President's Message

Hi everyone,

I can't believe it is already April and the HFMA Chapter year is almost over. I am happy to announce that our 2012 – 2013 election results are in. On May 21st, the following people will be installed as officers and board members for the upcoming year:

President – Sue Dimic
President Elect – Amy Vandecar
Secretary – Mike Berryman
Treasurer – Doug Banks
Assistant Treasurer – Sara McGlynn

Your 2012 – 2013 Board members are:

Sharon Bayliss, David Buckley, Cheryl Comeau, Mike Marulli, Nancy Rocker, Kristina Wong, Michael Klett, Rhonda Main, Luke Meert and Tina Wood.

Please plan on joining us the morning of May 21st at Providence Hospital where these folks will be sworn in for the upcoming year. We will also be presenting our Chapter Award winners at this meeting. I could tell you who the winners are, but that would be no fun! The meeting will be FREE to attend and will also include speakers from the State of Michigan who will give us updates on the Dual Eligible program as well as a budget update and updates on the work being done by other hospital workgroups.

The month of April also brings some additional educational opportunities before we settle in to summer. Our last FREE Regional Webinar, entitled “What Should we be Doing Now? Positioning your Facility to Thrive in the Evolving Healthcare Market” will be held on April 13th. On April 17th the Revenue Cycle Committee will be hosting their next meeting – “Building a Bridge between Healthcare Reform & Healthcare Payments” at Providence Hospital, and finally, on April 26th, the Annual HFMA/MACPA conference will be held at the Suburban Collection Showplace in Novi. Details for all these events can be found at our website - www hfmaemc org
This will be my last President’s message before I pass the gavel to Sue Dimic. I want to thank all the officers, board members, committee chairs and especially Susan Stokes, our administrative assistant for all the support this past year. The last four years I have served as a Chapter Officer has truly been a rewarding experience. I have met so many great people, both from our Chapter as well as other Chapters and I am thankful for the opportunity I had to represent the Eastern Michigan Chapter. We have a great group of volunteers that make it an enjoyable experience to get involved in Chapter leadership. I would encourage anyone who had been thinking about getting more involved to do it, you will not regret it!

Hope to see you soon.

Mark

UpFront – Editor’s Letter

By: Michelle Giurlanda and Sherrie White Co-Editors

SPRING HAS SPRUNG!

Don’t know about the rest of you but we have been enjoying these 80 degree days. Who would have thought that the weather would break so many record highs in the month of March? Spring is an exciting time. Flowers are coming up and the birds are singing (I hear them every morning). The grass is turning green and the trees are starting to bud. It’s a time of renewal. It’s nature’s way of giving us a kick in the seat of the pants and telling us to get moving. Yard work, tilling the garden, cleaning out your closet and packing away winter items and getting those screens in the windows are part of our spring ritual. I am working on getting my motorcycle out of storage and Michelle is getting her boat ready to hit the water.

Spring is also a time of personal and spiritual renewal. When you are cleaning out those closets and attics, donate those items to your favorite charity. It’s also a good time for volunteering in your community, your church or HFMA. Join an exercise class or ride your bicycle in the park. Eat more fruits and vegetables, and drink plenty of water to stay hydrated, and don’t forget the sunscreen.

Since we are talking about renewal……don’t forget to renew your HFMA membership!

Happy Spring,
Sherrie and Michelle

Call for Articles

Do you have a best practice in your field? Have you overcome a challenging business issue? Share your knowledge with your fellow HFMA members. Please submit articles to Michelle Giurlanda mgiurlanda@beaumont.edu or Sherrie White slwhite@beuamont.edu The next HealthCents deadline is May 18, 2012.
The Sustainable Growth Rate Formula and Other Financial Challenges for Physicians

By: Steve Fehlinger, FHFMA
HFMA-EMC Program Committee Member
steve.fehlinger@lubawaymasten.com

What is the Sustainable Growth Rate or SGR?
The Balanced Budget Act of 1997 was enacted on August 5, 1997 and replaced what was called the Medicare Volume performance Standard with the “Sustainable Growth Rate” (SGR) provision for Medicare payments to doctors under Medicare Part B.

Do not confuse this with the sustainable growth concept first published by Robert C. Higgins in financial literature in 1977. That SGR is an estimate of the maximum growth rate a firm can achieve, given the firm’s profitability, asset utilization, desired dividend payout, and financial leverage ratios.

Perhaps Congress should have chosen UGR which is more suitable for cost escalation that has become unsustainable. The only year the cuts required under BBA 1997 when into effect was 2002, when the formula called for a reduction of 4.8 percent. Every year since then when cuts are due, Congress has intervened and overridden the reduced update under the formula. The intent of the SGR was to constrain the growth in Medicare physician expenditures by limiting Medicare payments to physicians to the growth rate of the economy by incorporating the following estimated cost factors into the SGR update formula:

- The change in fees for physician’s services
- The change in the number of beneficiaries enrolled in Medicare fee-for-service system
- The 10-year average annual change in GDP per capita
- The change in expenditures due to law and regulation

Because of the way the SGR formula developed, the required expenditure reduction has been getting larger every time the reduction is delayed. Many physicians were hopeful that the SGR would be repealed as part or ACA, but that did not happen.

The Present State of Affairs under the SGR
On February 17, 2012 Congress averted a 27.4% cut in the Medicare physician payment rates that would have become effective March 1, 2012. This scheduled reduction was driven by the sustainable growth rate formula. The legislation also extended several small Medicare payment provisions that were set to expire after February 29, 2012. These include payment extensions for physicians practicing in rural and low-cost areas, exceptions to limits on certain outpatient therapy services, an enhancement in pay rates to sole community hospitals with fewer than 100 beds, and an increased rate for ambulance services. In addition, hospital geographic reclassifications were extended, but only through March 31, 2012.

While the reduction in payments was averted, it froze physician payments for 10 months at a cost of
$20.9 billion. This cost will be paid for by payment reductions primarily to hospitals and clinical laboratories:

- $6.9 billion in reduced payments for hospital and nursing home bad debts expenses
- $5 billion in reduced funding for certain public health and prevention services enacted under the ACA
- $4.1 billion from reduced payments to hospitals for disproportionate share
- $2.5 billion in Post Hurricane-Katrina payments for Louisiana Medicaid, and
- A two percent reduction in clinical laboratory payments: $2.4 billion.

The temporary patch to the SGR payment reduction formula only delays a growing problem. Physicians will now face an impending 32% payment reduction in 2013 and a budget hole of $300 billion. Many anticipate that in five years, this deficit will grow to $600 billion. Since 2012 is an election year, another pay patch is anticipated in December 2012 because this will be a lame-duck session of Congress. Such a delay would put off the delay in cuts a couple of months probably until March 1, 2013.

Other Financial Challenges for Physicians

It is important to note that not all physicians are facing crisis. This is because about 50 percent of the nation’s physicians are employed by hospitals or hospital systems. Of the remaining 50 percent of physicians, cardiologists and oncologists have been especially hard hit. This again is due to Medicare payment policy changes. Last year CMS significantly reduced payments to cardiologists for echocardiograms, stress tests and similar testing procedures. The payment reduction was based on a survey by the American Medical Association for CMS. This assessment excluded many cardiologists in private practice from the survey. It is believed this was done intentionally because private practice cardiologists to a large extent have dropped out of the AMA.

Oncologists are also suffering but not because of the AMA. They are suffering from cancer treatment chemotherapy drug payments that often do not cover their costs. What exacerbates the problem is that private insurers adopt payment structures that are modeled after what Medicare pays. This is especially common when the Medicare payments are being reduced.

If the SGR formula and other Medicare payment reductions were not enough to give physicians heartburn, a recent Wall Street Journal article highlighted further financial concerns for physicians in medical practice. A number of family practice physicians have begun to use electronic medical records, call patients at home, and coordinate with other specialists and hospitals to improve patient care. These are the things policy makers and insurers say physicians should be doing to improve patient care. In many cases, these enhancements are not reimbursed under traditional insurance contracts. The article cited an example of a three physician practice that gave up $200,000 in revenue from patient visits to make the medical home practice transition.

The Advisory Board has estimated that for a five-doctor practice, the first year cost for conversion to a medical home practice is between $126,000 and $356,500. This is the cost to upgrade information technology systems, add and educate staff, and pay for outreach and care coordination.

In the Wall Street article, officials from Aetna, WellPoint and UnitedHealth have indicated that they are
moving forward with payment reform to encourage physicians to adopt alternative payment options. Prudently, physicians remain cautious about whether payments will continue beyond demonstration projects. This uncertainty will drive more physicians to the employment security offered by hospitals or integrated delivery systems, a trend fueled by the prospect of the development of accountable care organizations.

Health Care Costs and Economic Realities
Hospitals lose $150,000 to $250,000 per year for the first three years of physician employment. The losses decrease about 50 percent after three years. In the end, ambulatory office practices seldom turn a profit for hospitals. The losses from employing primary care physicians may be offset in part by referrals to specialists that use the hospital. Although some physicians would prefer autonomy to employment, the reality is that hospitals are under pressure to engender cost-saving strategies for their own survival. The expectation is that this struggle for survival will eventually benefit patient customers if savings are passed on through lower costs.

A point to ponder – unsustainable describes health care costs continuing to absorb a larger percentage of GDP each year -- if something cannot go on forever, it will eventually stop.
Welcome New Members

New members of the Eastern Michigan Chapter are an important part of the Chapter’s continued success. Please take a moment to contact our new members and share your experiences about our Chapter. We value their membership and encourage them to become active on Chapter committees.

Kate Nagy, Vice President/Treasury Management
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Do you Measure up? Improve your Practice’s Profitability by Participating in Benchmarking Studies

By: Harold Burns, CMA, CPA, Managing Director
UHY LLP’s National Health Care Group – re-print of article
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Benchmarking is the process of analyzing practice business data and applying that information to achieve business growth and improvement. It also helps with earlier detection of existing and potential problems. The benefits of benchmarking can be significant and become a vital part of your internal practice feedback system, allowing consistent monitoring of performance and identification of efficiencies and opportunities.

Your practice should use both internal and external standards in its benchmarking approach. Internal standards include the practice’s financial statements, productivity and accounts receivable information. They can be compared against themselves by “trending” information or by comparing internal standards of your practice to external standards. In contrast, external standards are benchmarking tools or information from sources outside your practice and can be obtained from your individual specialty society, as well as a number of national medical associations. These standards are a good comparison indicator to how you measure up against other practices similar in size or specialty.

The first step of the benchmarking process is to determine exactly what you would like to benchmark. Factors such as geography, age, size and style can impact your practice and should be examined to determine accurate data. An excellent start to your benchmarking process is to use the following six measures that are in effect, the “vital signs” of your practice and are readily available from your internal records.

Average Gross Charges
When combined with other indicators, this is a meaningful benchmark factor and measures how hard and efficiently the physicians are working. Since medical services are discounted by insurers, it is not a good gauge of how much money they are generating, but when used within the same specialty group, can be a useful tool to evaluate production patterns.

Average Net Receipts
This number represents the total cash receipts deposited in the bank for all services rendered, reflecting the amounts paid after discounts, contractual adjustments and write-offs. By comparing net receipts to gross charges and trending over time, billing effectiveness, potential collections issues and internal security can be determined.

Gross Collection Ratio (GCR)
This ratio gives a first look at billing efficiency and effectiveness and is calculated as net receipts divided by gross charges. It shows how much is received on every dollar charged. However, it needs to be assessed with care as the ratio is dependent on the payor mix and fee schedules.

Please see Do you Measure up? on Page 8
Net Collection Ratio (NCR)
This calculation is determined by dividing net receipts by gross charges less adjustments. This measurement is more sensitive than the gross collection ratio as an indicator of billing effectiveness but the two measures should be monitored together to gain a proper billing assessment. For example, if a practice’s NCR is almost 100 percent, while their GCR is around 60 percent, this may indicate that the practice is not charging enough. Insurers will pay only up to what practices ask for up to their maximum allowances. If the GCR is high but the NCR is low, this could indicate a serious problem with collections. On the other hand, if the GCR is low relative to the benchmarks, the practice may be charging too much. Ideally, collection rates should be between 90 and 100 percent after write-offs are taken. For a thorough and complete evaluation, you should understand your payor mix and what the reimbursement rates are in the market in which you practice. Ultimately, how much you collect out of what you are entitled to, according to your contracts, requires close monitoring of contractual and non-contractual write-offs.

Overhead Percentage
This percentage includes the non-physician expenses of the practice. The ratio used is expressed as a percentage of overhead expense divided by total revenue. To obtain the clearest picture of non-physician overhead, physician compensation, payroll taxes, benefits and retirement contributions, as well as dues subscriptions and CME expense should be excluded from total expense.

Average Physician Compensation
Care should be taken in selecting benchmark data for comparison for this metric as there are many different nuances in how the data is collected, defined and reported. For example, compensation data is reported by geography, specialty, percent of capitation revenue, etc. Physician compensation can be compared to production data to determine how well your compensation plan is working. Each of these benchmarking indictors can be easily tracked and analyzed by putting together a spreadsheet comparing the practice (or sub-group) to the benchmark and then calculating the comparison. Ideally, your benchmarking efforts will show that your practice is best in class and areas in which your practice’s bottom line could benefit from adjustment.

The above examples are just a few of the many benchmark indicators that can be used to assess your practice. Benchmarks can not only be used to measure financial soundness and overhead expenses but also managed care factors, patient encounters, services production and client satisfaction. Each practice is unique and there may be other factors that should be considered as well. Benchmarking should be performed at least once a year or more frequently if possible.
CFOs from Major Hospital Systems Share Views on Changing Healthcare Environment

By: Elyse Berry, FHFMA, Director Provider Contracts
Molina Healthcare
elyse.berry@molinahealthcare.com

On February 21, over 120 HFMA members and guests heard the views of three local CFOs on critical issues facing local hospitals in light of governmental changes coming in health care reform.

The CFOs expressed common challenges and strategic responses in the “tsunami” of health care reform:

- Bottom line financial viability as insurance and Medicare/Medicaid plans restructure payments and fully implement value based purchasing.
- While growth is always important, unit cost is now more critical than expansion.
- The local physician pool is aging, with 80% expected to retire in 5-10 years.
- Population health management will be the wave of the future. The current structure, which is based on number of admissions, doesn’t have the right incentives to reduce the total cost of care and make the region competitive.
- To survive and thrive long term, hospitals will need to partner and clinically integrate with physicians to share savings and provide value based services to government and insurance purchasers.
- Payment structures will move away from “per click” to integrated care models that reduce cost and improves quality.

Each of the CFOs shared plans at their respective hospitals to respond to the changing environment.

The CFO panel pictured here right to left: Nickolas Vitale, Beaumont Health System; Patrick McGuire, St. John Providence Health System; James Connelly, Henry Ford Health System. Standing: Matthew Weekley, Plante Moran, moderator.
Centers for Medicare and Medicaid Services Announcement

By: Kenneth R. Marcus, Partner
Honigman Miller Schwartz and Cohn LLP
kmarcus@honigman.com

On March 16, 2012 the Centers for Medicare and Medicaid Services announced as follows:

1. Revised SSI ratios for the Medicare DSH calculation for FY 2006 through FY 2009 are available; see the link below.

2. In addition to including MA patient days in the ratios for FY 2006, 2007, 2008, and 2009 CMS has also calculated the SSI ratios in the manner proscribed by CMS-1498-R. To view these ratios, please visit the download section in the link referenced below.

3. Information regarding the MedPAR claims run out and the SSI eligibility file used to calculate ratios can be found within the excel files in the link referenced below.

4. Providers who are interested in obtaining the data used to calculate their FY 2006–FY 2009 ratios are encouraged to submit a Letter of Request along with a DSH Data Use Agreement. For additional information, please visit the link below regarding the related links section.

Please see this link for the downloads referenced.  http://www.cms.gov/AcuteInpatientPPS/05_dsh.asp

As a result of the release of this information, the Intermediaries are expected to complete preparation of NPR’s that have been delayed over the past several years.

Please feel free to contact me to discuss the implications of this release of information.

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New Member Profile – Jamie Zaniewski

Organization: Beauumont Health System
Title: Facility Contract Specialist
HFMA Member Since: September 2011
Years in current position: One Year

“Getting to Know You” questions.

1. Favorite soft drink? Fountain Diet Coke
2. Top 3 songs on your iPod? “We Are Young” by Fun, “Paradise” by Cold Play, “Set Fire to the Rain” by Adele
3. Greatest indulgence? Law and Order marathons
4. If I had time, I would like to learn: To speak Russian
5. If I had time, I would like to travel to: Eastern Europe
6. Favorite midnight snack: Zesty Dill Pickles
7. Three things you’ll always find in my fridge: skim milk, yellow peppers & ketchup
8. What is in your briefcase? I don’t own a briefcase
9. You would be surprise to know: I’m 100 % Polish
10. Greatest career achievement: Achieving meaningful employment in the sector I am most passionate about.
11. In case of fire, I would grab my: My Pitbull/Bull Mastiff George
12. Proudest moment: Receiving my Master in Public Policy from Pepperdine University
13. Favorite breakfast: Mushroom, green pepper and cheese omelet
14. Restaurant we might bump into you: Kona
15. Favorite saying: “Courage is what it takes to stand up and speak; courage is also what it takes to sit down and listen.” Winston Churchill
16. Person I would like to meet: Governor Chris Christie
17. Last book read: In the Garden of Beasts
18. Dream automobile: Porsche 911
19. Someday I hope to: Become a public servant in elected office
Efficiency Calculation Answers

Laurie McIntee, Manager of Facility Reimbursement & Hospital Pay for Performance Programs from BCBSM gave these follow-up responses to a couple of questions that were not answered at the Insurance and Reimbursement Update Meeting on March 22, 2012. Below are the two questions regarding the P4P efficiency component:

1. What will the weights be next year (7/2013) for the three year weighted average? As stated at the meeting, it will be 50%, 35% and 15% (current year to latest year) as noted in the Cost-per-Case calculations in the PDF.

2. Will the second efficient measure (CPC compared to the statewide inflation factor) be weighted similar to the first efficiency measure (CPC Compared to the statewide mean)? Yes, it will be weighted and the documentation attached provides the details.
Thank you!!

Attendees of the Insurance & Reimbursement member meeting donated 120 pounds of “healthy snacks” to Gleaners Food Bank on March 22, 2012. Diane Justewicz won the $25 gift certificate in a raffle for those who contributed. Thank you to all who donated items to this important cause.

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☐ Partnering to prevent billing rejections
☐ Healthcare Reform Transition Assistance
☐ All of the Above

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The Accountants’ Holiday List - Recap

By: Sharon Bayliss, Co-Chair
Accounting & Reporting Committee
sharon.bayliss@oakwood.org

The Eastern Michigan Financial Accounting and Reporting Committee wrapped up 2011 on November 29 with what is becoming an annual tradition, The Accountants’ Holiday List, a great presentation and accounting update provided to 45 attendees by Dave Nathan and Marc Carlson of Ernst & Young. This was the second year for the speakers to present their very timely update on new accounting guidance as most health systems and hospitals were gearing up for their year-end close or nearing the midpoint of their fiscal year.

As always, 2011 was a busy year for the FASB, and Dave and Marc had plenty of updates to provide to the group. Revenue-related guidance was a focus of a portion of their presentation, with reminders about measuring charity care for disclosure in the footnotes to the financial statements which was effective for fiscal years beginning after December 15, 2010. One of the more significant changes to revenue discussed was Accounting Standards Update (ASU) 2011-07: Presentation of Net Patient Service Revenue. This ASU made the determination that for health care entities which recognize revenue at the time of service without regard to the patient’s ability to pay, the allowance for doubtful accounts/bad debts would be presented as a deduction from net patient service revenue rather than as an operating expense. Additional footnote disclosures are also required.

Another ASU, ASU 2010-24: Presentation of Insurance Claims and Related Insurance Recoveries, is effective for fiscal years beginning after December 15, 2010, and requires that liabilities cannot be presented in the financial statements net of any anticipated insurance recoveries. Instead, there must be a gross up of the liability with a receivable recorded for the anticipated recovery amount.

Dave and Marc also spent time discussing the accounting for Medicare EHR incentive payments and the two approaches being used currently, the grant model and gain contingency model. The preferred model is the gain contingency and it requires that the incentive payments would be presented as other income in the statement of operations and not included in net patient service revenue.

Dave and Marc discussed that auditors will likely spend more time testing the valuation of the investments as the SEC and PCAOB have increased their focus on the fair value information provided by third-party pricing sources. They suggested that the hospitals and health systems start gathering information on how the securities in their portfolios are priced by their third-party sources.

One item that may save the health systems a bit of time is ASU 2011-08: Testing for Goodwill Impairment. This ASU allows companies to perform an optional qualitative assessment to determine if the traditional 2-step test is needed, which may save companies time and resources in performing the assessment. Dave and Marc cautioned that this qualitative assessment will still require quantitative support. If the qualitative
assessment indicates that it is more likely than not that the fair value of the reporting unit is less than the carrying value, the two step test must be performed.

Additional information covered included capitalized software costs, capitalizing ICD-10 costs, and an overview of some of the changes to the AICPA Healthcare Accounting & Audit Guide.

Overall, it was a great way to get caught up on the issues that would likely impact our organizations and to get ready for year-end. Please look for the presentation again towards the end of 2012 and join us for our committee meetings to get caught up on the current year developments!
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