FORMATION OF A RURAL ACCOUNTABLE HEALTHCARE ORGANIZATION

Rami Saydjari, MD, MBA, FACS
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FORMATION OF A RURAL ACCOUNTABLE HEALTHCARE ORGANIZATION

An Organizational Action Project

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Faculty Advisor: Don P. Clark, Ph.D.

Beaman Professor of Business,

The University of Tennessee - Knoxville

Prepared by: Rami Saydjari

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Table of Contents

Executive Summary

Purpose

The purpose of this study is to investigate and plan the implementation of an Accountable Care Organization (ACO) centered on a small rural hospital within the Franciscan Alliance, a multi-hospital network located in Indiana.

Background

The debate over health care reform in the United States includes a renewed awareness of system-wide shortcomings including poor quality, rising costs, and a current reimbursement structure that fails to address either problem. Medicare data reveals that spending per patient does not correlate with the quality of care delivered. The Patient Protection and Affordable Care Act of 2010 (Affordable Care Act) created the Medicare Shared Savings Program, which creates incentives for improved quality and efficiency to a new category of provider: the ACO.[1] The program will start in 2012 and seeks to reward providers financially using a portion of the savings anticipated to accrue from providing effective and efficient care.

What is an ACO?

There are many definitions of what precisely constitutes an ACO. In a broad sense, ACOs consist of providers who are jointly accountable for achieving measurable quality improvements and cost reductions in healthcare spending. ACOs may involve a variety of provider configurations, ranging from integrated delivery systems and primary care medical groups to hospital-based systems and virtual networks of physicians such as independent practice associations. If anything, the alternative models emphasize that the definition of an ACO is not so much a structure, or even a process, but an outcome. An ACO is about reducing or controlling the costs of health care for a population of individuals while maintaining or improving the quality of that care.

The Current State

In the present healthcare delivery system even when individual services meet benchmarks for clinical quality, frequently there is not enough coordination of that care across multiple clinical settings. Currently providers receive incentives to provide more services since they receive income based on fees for services they perform.

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[1] Congress, United Sates. "Complation of Patient Protection and Affordable Care Act." 2009. ttp://docs.house.gov/energycommerce/ppacacon.pdf.

In addition, preventive services are underutilized and adherence to evidence based medical management of many chronic diseases is poor.[2] The Institute of Medicine (IOM) report confirms that medical errors and other safety problems are common and result in thousands of deaths and perhaps billions of dollars in wasted health care costs.[3] These weaknesses in the healthcare system are reinforced by current payment systems, which tend to promote high-volume and high-intensity care without regard for quality. These flaws in the healthcare delivery system have led many stakeholders to call for reform.

The Future State

Pilot programs such as those at Advocate Health and Geisinger Health System, HealthPartners in Minnesota, Intermountain Healthcare in Utah and Kaiser Permanente use more evolved, patient centered primary care services and have demonstrated improved clinical outcomes and decreased costs consistent with the primary rationale in the Affordable Care Act.[4]

Evidence has accumulated in the past decade validating the model of a patient centered medical home, which reduces error and improves quality all while reducing cost.[5] These goals have been the holy grail of healthcare reformers for many years. Payment models employed in pilot programs have used methodologies such as bundled acute case rates, which cover all services related to treatment for a specific illness episode have been successful in realigning the financial incentives of the involved providers.[6] Global payments have also been used successfully to reduce cost. In this model, the payor gives a single payment to the providers to cover all the health needs of a patient during a specified time interval.

Tightly integrated healthcare delivery systems in which physicians, hospitals and other stakeholders partner in the care of patients such as an ACO, are a potential solution according to many experts. The recently enacted Patient Protection and Affordable Care Act (PPACA) promote the development of ACOs.

Introduction

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[2] McClellan, M et.al. "A National Strategy to Put Accountable Care in Place." *Health Affairs*, 2010: 982-990.

[3] Kohn LT, Corrigan JM. *IOM. To Err Is Human: Building a Safer Health System.* Washington, DC: National Academy Press, 2000.

[4] MedPAC. "Report to the Congress: Improving Incentives in the Medicare Program. Chapter 2." 2009. http://Epic.medpac.gov/chapters/Jun09_Ch02.pdf (accessed May 13 2011)

[5] Reid, R. J. "The Group Medical Home at Year Two: Cost Savings, Higer Patient Satisfaction, and Less Burnout for Providers." *Health Affairs* 29, no. 5 (May 2010): 835-43.

[6] Rosenthal, MB. "Beyond Pay for Performance." *N Engl J Med*, September 18, 2008: 1197-200.

Faced with the dual challenges of providing services to a greater number of individuals and ever increasing healthcare spending, healthcare providers must learn to maximize the value of care delivered to consumers by reengineering healthcare delivery. In response to these challenges, this organizational action project (OAP) will explore the creation of an ACO in a rural market. The OAP will detail the ACO leadership, infrastructure and cultural disposition required to be successful in the Center for Medicare Services (CMS) Shared Savings Program and the broader ACO healthcare market.

Background

Over the past decade, there has been a growing focus on holding healthcare providers more accountable for the quality of the healthcare that they deliver. Numerous studies have revealed unacceptably high rates of medical errors and hospital-acquired infections causing patient injury and death.[3] These studies also show that health care providers underutilize preventative care as substantiated by low immunization rates and inadequate health care screenings. These faults have led to an increasing number of quality measurement and pay for performance programs initiated by employers, government and private insurers. These programs are designed coax healthcare providers to deliver a minimum level of quality and to raise the standard over time. [7]

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[7] Shortell, S. C. (2008, July 2). Health Care Reform Requires Accountable Systems. *JAMA , 300* (1), pp. 95-97.

Healthcare providers are not often accountable for the cost of the healthcare services delivered to patients. Under the Medicare fee-for-service program, if Medicare covers a service, a healthcare provider can deliver that service to a Medicare beneficiary, even if a cheaper service or no service at all, would have achieved a similar or better outcome.

Presently, commercial insurance plans and Medicare Advantage plans that pay providers on a fee-for-service basis institute barriers to discourage the use of services viewed as unnecessary or unnecessarily expensive. It is important to note that health care plans take these steps not by the provider. Past experience with similar attempts at controlling costs by Health Maintenance Organizations (HMO) in the 1990s resulted in widespread resistance by both patients and providers resulting in a media backlash and in many cases, HMO failures.

The high and rapidly growing cost of healthcare in the U.S. has resulted in growing interest reforming the current system. Such reform involves finding ways to encourage health care providers, rather than health insurance plans to assume greater accountability for the overall cost as well as the quality of healthcare delivered to patients.[8,9]

Given the current pressure for healthcare reform from third party payors, government entities such as the CMS and legislative initiatives such as the Healthcare Reform Act, it is essential that hospitals incorporate strategies that address reform issues in their planning efforts. Studies reveal

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[8] Pittsburgh Regional Health Initiative. (2009, August). *Accountable Care Networks: Transitions from Small Practices and Community Hospitals.* Retrieved June 15, 2011, from http://Epic.phri.org/docs/Accountable%20%Care%20Networks.pdf

[9] Greene, R. B. (2008, July-August). Beyond the Efficiency Index: Finding a Better Way to Reduce Overuse and Increase Efficiency in Physician Care. Health Aff (Millwood) , 27 (4), pp. w250-9.

that more integrated, interdisciplinary medical delivery systems such as an ACO are among the best performing and lowest cost models for organizing healthcare delivery.[10,11,12,13]

The rationale for an ACO model includes several assumptions about the value of ACOs that we can extrapolate from currently operating health care delivery models like Health Maintenance Organizations (HMOs). These include increased accountability for a patient population and better coordination of services reimbursable under Medicare. In addition, an ACO encourages investment in infrastructure and the development of care delivery processes that are high quality, transparent, and efficient.[14,15]

Moreover, ACOs are deigned to promote meaningful, performance-based incentives. The arguments in favor of such reform include a number of observations. Public health plans appear to do a better job of containing cost than private insurance. Medicare medical spending rose 4.6% annually compared 7.3% for private health insurance in the 10 years from

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[10] Cohen, J. T. (2010, March 11). *A Guide to Accountable Care Organizations, and Their Role in the Senate's Health Reform Bill.* Retrieved May 5, 2011, from http://Epic.healthreformwatch.com/2010/03/11/a-guide-to-accountable-care-organizations-and-their-role-in-the-senates-health-reform-bill/

[11] Fisher, E. (2007, Jan-Feb). Creating Accounable Care Organizations: The Extended Hospital Staff. *Health Aff (Millwood) , 26* (1), pp. w44-57.

[12] Miller, EPIC. (2009, September-October). From Volume to Value: Better Ways to Pay for Health Care. *Health Aff (Millwood) , 28* (5), pp. 1418-28.

[13] Miller, EPIC. (2009). *How to Create Accountable Care Organizations. Center for Healthcare Quality and Payment Reform.* Retrieved June 23, 2011, from http://Epic.chqpr.org/downloads/HowtoCreateAccountableCareOrganizations.pdf

[14] Flareau, B. a. (2011). *Accountable Care Organizations: A Roadmap for Success.* Virginia Beach, VA: Convurgent Publishing.

[15] Fisher, E. M. (2009, January). Fostering Accountable Health Care: Moving Forward In Medicare. *Health Aff (Millwood)* , pp. 27-36.

1997–2006.[16] Secondly, public insurance arguably has better payment and quality-improvement methods based on its large databases, new payment approaches, and care-coordination strategies.[17]

An ACO is a health care delivery model that incorporates many of the stated goals of health care reform. These goals include greater integration of health care delivery along with linking payment to quality, adherence to evidence based guidelines, achieving better clinical outcomes and yielding a better patient experience all while lowering the total cost of care.[18,19] An ACO is a provider-led organization whose mission is to manage a broad spectrum of healthcare including the overall costs and quality of care for a defined population. Dr. Elliot Fischer of Dartmouth Medical School coined the term ACO around 2007.[8]

One possible model of ACO implementation is a bundled payment arrangement for the management of chronic conditions. In a bundled payment format, providers would have shared accountability and responsibility for the management of chronic conditions such as coronary artery disease, diabetes, chronic obstructive pulmonary disease and asthma. The Congressional

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[16] Medicare Payment Advisory Commission. (2009). Accountable Care Organizations: Improving Incentives in the Medicare Program. Report to Congress, Washington, DC.

[17] Devers, K. a. (2009). *Can Accountable Care Organizations Improve the Value of Health Care by Solving the Cost and Quality Quandaries? Robert Wood Johnson Foundation*. Retrieved July 2, 2011, from http://Epic.rwjf.org/qualityequality/product.jsp?id=50609

[18] Congressional Budget Office. (2008). *Option 37: Allow Physicians to Form Bonus Eligible Organizations and Receive Performance Based Payments. Volume 1. Health Care*. Washington, DC: CBO.

[19] Nelson, B. (2009). *Quality over Quantity*. Retrieved May 29, 2011, from http://Epic.thehospitalist.org/details/article/477391/Quality_over_Quantity.html

Budget Office estimates that ACOs could save Medicare at least $4.9 billion through 2019 using this model.[20,21]

An example of a currently successful ACO is Advocate Physician Partners and Advocate Health Care in northern and central Illinois. Advocate Physician Partners has been in existence for over 15 years. This ACO serves over one million patients. Approximately 230,000 of these patients are in an HMO setting and over 700,000 in a fee-for-service setting.[22]

One of the unique arrangements of the Advocate ACO is its governance structure. A joint operating board of the two partner organizations is responsible for decision. Advocate Care Partners and Advocate Health Care have equal voting rights on the board. Advocate Care Partners represents over 2700 independent physicians in solo practices, small group practices, or larger multispecialty groups. Advocate Health Care represents 10 hospitals and approximately 800-employed physicians.[14]

Advocate's joint board has successfully signed fee-for-service contracts with all major managed care organizations in northern Illinois. In addition, Advocate has also signed two at-

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[20] Hastings, D. (2009). *Accountable care organizations and bundled payments in Health Reform.* Retrieved May 14, 2011, from http://Epic.ebglaw.com/files/37716_BNA%20Article%20%20Accountable%20Care%20Organizations%20and%20Bundled%20Payments%20in%20Health%20Reform.pdf

[21] The Congressional Budget Office (CBO) and the staff of the Joint Committee on Taxation (JCT) The Direct Spending and Revenue Effects of an Amendment to EPIC.R. 4872, the Reconciliation Act of 2010. Retrieved May 27, 2011, from http://Epic.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf

[22] Pizzo, J. &. (2011). *Getting from There to Here: Evolving to ACOs Through Clinical Integration Programs.* Kaufman, Hall & Associates. Chicago: Kaufman, Hall & Associates.

risk contracts in which it receives a flat fee per patient per month and is then responsible for delivering all health care for that patient during the contract period. Advocate has less than 15% of all physicians and hospitals in its market and the Federal Trade Commission (FTC) has explicitly allowed the partnership to contract with independent physicians to provide services through the ACO.

One of the focuses of Advocate's joint board is to ensure that physicians meet quality goals. All physician members are required to use registries and implement electronic health records. Physicians who do not perform at the level expected are removed. In 2010 alone, Advocate decided to remove 52 physicians from the group. The Advocate organization has an excellent reputation for providing quality care while delivering significant cost containment. Thomson Reuter has consistently ranked it in the top 10 of over 252 health care systems in terms of both outcomes and commitment to quality improvement.

Purpose

The purpose of this thesis is to outline the development and implementation of an ACO in a rural environment to be designated Franciscan Alliance – New Horizons Health (FANH). An integrated physician network called the Franciscan Physician Network will be created and combine with the local hospital to create an ACO which will be a separate legal entity compliant with the Health Care Reform Act. The ACO will seek nothing less than to reshape the value proposition for the patients it serves. The ACO decisions will shape its decisions based on the quality and cost metrics integral to providing value to patients.

Market Setting

The Franciscan Alliance is a 501(c)(3), not-for-profit, faith-based clinically integrated network of hospitals and providers in Indiana and Illinois that includes hospitals, physician groups, joint ventures, ambulatory surgery centers, home health agencies, post-acute and long-term care facilities, as well as employed physicians, owned and independent health plans and health administrative entities. The Franciscan Alliance has a long history of serving individuals in both urban and rural settings, including Montgomery County, as well as all of nearby Fountain County.

Our local hospital, St. Elizabeth Regional Health – Crawfordsville (SERH-C), is part of the Franciscan Alliance. SERH-C is 25-bed acute care facility with total operating revenue of $4,083,682 and net revenue of $1,254,263 in 2010. The total assets of the hospital were $42,835,159 in 2010[23].

SERH-C is the smallest and most rural of the 14 Franciscan Alliance hospitals and serves primarily Montgomery County (population 38,124) and neighboring Fountain County (population 17,240). Twenty-six point nine percent (26.9%) of Montgomery County's population was aged 65 or older meeting the most common eligibility criteria for Medicare insurance.[24] The overall population of Montgomery County is projected to increase by 3.2%

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[23] GuideStar. (2009, December). Projected from *Franciscan Alliance - Form 990*. Retrieved September 5, 2011, from Guidestar.org: http://Epic.guidestar.org/FinDocuments/2009/351/330/2009-351330472-06a78298-9.pdf

[24] U.S. Census Bureau. (2010, March 1). Retrieved September 5, 2011, from http://quickfacts.census.gov/qfd/ststes/18/18107.html

between 2010 and 2015. In 2010, there were 1,692 admissions to SERH-C. Sixty-four percent of these admissions were Medicare patients. SERH-C handled a total of 20,681 emergency department (ED) visits in 2010. Approximately 5.7% of these ED visits resulted in admission to the hospital.

The map in Appendix A highlights the major areas served by Franciscan Alliance SERH-C providers (propose FANH service area). According to recent census projections, this area is expected to see a population growth rate of 5% for individuals aged 65 and above from 2009 to 2014. I have displayed the Medicare charges for the service area between 2007 and 2009 in Appendix B. these are useful data in projecting financial data in pro forma statements.

Government insurance accounts for approximately 50% of the local total payer mix, with roughly 40% of that total being Medicare. Anthem dominates the commercial insurance market (approximately 60-65%), with United Healthcare, Cigna, and Aetna holding a smaller portion of the market. Local health plans, including ADVANTAGE Health Solutions also play a key role. There are an estimated 21,187 Medicare eligible individuals living in the proposed FANH service area. With a 5-year projected growth rate of 5%, this aging population will require a continuum of services from wellness to acute and post-acute care, creating the need for more efficient delivery of healthcare services.

Chronic diseases are the most prevalent and costly health problems in Indiana. Hoosiers have significantly higher rates of chronic diseases than the national average, costing the state of Indiana billions of dollars per year in the treatment of these chronic diseases, their related complications and lost productivity. Comparable to national trends, heart disease, cancer, and stroke top the list of chronic conditions and research by Mobilizing Action Toward Community Health (MATCH) has correlated these diseases with the alarming rates of obesity (30%) and tobacco use (27%) prevalent throughout the state.[25]

These issues are especially widespread in the FANH service area as noted in the 2010 Indiana County Health Rankings. Montgomery County ranked in the top quartile for chronic conditions and poor health status. In order to address the root causes of these and other health problems throughout the state, healthcare providers must address those processes and systems that engage the patient and have proven effective in treating these conditions. Examples of these programs include health profiling, lifestyle and wellness initiatives, motivational interviewing, and member incentive programs, all of which have a preventive focus.

The information gleaned from these interventions allows identification of the "low hanging fruit" and provides insights on how to address the closing of gaps in the continuum of patient care. The ACO will utilize structures such as care coordination processes, and health information technology that enhance population health, safety, and the patient experience to

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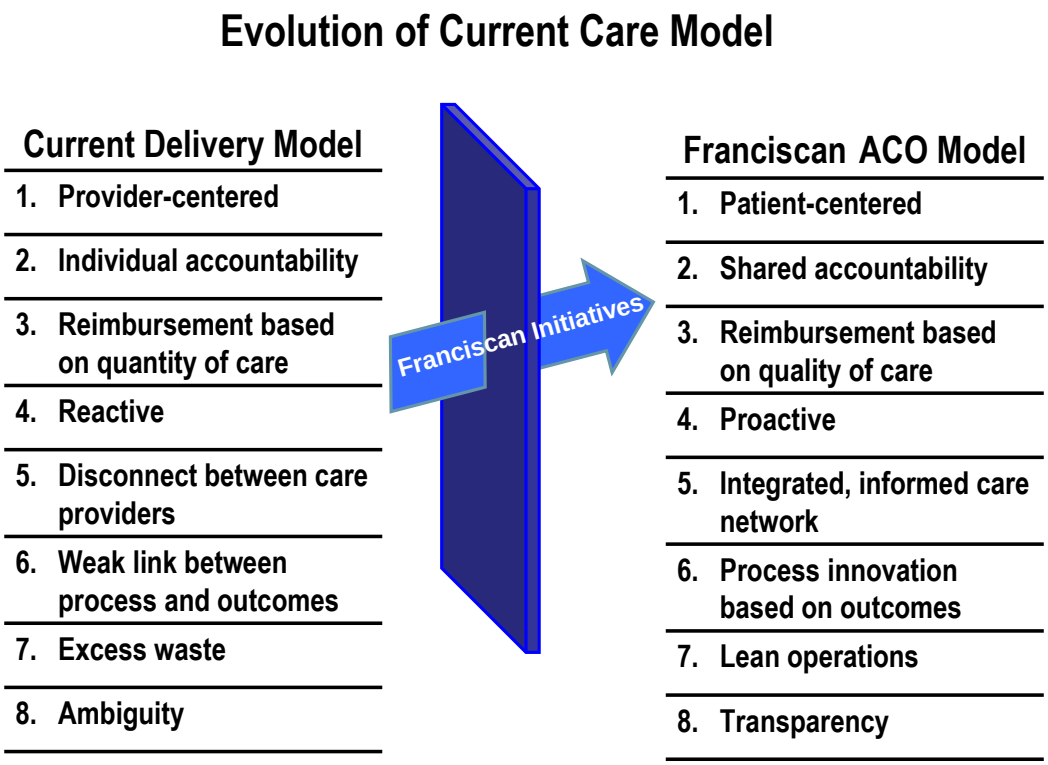
[25] Indiana State Department of Health. (2010). *Division of Chronic Disease Prevention and Control (CDPC).* Retrieved May 1, 2011, from http://Epic.in.gov/isdh/24725.htm

accomplish these goals. To achieve this goal, FANH must develop structures, processes and technology that address the issues presenting access barriers in the current healthcare delivery system. The evolution of these requisites is illustrated in Exhibit I.

Exhibit I: Evolution of Proposed ACO



The processes outlined in Exhibit I allow for the creation of a truly integrated accountable care network, both clinically and economically, that has the elasticity and functional capacity for

all provider needs with respect to practice structure, the ability to function in a transparent manner for the benefit of patient care, care delivery, and containment of overall costs.

Healthcare Reform - A Brief History

As far back as the 1930s, experts recognized the need to reform health care. Isodore Falk (1936) stated, "The greatest need is not to find more money for purchase of medical care, but to find newer and better ways of budgeting the costs and spending the money wisely and effectively".[26] Meaningful efforts to achieve healthcare reform in the United States arguably began in 1933 with President Franklin D. Roosevelt. The original draft of his Social Security legislation included publicly funded health care programs. The American Medical Association vigorously opposed these reforms. Because of the AMA efforts, Roosevelt ended up removing the health care provisions from the final markup of the bill in 1935.

Following the Second World War, President Harry Truman called for universal health care as a part of his Fair Deal plan in 1949 but once again strong opposition defeated that part of his Fair Deal legislation. President Lyndon B. Johnson signed the Medicare program legislation into law in 1965 that gave Americans 65 and older access to publically funded health insurance. Although still strongly opposed by the organized medical community and politically divisive, Medicare passed due primarily due to significant popular support for Johnson's Great Society program.

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[26] Fawke, I. (1936). *Security Against Sickness: A Study of Health Insurance.* Chicago: Doubleday, Doran & Company, Inc.

In 1974, President Richard M. Nixon introduced the Comprehensive Health Insurance Act, which would have mandated employers to purchase health insurance for their employees, and provided a federal health plan, similar to Medicaid, that any American could join by paying on a sliding scale based on income. Political infighting between democrats and republicans defeated Nixon's initiative as well as a number of subsequent attempts at health care reform including President Bill Clinton's attempt in the early 1990s.

In December 2008, the Institute for America's Future launched a proposal that essentially advocated a public health insurance plan to compete on a level playing field with private insurance plans. This was to become the basis of President Barrack Obama's health care plan, The Patient Protection and Affordable Care Act (PPACA). Section 3022 of PPACA promotes development of ACOs and establishes financial incentives for ACO development through the Medicare Shared Savings Program effective January 1, 2012. The PPACA defines an ACO as an organization whose primary care providers are accountable for coordinating care for at least 5,000 Medicare beneficiaries. The ACO may include group practices, networks of practices, hospitals, hospital-physician joint ventures, and other groups (Appendix C).

How Does an ACO Differ from an HMO?

At first glance, it may appear that the underlying principles of accountable care are nothing more than a reincarnation of 1990's era managed care and health maintenance organizations (HMO). While these two entities share some characteristics, there are some very important

distinctions. Both ACOs and HMOs manage risk, require the construction of physician networks and manage utilization of limited resources to realize cost reductions.

ACOs focus on creating value, not denying healthcare service**.** Although cost reduction is the ultimate goal, quality and patient satisfaction are built-in incentives. ACO design will likely provide more service (especially preventative services) since it is in their best interest to do so. ACOs achieve this goal by shifting the value curve to emphasize health promotion while moving away from high-cost, high-risk settings.

Another distinguishing feature is that HMOs morphed into large regional bureaucracies that added cost and complexity. ACOs on the other hand seek to narrowly manage healthcare in small, simple and local settings.

HMOs failed financially because their structure required front end, capital intensive investments in member's health that was lost if the patient then moved on or switched payors. Conversely, in the ACOs accrue financial gain earlier through the shared savings program. Reward comes from driving down cost and creating value early in the equation to achieve shared savings annually[27].

Physicians are more likely to accept vertical integration in this era compared to the past. Tightly managed models of healthcare delivery require significant physician cooperation and collaboration. In the 80's and 90's, physician practices were principally in the form of solo and small groups. However now many physicians have already opted for an employment model and

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[27] American Hospital Association. *Accountable Care Organizations.* American Hospital Associaiton Committee on Research

this trend is rapidly accelerating. This is likely due to the increased sense of financial security physicians find when employed. Large physician groups and integrated healthcare delivery systems are now commonplace. Moreover political relationships with hospitals have markedly improved compared to the conflicts that marked the HMO era.

ACOs offer a wider and more flexible range of payment models. The capitation payment model that characterized HMOs required physicians to take global risk and responsibility for cost. Managing healthcare to a fixed payment felt unnatural to physicians and they rebelled. ACOs can offer a variety of payment mechanisms, including a strong fee for service component more familiar to physicians. When combined with shared savings and appropriate benchmarking of cost and quality this can offer the best facets of both systems.

Finally, information technology (IT) has matured and transformed population health management. The sophistication of information systems that integrate clinical and financial data has advanced dramatically in the past decade. Automated tools required to manage patient populations now allow ACOs to aggregate data and use information to understand trends to assist in the care process. These robust IT systems did not exist in the era of HMOs and managed care.

It is important to distinguish between giving healthcare providers greater accountability for the cost of the care their patients receive (ACOs) and transferring insurance risk to them (HMOs). A major reason for the consumer and provider backlash against managed care and HMOs in the 1990s was that many health insurance plans transferred all risk to the provider using instruments such as traditional non-risk-adjusted capitation contracts with providers.[19]

The inclusion of partial or total insurance risk (HMOs), rather than just the performance risk (ACOs) caused many ill-equipped provider groups to suffer financially in the 1990s when dealing with HMOs. The HMO approach creates a strong and undesirable incentive for providers to avoid high risk patients who have multiple or expensive-to-treat conditions, and makes providers financially vulnerable if they have an unusually high-cost patient or an unusually high number of patients with multiple or severe conditions.

Thus although HMOs and ACOs share some superficial similarities the structure and historical context of ACOs clearly distinguish them from HMOs and place them in a position to succeed were HMOs failed.

How is an ACO Expected to Create Value for the Company?

Rural hospitals have been the healthcare backbone for many communities in the past century. However, over the past few decades, many rural hospitals have faced challenging financial problems due to shifting market forces. These market forces have tended to regionalize health care delivery and reduce the operating margins of the remaining viable hospitals to less than 2%. This shift has forced many rural hospitals to close, while others have merged with other hospitals, eliminated or reduced services, or taken other actions to remain viable.

Current and forecasted changes in the health care delivery business will likely place further strain on rural health facilities. The timely development and implementation of an ACO delivery model offers the best chance for rural hospitals to remain financially viable by creating value for the hospital, its physician partners and the patents they serve. In addition, if we are first to

develop a successful ACO in our region, we can market it to private third party payors, which generally provide higher reimbursement initially. This will help defray the anticipated costs of converting an organization to an ACO.

Hospitals represent nearly 40% of healthcare expenditures in the United States. There are several areas where ACOs can reduce cost ad increase value. Hospitals and ACOs can seek to improve their efficiency.[28] ACOs can use the industrial techniques of Lean and Six Sigma, successfully transferred to hospital operations, if the correct supportive culture is in place. This has allowed such hospitals to significantly reduce waste and improve efficiency.

Improved cooperation between hospitals and surgeons can reduce the costs of surgeries by 10-40% through in areas such as more efficient scheduling and more standardized purchasing of medical devices. Using lower-cost treatment options such as reductions in pre-term elective inductions and reductions in the use of Cesarean sections for normal deliveries, ACOs can reduce labor and delivery costs while the quality of care for the patients is simultaneously improved.[29]

Hospitals and ACOs can reduce adverse events. A significant number of patients still experience preventable healthcare-acquired infections, deep venous thrombosis, pulmonary embolism and other adverse events. Work pioneered by the Pittsburgh Regional Health Initiative

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[28] Bohmer, R. L. (2009, August 6). The Shifting Mission of Health Care Delivery Organizations. *N Engl J Med , 361* (6), pp. 551-3.

[29] Sakala C, C. M. (2009, April). Evidence Based Maternity Care: What It Is and What Can It Achieve. *Obsete Gynecol , 113* (4), pp. 797-803.

demonstrated that integrated delivery organizations can dramatically reduced or even eliminated through low-cost techniques. [30]

The reduction in preventable readmissions is another potential increase in the value proposition for patients. Some hospital-acquired infections and adverse events manifest themselves after discharge and result in preventable readmissions to the hospital.[31] Closer outpatient clinical follow up and transition care as well as the use of clinical pathways which start with admission to the hospital and follow the patient both at home and at the primary care provider's office can significantly reduce readmissions. Such readmissions will trigger financial penalties in the era of healthcare reform. [32]

Some opportunities for cost reduction will require coordinated involvement of primary care providers, hospitals, specialists, and patients. Still other situations will require the development of new settings for care such as medical homes or require coordination between healthcare and non-healthcare services such as social work. [33] The American Academy of Family Practice in 2008 defined patient centered medical homes as a setting that "integrates patients as active participants in their own health and well-being. A Physician will lead a medical team that coordinates all aspects of preventive, acute and chronic needs of patients using the best available

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[30] Feinstein, K. (2010). *A Modern American Social Movement Takes Shape: The View from the Ground.* Pittburgh, PA: Jewish Healthcare Foundation.

[31] Shannon RP, C. D. (2008, December). Economics of Central Line Associated Infections. *Am J Infect Control , 36* (10), pp. S171 - 175.

[32] Coleman EA, P. C. (2006, September 25). The Care Transitions Intervention: Results of a Randomized Control Trial. *Arch Intern Med , 166* (17), pp. 1822-8.

[33] Starfield B, S. l. (2005). Conribution of Primary Care to Health Systems and Health. *Millbank Q , 83* (3), pp. 457-502.

evidence and appropriate technology. These relationships offer patients comfort, convenience, and optimal health throughout their lifetimes."

The improved management of complex patients and disease processes is another opportunity for adding value to the healthcare system. Patients with multiple diseases, individuals with rare conditions, drug abusers, the chronic mentally ill require multiple, often expensive services from a healthcare delivery system.[34] A vertically integrated healthcare system such as an ACO has to the potential to manage such expensive disease more efficiently.[35] The costs for the ACO and the payment mechanisms used to compensate the ACO should be severity-adjusted to attenuate insurance risk inherent in the care of patients. For example, if an ACO is caring for a population of patients and the costs of that care go up, the payor should divide this cost. Did the cost increase due to inherent risk factors (e.g., the population simply got older) or did the estimated share increase due to the cost of treating individuals with the same level of disease severity (e.g., a higher proportion of people with mild coronary artery blockage received cardiac bypass surgery possibly indicating poor cost control by the providers). Payors should hold the ACO accountable latter share of the cost increase, but not the former.

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[34] Sweeney L, EPIC. A. (2007). Patient Centered Management of Complex Patiets Can Reduce Costs without Shortening Life. *Am J Manag Care , 13*, pp. 84-92.

[35] Deloitte. (2010). Accountable Care Organizations. Retrieved May 14, 2011, from http://Epic.deloitte.com/view/en_US/us/Industries/US-federal-government/center-for-health-solutions/research/bc087956da618210VgnVCM100000ba42f00aRCRD.htm

It is important to recognize that there is no absolute method for distinguishing between insurance risk and performance risk.[36] A myriad of mechanisms exist to control provider risk. These include severity adjustment systems, insurance stop-loss provisions and reinsurance. However, there are always unforeseeable and difficult to quantify differences among patients that could result in a particular provider experiencing unusually high or low costs. It will be important to design and monitor the reimbursement methodology for ACOs to ensure they do not inappropriately accept or transfer insurance risk to providers.

Proposed Structure of the ACO

The FANH ACO will operate in West Central Indiana. The Board of Directors will guide the direction of the organization, with two physician-led committees (Professional Services and Finance & Operations) and a Regional Executive Director reporting to the Board. This physician-led structure ensures that necessary care delivery, financial, and behavioral protocols are in place for quality care provision. [Exhibit II]

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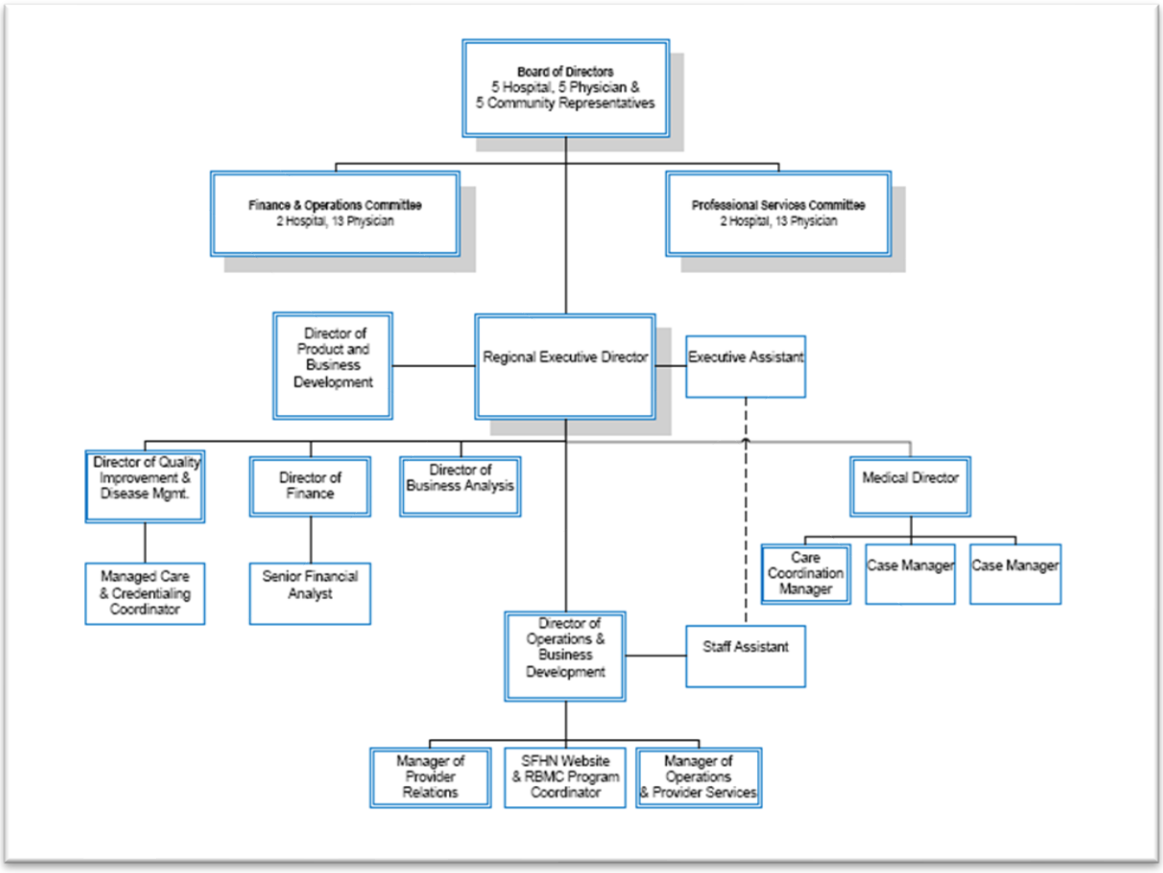
[36] Fader, EPIC. C. (2010). Are Accountable Care Organizations in Your Vocabulary? Retrieved June 17, 2011, from http://Epic.pepperlaw.com/publications_update.aspx?ArticleKey=1757

Exhibit II: Corporate Structure of the FANH - ACO



With solid physician and administrative leadership, FANH will have the clinical expertise to become a leader in care delivery innovation and quality initiatives. Working in conjunction with State initiatives such as the Indiana Health Information Exchange's (IHIE) Quality Health First (QHF), FANH will use evidence-based care protocols and quality guidelines to maximize the value proposition in health care. FANH will issue reports detailing individual provider performance against benchmarks and peer data to ensure patients are receiving appropriate, high-

quality care. FANH will also use these reports to decide which physicians will continue to participate in the network.

The overall organizational structure of FANH will consist of discrete departments with a centralized Executive Director designed to allow the Network to easily receive and distribute payments to participating providers. FANH will be well positioned to successfully manage various types of contracts for commercial and government–based insurance and managed care organizations, including fee-for-service, full and partial risk with capitation, and pay-for-performance. FANH will also utilize pay-for-performance initiatives internally, with providers receiving incentives based on quality and other metrics. In addition, the FANH will routinely perform the following functions:

- *Negotiate*: risk agreements with managed care organizations; fee-for-service and capitation reimbursement risk agreements for all types of healthcare services;
- *Adjudicate*: industry standard healthcare service claims, including fee-for-service and shadow/encounter claims;
- *Manage:* capitation payments to primary, specialty and DME providers; member eligibility files received from commercial and government based managed care organization contracting partners; pharmacy benefit utilization, including biopharmaceuticals;
- *Provide:* Medical Management services, including but not limited to those on site and remote inpatients cases, for emergency department “frequent fliers”, prior authorizations, disease management, and development of policies and procedures, including appeals and grievances, per State Department of Insurance regulations;
- *Credential:* providers according to NCQA standards;
- *Develop:* management data reports of healthcare services utilization and distribute these to providers and other key stakeholders;

- *Evaluate:* vendors and negotiates terms for provider stop loss coverage and subrogation claims management.

Participating in the FANH will be an integrated network of providers in West Central Indiana, which will be, designated the Franciscan Physician Network. , These Franciscan Alliance ACO participants will collaborate to engage in true coordination of health care delivery for patients. With a solid data infrastructure facilitating information sharing and the utilization of resources such as discharge planners, care managers, physician and non-physician providers, and support staff, these entities will employ evidence-based medicine, quality management strategies, and performance oversight to assist in delivering high-quality care. The FPN will include a comprehensive array of primary care and specialist physicians noted in the Table I.

Table I. ACO Specialties

Family Practice	Neurosurgery
Internal Medicine	Oncology
Pediatrics	Orthopedics
Breast Surgery	Pain Management
Cardiology	Perioperative Consultation
Endocrinology	Plastic Surgery
Gynecologic Oncology	Psychiatry
Hematology	Rheumatology
Joint Replacement Surgery	Sports Medicine
Maternal Fetal Medicine	Vascular Care

The foundation of the FANH will be built upon four core elements: infrastructure & collaboration; technology & interoperability; population management; and a sound financial model. The following describes how these pieces work in coordination to create a sustainable ACO.

Health Plans

Advantage Health Solutions, Inc. (ADVANTAGE) is an Indiana-based health plan and third party administrator with a majority ownership by the Franciscan Alliance. Established in 1999, ADVANTAGE has quickly become a strong player in the local payer market. Responsible for over 85,000 lives (6,000 Medicare Advantage) in Indiana, ADVANTAGE is NCQA accredited and is committed to reducing unnecessary waste, both in healthcare spending and in everyday operations, as evidenced by their high medical loss ratio of 92%. As a majority owner, the Franciscan Alliance has worked to fully integrate and align ADVANTAGE Health Solutions, sharing information, financial risk, and programming initiatives across organizations. Continuing this relationship, the FANH will contract with ADVANTAGE for administrative and care management services.

Realizing the importance of quality partnerships extends beyond providers, FANH will initiated discussions with every payer in the local market including Anthem, ADVANTAGE, Aetna, Cigna, Humana, United Healthcare, and local third-party administrators. In these discussions, the FANH will specify a readiness to engage in quality-based reimbursement mechanisms, with a focus on creating standardized quality metrics across all payers.

To maximize the benefits inherent in a clinically integrated delivery system, the FANH will endeavor to keep participants within the FPN. However, realizing that some outmigration will occur, the FANH, guided by FPN and ADVANTAGE, will implement policies and procedures to help manage both the health and cost of a population among non-ACO providers. This includes both "out-of-ACO network, in market" and "out-of-ACO network, out of market" patients. These strategies will focus on patient engagement and education, the creation of a "patient experience" value proposition when choosing Franciscan Alliance ACO providers, patient incentives, and discounted fee-for-service or case-rate contracts with individual providers and healthcare organizations.

FANH will evaluate and monitor the effects of its operations on access to care (particularly primary care), quality of care (using structure, coordination, process, and outcome measures), and patterns of utilization and expenditures. This will be done utilizing the data / technology infrastructure (EPIC electronic medical record) of FANH.

Information Technology

Electronic Medical Record

As of Feb. 26, 2013, all Franciscan Alliance hospitals, associated facilities and employed FPN physicians will be required to have implemented the Epic EMR system EPIC is a comprehensive, integrated suite of applications for electronic medical records. Epic fulfills current and future functional requirements for "meaningful use", facilitating real-time

information exchange and creating effective EHR interoperability among all data systems. This includes:

- Computerized order entry
- Drug interaction checking
- Maintaining an updated problem list
- Generation of transmissible prescriptions
- Patient engagement - sending reminders to patients, providing patients with an electronic copy and access to their records
- Checking insurance eligibility and submitting claims
- Capability to exchange key clinical information among care providers and patient authorized entities
- Capability to submit data to immunization registries, provide syndrome surveillance and lab data to public health agencies
- Quality measurement and reporting

The Franciscan Alliance currently uses Epic in the majority of outpatient facilities. We project that 96% of FPN providers using Epic by the end of 2012. This uniformity allows for information exchange and collaboration in managing patient care across both inpatient and outpatient care settings. Use of Epic also permits the flow of data across outside organizations and providers, producing a high level of integration and information sharing among providers both in and out of the Franciscan Alliance health system. Providers may view and share patient

data, including physician notes, laboratory and radiology results, pharmacy use, and treatment history. The following mechanism are used to share data:

- Employed Physicians via EpicCare Ambulatory EMR
- Community Physicians via a shared record
- Community Physicians via record exchange
- Paper-based Physicians via secure Web portal

Patients also have the ability to track their own health via MyChart; EPIC's secure online patient portal and personal health record application. Through MyChart, users can access parts of their medical records, enabling them to become informed and active participants in their healthcare. Patients can view laboratory and other clinical test results, track health metrics, schedule appointments, request prescription refills, and send/receive provider messages via this portal. The use of Epic technology throughout Franciscan Alliance Hospitals will guide workflow redesign and lead to significant improvements in care.

Data Management / Reporting

DocSite is a comprehensive data collection, management, reporting, and storage system. DocSite facilitates the coordination of care among various provider settings. A requirement of all FANH participants, this system collects data about patients and pushes performance, quality, and care data out to providers via easy to understand provider dashboards and reports. Employed (FPN) providers have this information embedded into Epic, while non-employed providers can access the information via a secure, personalized, web portal which also contains an "EHR Lite" to encourage the transition to electronic records. FPN providers can view notes and treatment

plans from physicians outside the medical group in real-time as they submit their data through this EHR portal. DocSite will also allow all providers in FANH to access information about their individual patients from a variety of sources, including lab, pharmacy, hospital inpatient and ambulatory service settings, and other physician visits within FANH.

Indiana Health Information Exchange IHIE

Formed in 2004, the Indiana Health Information Exchange (IHIE) is a non-profit organization that is the nation's leading health information exchange organization. IHIE participants include Indiana's major healthcare providers, payors, physicians and public and business leaders. With participation from 19,000 physicians, 70 hospitals, 100 clinics and surgery centers and other healthcare organizations, IHIE contains the health records of more than 10.3 million patients, handling more than 2.5 million transactions a day. Collectively, the Franciscan Alliance is the single largest contributor to IHIE, transmitting health information from 14 hospitals, as well as numerous outpatient facilities and physician offices.

Lean Operations

The Franciscan Alliance has already embraced the concept of Lean and Six Sigma. Numerous employees have begun training in both disciplines. FANH will use this training to focus on employing and expanding the use of lean six-sigma principles throughout the Franciscan Alliance Health System through employee education and process improvement initiatives.

The initial focus will be improvement initiatives in the emergency departments and outpatient offices as these are most likely to improve patient throughput without increasing resources or increasing cost.

Performance Measurement

As part of the CMS Shared-Savings Program, the FANH will accept responsibility for the cost and quality of care delivered to Medicare recipients for a 3-year period across all employed FPN physicians as well as independent physicians practicing within the FANH service area, who voluntarily participate in the FANH initiative and meet the FANH participation requirements. These include both primary care physicians and specialty physicians.

FANH will select initial ACO providers based on their employment status and/or historical relationship with the hospital system. In order to participate, providers had to meet the following minimum requirements noted in Table 2.

Table 2. Initial ACO Provider Selection Criteria

Install or maintain an internet connection at their practice site.
Install and utilize DocSite, the FANH data collection, integration, and management program.
For those physicians not utilizing an EMR, regularly submit information to DocSite via manual data entry or use of DocSite's "EHR Lite" feature.
Agree to the use of defined evidence-based protocols and specific quality metrics for FANH targeted conditions.

The Director of ACO Operations and members of the Finance & Operations Committee and Professional Services Committee will monitor adherence to the ACO minimum participation requirements. These physician-led committees, meeting on a quarterly basis, will perform peer-reviews on physician members who are not meeting the required quality/performance metrics. These committees have the authority to impose action plans on under-performing providers and, if necessary, de-credential such providers from the ACO. In exchange for participation, providers participating in the FANH will receive access to the resources noted in Table 3.

Table 3. ACO Provider Participation Benefits.

EPIC electronic health record and DocSite data management system and provider portal, which permits the provider to view patient treatment history, record and transmit patient treatment notes, and view personal quality & performance metrics as tracked by the system
Quarterly performance reports
Real-time performance feedback tracking both patient and provider quality metrics
Case managers
Practice improvement education
Nurse navigators for care coordination and support for care transitions
Franciscan Alliance Palliative Medicine (Hospice)
Behavioral health specialists
Franciscan Alliance Home Health Services

Provider evaluation will be ongoing, applying the metrics of the Institute of Medicine, and Meaningful Use measures in reports of performance and quality. These metrics support critical goals of the ACO (increasing care coordination and fostering better doctor-patient communication; reducing medical errors and improving patient safety; supporting delivery of evidence-based care; reducing disparities by recording demographic information; improving quality of care, while fostering more cost-effective delivery; and advancing payment reform by supplying needed data on provider performance). FANH will use the metrics listed in Tables 4 and 5 to facilitate management process.

Table 4. Provider Management Tools

Provider feedback via benchmarking and dashboards allowing for comparison of measures of physician and provider resource use.
Identification and promotion of the use of quality measures through pay for reporting.
Payment for quality performance.
Payment for value to promote efficiency in resource use while providing high quality care.
Alignment of financial incentives among providers.
Transparency and public reporting.

Table 5. Initial Metrics.

Quality metrics include patient clinical outcomes (e.g. BP control; lipid control; HgA1c in diabetes)
Patient Safety (e.g. Adverse drug events; Iatrogenic events)
Cost-efficiency. Metrics include: Reduction in Preventable hospitalizations (e.g. Ambulatory hospitalizations; short-stay hospitalizations; hospital readmissions). Specifically benchmarks will be established regarding reduction in ED Visits; reduction in redundant and inappropriate diagnostic services (e.g. Percent of diagnostic tests repeated within a clinically-inappropriate window; percent of clinically inappropriate diagnostic tests ordered); and prevention of hospital-acquired infections and adverse events (e.g. Hospital-associated infections, hospital-associated venous-thrombosis events, pressure ulcers).
Population Health. Metrics in at least one category smoking rates / cessation.

Within FANH, Medical Management services, integrated with the Care-ADVANTAGE programs including Wellness and Disease Management and Quality Improvement initiatives, will be responsible for conducting and monitoring evaluations. Medical Management utilizes standards established by NCQA, Indiana Department of Insurance (IDOI) and the CMS. The FPN Board of Directors will perform Medical Management services in a manner that meets all applicable standards, as well as the mission of the organization and its stakeholders.

FANH will have several standing sub-committees that provide additional oversight for Medical Management services and activities. I have listed all standing sub-committees that meet quarterly in Table 6.

Table 6. ACO Standing Subcommittees.

Physician Advisory Subcommittee (PAC): PAC will focus on clinically related issues including health management and wellness program development, medical policy development, review of clinical outcomes and provider related issues.
Quality Improvement Subcommittee (QIC): QIC will be s responsible for performing various oversight functions of the Medical Management program including review of utilization statistics, updating and approving clinical criteria, review of the Utilization Management processes and providing recommendations for process improvements.
Utilization Management Subcommittee (UM): UM will analyze Franciscan Alliance ACO utilization data in comparison to current industry standards and reviews medication utilization for specific disease states to identify ways to improve management of these conditions and designs interventions to improve healthcare outcomes. This committee reviews and approves Utilization Management policies and procedures and communicates them to the providers.
Pharmacy and Therapeutics Subcommittee: Pharmacy and Therapeutics will make drug formulary decisions, assesses the quality and level of service to members regarding the pharmacy benefit, and communicates pharmacy information and education to providers and members.
Behavioral Health Advisory Subcommittee (BHAC): BHAC will be responsible for providing input, expertise, and recommendations for inclusion in the Quality Improvement Plan for the behavioral health arena. BHAC reviews utilization performance, pharmacy, and quality indicators specific to behavioral health and reports on quality initiatives.

The results of evaluations will be used by the Franciscan Alliance ACO and other stakeholders to make specific changes in the Franciscan Alliance ACO in regards to the following: Policies, Payment Alternative Models, Incentives, Penalties, Education, Grading, Report Cards, and/or Censure.

Payment Models

Payment models will initially mirror the fee for service model using work relative value units

(wRVU) with a portion of the payment withheld unless the providers meet quality and cost containment targets. This model will evolve toward medical home fees and bundled acute care case rates and eventually global risk adjusted fees (capitation).

Return on Investment

In preparation for the Affordable Care Act CMS conducted the Physician Group Practice (PGP) Demonstration from 2005 to 2010.[37] This project utilized a hybrid payment model that consisted of routine Medicare fee-for-service payments plus the opportunity to earn bonus payments identified as shared savings. Eligibility was limited to large physician group practices with perceived experience and financial strength.

Participants in the demonstration project invested an average of $1.7 million or a mean investment per PGP provider of $737 in the first year to succeed in the demonstration. Despite the selection of participants with a strong profile for success, many PGP participants did not break even on their initial investment. [38]

Using the data from the PGP Demonstration and information contained in the 2008 report of the Government Accountability Office (GAO), the GAO characterized the financial characteristics of the 10 organizations participating in the demonstration project. The graph in

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[37] Centers for Medicare and Medicaid Services. (2009, August). *Physician Group Practice Demonstration.* Retrieved June 2, 2011, from http://Epic.cms.hhs.gov.gov/DemoProjectsEvalRpts/downloads/PGP_Fact_Sheet.pdf

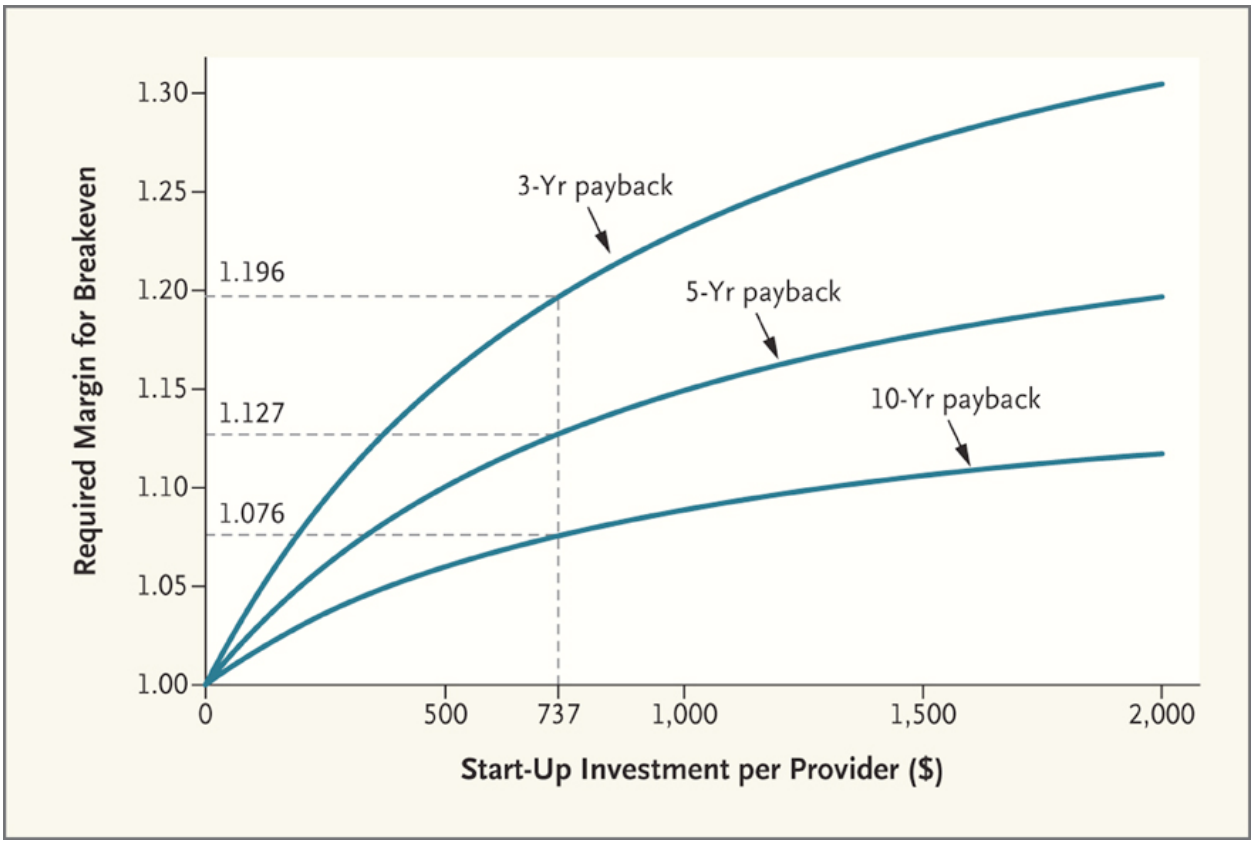
[38] Haywood, T. e. (2011, April 7). The ACO Model- A Three Year Financial Loss/. *New England Journal of Medicine , 364* (14), p. 364:e27.

Exhibit III exhibits this data from an analysis in a recent article in New England Journal of Medicine.[28] This data reveals the required margin and the time needed to recoup the original investment for the participants. At the mean investment per PGP provider of $737, the required margin to break was 13%. [28]

However, the current Medicare Shared Savings Program anticipates a performance period of only 3 years. According to the analysis by Haywood and his colleagues an ACO making the mean initial investment of $1.7 million will require a rather improbable cost savings of 20% for the 3-year period planned by CMS. Unfortunately, the available data indicate that eight of the 10 PGPs in the demonstration did not receive any shared savings payments in year 1. In the second year, six of the 10 practices did not receive any bonus payments, and in the third year, five of the 10 participant groups still did not meet criteria for a shared savings bonus. These failures could have been due to the short duration of 3 years for which data were available. Moreover, the participants did not receive benchmark feedback reports or bonus payments in a time frame originally promised which no doubt affected their ability to effect needed changes. Lessons learned suggest that physician groups alone may be ill equipped to succeed on their own.

The addition of a hospital as a partner with physicians as proposed in my OAP is, I believe, essential to the success off an ACO. A hospital or hospital system brings the needed capital and longer strategic planning horizon that make the high initial investments feasible. From the graph in Exhibit III, it would seem the period in which one can expect a reasonable return on the initial investment is in the range of more than 5 – 10 years.

Exhibit III. ROI on ACO Investment.



Excerpted from: (Haywood, 2011)

Using the information from ACO pilot projects, historical data for our local hospital (SERH-C) and current performance measures I constructed a set of pro forma financial statements projecting the cash flows and returns on FANH. These data are included in Appendices D - F.

Timeline to Completion

Our organization will develop some of the components of the ACO project concurrently during 2011 and 2012. I have been and will continue to be involved in the committees that create these components. The lynchpin of the ACO will be the Franciscan Physician Network (FPN). This will be a state wide multi-disciplinary physician network, which will integrate with the Franciscan Alliance hospital system through a joint governance structure. Each region within the Franciscan Alliance system will organize the local employed and non-employed physicians into a local network that will be a module within the larger FPN. On September 6, 2011 I accepted a position that will further these goals and ensure adherence to the projected timeline. I was recently hire by the Franciscan Alliance as President of the FPN for the western Indiana region. This opportunity is one of three such positions state wide and will give me significant input into the creation and structure of the FPN.

The FPN will be patient centered on the concept of medical homes anchored by primary care providers (PCP). These PCPs will be a team of family physicians, internists and mid-level providers such as nurse practioners. Throughout 2011 and into the future there will be regional coordination of recruitment efforts to ensure the correct balance of primary care and specialty care within each region. This balance will be important to the efficient management of any vertically integrated health care delivery network.

Another key component to a successful ACO will be the integration of a robust electronic medical record system. I am a member of the corporate wide Health Information technology Advisory Committee. This committee has oversight on the adoption of EPIC electronic medical

record by the entire Franciscan Alliance. Based on the recommendation of this committee's work the Franciscan Alliance has allocated 160 million dollars for the adoption of this industry leading electronic medical record platform. Our organization is in the process of the Epic conversion. The anticipated completion of the transition to EPIC at all facilities will be spring of 2012.

In January of 2012, I intend to present the completed OAP to the Franciscan Alliance Regional Board for consideration. Once the board approves, we will submit the proposal to CMS for review. Once this is complete, we will elect key members of the joint governance structure and plan to begin operations by July of 2012.

Research Questions

In order to qualify for a federally funded ACO under the PPACA, FANH must agree to become accountable for the care of a minimum of 5,000 Medicare fee for-service (FFS) beneficiaries and commit to a minimum 3-year participation in the ACO program. In addition, FANH will create a formal legal structure that would allow the organization to receive and distribute bonuses to participating providers. A joint leadership and management structure is also essential to properly align the efforts of physicians and the hospital. It is essential to implement an evidence-based care delivery system and infrastructure capable of tracking and reporting quality measures and cost. Finally, the entire organization must be culturally and organizationally patient-centered. Such change can take 3 – 5 years.

At least five core competencies are critical to the success of a fledgling ACO. The first core competency is highly effective leadership, this is essential to shepherd the transition of a

traditional volume based health care system to an ACO. An ongoing source of vision and direction is needed to ensure that the momentum for changed is maintained. This will almost certainly require credible physician leaders with both excellent clinical reputations and at least masters level business executive training. Such leaders will need to assemble a multi-disciplinary leadership team and provide sustained organizational commitment.

The second core competency is the ability to provide organizational focus and resource commitments over at least a five -10 year development period.

The third core competency is fiduciary in nature. CMS estimated that the transition to an ACO would cost 1.7 million dollars; however, a summary of four case studies by the American Hospital Association in May of 2011 found that the required investment was often more than 20 million dollars (more than 10 fold higher than the original estimate). Multiple cash flows will likely be required to fund and maintain ACO development within the organization. These cash flows include health system earnings, borrowing or bond issues and insurer investments. The organization will need to maintain excellent financial advice and management to support ACO development.

A fourth core competency is the development of right-sized and adaptable provider incentives. These incentives must be significant enough to alter behavior early in the ACO transformation. When more and better patient care data are available these incentives must then evolve to incorporate this new information. These incentives will include individual physician incentives, group/business unit incentives, team member incentives and inter-organizational

incentives.

Finally, the fifth core competency involves the launching of successful pilot initiatives These pilots must be large enough at the onset to create and maintain the momentum require to impel the ACO transformation. In addition, these pilot programs must be able to increase in size and scope as additional patients accrue to the system from multiple payer sources and patient populations (e.g. existing Medicare Advantage and commercial gain-sharing relationships, commercial employees, commercial insurer pilots, CMS pilots, etc.)

There are a number of operational issues related to risk management that the organization must address. The type of risk to be undertaken and the risk pool itself need to be accurately defined. Next, the ACO will have to assess the financial reserve requirements, financial carve-outs for tertiary care not available within the network, as well as catastrophic stop loss insurance pools required.

The ACO will budget for the investment and infrastructure requirements, especially as regards information technology needs. The organization will have to stay mindful of the financial incentives needed to aligned incentives between patients and providers (hospitals and physicians). The ACO must also consider the precise role of insurance companies

There are additional competencies for a successful ACO implementation that our organization should consider. Complete and timely information about provider performance is essential. Merely having an Electronic Health Record system is inadequate since it only tells the ACO about the services it has delivered, not about other services the patient may have received

outside of the ACO network. Therefore, a successful ACO will need a working relationship with payers or Health Information Exchanges in order to obtain the information needed in order to remain accountable for total costs and improve the quality of care delivered. The providers participating in the Medicare Physician Group Practice Demonstration project had to wait 18-24 months to receive data on the costs, which was far too slow to allow continuous improvement.

A successful ACO will need to develop the culture, technology and skill set to manage and coordinate health care across the entire continuum of services from home to hospitals to end of life care. Health professionals are trained and experienced in caring for acute episodic illness. However, accepting accountability for the total costs and quality of care associated with a large group of patients requires an additional set of skills and the technology to support it. Successful ACOs will need to standardize care and improve quality using clinical guidelines. In addition, the ACO will need to develop mechanisms for monitoring patent compliance with those guidelines. Implementation of such guidelines combined with internal utilization review should help curb overuse of health care services. The ACO must develop internal processes to track preventative care for patients to ensure the disease is not only treated but prevented when possible.

Patient education and self-management support will be important components of transitional care from hospital and office care environments to the patient's home. The organization should expect such efforts to pay dividends in terms of improved quality of care and decreased readmissions to the hospital as well as emergency department visits.

ACOs will require tightly coordinated care relationships with specialists and other providers in order to provide comprehensive and efficient care for patients. When hospitalizations do occur, the primary care provider will need to work closely with a hospitalist or other specialists to coordinate the hospital treatment with the patient's overall plan of care and to ensure that appropriate follow-up care is delivered after discharge.

The ability to measure and report on the quality of delivered care is essential to a successful ACO. The aim of creating an ACO is not just to reduce costs, but also to accomplish this reduction while maintaining or improving the quality of care. The goal is to improve value.

Summary

As the healthcare environment moves from fee-for-service to pay-for-performance and from fragmented to coordinated patient centered care, many healthcare providers are considering developing or merging with ACOs. This transition will require major shifts in corporate culture and strategic planning that some organizations will not be capable of in a timely manner.

Successful ACOs must be built upon the foundation of clinical integration which is fundamental to success in an ACO is the ability to collaborate on and coordinate care. A variety of different constructs can be used to integrate and align with physicians, including employment, co-management relationships, and physician hospital organizations. Employment is the simplest and most tightly integrated model. The trend toward hospitals employing physicians has accelerated dramatically in the last 5 years in response to market forces and perhaps in anticipation of future ACO formation. Whichever approach is selected it must create

interdependence among institutions and practitioners and facilitate collaboration and the sharing of information with a focus on improved clinical outcomes and efficiencies.

ACOs must be able to efficiently manage the care they provide. The goal of an ACO is to reduce the need for care by promoting wellness and managing illness, especially chronic illness. This represents a fundamental shift in priorities for traditional fee-for service hospitals. The ACO model will reward providers for quality; receiving payments for meeting certain measures surrounding the care, they provide thus insuring that an ACO does not focus exclusively on reduced utilization. This was a mistake seen in the HMO era of the 1990s. To achieve the dual goals of reducing utilization while promoting quality most experts agree that the use of evidence-based care pathways. These care pathways require the involvement of an integrated and engaged medical staff.

The ACO should provide the needed aligned incentives in terms of driving quality and cost efficiencies. Productivity based reimbursement will cause the organization to repeat the mistakes of the past and prevent the ACO driving value.

This requires a shift in physician practices from reimbursing for the number of services provided to reimbursing for managing health and reducing the need for services. In short, ACOs should reimburse physician for meeting value-based goals. IT infrastructure that enhances care coordination as well as allows for reporting quality metrics to government and private payors will be necessary for the success of an ACO.

These IT tools can provide clinical decision support to physicians to help ensure they follow the evidence-based care pathways that drive the group's ability to appropriately manage care.

Finally, although the development of ACOs may be driven initially by CMS, ACOs should not be limited to government payors. In order to affect medical expense and improve outcomes a wider contracting strategy is required.

The core of an ACO is an effective primary care base. Although the majority of healthcare expenditures and increases in expenditures are associated with specialty and hospital care, some of the most important mechanisms for reducing and slowing the growth in specialty and hospital expenditures are prevention, early diagnosis, chronic disease management, and other tools which are delivered through primary care practices.

A final observation is perhaps germane. Like any new venture, ACO formation is not without financial risk and general uncertainty. However, the infrastructure, cultural changes, and physician networks required to support them are interchangeable with almost any other reform endeavor. Thus, the investment is not in one particular model but in the future of health care delivery and can only serve, our patients better in the end.

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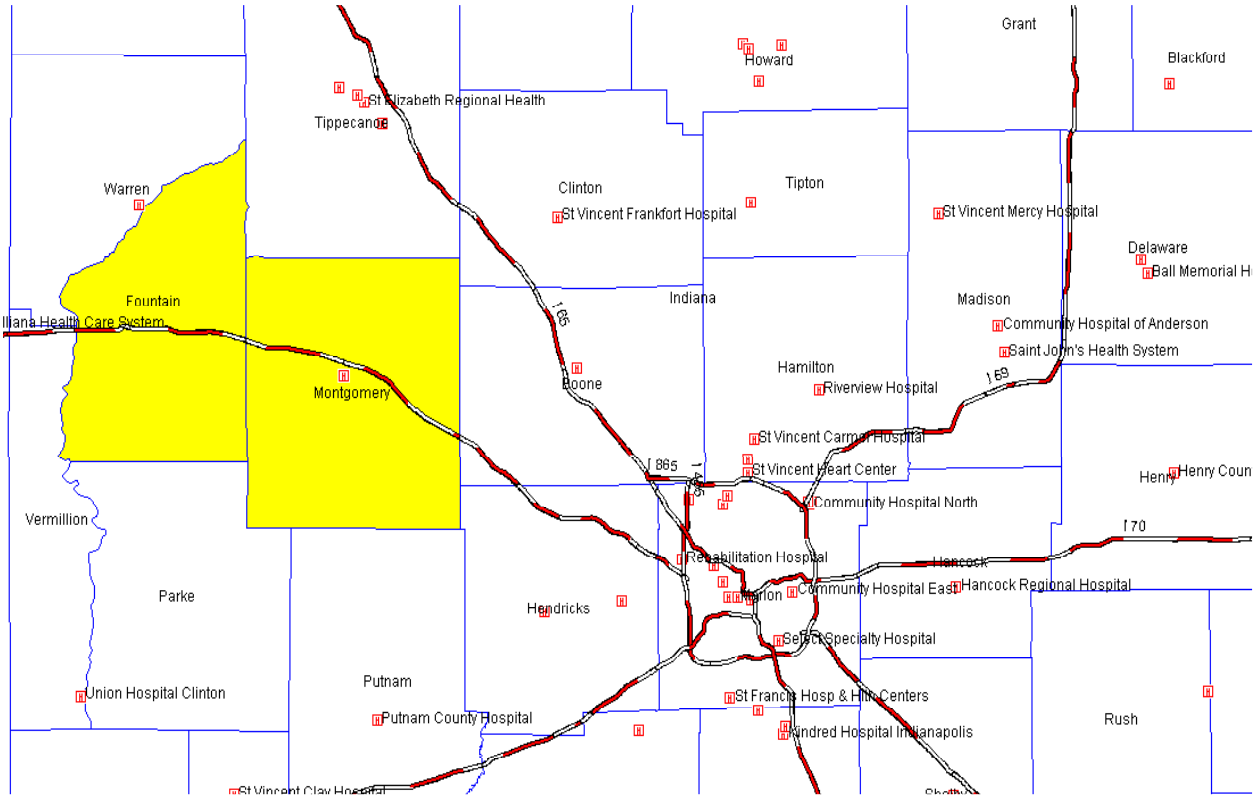
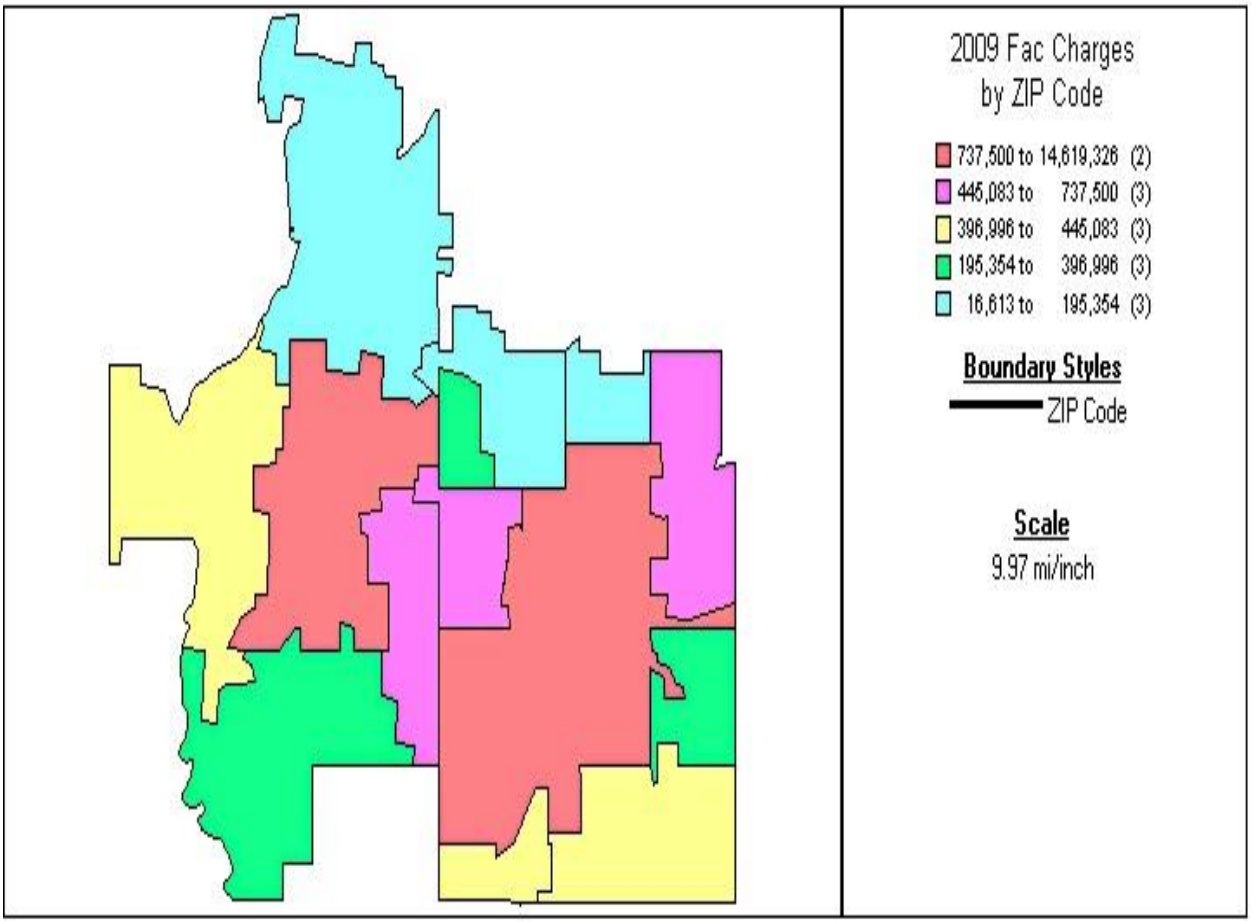
Appendix A. Service Area - FANH



Source: Thomson-Reuters 2010.

Appendix B. Medicare Charges in the Service Area

Medicare Market and Facility Charges by ZIP Code
Area: St. Clare Primary Service Area
Selected Medicare Facility: 150022 - St Clare Medical Center



	2009 Mkt Charges	2009 Fac Charges	2008 Mkt Charges	2008 Fac Charges	2007 Mkt Charges	2007 Fac Charges
	$57,443,556	$15,356,826	$44,993,837	$11,847,620	$44,207,935	$11,815,120
	$6,271,431	$1,603,488	$5,060,033	$818,660	$7,262,690	$1,367,912
	$16,539,286	$1,222,596	$15,089,857	$1,508,937	$14,624,394	$1,288,965
	$7,171,150	$753,114	$6,287,774	$899,550	$7,499,970	$931,959
	$12,265,257	$245,704	$12,207,808	$283,020	$12,137,309	$372,254

Appendix C. Statutory Requirements for Medicare ACOs

1. Groups of providers of services and suppliers, which can include: a. Physicians and other practitioners (referred to as ACO professionals) in group practice arrangements; b. Networks of individual practices of ACO professionals; c. Partnerships or joint venture arrangements between hospitals and ACO professionals; d. Hospitals employing ACO professionals; or e. Other groups of providers of services and suppliers deemed appropriate by the secretary of Health and Human Services (HHS).
2. Willingness to become accountable for the quality, costs, and overall care of Medicare fee-for-service beneficiaries assigned to it based on their utilization of primary care services.
3. Agreement to participate in the program for a minimum of three years.
4. A formal legal structure that would allow the organization to receive and distribute payments for shared savings to participating providers of services and suppliers.
5. Inclusion of primary care ACO professionals that are sufficient for the number of Medicare fee-for-service beneficiaries (a minimum of 5,000) assigned to it.
6. Provision to HHS of information necessary to determine the Medicare beneficiaries for whom the organization is responsible, the implementation of quality and other reporting requirements, and determination of payments for shared savings. a. Quality measures may include clinical processes and outcomes, patient and caregiver experience of care and utilization measures such as hospital admissions for ambulatory care–sensitive conditions. b. Additional quality measures may include care transitions, hospital discharge planning, and post-hospital discharge follow-up.
7. A leadership and management structure that includes clinical and administrative systems.
8. Processes to promote evidence-based medicine and patient engagement, report on quality and cost measures, and coordinate care.
9. Demonstration that the organization meets patient-centeredness criteria specified by the Secretary of Health and Human Services.

Appendix D. Current Medicare Charges and Projected Medicare Visits

Medicare Market Charges by ZIP Code
Area: Montgomery County
Ranked On: 2010 Market Patients Count (Desc)

ZIP Code	ZIP City Name	2010 Market Patients Count	2010 Market Patients %Down	2010 Total Charges	2010 Charge per Patient	2009 Market Patients Count	2009 Market Patients %Down	2009 Total Charges	2009 Charge per Patient	2008 Market Patients Count	2008 Market Patients %Down	2008 Total Charges	2008 Charge per Patient
47933	Crawfordsville	1,702	76.00%	$59,697,230	$35,075	1,666	79.10%	$50,686,758	$30,424	1,475	77.50%	$38,476,052	$26,085
47954	Ladoga	98	4.40%	$3,785,485	$38,627	84	4.00%	$2,873,739	$34,211	100	5.30%	$2,749,944	$27,499
47990	Waynetown	96	4.30%	$2,708,155	$28,210	101	4.80%	$2,788,558	$27,609	75	3.90%	$2,207,823	$29,438
47940	Darlington	82	3.70%	$2,994,781	$36,522	73	3.50%	$2,006,326	$27,484	44	2.30%	$1,195,090	$27,161
47955	Linden	72	3.20%	$2,859,015	$39,709	26	1.20%	$823,788	$31,684	39	2.00%	$1,520,035	$38,975
47989	Waveland	65	2.90%	$1,864,577	$28,686	50	2.40%	$1,529,788	$30,596	63	3.30%	$1,404,421	$22,292
47994	Wingate	51	2.30%	$2,048,712	$40,171	28	1.30%	$709,448	$25,337	32	1.70%	$735,725	$22,991
47968	New Ross	50	2.20%	$1,673,463	$33,469	48	2.30%	$1,351,431	$28,155	53	2.80%	$1,205,780	$22,751
47967	New Richmond	24	1.10%	$759,288	$31,637	31	1.50%	$646,400	$20,852	22	1.20%	$676,827	$30,765
		2,240	100.00%	$78,390,706	$34,996	2,107	100.00%	$63,416,236	$30,098	1,903	100.00%	$50,171,697	$26,365

Medicare Market Share 3.1
MCMS0006.SQP

Hospital Service Area File (HSAF)

Projected Medicare Outpatient Visits

ZIP City Name	Count	2009 Market Total OP Visits	2014 Market Total OP Visits	Market Change Count
Crawfordsville	27,240	59,105	60,377	1,272
Darlington	2,088	4,604	4,820	216
Ladoga	2,654	6,059	6,214	154
Waynetown	1,335	2,990	3,123	133
New Richmond	1,158	2,414	2,528	115
New Ross	1,283	2,732	2,823	91
Kingman	2,894	6,400	6,483	83
Linden	1,077	2,479	2,555	75
Wingate	621	1,411	1,471	61
Waveland	986	2,115	2,163	48
Hillsboro	1,165	2,682	2,700	18
Covington	5,394	11,591	11,527	-63
Veedersburg	4,088	8,903	8,788	-115
Attica	6,317	13,802	13,676	-127
	58,300	127,288	129,248	1,960

Source: Thomson-Reuters 2010.

Appendix E. Current and Projected Performance Measures (growth from 2010 and 2011 was projected forward).

Transition to ACO

PERFORMANCE INDICATORS	2009	2010	2011		2012	2013	2014
Admissions	824	728	731		735	739	743
Average LOS (length of stay)	2	2	1.7		1.7	1.6	1.7
Patient Days	594	511	1210.7		1217.0	1218.1	1228.0
Charge per Day	2092	2016	2054		2054	2041	2050
ER Visits							
ED Visits IP (Admitted)	541	515	528		528	523	526
Emergency Visits OP	8359	8378	8,369		8,369	8,372	8,370
Total Visits	3827	3824	8,896		8,896	8,895	8,896
Surgeries							
Hospital							
Surgery	181	237	209		209	218	212
Endoscopy	106	52	79		79	70	76
Total	123	124	287		287	288	288
Ambulatory Surgery Center (ASC)							
Surgery	369	353	361		361	359	360
Endoscopy	553	506	530		530	522	527
Cataracts	144	155	149		149	151	150
Total	1066	1014	1,040		1,040	1,031	1,037
Total Surgeries	1189	1138	1,327		1,327	1,319	1,325

Appendix F. Financial Statements & Pro Forma.

BALANCE SHEET	2009	2010	2011	Transition to ACO	2012	2013	2014
Assets							
Current Assets							
Cash and Cash Equivalents	1,057,445	1,254,263	1,155,854		1,205,059	1,180,456	1,192,757
Patient Accounts Receivable	10,379,107	10,494,169	6,957,759		9,277,012	8,909,646	8,381,472
Allowance For Doubtful Accounts	-3,602,513	-3,714,550	-2,439,021		-3,252,028	-3,135,200	-2,942,083
Net Patient Accounts Receivable	6,776,594	6,779,618	4,518,737		6,024,983	5,774,446	5,439,389
Inventory	1,154,167	1,198,066	784,078		1,045,437	1,009,194	946,236
Other Current Assets	934,289	762,019	565,436		753,915	693,790	671,047
Total Current Assets	9,922,495	9,993,966	11,542,843		15,054,377	14,432,332	13,688,818
Assets Limited As To Use							
Temp Restricted	44,855	66,770	55,813		61,291	58,552	59,922
Perm Restricted	4,162,893	4,378,657	2,847,183		3,796,245	3,674,028	3,439,152
Total Assets Limited As To Use	4,207,748	4,445,427	2,902,996		3,857,536	3,732,580	3,499,074
Property, Plant and Equipment							
Land	1,000,120	1,000,120	666,746		888,995	851,954	802,565
Land Improvements	1,391,783	1,405,040	932,274		1,243,032	1,193,449	1,122,919
Buildings	27,478,297	28,398,553	18,625,617		24,834,155	23,952,775	22,470,849
Leasehold Improvements	432,855	485,355	306,070		408,093	399,839	371,334
Equipment	19,622,664	21,085,823	13,569,496		18,092,661	17,582,660	16,414,939
Construction In Process	785,182	205,758	495,470		350,614	423,042	386,828
Gross Property, Plant and Equipment	50,710,900	52,580,648	34,595,673		45,817,551	44,403,719	41,569,434
Accumulated Depreciation	-22,392,244	-24,502,664	-15,631,636		-20,842,181	-20,325,494	-18,933,104
Net Property Plant and Equipment	28,318,656	28,077,984	18,964,037		24,975,370	24,078,225	22,636,330
Intangible Assets, net of Amortization	35,290,328	317,781	317,781		317,781	317,781	317,781
Total Assets	**177,675,620**	**144,712,804**	**101,733,205**		**133,909,898**	**129,207,775**	**121,535,659**
Liabilities and Fund Equities							
Current Liabilities							
Accounts Payable and Accrued Expenses	1,267,227	2,520,574	1,262,600		1,683,467	1,822,214	1,589,427
Accrued Payroll and Related Expenses	1,094,326	1,324,131	806,152		1,074,870	1,068,384	983,135
Third Party Payable	202,867	268,967	235,917		252,442	244,180	248,311
Current Portion of LT Debt	318,994	310,741	314,867		312,804	313,836	313,320
Other	-636,926	-1,131,305	-884,115		-1,007,710	-945,912	-976,811
Total Current Liabilities	2,246,488	3,293,108	1,735,422		2,315,873	2,502,701	2,157,382
Long-Term Liabilities							
Pension Liability	-1,065,704	-1,189,910	-1,127,807		-1,158,858	-1,143,332	-1,151,095
Long-Term Debt, Net of Current Portion	622,024	327,054	474,539		400,797	437,668	419,232
Estimated Insurance Liabilities	15,000	15,000	15,000		15,000	15,000	15,000
Total Long-Term Liabilities	-428,680	-847,855	-638,268		-743,061	-690,664	-716,863
Total Liabilities	**1,817,808**	**2,445,252**	**1,097,154**		**1,572,811**	**1,812,036**	**1,440,519**
Net Assets							
Net Assets Unrestricted	68,844,658	71,713,671	46,852,776		62,470,368	60,345,605	56,556,250
Increase(Decrease) in Net Assets	2,869,013	-35,769,191	0		0	0	0
Temporarily Restricted Funds	44,855	66,770	55,813		61,291	58,552	59,922
Restricted Funds	4,162,893	4,378,657	2,847,183		3,796,245	3,674,028	3,439,152
Total Net Assets	**75,921,419**	**40,389,907**	**49,755,772**		**66,327,904**	**64,078,186**	**60,055,324**

	2009	2010	2011	Transition to ACO	2012	2013	2014
CASH FLOW STATEMENTS (in thousands)							
OPERATING ACTIVITIES	1,026	1,055	1,041		1,041	1,046	1,042
Depreciation of Pre-Paid Expenses	1,702	25	863		863	584	770
Amortization of deferred financing costs and intangibles	1,046	1,001	1,024		1,024	1,016	1,021
Provision for Doubtful Accounts	0	(10)	(5)		(5)	(7)	(6)
Gain on sale of PPE	0	0	0		0	0	0
Equity in earnings of investments in unconsolidated affiliates	(18)	(90)	(54)		(54)	(66)	(58)
Restricted contributions and investment income	0	15,013	5,004		6,672	8,897	6,858
Write-down of impaired asset (reduction in gross intangible value)	0	0					
(Increase) decrease in assets	(456)	(1,003)	(729)		(729)	(820)	(760)
Patient AR	(13)	(19)	(11)		(14)	(15)	(13)
Inventories of Supplies	(42)	0	(21)		(21)	(14)	(19)
Other assets (both short- and long-term)	0	74	25		33	44	34
Increase (decrease) in liabilities	(273)	0	(137)		(137)	(91)	(122)
Accounts payable and accrued expenses	131	513	215		286	338	280
Accrued payroll and related expense	75	98	87		87	91	88
Estimated third-party payor settlements	(397)	28	(123)		(164)	(86)	(124)
Accrued pension liability	0	(53)	(27)		(27)	(36)	(30)
Estimated insurance liabilities	(224)	0	(112)		(112)	(75)	(100)
Other liabilities	2,557	(212)	7,040		8,743	10,805	8,863
Total Operating Activity adjustments	3,773	16,421	10,097		10,097	12,205	10,800
Net cash provided by Operating Activities	8,887	32,842	24,177		27,584	33,816	28,525
FINANCING ACTIVITIES	264	0	132		132	88	118
Proceeds from issuance of debt (short term loans/LOCs incl. in CP LTD)	133	(127)	2		3	(41)	(12)
Principal Payments on LTD	18	(3)	7		7	4	6
Restricted contributions and investment income	0	90	30		40	54	41
Receipt of minority investment in consolidated affiliate	416	0	172		183	105	153
Net cash provided by Financing Activities							
	0						
INVESTING ACTIVITIES	(1,121)	0	(560)		(560)	(374)	(498)
Purchase of PPE - cash paid	(2,959)	0	(1,480)		(1,480)	(986)	(1,315)
Purchase of intangible asset (increase in gross intangible value)	0	(926)	(463)		(463)	(617)	(514)
Contributions	0	0	0		0	0	0
Capital distribution from investment in unconsolidated affiliate	0	0	0		0	0	0
Investments in (loans to) unconsolidated affiliates	17	10	14		14	13	13
Increase/decrease in assets limited as to use and ST investments	0	(102)	(51)		(51)	(68)	(57)
Capital distribution received from investments in consolidated affiliates	(4,063)	(1,017)	(2,540)		(2,540)	(2,032)	(2,371)
Net cash used in Investing Activities	0	0					
	0	0					
Non-cash transactions	55	26	40		40	36	39
CIP included in AP - current period	(55)	(26)	(40)		(40)	(36)	(39)
CIP included in AP - previous period	0	0	0		0	0	0
Transfer of assets to another facility	0	0	0		0	0	0
Total Non-cash transactions	0	0	0		0	0	0

Transition to ACO

	2009	2010	2011		2012	2013	2014
INCOME STATEMENT (in thoudsands)							
Routine Bed Revenue	3,355,822	3,112,885	2,156,236		2,874,981	2,714,701	2,581,972
Ancillary Revenue	12,512,423	11,366,544	11,939,483		11,939,483	11,748,503	11,875,823
Total Inpatient Revenue	15,868,245	14,479,429	14,095,719		14,814,464	14,463,204	14,457,796
Outpatient Revenue	36,097,351	39,663,426	37,880,388		37,880,388	38,474,734	38,078,504
Total Patient Service Revenue	51,965,596	54,142,854	51,976,107		52,694,853	52,937,938	52,536,299
Deductions From Revenue							
Contractual Allowances	2,622,902	2,731,074	2,676,988		2,676,988	2,695,016	2,682,997
Charity Services	275,878	300,858	192,245		256,327	249,810	232,794
Other Deductions	14,074	1,688	5,254		7,006	4,649	5,636
Total Deductions From Revenue	2,912,854	3,033,620	2,874,487		2,940,320	2,949,476	2,921,428
Net Patient Service Revenue	49,052,742	51,109,234	49,101,620		49,754,532	49,988,462	49,614,872
Other Operating Revenue							
Premium Revenue	3,191	2,063	2,627		2,345	2,486	2,415
Other Operating Revenue	33,006	31,799	32,403		32,101	32,252	32,176
Total Other Operating Revenue	36,197	33,862	35,030		34,446	34,738	34,592
Total Operating Revenue	**49,088,940**	**51,143,096**	**49,136,650**		**49,788,978**	**50,023,200**	**49,649,463**
Operating Expenses	642,744	620,969	631,856		631,856	628,227	630,647
Salaries & Wages-Non Physicians	311,873	309,448	310,660		310,054	310,357	310,206
Salaries & Wages-Physicians	35,237	28,264	31,751		31,751	30,588	31,363
Purchased Labor	229,918	246,748	238,333		238,333	241,138	239,268
Employee Benefits-Non Physicians	33,138	43,600	38,369		38,369	40,112	38,950
Physician Fees-Non Employees	47,835	53,385	50,610		50,610	51,535	50,918
Corporate Office Assessments	77,074	77,614	77,344		77,344	77,434	77,374
AIS Fees	3,854	2,881	3,368		3,368	3,205	3,313
COEP Fees	2,050	2,053	2,051		2,051	2,052	2,051
Central Procurement Fees	93,961	106,922	100,441		100,441	102,602	101,161
Drugs & Pharmaceuticals	144,850	141,501	143,176		143,176	142,617	142,990
Medical Supplies	18,947	18,879	18,913		18,913	18,902	18,909
Other Supplies	34,067	34,324	34,195		34,195	34,238	34,209
Utilities	62,851	74,352	68,601		68,601	70,518	69,240
Repairs and Maintenance	157,191	156,721	156,956		156,956	156,878	156,930
Purchased Services	4,766	2,222	3,494		3,494	3,070	3,352
Legal Fees	24,638	22,087	23,363		23,363	22,938	23,221
Insurance	57,463	81,120	69,292		69,292	73,234	70,606
Interest	258,140	102,247	180,194		180,194	154,212	171,533
Depreciation & Amortization	99,008	94,799	96,904		96,904	96,202	96,670
Provision for Doubtful Accounts	144,035	125,116	134,576		134,576	131,422	133,524
Other Expenses							
Total Operating Expenses	**2,483,641**	**2,345,251**	**2,414,446**		**2,413,840**	**2,391,482**	**2,406,437**
Add: Interest Expense	57,463	81,120	1,880		1,906	1,152	67
Add: Depreciation & Amortization	258,140	102,247	4,889		4,956	1,521	154
			0		0	0	0
Operating EBITDA	169,401	260,292	5,829		5,909	3,691	209
Non-Operating Income							
Investment Income	5,081	2,899	108		110	42	4