HEALTHcents

Eastern Michigan Chapter

February 2004

Volume 1,Issue 17

President's Message

Greetings HFMA members to a new calendar year! The upcoming months will provide some exciting and challenging times as we strive to achieve our chapter goals. Membership has been steadily increasing and we are financially sound at present. We are also fortunate to have strong committee chair members, which is essential to the performance of our chapter.

One of our longtime members is moving on to bigger and better things this month. Tammy Chinavare, a current board member, has accepted a position with a hospital in New Mexico. Tammy has been a member since 1993 and has co-chaired the social committee for the past several years. She has done a great job of putting together various special events throughout the years, most notably the annual golf outing in June. We wish Tammy well in her new endeavors. Her board position will be filled as part of the upcoming elections in February.

In other news, Tom McNulty, a retired member, was kind enough to work with the Detroit Athletic Club (a current member) to obtain a room for our May 20th member meeting. This is the first time that we have ever held a meeting at this unique Detroit establishment. We are planning a fun, relaxing evening with spouses being welcome to participate. So, please mark your calendars for the 20th.

Jeff Ewald

MEMBER MEETING ANNOUNCEMENT

2004 INSURANCE AND REIMBURSEMENT UPDATE

Thursday, March 18, 2004

Holiday Inn—Livonia

Medicare Update—Marilyn Litka-Klein
Medicaid Update—Brenda Fezatte
Commercial Payor Update—Joseph Aoun
Prescription Drug Act Update—Kenneth Marcus

Larry Goldberg—Director Deloitte

For additional Information, e-mail Susan Stokes:
susan-stokes@hfma-emc.org

Mark Your Calendars!

Member Meeting
Thursday May 20, 2004
Detroit Athletic Club—5 PM
Speaker: Stan Sleight

Mark Your Calendars!

Annual Golf Outing
Thursday June 10, 2004
Tanglewood Golf Course
South Lyon

November 13, 2003 Member Meeting

Understanding the Pharmacy Benefit and Managed Care Products, the Next Generation

Members attending the November 13 meeting heard two dynamic and timely presentations. Sheldon Rich, President SJR Associates, explored the topic of Understanding the Pharmacy Benefit in Managed Care. Pharmacy costs are increasing faster than any other component of healthcare while members are insulated from these costs because of traditionally low co-pays. Some of the contributing factors to increasing pharmacy costs include, increased utilization, price increases, dose escalation, higher entry price, shift to new drugs and Direct to Consumer advertising. Other factors include drug misuse and non-compliant patients.

There are several ways for Managed Care to control these rising pharmacy costs. Benefit design including required deductibles and co-pays will contribute to a patient's awareness of the cost of drugs. A co-pay that is a percentage of the cost of the drug is particularly effective. A three-tier co-pay design, generics, brand formulary, and non-brand formulary, is becoming increasingly popular. Four and five-tier co-pays, which add consideration for acquisition costs and biotech drugs are not far in the future. Benefit design may also include coverage exclusion, generic substitution and limited provider networks. Use of a formulary, already practiced by 95% of HMOs, will also help to lower costs. Extending coverage to over the counter (OTC) drugs, which are cheaper than their RX counterpart is another way to lower cost. Other strategies briefly discussed are prior authorization programs, step-care protocols, drug utilization review (prospective, concurrent or retrospective) and physician pharmacy incentive programs. Patient education programs are important; however, the high turnover rate, 20% in most managed care plans, can make this effort difficult. The future will bring increased coverage and costs though at a lower rate because of shift to generic and OTC drugs. Most important are the pharmacoeconomic studies proving the cost effectiveness of pharmaceuticals.

Karen McGrath, Director of Managed Care, Corporate Revenue Management, Trinity Health, spoke about Managed Care Products, the next Generation. The change in health care coverage is a result of the higher cost of benefits, the providers' unwillingness to accept risk sharing and Managed Care's inability to manage Medicare and Medicaid at the reimbursement rates provided by the government. In addition there is consumer demand for less interference and more choice. The result is new products and designs such as consumer driven and self-directed plans, defined contribution plans, medical savings accounts, tiered networks and other health reimbursement arrangements. Another option is existing HMO/POS/PPOs with higher out of pocket costs. Under a consumer driven health care model consumers should become active participants in managing their care since they select and purchase the benefit options arranged for them by their employer. While ideally they would change their behavior this is questionable. For example, capitation did not change physician behavior. Some very early results indicate that higher co-pay, defined contribution plans and tiered networks all reduce annual costs. Medical economists predict that these products will have a 10-year life span. Potential advantages of these plans include consumer involvement resulting in improved efficiencies such as no duplicate tests, early discharge, less frequent use of ER and use of available alternatives. Potential drawbacks include higher administrative costs and consumer confusion because of complex plan design. In addition, costs could actually increase if only healthy employees select these products. Potential implications for providers include diligence when working with health plans regarding product variations. Providers will need to improve patient processes and communication by verifying eligibility, collecting patient payments, providing information and possibly justifying the costs of care. Other potential provider implications include decrease in utilization due to patients choosing necessary care and increase in bad debt because of more patient costs. Providers can protect themselves in part by developing contracting guidelines, sharing best practices, implementing denial management strategies and improved decision support systems to regularly evaluate payor performance.

Consumer Driven HealthCare is offering a free, 3-issue trial. Order online at www.nhionline.net/products/cdh.htm or call 800-597-6300.

10th Anniversary—Michigan Health Law Institute
Thursday & Friday—March 4 & 5, 2003

MSU Management Education Center

Register on-line: www.icle.org/health

Healthcents Newsletter : Maryanne VanHaitsma, Editor:
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Please send all comments/questions/articles to me at the above e-mail address. See calendar for submission deadlines. Thank you for your continued support!

ACCESS THE MEMBERSHIP DIRECTORY ON-LINE
www.hfma-emc.org

WELCOME NEW MEMBERS

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What does the future hold for Healthcare?

Some random thoughts supplied from different sources.

- It is going to get more complicated, confusing and chaotic before it gets simpler, easier and better. Remember that HIPAA was supposed to make it simpler.

- For profit hospitals are winning the race. Specialty hospitals without Emergency Rooms located in high income areas will really make big money. All of these successes will take away from Non-profit Hospitals, especially those who serve the poor. My source for this projection was CMS Health Care Industry Market Update of July 14,2003.

- Patient Accounting: less people but more smarts. Less service support personnel but those who remain will be system conscious experts. Remember the days of filers, typists, billers, and input people. As we go electronic the need for systems knowledgeable personnel increases. The Patient Accounting Office in the future will have fewer personnel, less paper and better qualified personnel.

- Your Doctor's second language will be English. Have you checked out how much it cost to become a Doctor. The tuition hikes of 10% or more hit aspiring physicians, if fact they go to school at least twice as long. Physicians net earnings are going down. But malpractice is going up. This means our young people with the skills and abilities will become Engineers. According to USA Today the "…number of admissions to medical school has dropped for the sixth year in a row." In the last five years the numbers are off by more than 25%.

- We will go full circle and return to Government Hospitals. Thank you Jennifer Granholm the DMC really needed the money. Yes, the DMC takes care of the poor, the indigent and the desperate and they cannot survive on miserable Medicaid payments. Actually, all hospitals cannot survive on the measly Medicaid money. A long, long time ago in a land far away, I worked in a public hospital called Wayne County General Hospital. This was a large healthcare provider to the Western Wayne County communities. Our customer base was 40% Medicaid and 40% indigent care. The Wayne County Government picked up the difference.

Apparently we are going full circle.

MEDICARE THE RULE AND THEN THERE ARE MORE RULES AND SO ON AND SO ON …

Please take a few minutes to read this overview of Medicare documentation. The article is intended for all to read so you can gather the diverse and comprehensive information that Patient Financial Services must stay abreast of.

Or maybe we could say to bill Medicare please review the following documents and updates: CMS Manuals, Medicare Memos, CMS Transmittals, CMS Memoranda's, UGS Hot Topics, LMRP Policies, National Coverage Determinations.

All HFMA members want to comply with the rules, policies and regulations of Centers for Medicare & Medicaid Services. We wish to keep our Clinical Directors informed but the information flow from CMS seems very complicated. It is!

I have made an attempt to simplify and identify a process for compliance dissemination. I will do so by defining each of the CMS resources and suggesting a course of distribution.

CMS Manuals: They come in two forms paper and electronic. Our CMS Manual fits in two very large binders. I recommend you use it for reference or research but don't try to read it. There is a continuous flow of updates to the manual that come in the form of Transmittals. Please don't even try to share this with Clinical Directors unless a specific issue is of concern.

CMS Transmittals: http://cms.hhs.gov/manuals/memos/comm_date_dsc.asp; Are updates to the CMS Manual. This is a more manageable collection of information. I recommend you share your updates with Clinical Directors when it directly relates to their areas CMS had 30 Transmittals for November 2003. Transmittals are for all manuals: Nursing Homes; Hospitals; Home Health Agencies; Mental Health Facilities and so on. What we are looking for are "PUB 10 or PUB 100" hospitals.

CMS Memoranda's (aka PMS): are similar to Transmittals but not specific to a specific manual. *http://cms.hhs.gov/manuals/memos/comm_date_dsc.asp* .. Think of PMS as a policy or procedure guideline in general terms. Information in Memoranda's may help clarify the confusion from reading the manual or the updated Transmittals. This to can be shared with appropriate clinical areas.

Medicare Memos: *http://www.ugsmedicare.com/*. Now we are into some serious fun reading. Not only do I read it cover to cover but we copy relevant sections to share with other departments. This gives us the "heads up" to what is happening at CMS. The good news is the Medicare Memo comes only once a month. The bad news is you now have to download and print it your self. It varies in length from 35 to 180 pages.

UGS Hot Topics: http://www.ugsmedicare.com/HotTopics/HotTopicsIndex.asp; This is an internet site to visit daily. United Government Services (UGS) is our contracted intermediary for Medicare. The Hot Topics are defined by UGS as a "short notice of significant impact". This is an area I often print updates and distribute to relevant clinical, accounting or billing areas.

LMRP or Local Medical Review Policies: *http://www.ugsmedicare.com/LMRP/LMRP_Main_Index.asp*
The Local Medical Review Policies identifies unique requirements for our intermediary (UGS). This can be an interpretation or definition of any of the above as required by our (Michigan) intermediary. These policies can vary from intermediary to intermediary. UGS has comparatively few LMRPs compared to other Medicare intermediaries. I expect that 2004 we will see a notable increase in the number of LMRPs released.

National Coverage Determinations: *http://www.cms.hhs.gov/coverage/default.asp* National Coverage Determinations are the most recent addition to the CMS documents. National Coverage Determinations are policy statements to all providers. CMS is attempting to overview all the intermediaries and their unique LMRPs that may conflict or be silent on issues CMS wants known.

There are many publications that can be purchased and consulting groups willing to be contracted to aid you through the maize of information. At Chelsea Community Hospital we use a team approach.. Two of my Team Leaders work with me to ensure we recognize the impact of the information and make the proper distribution. In addition our Executive Vice President review the Medicare Memo in detail for emphasis on distribution.

Every Healthcare Organization needs to identify their key people to monitor and share the information to be a successful and compliant participant with CMS.

David Cavell, CHFP
Business Office Director
Chelsea Community Hospital

hfma
Eastern Michigan Chapter

CHAPTER CHAMPIONS
SPONSORSHIP PROGRAM
2003 – 2004

Last year, the corporate sponsorship committee developed a variety of levels that allows advertising your firm or product though our website, newsletter or educational programs. Building upon the Chapter Champion sponsorship program, we again offer this opportunity. You could be a SUPERSTAR, a WINNER, a PLAYER or a SPONSOR for the Website, an Educational Program or Newsletter.

Contact Shelley Lake (248) 544-2300 at slake@voyager.net or Deborah Sieradzki at (586) 292-6446 at sieradeb@yahoo.com for more information.

February Special - Two ¼ page Newsletter Advertisements (with a link to your website) for only $400.

Call or e-mail as space is limited.

The Revenue Cycle Diet

As patient financial services professionals, you have a decision to make. Is it time to put your organization on a revenue cycle diet? To begin the Revenue Cycle Diet, you won't have to worry about low carbs, low fat, calories, portions, points, or cholesterol. You won't need to go to a meeting, get weighed, or join a gym. Just like losing weight, the Revenue Cycle Diet is a life-style change-and not always a simple one.

So how is the Revenue Cycle Diet like a weight-loss plan? Simply put, you must reduce your intake, eliminate old habits, increase your energy, and monitor your progress. It sounds so easy, and yet it is so difficult. Just as in the weight-loss industry, millions of dollars are spent yearly on products, books, and services designed to help ensure that your revenue cycle "diet" succeeds.

The Revenue Cycle Diet starts with realizing that we have starved registration points, our clinical staff lack complete knowledge of revenue generation, and inadequate charging processes are in place in our healthcare facilities. Our focus has been on billing and receivables management staff, collection techniques and "bill scrubbers," and consulting engagements. We've evolved from the accounting department, to the business office, to the patient accounting department, to the patient financial services department, and now to the revenue cycle. Along with the departmental name changes, the management styles have also changed. Properly registering a patient is like remembering to eat breakfast when you're trying to lose weight-it provides a foundation for the rest of the process. Proper registration of a patient is absolutely the most critical function at your facility. In the first steps of the Revenue Cycle Diet, we are eliminating old habits, increasing energy, and monitoring progress. In too many facilities, the registrar position is a low-level, "starting" position that doesn't pay well. The person often receives inadequate training. How registrars are paid and trained is critical to the revenue cycle diet.

We immediately need to rethink the registrar position, paying attention to the unique responsibilities and skills required. Requirements and responsibilities are being added daily to the registrar's job description (e.g., point-of-service collections, knowledge of a multitude of payers, prior approvals, authorizations, and financial counseling). Start now, start today, and start with registration. The following "recipes" can help you succeed. Use of the recipes involves incorporating your particular ingredients (urban, rural, large, small, union, non-union) and sharing the recipes with the complete revenue cycle team. Just like breakfast, start at the beginning.

Recipe I for Registration Success

1. Review registrar job descriptions (watch upcoming PFS Forum News for examples of revenue-cycle job descriptions) and update them appropriately based on responsibilities and experience levels
2. Review salary levels for registrar positions with comparable positions having similar responsibilities. Update levels of pay to correspond with those of comparable positions (union facilities may need to review contracts).

Mix together staff from human resources, finance, an existing "star" registrar, and a new registrar. Marinate over an agreed-upon time frame and serve new job descriptions and pay levels to the staff.

Recipe II for Registration Success

1. Hold three or more meetings with all registrars to discuss planned changes to their positions and responsibilities so that rumors are dispelled and the correct information is presented.
2. Establish a three-month monitoring period with specific monitoring points (based upon the responsibilities outlined in job descriptions and agreed-upon critical errors) before new salary increases take effect. Promise retraining for areas not meeting established point levels during the three-month period.
3. Retraining should include at least two shifts spent with the accounts receivable staff, customer service, and billing. Retraining must also include one class on the uniform bill and how the registration data collected flows to a claim form. Registrars should be accountable for and correct their own mistakes. Be warned that a focus on accountability may cause some registrars to look for jobs elsewhere. Look at it as an opportunity to fill those positions with qualified staff.

Recipe III for Registration Success

1. Establish a monitoring chart (include the starting point and percentage of critical errors at the start of the monitoring period). These figures are available, but you may need to dig deep within your information system to produce them.
2. Place the chart in an area that is seen daily by staff and be diligent about updating the chart weekly.
3. Base reviews on individual monitoring points and revise retraining and/or discipline as appropriate. Making the Connection.

I began my career as a registrar on the second shift in the emergency room (not a department-a room) at Bronson Methodist Hospital in Kalamazoo, Mich. I learned the hard way to "do it right the first time." My healthcare career began B.C. (before computers and self-correcting typewriters), when errors made in registration had to be manually corrected, not once but 17 times. My training taught me minimal triage skills (airway, bleeding, circulation) and how to complete a 17-part form. Every, and I mean every, box on the form had to have an answer. The format of the form satisfied the billing requirements of that era, and we were shown how the data elements translated to the billing form used. I realized how important the questions asked in registration were, and because I understood their specific purpose, I tried hard to gather the information needed and to identify what information I could not obtain from the patient.

Every registrar must understand that the information they gather serves a purpose, and the purpose supports their paycheck. A walk-through of the process of what happens to collected patient data can be helpful for a new registrar and maybe even for some seasoned staff in your facility today. Could you actually follow the process?

So take a little time, slow down a bit, eat breakfast, and begin your journey to success on the Revenue Cycle Diet.

Shelley Lake serves on H.F.M.A.'s PFS Forum, is a member of the Patient Accounts/Revenue Cycle Committee, Eastern Michigan Chapter and the State Uniform Billing Committee. She actually practices what she preaches. She can be reached via email at slake@artusmrm.com

THE LATEST ON NEW CODE SETS

By John Hawkins, QuadraMed Affinity Financial Product Manager, member Virginia Chapter HFMA

At the recent WEDI (Workgroup for Electronic Data Interchange) meeting in Washington, Ms. Pat Brooks of CMS facilitated a session focusing on the pending migration to the use of ICD-10 codes.

The transition to ICD-10 codes, a code set included in HIPAA and its processes, is just beginning its trip down the regulatory path. It was just a few weeks ago the National Committee on Vital and Health Statistics (NCVHS) finally agreed that ICD-10 codes would become a HIPAA acceptable code set.

With this decision, the next step in the process is the publication of a Notice of Proposed Rule Making (NPRM) with its corresponding comment period.

Currently, there is no estimate when the NPRM might be published. Ms Brooks indicated that the implementation would occur on October 1st to coincide with the yearly DRG changes. She pointed out that moving to ICD-10 would potentially open the door to the use of severity adjusted DRGs by CMS.

According to these recent discussions, the earliest the ICD-10 code set could be implemented would be October 2007 with the possibility that it might be October 2008 or later. This change includes the migration to ICD-10-CM for diagnosis codes and ICD-10-PCS for procedures. The change only affects inpatients. CPT/HCPCS will continue to be the code sets used for outpatients.

The migration to ICD-10 from ICD-9-CM means coders will need to use the 120,000 diagnosis codes compared to 13,000 for ICD-9-CM. They will also need to use 200,000 procedure codes versus today's 4,000. Using these expanded code sets allows for much more specific coding of diagnosis and procedures. It also provides a more accurate portrayal of the patient's treatment.

A Blue Cross/Blue Shield Association study estimates that industry costs to make this code set change will be between six and fourteen billion dollars.

As the HIPAA process puts the new code set in use, we all should stay tuned to the latest details of this significant change affecting our industry.

Keep recruiting those new members. The Member-Get-A-Member recruiting incentives continue through April 30, 2004, and include HFMA apparel items, gift certificates, and a chance to receive $2,500 cash.

Recruit... and Win...
~ 1 or 2 new members - Your choice of an HFMA apparel item (worth approximately $25)

~ 3 or 4 new members - $100 gift certificate redeemable at hundreds of brand-name merchants plus an entry for each member you recruit into a $1,000 cash prize drawing

~ 5 or more new members - $150 gift certificate redeemable at hundreds of brand-name merchants plus an entry for each member you recruit into a $2,500 cash prize drawing

NEW!! For every member recruited from June 1, 2003 through April 30, 2004, receive one entry into the drawing for our new ULTIMATE REWARD -- a $5,000 travel gift certificate from Tower Travel!

Visit www.hfma.org/members/strength for full details.

The Eastern Michigan Chapter is also offering a free golf outing registration to the member who recruits the most new members for our chapter this year. Visit the website www.hfma.org/join or call 800-252-hfma, ext. 2 for more information.

Kristi Nagengast
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Eastern Michigan Chapter 2003-2004 Calendar

FEBRUARY

2-19-04	I & R Committee Meeting (Robbins Executive Park West, Troy; 8:30AM)
2-23-04	Healthcents material submission deadline
2-25-04	FADS Committee Meeting (St. John, 28000 Dequindre; 8:30AM)

MARCH

3-10-04	Internal Audit Committee (St. John, 28000 Dequindre; 3:30 -5PM)
3-18-04	Member Meeting - Insurance and Reimbursement Annual Update (Holiday Inn Livonia West; 8AM)
3-18-03	Membership Committee Meeting (following member meeting)
3-22-04	Healthcents material submission deadline
3-23-04	Physician Practice Committee Meeting (St. John, 28000 Dequindre; 9AM)
3-24-04	FADS Committee Meeting (St. John, 28000 Dequindre; 8:30AM)

APRIL

4-07-04	Managed Care Committee Meeting (St. John, 28000 Dequindre; 8:30AM)
4-07-04	Internal Audit Committee (St. John, 28000 Dequindre; 3:30 -5PM)
4-15-04	I & R Committee Meeting (Robbins Executive Park West, Troy; 8:30AM)
4-19-04	Healthcents material submission deadline
4-19-04	"Principles of Hospital Reimbursement" Seminar, Providence Hospital—Southfield (9-5) horwitz@oakland.edu
4-20-04	"Medicare Hospital Cost Report Workshop", Providence Hospital—Southfield (9-5) horwitz@oakland.edu
4-21-04	FADS Committee Meeting (St. John, 28000 Dequindre; 8:30AM)

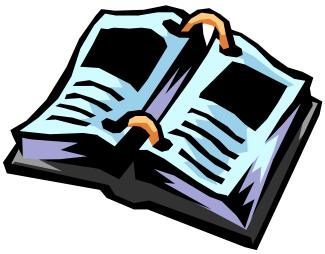
MAY

5-12-04	Internal Audit Committee (St. John, 28000 Dequindre; 3:30 -5PM)
TBD	Member Meeting (Detroit Athletic Club - Evening Meeting)
	Membership Committee Meeting (Prior to member meeting)
5-20-04	I & R Committee Meeting (Robbins Executive Park West, Troy; 8:30AM)
5-24-04	Healthcents material submission deadline
5-25-04	Physician Practice Committee Meeting (St. John, 28000 Dequindre; 9AM)

JUNE

6-9-04	Internal Audit Committee (St. John, 28000 Dequindre; 3:30 -5PM)
6-10-04	Annual Golf Outing – Tanglewood Golf Course – South Lyon

MARK YOUR CALENDARS!



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