists

Median 2010 revenue: \$1,382,704
 Median 2010 hospital compensation: \$401,000
 Revenue-to-compensation ratio: 3.45:1 ■

28 Statistics on Highest On-Call Coverage Per Diem Payments

By **Bob Herman**

Average per diem payments of emergency on-call coverage vary widely across medical specialties, from a low of \$240 for psychiatry to a high of \$2,710 for trauma surgery, according to data from MD Ranger's Physician Contract Benchmark Report.

Here are the mean emergency on-call coverage per diem payments of 28 medical specialties, based on MD Ranger's most recent data.

- Orthopedic surgery — trauma: \$2,710
- Trauma surgery: \$2,180
- Neurosurgery: \$1,440
- Hospitalists: \$1,340
- Anesthesia: \$1,280
- General and trauma surgery: \$1,270
- Critical/intensive care: \$1,200
- Anesthesia — OB: \$1,160
- Orthopedic surgery: \$1,120
- General surgery: \$980
- Obstetrics/gynecology: \$810
- Cardiovascular surgery: \$710
- Facial injuries: \$710
- Cardiology: \$660
- Gastroenterology: \$620
- Neurology: \$570
- Internal medicine/family practice: \$540
- All plastic and hand surgery: \$520
- Plastic surgery: \$490
- Vascular surgery: \$430
- Radiology: \$420
- Hand surgery: \$400
- Pediatrics: \$370
- Pediatric medical specialties: \$360
- Urology: \$360
- Otolaryngology: \$350
- Ophthalmology: \$280
- Psychiatry: \$240 ■



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8 Biggest Mistakes an ACO Can Make (continued from page 1)

1. Lacking an appropriate governance structure where all constituents are at the table. Everyone in an accountable care organization needs to be on the same page. If one party is left out, integration is likely to fail. All partners need to have “the willingness to re-design the healthcare system,” says Judy Rich, CEO of Tucson (Ariz.) Medical Center, one of the 27 new CMS ACOs. “Our physician partners are committed to the success of our ACO.”

Neither a hospital nor physicians should dominate an ACO — it takes effort from both sides of that aisle says Bill Frack, vice president of global healthcare consulting firm L.E.K Consulting. In order to formally encourage input from all parties participating in the ACO, the ACO’s governing board should include representatives from the hospital, physician groups, any other participating providers, such as post-acute care groups, and patient populations. “Because you have to have coordination, you need the major players all at the table in relatively equal capacity,” Mr. Frack says. Maintaining a two-way street between hospital and physician groups partaking in an ACO is essential from day one, long before formation. Initial collaboration will lay the groundwork for the shared savings, quality of care measurements and collaboration models to follow.

“Physicians need to be actively involved and assume proactive leadership roles for ACO development from the very outset, rather than being asked to rubber stamp a hospital-driven process,” Mr. Frack says.

2. Operating under existing economic incentives incompatible with the intent of an ACO. Accountable care relies on different payment models to achieve its end result. While CMS’ new ACOs maintain aspects of a fee-for-service model, ACOs by definition seek to rid of a system that pays physicians solely for providing services. The purpose of an ACO is to ensure a patient is staying healthy and that the organization is cutting costs associated with caring for that patient. Physicians who work in an ACO and respond to that goal should be proportionally reimbursed for carrying their weight; it makes sense to offer physicians financial incentives to spur savings.

The purpose and challenge of integrated care is “to develop a payment system based on the value of work we do based on health outcomes of the patients,” says John Toussaint, MD, with the ThedaCare Center for Healthcare Value in Appleton, Wis. and author of *Potent Medicine: The Collaborative Cure for Healthcare* (2012). “We don’t get paid much to prevent,” says Dr. Toussaint. He says the fee-for-service payment model that has reigned supreme for some time is “fundamentally flawed right now.”

An ACO could technically have all the measures in place that make it appear destined for success — integrated care, core measures to assess quality delivery, a competent information technology plan that allows for data sharing — but if the organization fails to revolutionize the way it pays physicians, it is in serious jeopardy. A shared savings model that provides physicians with an incentive to go beyond simply providing services for patients will provide an incentive to curb costs, and some form of capitated payment will eventually follow.

“Physicians need to be actively involved and assume proactive leadership roles for ACO development from the very outset, rather than being asked to rubber stamp a hospital-driven process.”

— Bill Frack, Vice President, L.E.K Consulting.

3. Failing to address antitrust issues.

Potential legal barriers, including antitrust laws, could slow or halt the development of an ACO. Federal law, as well as laws in some states that address anticompetitive price fixing, has the potential to undermine ACOs. Many providers, including former competitors, may pool resources to create ACOs to improve quality of care potential, but doing so could spur an antitrust investigation.

It’s a sort of Catch 22. “The components critical to the success of ACOs could make them impermissible under federal law and some state laws,” writes the Coker Group in its new book *The Healthcare Executive’s Guide to ACO Strategy* (2012).

In its joint statement on the matter, the Federal Trade Commission and Department of Justice in October 2011 said that “under certain conditions ACOs could reduce competition and harm consumers through higher prices or lower quality care.”

Fortunately for ACOs, FTC and DOJ have embraced so-called “antitrust safety zones” for CMS ACOs. Independent ACO participants providing the same service and that provide no more than a combined 30 percent of those services in what is known as their primary service area — defined as the lowest number of postal zip codes from which the ACO draws 75 percent of its participants — are protected under the antitrust safety zone. They will not be investigated unless under extraordinary circumstances.

In addition, rural exceptions exist for ACO participants in areas with small populations where very few other practices likely to participate in an ACO. Other ACOs that fall outside the safety zone will not raise competitive concerns, so long as they do “not impede the functioning of a competitive market.”

But there are ways an ACO could do just that. A few things the DOJ and FTC say will raise antitrust flags:

- Collusion among competing ACOs for services that fall outside the ACO.
- Preventing private payors from directing or incentivizing patients to choose providers that may fall outside the ACO, or “anti-steering” contractual clauses.

- Tying sales of ACO services to private payor purchase of other services from providers outside the ACO, and vice versa, including providers affiliated with an ACO participant.
- Contracting on an exclusive basis with ACO physicians, hospitals, ASCs or other providers and discouraging those providers from contracting with private payors outside the ACO.
- Restricting a private payor’s ability to make available to health plan enrollees performance information that will aid enrollees in evaluating providers in health plan, if the information is similar to measures used in Shared Savings Program.

There are other exceptions, and the FTC and DOJ will offer an expedited 90-day review for CMS ACOs to ensure they are not violating antitrust laws. To be sure though, providers looking to form an ACO should consult a competent healthcare lawyer versed in new legal issues surrounding accountable care.

4. Not making information technology a top priority. ACO data needs to be delivered at the point of care and should be organized in a way that proves outcomes and cost reduction.

“Without the ability to share and exchange information at the point of care, achieving the objectives of an ACO would be extremely limited, if not impossible,” writes the Coker Group.

An efficient IT sharing system could be in place, but it also needs physicians trained to input data into it. Elliot Fisher, MD, and Stephen Shortell, PhD, say, in an article for the Commonwealth Fund, that quality of care information is essential for measuring how well an ACO is working.

While they acknowledge the “release of provider- and plan-specific pricing information raises issues of contractual commitment and competitive advantages on one hand and antitrust on the other,” the authors also weigh in on the importance of tracking data over the course of an ACO’s history. “Without at least some common information on the quality of care, resource use and relative pricing on the part of ACOs, it will be impossible to assess their performance,” Mr. Fisher and Mr. Shortell write. “And without community-level aggregation, we will be hard-pressed to know whether new payment model is having an impact on what matters: the quality and affordability of care and health of our communities.”

Therefore, information technology and data maintenance is important not only for an individual ACO but for the future of accountable care organizations as a whole. If each ACO pulls its weight and implements robust, sweeping IT solutions that allow it to effectively measure quality of care, that can then be used by physicians, hospitals, payors and policy makers to make an assessment. They’ll know what is and isn’t saving money and what is and isn’t improving the health of the patient who is supposed to be in the center of accountable care.

5. Not establishing a meaningful set of quality measures to rate ACO success.

How does your ACO analytically measure its success beyond cost reductions? CMS reduced its list of ACO quality measures from 65 to 33 in an effort to appeal to more providers, sensitive to concerns over administrative burdens. But without thorough quality measurements in place, it will be extremely difficult to gauge how successful an ACO is at accomplishing what it seeks to provide.

In order to facilitate quality measurements, ACOs will need to have in place a system available to all parties involved in patient care, and that allows for efficient tracking of patient outcomes. It’s in the best interest of the individual ACO and the new organization model as a whole.

“Much will be gained by forging agreement on a set of measures for a core set of ACO capabilities,” write Mr. Fisher and Mr. Shortell. “Without this, it will be difficult if not impossible to compare findings across studies and cumulative knowledge will be seriously compromised.”

6. Failing to involve payors. Mr. Frack says research shows payors and providers don’t often share data used in negotiations between the two. They sometimes quell information sharing out of a lack of trust for one another. Providers, for instance, concerned that data will be used against them, may hesitate to paint payors a full picture. But for an ACO to be successful, payor collaboration with hospitals and physicians will be crucial, Mr. Frack says.

“Payors have a tremendous amount of sophistication in terms of risk management and data,” he says. “They have a more longitudinal view of a patient’s record.”

For ACOs to be successful, all parties will need to agree upon care metrics and be willing to both share in financial gains and assume financial risks.

7. Failing to realize the patient is at the center of care in an ACO.

Ms. Rich, the CEO of Tucson Medical Center, says the goal and expectations of everybody involved with an ACO needs to be very clearly spelled out, and the focus must be on the patient, not the hospital. A hospital could be incredibly efficient at gathering patient data and entering it into organized, controlled databases — but if it doesn’t consider data a means to an end — that end being patient care — data is a moot point.

“We will fail if we misinterpret the role of the patient,” she says. Technology is intended to empower care providers, not replace them. As stated above, a strong IT system is an essential element of an ACO, but it leads to the health of a person: the patient. It’s not just about showing patient improvement through data, though

better data will inevitably help ACOs track progress made. Dr. Toussaint calls it a revolutionary change in the delivery model. He says integrated care “turns the industry on its side. What we’re focused on is the patients experience and not on our own experience as a provider.”

8. Underestimating the time it takes to form an ACO.

Mr. Frack says this is a glaring issue he observes when consulting with hospital leaders, physicians and others in healthcare looking to start an ACO. He notices administrators and physician group representatives will begin to brainstorm and discover how many elements go into an ACO — structure of the organization, metrics, reimbursement models, electronic medical records and payor contracts to name a few. And then, six months into ACO discussions, the leaders will be addressing the same issues, but with a list of concerns that has doubled. Mr. Frack says at that point, the ACO decision makers are looking at value-added topics such as the future organization’s ability to manage post-acute transitions or it’s ability to not only integrate systems but actually coordinate care effectively.

Max Reiboldt, CEO of the Coker Group, agrees with Mr. Frack’s assessment that executives and physicians looking to start an ACO underestimate the time and financial commitment involved in form one. “We are asking everybody to take a dramatic step, make a dramatic change,” Mr. Reiboldt says. “There has to be a lot of educational opportunities to pull this together.”

Mr. Frack notes that more than half of all groups who explore an ACO fail to develop one. That being said, he expects to see — and he is by no means alone — many more accountable care organizations sprout up in the near future — he predicts more than 500 will form in the next five to 10 years. Those that avoid common mistakes made during formation will become models that work in the long run. ■

7 Steps to Navigate Payment Allocation Under ACOs

By Sabrina Rodak

Under the Medicare Shared Savings Program, a Medicare ACO can receive payment for meeting quality metrics and reducing costs. If a Medicare ACO reduces its Medicare expenditures below a benchmark, it is eligible to receive part of the savings from Medicare — up to 50 percent for ACOs in the shared savings only track and up to 60 percent for ACOs in the shared savings/losses track, depending on the ACO’s performance score. In the first year, an ACO can collect on this potential shared savings if it reports on all 33 quality measures. Performance requirements for savings will then be phased in, such that in the second year eligibility for savings will depend on the ACO’s performance on 25 measures

and reporting on eight, and for the third year, performance on 32 measures and reporting on one measure.

For the second and third year, the ACO must meet the quality performance standard on 70 percent of the measures in each of four domains to receive savings. The domains are patient/caregiver experience, care coordination/patient safety, preventative health and at risk population. The potential shared savings an ACO can receive incentivize meeting quality and cost benchmarks, as these funds would supplement participants’ fee-for-service Medicare payments. Unlike Medicare fee-for-service payments, however,

which follow specific rules set by CMS, each ACO creates its own system for allocating the shared savings among its participants.

Commercial ACOs typically use a similar payment structure, in which participants are compensated based on Medicare's fee-for-service rates or productivity and have the opportunity to receive additional payments by achieving certain quality and cost goals. In contrast to a Medicare ACO, a commercial ACO can create its own set of metrics and thresholds for receiving performance-based payments. Wade Johannessen, PhD, a director at Sg2, says it is common for commercial ACOs to split potential shared savings between the payor and ACO equally, as is possible under the Medicare ACO program. As in the Medicare ACO model, the commercial ACO also independently decides how to divide its share of the savings among participants.

The question of how to allocate payments in an ACO is one of the most difficult questions facing healthcare leaders. Here are seven steps to follow when deciding how to share payments fairly while maintaining a profit.

1. Commit to collaboration and transparency. The premise of an ACO is that different healthcare providers will work together to achieve better outcomes. As such, it is essential that each participant of the ACO commit to being transparent and to negotiating shared payments in a cooperative manner. This negotiation should occur at the very outset, according to Dr. Johannessen, as sharing savings is one of the core features of an ACO.

Being honest and open is especially important when forming new relationships with physicians, who may mistrust the hospital due to historically weak relations between physicians and hospitals. "If you're going to have a successful ACO, all parties are going to have to feel that they are recognized

for their work and come to some sort of agreement, says Beth Kase, JD, an attorney at Fenton Nelson.

Participants of the California Public Employees' Retirement System ACO, which include San Francisco-based Dignity Health, Blue Shield of California and Hill Physicians, collaborate to create a risk share agreement and cost targets. Negotiations related to the risk share agreement began in early 2009, and the ACO launched Jan. 1, 2010. "A critical element to building trust and collaboration is the agreement that all three parties will share risk in all healthcare service categories," says Michael Blaszyk, CFO of Dignity Health. Commitment by senior leadership to work cooperatively and transparently has also been key to successfully working together, he says.

2. Establish non-incentive payment methodology. Under the Medicare ACO model, physicians and other providers will continue to be paid on a fee-for-service basis. In commercial ACOs, the commercial payor may use fee-for-service as the basis, or a different model of compensation. Ms. Kase and Harry Nelson, JD, managing partner of Fenton Nelson, suggest commercial payors may use the resource-based relative value scale, which is the method Medicare uses to determine physicians' fees. Under this model, each procedure is assigned a relative value that is based on physician work, practice expense and malpractice expense and adjusted for geography; this relative value unit is then multiplied by a conversion factor.

"Being an early model, we are likely to see a smaller incentive component. There will be some money reserved for incentives linked to outcomes, but the vast majority will inevitably be tied to an RBRVS system or something like it because there is not enough data or infrastructure to set up a [solely] outcome-based system in America at this point," Mr. Nelson says.



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3. Assess the population. As part of developing a payment allocation system for shared savings, ACO participants need to assess the population mix in their community. The type of population can determine which participants in the ACO will bear more risk, and who should therefore receive a greater portion of the savings. If a commercial ACO is in a community with a high percentage of Medicare patients, for instance, the hospital may have more expenses compared to an outpatient center because Medicare patients are more likely than non-Medicare patients to require hospitalization. The ACO may thus decide to give a higher share of the savings to hospitals because they would spend more on the patients to meet quality goals.

Each ACO's unique mix of population, geography and providers necessitate that each organization create a payment structure that is best suited to it. "ACO partners should consider their market, strategic objectives and the environment as they customize [the ACO] to meet the needs of their respective communities," Mr. Blaszyk says.

Similarly, under the Medicare ACO model, CMS will set each ACO's cost benchmark by using separate cost categories for different populations, including end-stage renal disease patients; disabled patients; aged/dual eligible Medicare and Medicaid beneficiaries; and aged/non-dual eligible Medicare and Medicaid beneficiaries.

4. Designate responsibilities for services. Determining responsibilities for providing services is important as it creates accountability for meeting quality and cost metrics and clearly identifies who should get paid for each service. To reduce spending, the ACO should take into account different healthcare settings' costs for providing the same service when designating responsibility for services. For example, it may be less expensive to provide imaging in a physician office rather than a hospital.

Discussing each provider's costs for services is essential in creating a fair payment distribution model. "Separate out what the profits are from what the real costs are," Mr. Nelson says. "Have a conversation about who's providing what personnel and what services, and what the costs are, and figure out how to allocate profits based on achieving shared goals."

5. Agree on metrics. Each ACO participant's share of savings will be given only if that participant meets the ACO's quality and cost goals. "There is essentially a savings pool and the ability to achieve that payout is determined by the providers' performance on quality measures," Dr. Johannessen says. "You may be eligible for fifty percent, but that's subject to meeting various quality gates." Because payments are partly based on meeting quality goals, the ACO needs to agree on the metrics for which each participant will be held accountable. "Some have a graded approach, some have a threshold approach and others have a complex outcome-based numerical grade that determines the percentage of the total dollars allocated to you," says Akram Boutros, MD, founder and president of BusinessFirst Healthcare Solutions.

The shared savings model has specific metrics Medicare ACOs must meet to receive incentive payments. For example, in the patient/caregiver experience domain, one measure is "Getting timely care, appointments and information." Performance on each measure is scored; these scores determine what percent of savings the Medicare ACO can receive, which is capped at 50 percent and 60 percent depending on whether the ACO is in the savings only or savings/losses track.

6. Develop other revenue streams. One way to meet cost reduction goals is to lower healthcare utilization of high-cost services, such as by reducing hospital readmissions. Many of hospitals' services are high cost; reducing utilization of these services would thus generate less revenue for the facility. "If hospital spend is about 50 percent of healthcare dollars and physician spend is about 15 percent, most of the savings are going to come from the fifty percent," Dr. Boutros says.

Savings from meeting utilization goals will thus be particularly important for hospitals, as reduced utilization will most likely cost hospitals more than other providers. "A lot of the savings are going to be generated by better coordinating care which should lead to fewer hospitalizations and reducing revenue to the hospital," Dr. Johannessen says. Hospitals can recoup some of their lost revenue from the shared savings, but they may not be able to balance out the losses completely. "Without growing market share, no amount of shared savings will make up for the likely decrease in revenue to the hospital," Dr. Johannessen says. This risk necessitates that hospitals create new means of revenue, such as providing more outpatient services, to outweigh this potential loss.

For example, some hospitals are providing management services. "They have been acting as management service organizations, but they will [be] even more so in an ACO structure," Ms. Kase says. Other options for hospitals to gain revenue include providing administrative services, such as coordinating information technology and billing services. Hospitals may also partner with a physician group to form a surgery center and would receive some profits based on that ownership, according to Ms. Kase.

"Hospitals need to find another model to preserve their profitability and their relevance," Mr. Nelson says. "One of the reasons we see hospitals moving to the [medical] foundation model in California and integrating with physicians is to find ways to get at physician revenue and provide more outpatient services. They are moving to revenue streams that are not based on hospitalization, but a whole range of outpatient services."

7. Determine risk and calculate percentages. After assessing the population, designating service responsibilities and agreeing on metrics, the ACO can estimate the amount of risk each participant bears in meeting benchmarks for shared savings. The ACO can then decide what percentage of savings each participant should receive based on the participant's risk.

The CalPERS ACO uses "a three-way risk-sharing [model] with upside and downside risk for achieving cost and quality targets in five categories: total facility, professional, mental health, pharmacy and ancillary," Mr. Blaszyk says. The ACO participants decided to overlay the existing payment terms with the three-way risk agreement to best align incentives. The terms of the risk share agreement are renegotiated by the three ACO participants annually. The payment/reimbursement terms are negotiated independently of the risk share agreement and occur confidentially between Blue Shield of California and Dignity Health and Blue Shield of California and Hill Physicians.

Dr. Boutros says payment breakdowns for hospitals and physicians vary the most from one ACO to another, whereas post-acute care organizations typically receive about 10 to 20 percent of savings. An ACO may decide to give physicians and hospitals an equal share, but often physicians end up receiving less, according to Dr. Boutros. For example, an ACO may allocate 50 percent of savings to the hospital, 40 percent to physicians and 10 percent to post-acute care.

The difference in payments for physicians and hospitals depends largely on the integration of physicians with the hospital. "The biggest deciding factor I've noted is the viewpoint of the most senior leader in the organization," Dr. Boutros says. "If they see physicians as clear partners, they tend to be more equitable with the share; those who see physicians as a necessary 'cog in the wheel' tend to give them less." ■

Physician Strategy as the Foundation to Improving Community Health

By Imran Andrabi, MD, Senior Vice President and Chief Physician Executive Officer, Mercy

Physician strategy is top of mind for many hospital leaders. As Lewis Carroll once wrote, “If you don’t know where you are going, any road will get you there.” This is true for hospital and health system strategy and especially true for physician strategy. Physician strategy is the foundation around which health systems are built. Hospitals and health systems without a strong physician strategy aren’t going to be able to play a significant role in the marketplace in the future. After all, physicians — together with their patients — ultimately control healthcare market share, volume and, as a result, financial success.

Today the “buzz word” around physician strategy is clinical integration. Although a few prominent health systems have long been clinically integrated, others are just beginning their efforts to more formally align their hospitals, physicians and other providers. Clinical integration can mean a lot of things, but generally it refers to managing the entire continuum of care for our patients — from preventing disease, to treating them in the office, and coordinating their care during and after a hospital admission.

To me, as a family medicine practitioner for the last 20 years, this is simply what most primary care providers do every day. Now, healthcare leaders are working to make this type of coordination the industry standard. We must formally develop it among all types of providers through truly putting the patient at the center and developing clinical protocols enabled by infrastructure that provide the right care at the right time, in the right setting with the right overall experience for the lowest cost. This, of course, is where healthcare is heading, and it’s being directed there by new healthcare practices that prioritize value over volume.

Beyond primary care

To be successful, physician strategy must consider how the hospital will strengthen relationships among its organization and among all physicians. Primary care strategy and specialist strategy should be considered holistically. When I hear healthcare leaders ask if they should develop a primary care strategy or a specialist strategy, as a physician, I scratch my head. A primary care physician cannot take care of a patient alone, and neither can a specialist. A health system’s physician strategy must find the right balance in the development of primary care and specialty care networks. Focusing on one or the other doesn’t fit with the future of healthcare delivery we face.

Primary care providers, though, are surely the foundation upon which healthcare delivery is built. They coordinate care among various specialists and facilities to ensure the best care for their patients.

Because of this important role, Mercy is developing a medical home model for our primary care practices. Through this, we will help build the systems and infrastructure — human, technological and structural — needed to coordinate care.

Beyond employment

Hospitals and health systems today seem to be in an ongoing race to employ physicians, for reasons driven by both the hospitals and physicians. But, there are many ways to achieve integration outside of employment. At Mercy, we anticipate significant growth in the number of physicians we employ in the next two to three years. However, we do not have a mindset of driving physicians solely into an employment structure. Rather, our goal is to partner with our physicians by providing them options to set them and their patients up for success. Other alternatives that are frequently utilized include but are not limited to: joint ventures, clinical co-management models, shared savings models, and utilization of clinical and practice management tools to name a few.

For the physicians we do employ, we are currently implementing a new governance model that gives them even more control over their practice and setting strategy for their group. A governing board of representative physicians will oversee all aspects of the operations of the employed physicians, through physician-driven committees tasked with guiding the day-to-day operations, strategy, business development, quality, IT, finance and leadership development. When we started this process I really wasn’t sure about how we would get physicians excited about participating, but the reality is that more and more physicians are interested in being part of designing the solutions to a complex healthcare delivery model rather than be passive, sitting on the sidelines and reacting to what comes next.

We’ve also launched a clinical integration oversight group with representation from our hospitals, employed and independent physicians, which has been tasked with exploring how we might develop a clinically integrated organization that is capable of adapting to the changing landscape of the new healthcare delivery and payment system.

One thing that is important to remember, though, is successful clinical integration is achieved through a lot more than physician employment. An employed physician is not automatically an engaged physician. Physicians also have to be activated and motivated for the right reasons to play an active role in the creation of the right models of care. Hospitals can’t simply hire physicians or contract with them and expect for care to magically be coordinated and value-driven. Instead, organizations must be careful to provide the infrastructure needed to achieve this. For example,



Mercy has invested heavily in implementing an integrated electronic health record that allows for a single chart per patient irrespective of where care is delivered — be it in a physician office, a hospital or an emergency department. This type of information sharing, we hope, will help to break down the silos that can exist among the various sites of care, that reduce duplication, improve quality of care, improve patient safety and lower costs for our patients and the healthcare system overall. We are also exploring the development of technological infrastructure for data mining. We want to be able to provide analytics to our physicians that help them understand their work against certain outcomes and benchmarks and inform sound high-quality clinical decision making.

Linking back to our mission

This type of data, reporting and transparency is necessary not only to show the impact we have on our individual patients but also to show our impact on the communities we serve. Have we truly been able to improve care of the diabetic patient? Better controlled hypertension? Reduced the incidences of coronary artery disease? The list goes on and on. At Mercy, our mission is to “extend the healing ministry of Jesus by improving the health of the communities we serve, with a special emphasis on those who are poor and underserved.” How can we improve the health of our communities without population health management? It’s clear a future of value-based, population-driven care is where healthcare is headed, and in my opinion, where it must head.

Any health system’s two most important customers are their patients and physicians. Any health system’s greatest asset is its people who provide care to the patients who seek it from them. We live in interesting times. We have been here before in healthcare. It seems difficult and overwhelming at times, but we are a resilient group. We have come up with innovative ways of facing these challenges before and I am sure that, even though it might seem difficult at times our industry has the intelligence, the drive and the desire to create new solutions that we never thought possible. Our healthcare, and our country, will be better because of it. ■

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Hospital CFO Panel: How Are You Approaching Your Fiscal Strategy Right Now?

By Bob Herman

The Medicare hospital trust fund is projected to become insolvent in 2024. Hospital credit downgrades are predicted to outpace upgrades. The healthcare reform law will impact hospital revenue. Bank letters of credit are shaky. Collections are getting tougher to collect on both the front and backend.

This isn't a lightning round on a healthcare finance game show. These issues — and many more — are only the tip of the iceberg for what hospital and health system CFOs have to deal with today. However, the panic button does not need to be pressed.

Taking a step back to outline and monitor the progress of specific financial challenges that lie ahead is a good first step for hospital and health system CFOs that feel overwhelmed. Here, four hospital and health system CFOs — Carl Biber of Columbus Regional Healthcare System in Whiteville, N.C.; Denis Conroy of Northeast Health System in Beverly, Mass.; Dan Fromm of Fairview Health Services in Minneapolis; and Mark Krieger of Barnes-Jewish Hospital in St. Louis — share how they are dealing with the biggest healthcare financial challenges of the times, ranging from government reimbursement and commercial payor negotiations to ICD-10 and the credit markets.

Question: What are some of the biggest issues facing your hospital's or health system's finances today?

Carl Biber: There's a number of paradigm shifts happening in the industry right now, one being the emphasis on quality. That's not a new idea as much as it's keeping in mind that the patient is truly at the center of receiving that service. With any industry, the customer is always number one. Right or wrong, whatever the customer perceives as "value" is what we're trying to understand and provide.

Patients know what they want, and it originates from the two basic questions: 1) What's wrong with me? and 2) Am I getting treated? From their perspective, the rest is just processes or systems they have to go through to get to the value.

As we continue down the road with various stakeholders, we cannot expect reimbursement to go up in any way, shape or form. We are a low-cost provider, and our charges are some of the lowest in [North Carolina]. From a strategic business perspective, we're in great shape, but the way we see the environment unfolding, we



Carl Biber



Denis Conroy



Dan Fromm



Mark Krieger

have to continue increasing the value proposition 5 to 10 percent over the next three to four years to remain viable in the community.

Denis Conroy: One is as we switch to a budget-based payment system from fee-for-service, we are having to change the way we managed in this environment. We have a physician hospital organization, and we have been doing [global payments] for commercial contracts, so we have a little bit of a leg up. But with Medicare going to an ACO arrangement, we have to get even better at it.

Another issue relates to the financial markets, principally the interest rates. We have interest rate swaps and defined benefit pension plans, both of which are negatively affected by the low interest rate environment. There are positive impacts of the lower rates as well, but the calculation of pension liabilities and swap market values are very sensitive to interest rates, and they haven't been in our favor recently.

Dan Fromm: The list is broad and expanding. However, there are four issues that are high priorities as I think of challenges to our financial health. One is the growing strain on all sources of revenue — commercial and government. Two, we have numerous challenges resulting from new healthcare delivery models, including new payment models. Three, slow economic growth has weakened the macroeconomic environment. There have been lower utilization patterns and increased exposure to uncompensated care. Lastly, balance sheet pressures are increasingly driven by continued volatility in markets, swap portfolios, access to capital and liquidity issues.

In addition to these four areas, there are also increasing costs in attracting and retaining our workforce, and IT costs are spiraling out of control. A newer trend is the convergence of clinical and financial issues. That's certainly something we're paying close attention to.



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Mark Krieger: Always at the top of mind is the reimbursement environment. There are challenges over the horizon with healthcare reform, and that makes us think continually, “How do we deliver high-quality healthcare at a better price point? That challenge begins with our employees. Engaging employees and the medical staff revolves around value proposition of, “How do we deliver excellent outcomes and excellent service so there’s more value for the patient?” A lot of the conversation is around value, supply costs, capital costs — better healthcare outcomes at a lower cost. Changing the paradigm is the only way you can change both.

Q: How do Medicare and Medicaid factor into your organization’s overall fiscal strategy right now?

CB: Medicare is about 50 percent of our patient base, and Medicaid is about 20 percent. Ten percent are uninsured. On the Medicare side, an average hospital will barely cover its costs. Medicaid, for an average hospital, gets reimbursed 75 to 80 percent of their costs. There isn’t any other industry I’m aware of that has that kind of dynamic. That’s the healthcare environment we’re in right now, and that’s our challenge. Part of our strategy plan is marketing and meeting the needs of those who do have insurance. Most hospitals aren’t this heavy in Medicare and Medicaid, but it’s our mission.

DC: They are a high percentage of our business. Between the two, they are roughly 50 percent. Neither of them pays very well. We were on a trajectory to get our expense structure in line to make money on Medicare, but some of the cuts are starting to materialize — and there are more on the horizon — so it’s hard to get there.

We qualify for Disproportionate Share Hospital payments, but it appears that will be going away. And who knows what’s going to happen with sequestration. These pressures contributed to us entering affiliation discussions with another not-for-profit organization, the Lahey Clinic. Lahey has a wide range of tertiary services, and for a number reasons, they are a very good affiliation candidate for us. We’re about 15 miles apart, and we complement one another in services and geography. They are very much an adult specialty, tertiary place, and we have OB, pediatrics, long-term care and behavioral health — it’s a good fit that way as well.

DF: We have strategies for each. At the federal level, we are trying to play a role in industry reform. We are one of the 32 organizations participating in Medicare’s Pioneer ACO project. At the state level, there are increasing exposures from a budget perspective. We have been in discussions with lawmakers to develop alternative models of care and payment for these populations as well. Our work began several years ago with various commercial payor partners to develop new payment models that reward value created by increased patient satisfaction, higher levels of quality and reduced total cost of care. Now, the state and federal governments are mirroring what we’ve done on the commercial side.

MK: We’re looking at the broader picture of the need for deficit reduction and the challenges the federal and state governments have with their budgets. Under any scenario, regardless of what political environment or legislation there is, there will be less dollars coming from [Medicare and Medicaid]. We’ve evaluated healthcare reform as it is now on the books, and even if it were to change in the Supreme Court or in future legislative action, there’s going to be less dollars coming our way. Ten years out on the horizon, we are projecting what that impact will be on our organization, and it’s significant. We’re looking at decreased [reimbursement]. Medicare is about 35 percent of our payor mix, and Medicaid is about 20 percent.

Q: Can you explain how payor and managed care negotiations have evolved over the past 12 to 18 months?

CB: Even though our hospital is owned by the county, we have a specialty group that manages the payor negotiations with managed care payors.

DC: We have three major commercial payors in Massachusetts — Blue Cross Blue Shield, Harvard Pilgrim and Tufts Health Plan. We have relatively recent contracts with two of the three — Blue Cross and Tufts. In both cases, we’re trying to get away from the fee-for-service arrangement to more of a risk-based one. The Blue Cross product is called the Alternative Quality Contract, and that has a budget and quality component. We’re now in our third year, and I think it has the incentives in the right places. There’s enough quality money in there so it’s not lip service. Tufts has the same kind of arrangement but more of the focus is efficiency.

As a result of the intervention of the state regulators, we expect the payment levels are headed toward a fairly narrow range. All three HMOs are not-for-profit and are very much focused on the long term. We’re an important provider for all three. It’s still a negotiation process, but it’s not an acrimonious one.

DF: We have four major commercial payors in the Twin Cities that dominate the marketplace. We’ve done work with all four to develop new payment models. [Negotiations] have become more collaborative and less adversarial. We have been able to find shared goals and objectives as we look to reduce total costs of care and improve quality. Our negotiations have been grounded in principles developed around those goals, and I’ve found them to be a lot more collaborative and less contentious. It’s a much different perspective today than several years ago. That’s not to say all ills have been solved, but I would say in general, the approach is very different.

MK: What we see from [commercial and managed care payors] is the same challenges that we’re seeing from government payors. Managed care payors represent employers, who are also having challenges with regards to their cost structures. So we see the same types of focus on value-based purchasing and pay-for-per-

formance in those negotiations. It’s very much mirroring what we see coming from the government. The one area not mentioned is self-pay — we have about 5 to 7 percent who are uninsured.

Q: What are some of the major initiatives you and the hospital are focusing on right now in the revenue cycle, billing and collections departments?

DF: We have tactics and strategies across the entire revenue cycle. On the front end, we are looking at how we increase our self-pay conversion rate by helping uninsured patients find coverage alternatives. Clinical documentation and charge capture are also a major focus in the mid-revenue cycle, and then on the back end, we are continuing to be as efficient and effective with our follow-up collection processes as we can be. Clearly, technology is becoming an important factor as we see higher exposure to patient liability expenses, which are costlier to collect, so we’re looking to automated workflow solutions to help make the process more efficient.

MK: Significant efforts are under way in upgrading our tech platform. It’s a BJC HealthCare-wide effort. We’re in the process of implementing an entirely new registration and patient accounting system. We’re also looking at upgrading our electronic medical records system, so there’s a whole effort of upgrading the technology platform.

As part of that, we’re looking at all of the processes to make sure we eliminate defects in the registration and scheduling areas and having all the required certifications to assure payors will agree to pay for care you provide. These new systems that are being implemented incorporate tools to allow you to do that in the front end of the process, where it ought to be done. It’s a lot of workflow changes for employees as well as the physicians.

Q: How has the ICD-10 delay impacted your operational strategy?

CB: Even with the announcement of [CMS] delaying [ICD-10], we are still going forward with it. There’s no risk in adopting early. Even if we meet initial deadlines and no one else is ready, we can still submit everything in ICD-9. We’re going to meet our milestones and tweak things on the backend so everything is perfect.

Is it going to cost any resources? Yep. But we’re making sure everyone will be trained because we’re expecting a less productive system when it comes to coding — and that’s from everything we’ve heard from those who have gone from ICD-9 to ICD-10. We’re being conservative so we have enough resources and make sure we have everything.

DC: We exhaled and said “phew!” after hearing about the delay. It’s a significant undertaking that we’re just getting started to do. The Version 5010 billing requirements that we just got through was rocky enough so we weren’t looking forward to ICD-10 following on quickly.



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DF: Right now, the delay has not affected us. We started on [ICD-10 conversion] early and built what I think is a very robust, thoughtful plan. We're continuing to move forward, and even with an extra year, there's still a lot of work to do. The delay hasn't deterred us at all, and we hope it won't deter others either.

MK: We have our ICD-10 conversion project under way. Despite what looks like an assured 12-month delay, we very much welcome that. It's a significant change for all healthcare organizations and will require significant education of our workforce as well as how we interact with physicians. [The delay] is welcome, but we won't be slowing down our efforts. There's quite a bit of work to do. The delay will just allow us to have excellent execution, but it won't change our focus.

Q: What has the hospital bond market been like, and how would you characterize your hospital's or health system's current credit standing?

CB: The bond market, with the crash and credit markets of the past three to four years, has really gotten sharp and specialized. It's healthy — there's capital out there, and hospitals want to use capital to meet needs in the next five to 10 years. We have a strong balance sheet, with an investment-grade rating, but the pressure with any hospital is going to be on the operating side.

DC: Our credit rating is OK. We've been consistent at Baa2 by Moody's — which is investment-grade. Moody's just announced a potential downgrade of the short-term credit ratings of some banks, one of which provides credit support for some of our bonds. As such, we're looking at the different options right now in case they are downgraded. It's an immediate concern. Fortunately, we have good enough relationships with the banks and have decent enough credit, so if we need to, we could replace the credit support or restructure the debt in some way.

DF: We have A-rated credit, and maintaining that credit worthiness is important to us. We're working hard to make sure we remain fiscally strong and address the issues that markets see as important. It's important to be responsive to the challenges facing our industry and make wise investment decisions in a changing environment.

MK: We're part of the BJC HealthCare, and that is really managed at the system level by Kevin Roberts. However, we have a positive relationship with the debt markets. We are in very good shape in terms of borrowing, and the environment is favorable in terms of interest rates. Major facility improvements are on the horizon, and the current environment is conducive with our strong balance sheet.

We are in the process of looking at a major campus renewal, but no final decisions have been made. We know we have a campus that has been aging. We still have a very large complement of semi-private rooms — about 65 percent of our beds are semi-private — and one of our goals is to move that number in a positive direction, more like 80 percent. That's a major facility renewal effort.

We also have some of our key programs, like the Siteman Cancer Center, that have been growing significantly. We need to provide some capacity for growth in cancer, transplant programs, heart and vascular services, neurosurgery and neurology. We've been seeing growth in all of these and need to provide capacity to take on continued growth. This is in the planning stages, but there is nothing definite at this point in time.

Q: What are your biggest financial concerns in the upcoming year or so?

CB: We've got a number of strategic initiatives in a rolling five-year plan. We want to remain nimble yet meet the needs of the community. As much as we want to make sure there's enough cash flow to meet those [initiatives], I can't bet on that. Our goal is to make sure we have everything in operations to meet our needs in three to five years. If we're short of that, we may have to go to the market and find alternatives.

Sustainability, long-term, will be a serious challenge. For the first time, we hear about institutions talking about hours of cash [on hand]. The normal metric is days cash. I've never heard of that before, and that's very concerning. No community should be put into that position. It's terrible to hear a hospital could be hours away from closing its doors. Local communities need healthcare.

DC: Our affiliation with the Lahey Clinic closed on April 30. We are focusing on bringing these organizations together. We'll get some savings by combining organizations. We're not closing any campuses because there is not a lot of duplication of services. We're going to focus on capturing market share, doing better under risk [payor] contracts, operating efficiently and saving on capital.

DF: Pressure on operations is something that's a concern. We see those pressures growing, while our capital appetite is still strong. We want to perform well and create financial capacity for future investment.

MK: We're focused on the value proposition, and that is engagement with the medical staff and engagement with employees. We have to be able to improve outcomes with lower costs, but the key is engaging our key stakeholders. We spend a lot of time with regards to communicating our employees, internal communications and leadership training at all levels of management. We're also

partnering with medical staff on supply costs and are changing relationships with vendors and partnering with them in different ways to improve efficiencies. In all of this, we've been working with lean principles in the way we do our work. We really have to partner with employees in a different way, and lean methods are how we are doing that.

Q: How would you advise other hospital or health system CFOs to reach financial viability within the next one or two fiscal years?

CB: We're trying to keep the community involved in strategic planning and what the community sees in the next five to 10 years. We want to stay local. We utilize regional and national resources for various reasons, but most healthcare markets are driven by local and regional forces. My advice: Be attuned to what the [local community] market needs are. Keep them first. If I'm not doing something that's adding value to patient, am I adding value? Our focus is really trying to stay on the customer. That's who we are here for, and we have to be nimble. Over the next two to three years, things could easily shift down the road. It's tough right now.

DC: We're a relatively large community hospital system, about \$375 million in hospital revenue, another \$100 million in our senior health unit and behavioral health units. We have decent size, and we're struggling with overhead costs associated with a hospital in today's world. There are regulatory issues, payment issues, trying to become an insurer as well as hospital — it's hard for me to believe smaller hospitals will be able to stay independent. My general advice to my friends at other community hospitals is to dust off those affiliation plans and see where there is a good fit because it's going to be awfully difficult to go alone.

DF: Make sure you have a strong planning function. We're continuously monitoring and trying to stay abreast of issues that will have an impact on our organization, short and long term. We try to get ahead of those issues, anticipate the potential impact on our organization and proactively develop solutions.

MK: It's a longer journey than one or two years. I may be repeating myself, but I can't emphasize this enough. You have to engage the workforce. The way they do their jobs and see themselves as part of the improvement effort — they are on the frontlines where the work is being done. They know where the inefficiencies are. Making them a part of the solution is the only way this will work. There are no silver bullets or quick fixes. It's a long journey, and you have to partner with your stakeholders to provide healthcare at a better price point. ■

CMS Releases FY 2013 IPPS Proposed Rule: 12 Points to Know

By Bob Herman

CMS issued a proposed rule for hospitals paid under the Inpatient Prospective Payment System and the Long-Term Care Hospital Prospective Payment System that would increase Medicare's operating payments to acute-care hospitals by about 0.9 percent — or roughly \$904 million — in fiscal year 2013.

In addition, CMS looks to boost the emphasis on tying Medicare payments to value-based and quality-driven efforts as it proposed to expand the Value-Based Purchasing Program and Inpatient Quality Reporting Program.

“The proposed rule would implement key elements of the [Patient Protection and] Affordable Care Act's Value-Based Purchasing Program as well as the hospital readmissions reduction program,” said CMS Acting Administrator Marilyn Tavenner in a news release. “It also establishes the groundwork for extending Medicare's quality reporting programs beyond general acute-care hospitals to other types of facilities. It is part of a comprehensive strategy to use Medicare's payment systems to foster better care and better value in all settings, thereby reducing overall Medicare spending.”

Overall, CMS estimates total Medicare spending on inpatient hospital services will increase by about \$175 million next fiscal year. Here are some of the biggest elements of this year's Medicare IPPS proposed rule, which will affect roughly 3,400 acute-care hospitals and 440 long-term acute-care hospitals.

- Medicare payments to acute-care hospitals would increase by about 0.9 percent. Medicare payments to LTAC hospitals would increase by 1.9 percent, or about \$100 million.
- Hospitals that successfully participate in the Hospital Inpatient Quality Reporting Program — which authorizes CMS to pay hospitals to report certain quality measures to earn a higher update to their Medicare payments — would receive a total payment boost of 2.3 percent. Hospitals that do not submit successful quality measure would see a 2 percent decrease in Medicare payments but would still see a 0.3 percent update overall.
- CMS arrived at its proposed net payment rate of 2.3 percent by combining a 3 percent update of the hospital Medicare market basket (which adjusts for inflation, costs and other economic factors) with a -0.9 percent decrease from PPACA requirements and a 0.2 percent increase for documentation and coding updates.
- In last year's final IPPS rule, CMS finalized the policies of the Hospital Readmissions Reduction Program. These policies included a final definition of “readmission,” which refers to a patient admission to an acute-care hospital paid under the IPPS that occurred within 30 days of discharge from the same or another acute-care hospital, and the use of three 30-day readmission measures (acute myocardial infarction, heart failure and pneumonia), among others.

In this year's proposed rule, CMS proposed a way to calculate the ratio of a hospital's aggregate dollars for excess readmissions to the hospital's aggregate dollars for all discharges. This methodology, or the readmission adjustment factor, would result in a 0.3 percent Medicare payment decrease for hospitals.

- CMS proposed several measures for the Hospital Inpatient Quality Reporting Program. In order for hospitals to receive the full annual percentage increase, hospitals must report the required data on certain quality measures. In the proposed rule, CMS would reduce the

number of measures in the IQR from 72 to 59 for FY 2015 because some of the measures are duplicative from the Hospital Compare website (a full list can be found on pages 659 and 660). Seventeen total measures would be removed, as CMS also plans to add measures.

CMS based its recommendations on input from the National Quality Forum. Of the added measures, CMS wants to adopt three claims-based measures and one chart-abstracted measure on perinatal care, a structural measure and more survey-based measures for FY 2015 and beyond. A complete list of the proposed Hospital IQR Program measures for FY 2015 can be found on pages 705 through 708.

In addition, because more than 99 percent of sampled hospitals had validated data in the most recent fiscal year, CMS proposed to halve the annual random sample from 800 hospitals to 400 hospitals in FY 2014.

- On Oct. 1, 2012, CMS will begin making value-based incentive payments under the VBP Program to hospitals. The VBP Program will be funded for FY 2013 through a 1 percent decrease in hospital Medicare payments (in FY 2014, the percentage will be 1.25 percent, and by FY 2017, the percentage will cap at 2 percent). CMS proposed to add two requirements to the VBP Program for FY 2015: the addition of three care/outcomes measures and the addition of “Medicare spending per beneficiary” in the efficiency section.

The VBP Program for FY 2014 has been finalized (a complete list of clinical process of care, patient experience of care and outcome measures for the FY 2014 VBP Program can be found on page 795 of the proposed rule), and CMS began planning for the FY 2015 requirements. CMS proposed to retain 12 of the 13 clinical process of care measures from the FY 2014 program and adopt one new clinical process of care measure — “AMI-10: Statin Prescribed at Discharge.” For outcome measures, CMS proposed keeping the three 30-day mortality measures from the FY 2014 program while also adding two additional outcomes measures — “PSI-90” and the “CLABSI” (central line-associate blood stream infection measure). Patient experience of care measures will remain the same.

CMS also wants to adopt the Medicare spending per beneficiary measure to the efficiency category in FY 2015. CMS just added that measure to its Hospital Compare website. Blair Childs, senior vice president of public affairs for the Premier healthcare alliance, said many within the healthcare setting appreciate CMS' efforts to fine tune the VBP Program, but the new efficiency measure could cause risks to Medicare reimbursements. “While the [Medicare spending per beneficiary] measure in principle has merit, it still has not been tested and can't be replicated,” Mr. Childs said. “The end result is a lack of national data that hospitals can use to verify CMS' calculations, determine the appropriateness of the methodology or analyze true differences in performance.”

- In conjunction with the Centers for Disease Control and Prevention, CMS proposed adding two new conditions to the hospital-acquired condition payment provision list. The HAC payment provisions impact hospital payments for HACs that are high-cost, high-volume or both and could have been prevented through evidence-based measures. The two proposed conditions were surgical site infection following cardiac implantable electronic device procedures and pneumonia with venous catheterization
- Regarding graduate medical education and indirect medical education, CMS proposed increasing the timeframe for new teaching hos-

pitals to establish their caps for new GME and IME programs from three to five years.

- There are several expiring provisions of the PPACA that will go into effect in FY 2013. The Medicare-Dependent Hospital Program, which awarded extra payments to small, rural hospitals that rely heavily on Medicare patients, was extended by the PPACA through the end of FY 2012. Starting Oct. 1, 2012, those rural hospitals will no longer receive the enhanced payments.

The PPACA also amended the Low-Volume Hospital Payment Adjustment, but starting in FY 2013, hospitals that qualify for this Medicare payment adjustment will be paid on the former qualifications. For FY 2011 and FY 2012, a hospital could be considered a “low-volume hospital” if it was more than 15 miles away from another hospital and had less than 1,600 Medicare discharges. Now, hospitals would have to be more than 25 miles away from another hospital and have less than 200 Medicare discharges. These hospitals would receive a 25 percent payment adjustment instead of a payment update on a sliding scale.

- CMS proposed to postpone the implementation date of the “services furnished under arrangements” requirements for cost reporting periods beginning on or after Oct. 1, 2013. Currently, therapeutic and diagnostic services are the only services that can be delivered under arrangement

outside of the hospital to Medicare beneficiaries. “Routine services,” which include bed, board, nursing and other related services, must be delivered by the hospital. CMS has discovered many affected hospitals need additional time to abide by the requirements that only therapeutic and diagnostic services can be furnished outside their facilities.

- In order to help low-bed hospitals qualify for the soon-to-expire Medicare Disproportionate Share Hospital payments, CMS proposed to include labor and delivery beds in their total bed count. Consequently, this would impact indirect medical education payments because it would reduce the resident-to-bed ratio that determines IME adjustments. CMS projects included labor and delivery beds in the available bed day count would decrease IME payments by \$170 million in FY 2013.
- CMS will continue to update hospitals, payors and other healthcare providers on the conversion of the MS-DRGs from ICD-9-CM codes to ICD-10 codes. The final version of the ICD-10 MS-DRGs will be implemented at the same time as ICD-10 goes live, which was recently delayed until Oct. 1, 2014.

CMS will accept comments on the proposal rule until June 25 and will issue a final rule by August 1. ■

Moody's: 2012 Shows Even Mix of Hospital Upgrades, Downgrades

By Bob Herman

In the first quarter of 2012, Moody's Investors Service reported an equal number of upgrades and downgrades in the non-profit hospital sector, but Moody's analysts expect a negative outlook for non-profit healthcare providers for the remainder of 2012.

“While downgrades and upgrades were on par with each other during the first quarter, we expect downgrades to eventually outpace upgrades by the end of the year,” said Carrie Sheffield, an associate analyst at Moody's and the author of the first quarter report. “This assumption reflects the pressures facing the [non-profit] healthcare sector and the fact that the majority of hospital ratings under review are trending toward downgrade.”

As of March 31, five ratings were under review — four for possible downgrades and one for possible upgrade. The amount of debt on review for downgrade is \$604 million, far greater than the \$45 million of debt on review for upgrade.

Overall, there were 11 upgrades and 11 downgrades in the first quarter compared with five upgrades and six downgrades in the first quarter of 2011. Upgraded debt equaled \$2.75 billion compared with \$1.44 billion in downgraded debt, a ratio of 1.91 to 1.

Moody's also affirmed 65 ratings, which represented roughly three-quarters of all rating activity in the quarter and affected \$28 billion of debt. Eight of the affirmations led to positive outlooks, while five led to negative outlooks. ■

Fitch: Patient Admissions, Pricing Trends Mixed at For-Profit Hospitals

By Bob Herman

Fitch-rated for-profit hospitals experienced varying operating trends over the past year, as urban hospitals saw stronger volume growth but weaker pricing trends than hospitals in rural and sub-urban settings, according to a report from Fitch Ratings.

In the fourth quarter of 2011, same-hospital adjusted admissions increased 1.6 percent at for-profit hospitals in urban markets compared with the fourth quarter in 2010. In that same period, rural for-profits witnessed a 0.8 percent decline in same-hospital adjusted admissions due to weak activity in obstetrics and less acute service lines.

Throughout 2012, Fitch expects for-profit hospitals to receive larger payments from the Medicare and Medicaid Electronic Health Records Incentive Program. The ratings agency also predicts for-profit operators will remain active in the merger and acquisition market, as the acquired revenue has been a major contributor to adjusted admissions growth. ■

An Overview of Recent Challenges to Hospital Transactions: Is the FTC Really More Aggressive?

By: Kathleen Roney

Merger and acquisition activity in healthcare has increased over recent years, driven largely by challenging operating environments and decreasing reimbursements. At the same time, the federal government is encouraging better coordination of care with more advanced technology — both of which require significant investment — in order to reduce national healthcare costs. For these reasons, many hospitals and health systems have been considering transactions.

Recent uptick in M&A activity has given the Federal Trade Commission more healthcare transactions to review. According to an FTC report in March 2012, the agency has “redoubled its efforts to prevent hospital mergers that may level insufficient local options for inpatient services, challenging three such mergers in federal court in the past year.” FTC Chairman Jon Leibowitz has said the agency challenges anticompetitive hospital mergers in order to control healthcare costs.

The “redoubling of efforts” by the FTC is evident in challenges over the past few years. Some healthcare professionals view the FTC’s renewed focus as aggressive, and many hospitals and health system officials are confused. Since lowering healthcare costs is a major focus, it makes sense that the FTC would want to verify healthcare mergers and acquisitions are not anticompetitive. However, other arms of the federal government are producing regulations and rules that directly and indirectly encourage coordination and integration to decrease healthcare costs. When one way to achieve higher quality, better efficiency and lower costs is through consolidations and partnerships, it is no surprise that hospital executives are confused.

“Some healthcare professionals may feel that healthcare is regulated in ways different than regular commercial industries and therefore, hospitals and health systems should be treated differently by the FTC,” says Brian Browder, partner at Waller Lansden Dortch & Davis law firm. “The FTC has not been persuaded by that argument.”

In order to understand whether the FTC’s reviews have become more restrictive or if transactions are just more fervently crossing the anticompetitive line, it is important to review some mergers the FTC has challenged since 2010.

3 Recent FTC Challenges

OSF Healthcare & Rockford Health System

OSF Healthcare in Peoria, Ill., and Rockford (Ill.) Health System recently canceled merger plans due to the prospect of a two-year legal battle with the FTC. The affiliation, which began in February 2011, planned to merge Rockford Memorial Hospital with OSF’s Saint Anthony Medical Center. It would have reduced the number of acute-care hospitals in Rockford from three to two. The two entities argued that the consolidation would improve efficiency and quality of care in line with goals set by the Patient Protection and Affordable Care Act. The FTC challenged the merger in November 2011 claiming it would substantially reduce competition among hospitals and primary care physicians in the Rockford area, leading to higher costs. This April, a U.S. District judge ordered OSF and Rockford Health to suspend the planned merger until the FTC could hold an administrative trial in Washington. Shortly after the ruling, OSF and Rockford Health announced they had canceled the merger rather than pursue a legal battle.

St. Luke’s Health & ProMedica Health System

In the summer of 2010, Toledo, Ohio-based ProMedica Health System acquired St. Luke’s Hospital in Maumee, Ohio. ProMedica planned to pro-

vide capital for St. Luke’s to adopt electronic health record adoption to standardize care.

In January 2011, the FTC challenged the merger claiming it was anticompetitive since it reduced the number of competing hospitals in the area from four to three and allegedly would contribute to higher prices. Over a year later, on March 22, 2012, the FTC ruled that ProMedica’s acquisition of St. Luke’s did lessen competition and increased prices for general inpatient hospital services and inpatient obstetric services in the Toledo area. ProMedica has been given six months to divest St. Luke’s to an FTC-approved buyer. However, a month after the FTC’s final order, officials from ProMedica and St. Luke’s decided to file an appeal in the 6th U.S. Circuit Court of Appeals in Cincinnati.

Palmyra Medical Center & Phoebe Putney Health System

The FTC has waged a long court battle to stop the acquisition of Palmyra Medical Center in Albany, Ga., by the Albany Dougherty Hospital Authority, which owns Palmyra’s only competitor, Phoebe Putney Health System, also in Albany. The battle began in April 2011 when the FTC filed a formal complaint against the acquisition. In June 2011, the Georgia District Court heard arguments from both sides and a federal judge sided with Palmyra and Phoebe Putney. Later in the month, the FTC filed an appeal, and in July 2011, a preliminary injunction on the deal was granted. However, the court of appeals later ruled on the side of the health systems. The FTC then filed an appeal with the U.S. Supreme Court. The case is still pending. According to the FTC, the \$195 million acquisition illegally consolidates the market for acute-care hospital services in a six-county area and raises a strong risk for higher healthcare prices.

What is causing the confusion?

The above-mentioned transactions shed some light on the recent debate over the role of FTC in healthcare M&A. Some have called the FTC’s reviews aggressive because they have led to challenges such as the three mentioned above. Mr. Browder understands the rationale behind the FTC’s argument — with fewer hospitals in one market, price increases could potentially go unchecked. “Without competition, a hospital or system could theoretically set a higher price for a service and patients would have no other option for care but to leave the market,” he explains. “Moving forward, the challenge will be in finding ways to address this concern while establishing new coordinated care models, particularly in markets where hospitals are struggling to survive financially.”

According to the FTC enforcement policy, many hospitals and acquisitions do not present competitive concerns. The agency does not challenge mergers or acquisitions in which one participating hospital has an average of less than 100 licensed beds and an average daily inpatient census of less than 40 patients. These characteristics must be the same over the three most recent years. The FTC includes these parameters because some acute-care hospitals, like rural hospitals, meet these criteria and are unlikely to achieve the efficiencies that larger hospitals “enjoy” — efficiencies needed to integrate and coordinate care.

Additionally, the FTC states that the following scenarios are transactions which would not be considered anticompetitive: a merger unlikely to increase market power for a participating hospital; a merger that allows a hospital(s) significant cost-savings that would be otherwise unrealized; and a merger that eliminates a hospital likely to fail in its market.

“While there is not anything new about FTC reviews, in the current health-care landscape the agendas of federal agencies [and departments] are overlapping,” says Thomas Jeffrey, a partner in the healthcare and life sciences practice groups of Arent Fox, a law firm with emphasis on life sciences, real estate and finance. “While the FTC is curbing monopolies and antitrust behavior, [CMS] is enforcing regulations to improve quality and reduce cost. CMS is advocating higher quality, better efficiency and lower costs while the FTC is saying you should not combine if the resulting structure is anticompetitive,” says Mr. Jeffrey.

The need to bolster quality care, provide capital to adopt electronic medical records and standardize care through clinical protocols were cited as reasons for the St. Luke’s and ProMedica merger — advancements in care and technology that CMS and the federal government support. Similarly, the OSF and Rockford Health officials claimed their planned merger would improve efficiency and quality of care. They even went so far as to cite the PPACA as an instigator of the transaction.

Officials from all of the above-mentioned examples did not believe their transactions were anticompetitive. Gary Kaatz, president and CEO of Rockford Health, and Dave Schertz, president and CEO of OSF Saint Anthony Medical Center in Rockford, released a joint statement around the time of the FTC challenge saying they “have no question that the affiliation is competitively appropriate.” ProMedica believed the FTC’s challenge of its deal went against major themes of healthcare reform. In a statement ProMedica claimed the FTC’s antitrust challenge of the merger was “inconsistent with the integration and coordination that healthcare reform both encourages and requires.” Lastly, attorneys for the Palmyra and Phoebe Putney transaction, still battling the FTC’s challenge, believe they have the right to consolidate Palmyra and Phoebe Putney due to its public ownership, which exempts the transaction from federal antitrust laws.

What can hospitals, health systems do?

According to Mr. Jeffrey, beyond just following FTC regulations very closely, another way to avoid antitrust and anticompetitive challenges by the FTC may be demonstrating community benefit of the merger or acquisition. The benefit for the community has to go beyond the combined financial strength of the entities. While the combined financial strength may be a given, Mr. Jeffrey says that should not be the sole reason for a transaction.

“It is more effective to build the case that each facility involved in the merger could not achieve a new service or a new program without the combination of resources because of the transaction,” says Mr. Jeffrey. “For example, the need to develop a cancer center for the community which has limited oncology resources makes for a more defensible transaction,” says Mr. Jeffrey. “Position the merger as, not only would the financial health of the hospital be better, but the hospital will be able to provide better, more cost-effective care to the community through services that are unattainable without a merger.”

Since, the FTC is particularly concerned with mergers that result in only one hospital or health system in an area, the most viable solution may be to avoid “bread and butter” mergers that could lessen competition in an area. “If a merger could maintain competitiveness, the FTC may view it more favorably. However, it may be unrealistic to carve out aspects of a merger just keep the two entities competitive,” says Mr. Jeffrey. “Other than that, hospital executives just need to understand how to structure a joint venture or a merger so that the result is not anticompetitive.”

Although it may seem that the FTC has become overly aggressive in its reviews of healthcare transactions, antitrust regulations remain largely unchanged. Instead, any perceived increase in scrutiny is more likely a result of the FTC “redoubling efforts.” In order for hospital and health systems to see deals come to fruition, they should closely examine FTC rules and regulations before any sort of transaction to avoid anticompetitive elements and proactively make a case for the deal’s community benefits. ■

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Community Health Needs Assessment: 5 Phases to Compliance

By Edward Stall, Principal, Craig Anderson Jr., Senior Manager, Matthew Fadel, MBA, Associate, Dixon Hughes Goodman

The Patient Protection and Affordable Care Act enacted in March 2010 has had a significant impact on the evolving healthcare industry. The PPACA legislation has created a new sense of urgency within the industry to discover new care delivery models, increase access for healthcare and challenge the quality of care that is being provided to patients. New programs are being piloted (e.g., the accountable care organizations, bundled payments, etc.) and hospitals and physicians alike are critically evaluating their strategic responses to the proposed legislation. Regardless of what happens in Congress or the Supreme Court in 2012, health reform is inevitable, and there are requirements that healthcare systems need to understand in order to avoid constant regulatory pressure.

Buried within the 2,300 pages of the PPACA are four new requirements for 501(c)(3) hospitals. Specifically, the PPACA imposes new tax requirements on 501(c)(3) hospital organizations for tax years beginning after March 23, 2012. The law added two new sections to the Internal Revenue Code documenting the new mandates identified below:

1. Each tax-exempt hospital must adopt and implement written financial assistance and emergency medical care policies.
2. The hospital organization must limit charges for emergency or other necessary medical care.
3. Comply with new billing and collection restrictions.
4. Each tax-exempt hospital is required to conduct a Community Health Needs Assessment.

Arguably the most significant requirement, the Community Health Needs Assessment will necessitate a well defined approach and process from hospitals to ensure a successful completion of this IRS mandate.

In its simplest definition, a CHNA is the ongoing process for a hospital to evaluate the health needs of a community, which facilitates a prioritization of needs and strategies to address them. The PPACA legislation uses only one page out of 2,300 pages to define a CHNA. Thankfully the IRS posted a 26-page document in 2011 to provide further clarity on what could be seen as an intentionally ambiguous subject.

If a hospital is one of the 2,918 non-government non-profit hospitals in the US and it fits the following requirements, the hospital is subject to the CHNA:

1. The organization is required to be licensed by the state.
2. The IRS determines hospital care as the organization's principal function.
3. State-licensed hospitals operated through a disregarded entity or joint venture — treated as the activities of the tax exempt partner, multi-hospital systems, critical access hospitals organized as 501(c)(3).

In addition, it is important for multi-hospital systems to understand that each hospital is required to produce its own implementation strategy.

Beginning in 2012 the CHNA is required every three years. Hospital organizations not in compliance with this mandate will be penalized up to \$50,000 per year and can be at risk of losing non-profit status. In the past the assessment has been shared with local government agencies and other healthcare entities in order to coordinate the allocation of both public and private resources.

The IRS also requires a communication of results. Hospital organizations that perform the CHNA must make the report widely available by posting the written results on a website. Hospitals must also attach their Form 990 (from the IRS). The IRS plans to add questions reflecting the new reporting requirement for Form 990 in the future.

Framing your response

As hospitals embark on fulfilling the CHNA mandate, they should consider a well-defined scope and process. The scope can be simplified to three levels (compliance, coordination and coalition) that all meet the requirements of the PPACA and vary in the depth of assessment and the involvement from the community. As a hospital moves from compliance to coalition, the assessment shifts from health indicator analysis and individual interviews to detailed population health analysis and community task force.

By using the scope to create an end-in-mind mentality and to force an understanding of the objective for the assessment, it is acceptable and realistic to strive for compliance. Compliance avoids any governmental penalties and helps prepare an organization for health reform. The information necessary to become compliant allows each organization to increase coordination, quality and market awareness, while potentially decreasing cost. The organization also can use the CHNA to support informed decisions about services, health promotion and prevention programs. It is a support tool for managing

the health of a population across the episode of care. A hospital organization should take a proactive approach to follow a defined path that leads to a satisfactory response to the CHNA.

Once an acceptable scope is created, the hospital organization can analyze quantitative and qualitative data to assess the community needs of the entities involved and to create the implementation process.

The CHNA process

The core of the CHNA demonstrates the value each health organization brings to a community. Each organization should be committed to involving and informing the community in the process. It is recommended that local government officials, health agencies and other community leaders be included in the analysis.

Data assessment (secondary data). The data assessment performed should include the first requirement: develop a health profile of the county's population. After defining the service area for each hospital organization, analysis is performed on the population distribution. Typically, data is compiled based on the ZIP codes within each service area.

The objective is to obtain a distribution of age, sex, household income, payor mix, etc., all of which help to create an understanding of the social and economic condition of the community. The data must be analyzed not only to reform the current state but to recognize if access to care will be a barrier in the future. After analyzing an external view of the community, the hospital should review personal inventory. An environmental scan of the critical issues and forces impacting the future of the hospital can be performed (similar to a SWOT analysis). Assessing each hospital's strengths, weaknesses, threats and opportunities will be identified to build the foundation of an integrated, cohesive organization. Furthermore, a thorough analysis and/or review of existing physician alignment arrangements (if applicable) will be conducted to document the effectiveness of the existing alignment vehicle. Analysis of existing agreements will help optimize the hospital and physician relationships across the organization. Once this assessment is performed, community input should be provided.

Community input (primary data). Interview questionnaires, surveys or focus groups that are customized to various stakeholders (physicians, community, public health, school nurses, business community) will be developed to capture qualitative and quantitative responses including:

1. Individual objectives regarding hospital and community strategies
2. Critical success factors
3. Barriers to success
4. Underserved and chronic disease populations
5. Measure/indicators for success
6. Baseline data

The stakeholders must work together to determine the number of interviews needed to create a strong cross-section of perspectives and personal viewpoints. The community input should satisfy the second and third requirements of the PPACA, determine how the community perceives its health status and healthcare needs and enable the identification of the major risk factors and causes of health issues. The interviews must be carefully planned to align with the gaps in the data discussed in the data assessment phase.

Implementation strategy. The findings from the data assessment and community input phases will be used to create recommendations and an action plan to achieve success. This includes the development and delivery of an implementation plan to drive execution of the defined strategies. Components include a communication plan, priority initiative work plans, role and responsibility assignments, measure/indicators for success along with baseline data and project timelines. The Implementation Strategy phase will satisfy the last requirement of the PPACA legislation.

Reporting. As stated previously, the CHNA must be widely available to the public. The community needs to understand the explicit issues and must be equally invested in the transformation of their healthcare network. Some recommendations include:

1. Secure board approval as the approval step in conducting the CHNA
2. Determine communication report format
3. Hospital website (required)
4. Report to the community
5. Coordinate with community benefits statement
6. Coordinate with Form 990
7. The implementation plan can be used for three fiscal years without revision
8. Post to website prior to end of fiscal year to meet CHNA requirement
9. Leverage implementation strategy to demonstrate value as a tax-exempt organization meeting community needs
10. File 990 Schedule H

Monitoring. Through the implementation of each strategy, constant monitoring and updates must be performed to measure success. Demonstrated improvement is equally or even more valuable than performing the assessment. Performance indicators tied to community priorities will help the hospital organization monitor success on an annual basis.

How do I get started?

1. Determine hospital leadership of the CHNA. Proper sponsorship is critical to the success of any project with organization-wide implications. Key stakeholders would include: the CEO, the CFO, the head of planning and development, government officials, hospital board members, marketing officials, etc.
2. Confirm timing requirements and a high-level implementation plan for your organization. The project plan can be based off of the confirmed fiscal year end, which includes a reasonable timeline and established milestones. Anticipate approximately six to nine months to perform an adequate CHNA.

3. Review service area definition for the hospital organization. A recommendation would be to review the Stark II Area Definition, Metropolitan Service Area or the 990 Definition. A hospital organization can create a primary and secondary service area based on ZIP code and/or county discharge analysis.
4. Compile starting elements of a preliminary assessment using a web search of key sites to identify issues and challenges that can be detected early.
5. Guidance of potential model (compliance, coordination, coalition). Compliance and coordination can be hospital-led; coalition is much broader.
6. Determine strategy for internal or external partnering and evaluate benefits of a shared approach (community building, market perception, cost sharing). Also consider the response if a competitor asks you to collaborate.
7. Determine approach if multiple facilities are collaborating on a CHNA. Confirm common approaches and a tool to comply with federal regulations. Assign a leader for each facility and possible steering committee.
8. Inform the hospital's board on standards, timing and approach. The board should be informed early and their input should be requested. ■

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OIG Claims Georgetown University Hospital Overbilled Medicare by 659K

By Molly Gamble

A report from the Office of Inspector General claims Georgetown University Hospital in Washington, D.C., overbilled Medicare by roughly \$659,400 primarily due to misunderstandings of billing requirements.

The OIG has recommended the hospital refund the overpayments, which consist of 94 incorrectly billed inpatient claims for short stays and excess charges and 40 incorrectly billed outpatient claims. It also recommended Georgetown strengthen its controls to ensure full compliance with Medicare requirements.

The 609-bed hospital issued comments to the OIG, concurring that the 94 inpatient claims were billed incorrectly. The hospital disagreed with OIG's overpayment amount for the inpatient claims, however, claiming it should be less than \$634,653. The hospital said it anticipates lower figures once reimbursements are adjusted for the correct DRG assignments and Part B services provided.

The hospital has agreed to refund \$24,718 for the outpatient claims billed in error, but for inpatient claims, it "will process appropriate refunds to the Medicare Administrative Contractor" pending adjustment to reimbursement made for the services provided. ■

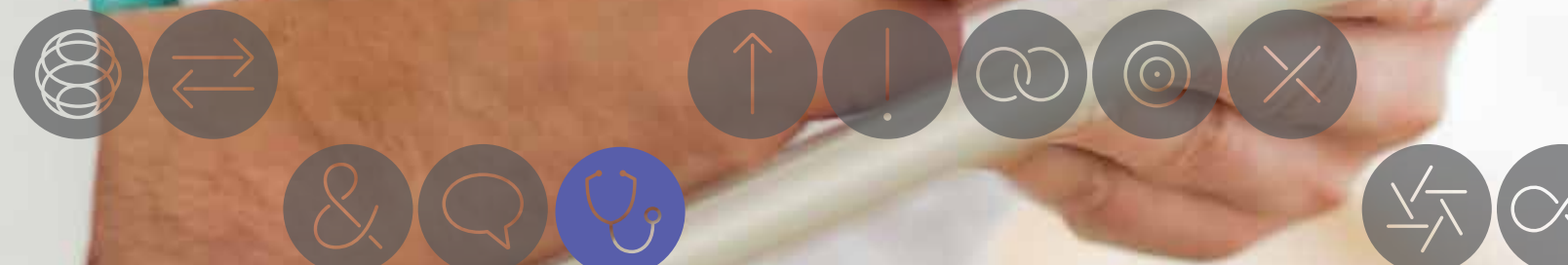
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The OR Efficiency Game Plan: Using Daily Huddles to Streamline Care

By Sabrina Rodak

Some hospital operating rooms are borrowing a practice from sports teams to boost efficiency: huddles. On the playing field, team members with different roles huddle to discuss strategies to win the game. In an OR, clinicians and staff can huddle to analyze and optimize the next day's schedule. Daily huddles in the OR can also improve communication and collaboration between physicians and staff, leading to greater employee satisfaction, improved safety and a better patient experience.

David Young, MD, managing partner of Surgical Directions and medical director of pre-surgical testing at Advocate Lutheran General Hospital in Chicago, Nell Panten, DNP(c), MSN, RN, CNOR, NEA-BC, chief nurse executive of Surgical Directions, and Cindy Mahal-van Brenk, RN, MS, CNOR, director of operations of surgical and GI services at Advocate Lutheran General Hospital, explain the inner workings of a successful daily huddle.

What are daily huddles?

At Advocate Lutheran General Hospital, a "HUDDLE" stands for Healthcare United for Daily Decisions through Leadership Enthusiasm. The huddle includes a group of OR stakeholders who meet every day at 2 p.m. for about 35 minutes to discuss 40 to 60 cases scheduled for the following day. The goal is to review any problems from the current day and prevent them from occurring in the future and to actively manage the surgical schedule for the next day. "We're trying to use collective intelligence to plan the next day and prevent any delays, cancellations or problems in a proactive way," Dr. Young says.

What is the agenda?

The huddle starts by recapping the day's problems, determining their root causes and planning to prevent the problems from recurring. Then, the team reviews all of the next day's cases. At Advocate Lutheran General, this is done by projecting the schedule for everyone to see and going through each case separately. Usually the scheduler calls out the case, after which the preanesthesia testing nurse provides the patient's clinical history. The team discusses patients who will need a pain block and those who may need special management, such as patients who have had previous pain issues and diabetic patients.

The team also identifies inefficiencies in the schedule, such as a case that is scheduled for too much or not enough time, and rearranges the schedule to avoid delays and cancellations. In addition, the huddle discusses patients who may have antibiotic problems due to multiple allergies.

Who participates?

The huddle should include a multi-disciplinary team of representatives from different stages of the surgical process — from schedulers to materials management to anesthesiologists. Including people from each area of the OR drives accountability, as each person plays an important role in creating an efficient process. For the huddle to be successful, everyone needs to be committed to the group; they need to arrive on time each day and understand the expectations. "You have to identify people who believe in proactive management of problems and are willing to put in the time to make it right," Dr. Young says. In addition, the huddle should consist of the same people to create consistency and allow the group members to form a cohesive unit, according to Ms. Panten.

A critical aspect of the huddle is that decisions are made collaboratively. "Everyone is working in a cohesive manner to do what's best for the patient," Ms. Panten says. While nursing management and the anesthesiologist typically lead the group, everyone is expected to contribute. "We believe in a just culture where everybody has a voice. That's why we involve all the different areas and feel that's really key. Everybody has an opportunity to speak," Ms. Mahal-van Brenk says.

The following areas should be represented in the huddle:

Daily Huddles: 7 Must-Have Participants

1. Surgical navigator
2. Scheduling
3. Preanesthesia testing
4. Anesthesia
5. Presurgery
6. Material management/sterile processing
7. Surgical leadership

1. Nurse liaison navigator. The liaison reviews problems that occurred that day to determine the root causes and prevent them from recurring.

2. Scheduling. This person is responsible for knowing the next day's schedule. The scheduling representative will also need to contact surgeons to change the schedule when needed. At Advocate Lutheran General, the scheduling representative calls out each case of the next day to start the patient verification process as the huddle reviews each one.

This allows the huddle to change the schedule the day before the surgery to improve efficiency. Calling the patient the evening before surgery also enables the scheduler to confirm the patient will arrive.

3. Preanesthesia testing. This person should know all the patients scheduled for the next day, as he or she provides the patients' clinical history and notes any potential problems from a clinical standpoint. At Advocate Lutheran General, the PAT nurse provides the history after the scheduler announces the case and also confirms the correct procedure is scheduled.

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- ▶ Surgeon Satisfaction
- ▶ Turn over time
- ▶ Close to cut time
- ▶ On time starts
- ▶ Block Time
- ▶ Materials/supply spend
- ▶ Labor spend
- ▶ Anesthesia service Levels
- ▶ And growing incremental OR Volume



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4. Anesthesia. The anesthesiologist is responsible for identifying patients with histories of adverse reactions and developing plans to manage these patients. The anesthesia representative should also help arrange the schedule to best manage patients with co-morbid diseases.

5. Presurgery. This person is responsible for communicating with staff to alert them of anticipated problems related to the following day's cases. For example, Advocate Lutheran General Hospital identifies all diabetic patients scheduled for the next day. The presurgery representative needs to ensure these patients have their weight, vital signs and blood sugar tested when they come in so the team can begin managing their blood sugar as soon as possible.

“You have to identify people who believe in proactive management of problems and are willing to put in the time to make it right.”

— David Young, MD, Managing Partner,
Surgical Directions

6. Materials management/sterile processing. This person is responsible for contacting the appropriate vendors when a device is needed for the next day's case and for ensuring the correct trays of materials are in sterile processing to be prepared for the next day. For example, if a total hip case is scheduled for the next day, the materials management representative would verify the implant trays have arrived.

Dr. Young says, “It is essential to include materials management and sterile processing in the huddle to communicate the importance of this role in the surgical process. If the correct materials are not prepared for each case, there can be delays, which decrease surgeon and patient satisfaction and create inefficiencies.”

7. Surgical leadership. The surgeon, who may participate by phone, is alerted to changes in the next day's schedule. Surgeons need to be aware of any schedule changes so they arrive on time for each case. The process is also audited by the executive director on a weekly basis to make sure that they have the tools they need to be successful and to remove recurring barriers.

How can daily huddles drive efficiency?

Dr. Young provides several examples of ways daily huddles can prevent delays and streamline processes.

Scenario 1

A patient scheduled for the next day has been on chronic pain medication and may have issues related to postoperative pain management. The presurgery representative in the daily huddle would notify the anesthesiologist caring for that patient. The anesthesiologist would then develop a pain plan that may include a regional block, according to Dr. Young. The huddle participants would also notify the advanced practice nurse in pain about the patient so he or she could plan to visit the patient in recovery and ensure the patient has an appropriate pain management plan. The huddle thus avoids a delay that may occur if the anesthesiologist does not find out about the patient's pain history until the day of surgery. In addition, the huddle puts in motion processes to ensure the patient's safety.

Scenario 2

A patient scheduled for the first case the next day has been on Coumadin and may need an international normalized ratio test the morning of surgery. The huddle may re-shuffle the schedule so this patient's procedure is performed later in the day — the third case, for example, to avoid a first-case delay if the INR is abnormal.

Scenario 3

A patient scheduled for the first case the next day is identified as having unreliable transportation to the OR. The huddle may move this case later in the day to prevent a first-case delay or cancellation.

Scenario 4

A patient scheduled for the afternoon the next day is diabetic. The huddle may want to move this patient earlier in the day to reduce the time clinicians need to manage the patient's blood sugar. Scheduling a diabetic patient for the morning reduces the chance of changes in blood sugar before surgery, which improves patient safety.

Conducting daily huddles in the OR creates a collaborative working relationship between OR team members so they can effectively prepare for the next day's surgical cases. Taking the time beforehand to identify potential delays and patient safety issues can decrease costs and improve efficiency, safety and satisfaction.

The huddle “smoothes” the daily operating schedule to decrease first-case start delays and decreases cancellations on the morning of surgery. This in turn, leads to increased profitability for the institution by not having an operating room sit empty for greater than 30 minutes or having a three to four hour case that has been cancelled with no case to shift into that operating room. ■



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The Next Iteration of Hospital-Physician Alignment: Making Medicare Profitable

By Lindsey Dunn

The idea of aligning physicians with hospitals and health systems is not new. In fact, it has been experimented with since the 1990s and the rise of managed care. In many cases those relationships crashed and burned, and the idea of physicians as hospital employees faded. Then, several years ago, the idea resurfaced, in part because of observations that systems with closely aligned and integrated physicians provided some of the best care at some of the lowest costs.

Today, most hospitals employ or at least contract with physicians in some way. Unfortunately, these relationships are often guided first by fear — fear of losing market share — and second by quality and efficiency objectives. In fact, quality and efficiency goals often aren't specific at the onset of a hospital's relationship with a group of physicians. For example, a hospital doesn't generally employ physicians with a stated goal of reducing congestive heart failure readmissions by a specific percentage — these goals are developed in concert with physicians.

However, according to Quint Studer, founder of the Studer Group, there is one goal that should drive future hospital-physician relationships from the onset: breaking even on Medicare.

"When hospitals look at their future, one reality is that they will have to reduce costs by about 20 percent over the next eight or nine years," he says. "But that's not all. A recent article in *New England Journal of Medicine* argues that lowering costs is not enough. It's also necessary to increase volume. It's this two-pronged need that is bringing hospitals and physicians together."

The article Mr. Studer is referencing is *The Savings Illusion — Why Clinical Quality Improvement Fails to Deliver Bottom-Line Results*, by Stephen S. Rauh, Eric B. Wadsworth, PhD, and William B. Weeks, MD. According to Mr. Studer, the article is a good starting point for leaders to get familiar with the healthcare system's cost layers — something that is outlined in the article.

"Understanding that many costs are fixed certainly doesn't mean organizations should give up their efforts to reduce costs and increase quality," clarifies Mr. Studer. "It's essential to do both. Value-based purchasing is a reality, and hospitals want to create great patient experiences so people will come back and refer others to [them]. But it's also important to work with physicians to put in tactics aimed at increasing volume, like lowering no-show rates and cross-referring other appropriate services."

Mr. Studer provides four steps for hospital leaders to work collaboratively with physicians toward this aim.

1. Explain and align goals. Help the physicians understand what the goals of the health-care system are and, to the greatest extent possible, align their physician organization's goals with those of the system. This generally means sharing elements of the hospital's strategic plan in a straight forward manner with physicians.

"It may not be necessary for physicians to understand every detail of a balance sheet or how bond ratings work," explains Mr. Studer. It is important to help them better understand how great of a profit margin the hospital needs to make in order to reinvest back into the hospital. And it's important that they have a solid grasp of why cost-saving and volume-creating tactics need to co-exist."

2. Gain physician input. After the physicians understand the goals, ask them for their thoughts on how to reach them. It is critically important to take a "shared governance" approach rather than expecting physicians to bend to the organization's will.

"The great majority of physicians want the healthcare system to do well," explains Mr. Studer. "They know what the barriers and frustrations are and can identify some of the first things that can be tackled to make care more efficient and effective. It would be a shame not to tap into their expertise."

3. Give them feedback. Just as physicians should give input to hospitals, so should hospitals give feedback to physicians. According to research by Studer Group, anywhere from 1 in 3 to 1 in 5 physicians don't get good feedback on their performance. Sure, they can look at their own productivity and collections, but in an era of accountable care, physicians need feedback on the quality of the care they provide.

"Physicians want to do well, and they're very good at moving their performance if they can see and understand data on it," says Mr. Studer. "Data must be accurate in order to gain physician trust, though."

He recommends hospitals commit to mining this data and sharing it through "data guides." In his opinion, referring to such feedback as a "report card" could be seen as negative. "You don't want to punish people; you want to make them better," he says



4. Watch care improve. Then, once data is shared, hospital leaders should provide resources, as needed, to help physicians make sense of it, and more importantly, gain feedback on any hospital-controlled barriers that may have led to lower scores.

Leaders don't necessarily need to formally guide physicians through how they might improve their scores, says Mr. Studer. In fact, they may be surprised to find physicians often get data and run with it.

"Doctors are very self-motivated," says Mr. Studer. "They will seek out other doctors with better outcomes and discover what they could do better."

While these four steps are just starting points for in-depth and specific clinical process changes, they are the ones that are likely to most closely involve hospital leaders.

"That's because clinical process improvements should be led by physicians, with support from administrators and not the other way around," says Mr. Studer. ■

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What We Need to Do if the Supreme Court Strikes Down the Healthcare Law

By Chuck Lauer, Former Publisher of *Modern Healthcare* and an Author, Public Speaker and Career Coach

If the Supreme Court strikes down all or part of the Patient Protection Affordable Care Act, as everyone seems to be predicting, it would be a stunning indictment of the self-interested deal making that created this very flawed law.

I want to say from the get-go that I believe in health reform. Anyone who truly understands the problems in healthcare today knows that reform is desperately needed. It will have to happen, one way or another, or we will all be sunk. But so-called “Obamacare” missed the mark.

Something monumental like health reform needed the sign-off of the American people. That never happened. According to the most recent poll, 53 percent of the people oppose Obamacare, and only 39 percent support it — a reading that hasn’t changed that much since the law was passed two years ago.

There was never any public debate. The architects of Obamacare cobbled together a bunch of deals with lobbyists who represented every nook and cranny in the healthcare industry. When the law was being drafted in 2009, more than 1,750 organizations and companies hired some 4,525 lobbyists to represent their interests, spending more than \$1.2 billion, according to a study by the Center for Public Integrity.

This year, when the Supreme Court agreed to consider challenges to the law, the big healthcare interests once again made their case, sending in a flurry of amicus briefs to the court. The 130-plus amicus briefs sent in are thought to be a modern record.

Because President Obama failed to lead on health reform and failed to forge strong public support, the law became a complicated mess that no one individual can possibly understand. The regulations for the law are said to be 2.1 million words long, which is about two and a half times the length of the King James Bible. How’s that for simplicity and transparency!

The degree of self-interest behind the law is appropriate to the level of political dialog we see all around us today. That dialog has shrunk to the narrowest of interests: “What’s in it for me?” Notions of fairness or concerns for the whole just get thrown out the window. In one political debate this year, the audience actually booed the Golden Rule — “Do unto others as you would have them do unto you.”

The rampant self-interest we wallow in today is not limited to any particular party. When the

new president began telling the world that he was going to push for a bill to change healthcare in the United States forever, all the special interests came forth.

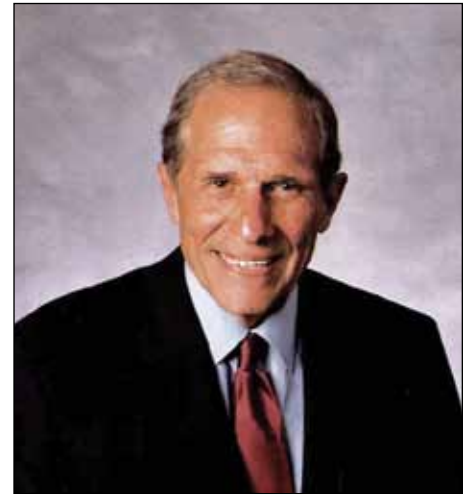
I have to say, some healthcare fiefdoms agreed to take significant hits in exchange for possible future gains. Hospitals, for example, agreed to take \$155 billion in Medicare cuts over 10 years, but in return they hoped to get more patients because healthcare coverage would expand. And there were some very cynical deals, such as completely stopping the growth of physician-owned hospitals. That group didn’t have enough clout to survive the stampede.

Even some big players with lots of clout, like the American Medical Association, lost in the deal making. To make up for the new Independent Payment Advisory Board, which will meddle with physician reimbursements, the AMA was assured that the law would get rid of the sustainable growth rate formula, which sets off automatic Medicare cuts that need to be overridden by Congress each time. In the end, however, the SGR fix was removed, because it would have pushed up the price tag, and that would have turned off some very skittish senators. The physicians had to be thrown under the bus.

The Supreme Court’s decision is expected by late June. If the court touches the law in any way, the cynical deals that were made two years ago will start falling like dominoes. If the court removes the individual mandate, insurers would have to raise rates, because people with preexisting conditions wouldn’t have to buy insurance until they got sick. The court could save the insurance industry by striking down the requirement to cover preexisting conditions. But the coverage mandate would be gone, and with it the extra patient volume that was promised to the hospitals.

The house of cards that is Obamacare would fall. However, that might not be so bad. Without all the special deals, it would then be up to the healthcare industry to save itself. The various constituencies in healthcare don’t need incentives to understand that things have to change. Every healthcare executive knows that if we don’t agree to serious changes, everyone will be hurt. Instead of vying with each other for special deals, we’d have to accept the simple fact: “United we stand, divided we fall.”

Healthcare leaders would have to embrace the values they teach within their organizations, which are all about “breaking down the silos”



and making sure people function in teams instead of like a bunch of prima donnas. Also, hospitals are starting to get very serious about efficiency, which will be an absolute requirement in the future.

But even as we talk about teamwork and efficiency, other values still embraced by the industry are getting in the way of reform. Healthcare is not used to viewing patients as customers, who have to be consulted and catered to. We’re the only industry I know that treats customers rather indifferently. We don’t make a point of asking patients what they want. And that was a major flaw of Obamacare: the public was never consulted. Americans were told what they should want and — surprise, surprise — they didn’t like it!

Before we decide on any reforms, we need to get feedback from the American people: It’s your healthcare system; what do you want it to look like? If Americans can’t stomach the individual mandate, which is patently obvious in poll after poll, then what would they agree on? There should be a national debate on the big-picture issues, such as whether healthcare is a right or a privilege, and who should finance it? This could be done in a series of town hall meetings.

Americans also need to be educated. If they are ignorant of the challenges in healthcare, they will be stampeded by incendiary terms like “death panels,” and they will not see any connection between the mandate to buy insurance and required coverage of preexisting conditions. We don’t have to throw out all of Obamacare. There are many parts of it that can be built on, such as accountable care organizations and insurance exchanges.

Focusing the people’s attention on healthcare requires leadership, which has been woefully lack-

ing so far. Whoever wins the presidential election this November needs to step forward and lead. The president needs to call on the American people to help forge a Magna Carta for healthcare. What are our healthcare priorities? How do we propose to get there?

Next, we need to create a healthcare Marshall Plan. Healthcare reform could be achieved without a lot of subsidies, because there is still a great of waste in the system. We need to identify it and eliminate it. I propose getting hospital supply chain directors involved, because they know where the waste is.

For an undertaking as immense as reforming healthcare in the United States, each of us needs to go beyond our own self-interest and look to the whole. President Lincoln said it best: "A house divided against itself cannot stand." Mr. Lincoln, living in an even more divisive era than our own, asked everyone to respond to "the better angels of our nature." That is what we need to do today. ■

Chuck Lauer (chuckspeaking@aol.com) was publisher of Modern Healthcare for 33 years. He is now an author, public speaker and career coach who is in demand for his motivational messages to top companies nationwide.

Hospital & Health System Transactions

Alegent Health in Omaha, Neb., and **Creighton University** in Omaha announced a strategic affiliation, which includes Alegent acquiring Creighton University Medical Center from Creighton and its partner **Tenet Healthcare** in Dallas.

Capella Healthcare in Franklin, Tenn., and **Mercy Health** in Oklahoma City, sponsor of **St. Joseph's Mercy Health System** in Hot Springs, Ark., signed an agreement to explore the sale of St. Joseph's Mercy to Capella Healthcare.

Champlain Valley Physicians Hospital Medical Center in Plattsburgh, N.Y., and **Elizabeth-town (N.Y.) Community Hospital** agreed to become part of a four-hospital affiliation with **Fletcher Allen Partners** in Burlington, Vt.

McLaren Health Care reached a resolution with CMS to reopen **Cheboygan (Mich.) Memorial Hospital**, which had closed after a proposed purchase by McLaren Health fell through due to unresolved licensing issues.

Dignity Health in San Francisco signed an asset purchase agreement with California-based **Prime Healthcare Services** for the sale of **Saint Mary's Regional Medical Center** in Reno, Nev.

Glendale (Calif.) Adventist Medical Center in Verdugo Hills, Calif., began discussions to acquire or merge with **Verdugo Hills Hospital**, also located in Glendale.

Health Management Associates in Naples, Fla., completed its joint venture with five Oklahoma hospitals owned by **Integrus Health** in Oklahoma City.

Hillsboro (N.D.) Medical Center and **Sanford Health** based in the Dakotas agreed to a letter of intent for an affiliation.

Bankruptcy court Judge Morris Stern accepted Pennsylvania-based **Hudson Holdco's** \$43.5 million bid for **Christ Hospital** in Jersey City, N.J.

Laurel Health System in Wellsboro, Pa., and **Susquehanna Health** in Williamsport, Pa., announced a definitive agreement for a partnership that will create a regional integrated health system for north central Pennsylvania.

Mercy Health System in Chicago affiliated with **Trinity Health**, a Catholic healthcare system in Novi, Mich.

The Massachusetts Public Health Council approved the planned merger between Beverly, Mass.-based **Northeast Health System** and **Lahey Clinic** in Burlington, Mass.

Noyes Health Services in Dansville, N.Y., formerly Livingston Healthcare System, and the **University of Rochester (N.Y.) Medical Center** began a collaborative agreement.

NYU Langone Medical Center and **Continuum Health Partners**, both based in New York City, signed a confidentiality agreement in their preliminary discussions toward a possible affiliation or merger.

Orlando (Fla.) Health acquired **Health Central** in Ocoee, Fla., for \$181.3 million after over a year of negotiations.

The Illinois Health Facilities and Services Review Board approved the acquisition of **Ottawa (Ill.) Regional Hospital** by **OSF Healthcare System** in Peoria, Ill.

The Federal Trade Commission required Toledo, Ohio-based **ProMedica Health System** to divest **St. Luke's Hospital** in Maumee, Ohio, citing anticompetitive effects of the systems' merger, but the leaders of both entities plan to appeal the decision.

Sacred Heart Health System in Pensacola, Fla., and **LHP Hospital Group** in Plano, Texas, completed a 40-year lease and asset purchase agreement to form a joint venture to lease and operate **Bay Medical Center** in Panama, Fla.

Salinas (Calif.) Valley Memorial Healthcare

moved forward with proposal plans from **Natividad Medical Center** in Salinas and **HCA** in Nashville, Tenn.

Southern Maryland Hospital Center in Clinton, Md., considered a strategic partnership.

St. Joseph Medical Center in Towson, Md., recommended a partner to its parent company, **Catholic Health Initiatives** in Englewood, Colo.

Georgia-based **Taylor Health Care Group** and **Central Georgia Health System** in Macon, formed a strategic partnership.

Texas Health Resources in Arlington signed a letter of intent with **Adventist Health System** in Altamonte Springs, Fla., to "enable the organizations to consider forming a company" to own and operate **Huguley Memorial Medical Center** in Burleson, Texas.

Twin County Regional Healthcare in Galax, Va., agreed to jointly own and operate **Twin County Regional** and its affiliated assets with **Duke LifePoint Healthcare** in Brentwood, Tenn.

The **University of Louisville** (Ky.) postponed its selection of a new healthcare partner for its University Hospital in Louisville.

Valley General Hospital in Monroe, Wash., and **Capella Healthcare** in Franklin, Tenn., suspended their partnership discussions.

Waterbury (Conn.) Hospital approved a merger with **St. Mary's Hospital** in Waterbury and **LHP Hospital Group** in Plano, Texas, in an "overwhelmingly" majority vote by its board.

Westerly (R.I.) Hospital Holdco, a limited liability company, submitted an official letter of intent for the acquisition of **Westerly Hospital**.

Non-profit **Willis-Knighton Health System**, based in Louisiana, finalized its purchase of **Bossier Medical Center** in Bossier City, La.

Hospital & Health System Executive Moves

Saint Joseph's Health System in Atlanta promoted **Tom Andrews** to president and CEO.

Saint Luke's Health System in Kansas City, Mo., announced **Ron Baker** as CEO of Saint Luke's East Hospital in Lee's Summit, Mo.

Steward Health Care System in Boston named **Kimberly Bassett** as president and CEO of Morton Hospital in Taunton, Mass.

Holy Family Medical Center in Des Plaines, Ill., named **Pamela Bell**, MBA, RN, BSN, as CEO.

Chestnut Hill Hospital in Philadelphia named **John Cacciamani**, MD, as CEO.

Nazareth Hospital in Philadelphia named **Nancy Cherone** as interim CEO.

Steward Health Care System in Boston named **Andrew Davis** as president of Carney Hospital in Dorchester, Mass.

Barrow Regional Medical Center in Winder, Ga., named **Todd Dixon** as CEO.

Lance Duke announced his resignation as president and CEO of Columbus (Ga.) Regional Healthcare System's flagship hospital, The Medical Center.

St. John's Medical Center in Jackson Hole, Wyo., named **Louis Hochheiser**, MD, as CEO.

Sanford Health based in Sioux Falls, S.D., named **Michael Hammer** CEO of its Sanford Worthington (Minn.) Medical Center and Sanford Worthington Clinic.

Hurley Medical Center in Flint, Mich., named **Melany Gavulic** as permanent president and CEO.

Madison Memorial Hospital in Rexburg, Idaho, announced **Rachel Gonzales** as CEO.

Sharp HealthCare promoted **Trisha Khaleghi** as senior vice president and CEO of Sharp Mary Birch Hospital for Women & Newborns in San Diego.

Mary Jo Lewis, CEO of HighPoint Health System in Gallatin, Tenn., announced her retirement.

Presence Health in Mokena, Ill., announced **Connie March** as president and CEO of its Continuum of Care.

Joe Mark, president and CEO of Redwood Memorial Hospital in Fortuna, Calif., and St. Joseph Hospital in Eureka, Calif., both part of St. Joseph Health System in Orange, Calif., announced his resignation.

Luke McGuinness, CEO of Cadence Health, which includes Central DuPage Hospital in Winfield, Ill., and Delnor Hospital in Geneva, Ill., decided to retire by the end of the year.

Tennova Healthcare in Knoxville, Tenn., named **Karen Metz** as CEO of Physicians Regional Medical Center in Knoxville.

Des Moines, Iowa-based Iowa Health System named **Michael Murphy** president and CEO of its accountable care organization.

Girard Medical Center in Philadelphia named **Michael Payne** as CEO.

Froedtert Health in Milwaukee announced longtime CEO **William Petasnick's** decision to resign.

St. Joseph Health System in Bryan, Texas, announced that **Tony Pfitzer** is no longer CEO.

Mike Poore, president and CEO of MedWest-Haywood Hospital in Clyde, N.C., announced his resignation.

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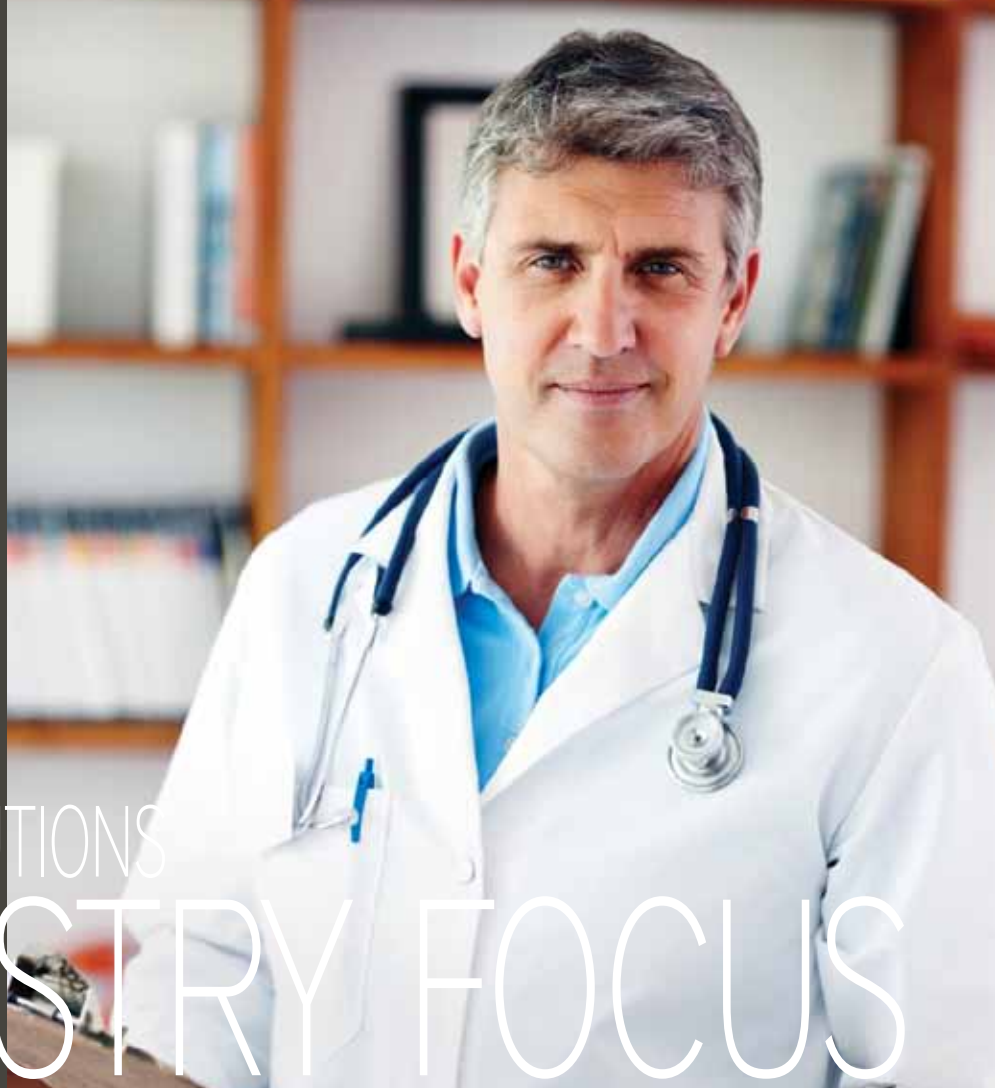
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