hfma Eastern Michigan Chapter
healthcare financial management association

# HealthCents

April 9, 2010
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Chapter Web site: www.hfmaemc.org

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MAKING IT Count

## President's Message

*By: Elyse Berry, FHFMA*

Greetings! It seems like every time I begin to write one of these messages, I am knee deep in some nerve wracking sports event----such as March Madness. Our Spartans certainly provided some excitement for us. I'm sure my heart stopped a couple of times!

What a wild couple of weeks as well in the health care industry. In the same weekend, we all heard the breaking news about the DMC sale to for-profit Vanguard Health Systems. Then Congress passed the health care reform bill. It is too early to tell what these changes will all mean to our industry, but I am sure the coming months will prove to be interesting.

The Chapter is also a flurry of activity this time of year. As the HFMA "year" is May 1 to April 30, we submitted tons of documentation for several Yerger Awards. We are in the process of completing our required reporting for year-end to assure the Chapter meets all of its goals, as well as finalizing the last educational programs for the year. This year the Chapter will submit four individual chapter and two multi-chapter Yerger Award submissions. Many thanks to Maria Abrahamsen, who led the project, along with others who have contributed to the submissions. Special thanks to all of our chapter volunteers who did such fine work to allow us the many submissions. The Chapter will receive word on the awards in May and receive them at ANI. If all goes well, we will need a big wagon to carry them all. To date, the Chapter is expected to complete the year meeting all of its goals assigned by National. Membership is currently at 618, with our goal for the year being 597. As we began the year our membership numbers dropped to 525. I must admit this was the goal that felt the most challenging---given the state of our economy and hospital cutbacks. Yet here we are through the great work of our Membership Committee---with higher than expected members. We are seeing new members from various hospital institutions and related industries, adding to the organizational diversity of our Chapter.

The results of our recent election are in. I want to congratulate the recently elected chapter officers and board members. Thank you for your commitment to the Chapter and your fellow members. For a list of the newly elected officers and board members, see page 2. Please give the new leaders your support and cooperation so we can keep the Chapter strong. At

Please see **President's Message** on page 2

**President's Message** from page 1

this time, I would like to extend thanks to two board members who will be leaving the Board, Mike Berryman and John Napiewocki. I am pleased that Mike will remain as co-chair of the Membership Committee and John will continue as Co-Chair of the Revenue Cycle Committee even though both are devoting time to new career endeavors at this time.

As I wind down this message and my year as chapter president, I want to say how honored I have been to serve in this role and the many other roles leading up to it. The Eastern Michigan Chapter rocks!!! I so appreciate the enthusiasm and fine work of the team of volunteers who have supported me. The past presidents, officers, board, committee co-chairs, and Susan Stokes, our administrative assistant, are the best group anyone who could ask for. With my new title of ***past president*** fast approaching, I want you all to know you have made this year go so smoothly and I owe you big time for all you have done.

Please be sure to join us for our Member Meeting in May with two outstanding speakers, Richard A. Swenson, MD, health care futurist, and our own Terry Moore, author and local health care leader. If you have heard Terry before, you know he is always entertaining and provides practical information to use in our work and personal lives. This time Terry will introduce us to his new book, "Reflections in the Rearview Mirror," which includes insights from well-known local and national hospital leaders. Dr. Swenson will focus on the issues of sustainability, self-care, and productivity. He will provide words of wisdom expected to inspire us to maintain high morale and passion in all we do.

At the meeting, we will also present chapter awards to many members and install the new officers and board. We certainly would like the support of the membership during this important event. I hope to see you there.

## Congratulations to our Newly Elected Officers & Board

2010 -2001 OFFICERS

*President*
Maria B. Abrahamsen, JD
mabrahamsen@dykema.com
*President-Elect*
Mark A. McIntosh
mmcinto1@hfhs.org
*Secretary*
Suzana Dimic
dimics@trinity-health.org
*Treasurer*
Amy Vandecar, CPA
avandec1@hfhs.org
*Assistant Treasurer*
Sara McGlynn, CPA
saramcglynn07@gmail.com

2010-2012 BOARD MEMBERS

Cheryl Comeau
comeauclc@comcast.net
Robert J. Dery, CPA
bob.dery@plantemoran.com
Donna M. Kopinski, CPA
dkopinsk@mcrmc.org
Michael A. Marulli
mmarull1@hurleymc.com
Christina M. Wong, FHFMA
wongcm@trinity-health.org

# Up Front - Editor's Letter – "Change and Acceptance"

*By: Maryanne VanHaitsma*
*Detroit Medical Center*
mvanhait@dmc.org

I think we have all chosen a dynamic profession in a challenging state! Ours is a business that continually evolves. We all recognize the challenges living and working in Michigan with the highest unemployment rate in the country. We all know of people who may be unemployed due to the auto industry, directly or indirectly. We are all grateful for our continued employment and health. Imagine if you were unemployed and had health issues to deal with? What does healthcare reform mean to all of us? We watch and hear everyday about the challenges faced by the population of people who do not have health care coverage. We feel the pain of the small businesses that struggle to make ends meet and worry about the cost of providing healthcare to their employees. I personally know of families in my suburban neighborhood that have children on Medicaid because both parents are unemployed, and this is the only option that they can afford. Every day I am grateful for the health of my family and continued employment. I am proud to work for a healthcare organization that continually works through the challenges that we all face. Is there ever one right answer? Can we solve the problems of the world? Doing nothing will never solve any problems, but making changes, no matter how small, can only help us move forward. A sense of community is never more important than today as many people continue to struggle with the basic in their lives. Gone are the days of the ostrich. We cannot continue to bury our heads in the sand. We look around and try to change the things that need to change. Even simple things like instilling and reiterating the importance of being green and recycling to our children. Educating them on the importance of living healthy lives. Working on our sense of community by starting with our co-workers and neighborhoods. I remember the phrase used by various parents at my children's school…It takes a village…" Working together towards common goals can only help all of us. Start small, but dream big!

**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 Maryanne VanHaitsma mvanhait@dmc.org or Jo Ann Roberts JRoberts@beaumonthospitals.com. Next HealthCents deadline is May 14, 2010.

# Is There a Doctor in the House? (When is Physician Supervision Required in a Hospital Outpatient Department?)

*By: Maria Abrahamsen*
*Dykema Gossett, PLLC*
MAbrahamsen@dykema.com

Beginning with the introduction of the APC system for Medicare hospital outpatient payment in 2000, CMS has been addressing in greater detail the requirements for physician supervision of hospital outpatient services. Effective for 2009, CMS tightened its requirements for physician supervision of therapeutic services on the main campus (one of CMS's infamous policy "clarifications"). The industry pushed back, and the physician supervision requirements for 2010 have been modified. Following is a summary of the 2009 and 2010 standards. Remember – if the required level of physician supervision is not present, the service is not covered by Medicare. This is an area ripe for inadvertent non-compliance.

CMS's physician supervision standards distinguish between services that are performed on the hospital's main campus versus in off-campus provider-based departments, and between therapeutic[1] and diagnostic services.

**2009**

| | ***On-Campus*** | ***Off-Campus*** |
|---|---|---|
| ***Therapeutic*** | *"Direct" physician supervision required in the hospital, and in each separate provider-based department (which apparently is a department in a building without inpatient beds)* | *Same as on-campus except there is no presumption of compliance. Separate physician is required in each provider-based department* |
| | *Physician is "presumed" to be present in the hospital (although not an exemption); no presumption of compliance for on-campus provider-based departments.* | *No presumption of compliance* |
| | *Physician must be "immediately available" (not defined) "throughout" the procedure/service (i.e., as long as patients are being treated at the site)* | *Same as on-campus* |

[1] These are services covered by Medicare as "incident to" the services of a physician, such as chemotherapy, surgery, radiation therapy and emergency. A service that is covered as a separate benefit category, such as physical therapy, is not subject to the physician supervision requirements outlined above. Cardiac and pulmonary rehabilitation are separate benefits and require direct MD or DO supervision.

| | | |
|---|---|---|
| | *NPPs[2] may not supervise* | *Same as on-campus* |
| | | |
| ***Diagnostic*** | *Hospital policy defines physician supervision standards. (However, in provider-based departments located on main campus, off-campus standards apply)* | *Physician supervision as required under the Medicare Physician Fee Schedule (i.e., "general," "direct," or "personal" is specified for each test)* |
| | | |
| | *NPPs may not supervise* | *Same as on-campus* |

**2010**

| | ***On-Campus*** | ***Off-Campus*** |
|---|---|---|
| ***Therapeutic*** | *"Direct" physician supervision required* | *"Direct" physician supervision is required* |
| | *Supervisor may be anywhere on campus (even in a non-hospital building) so long as immediately available* | *Supervisor must be in the provider-based department* |
| | *"Immediately available" = close enough to intervene when needed, and not engaged in another activity that would interfere with availability* | *Same as on-campus* |
| | *Supervisor must be qualified and hold privileges to perform the service (e.g. merely having skills to handle an emergency is insufficient)* | *Same as on-campus* |
| | *Supervisor available throughout entire procedure/service covered by the APC* | *Same as on-campus* |
| | *NPP may supervise, within limits of license and privileges* | *Same as on-campus* |
| | | |
| ***Diagnostic*** | *All outpatient diagnostic services (including those purchased "under arrangements") must be under same level of physician supervision as required under Medicare Physician Fee Schedule* | *Same as on-campus* |
| | *If "direct" supervision is required for a test, defined same as for on-campus therapeutic service* | *If "direct" supervision is required for a test, defined same as for off-campus therapeutic service* |
| | *NPPs may not supervise (except clinical psychologists for certain tests)* | *Same as on-campus* |

[2] "NPP" = specified non-physician practitioners, including physician's assistants and advanced practice RNs.

Please see **Doctor in the House** on page 6

We anticipate CMS will need to respond to multiple questions regarding application of the new rules/interpretations, such as:

1. What constitutes the "service" during which the supervisor must be present? For example, does it include administration of medications prior to the service?

2. What constitutes an off-campus provider-based "department"? If multiple services are offered in a single off-campus ambulatory building, is each a separate "department" that requires a separate supervising physician?

Hospitals need to monitor their compliance with the revised Medicare requirements, including confirming that the supervising practitioner holds the necessary qualifications and clinical privileges.

# Membership Committee News

*By: Christina Wong and Michael Berryman*

HFMA New Membership Discounts on Extended Membership – Encourage Your Colleagues to Join!

The extended membership option provides new members the opportunity to extend their HFMA membership through May 31, 2011, and save on their membership dues at the same time. There has never been a better time for new members to join HFMA. Encourage your colleagues to join!

Information can be found at:

http://www.hfma.org/membership/applications/

## 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.

**Rajeeva Sinha,** Associate Professor
Odette School of Business
rsinha@uwindsor.ca

**Patrick Fuelling,** Director
Doeren Mayhew
fuelling@doeren.com

**James L. Hughes**
Dickinson Wright PLLC
jhughes@dickinsonwright.com

**Donna I. Wesley**, Senior Manager – Financial Analysis & Treasury
UAW Retirees Medical Benefits Trust
dwesley@rhac.com

**Linda Alexander,** Administrative Director PAC & Physician Services RIM
Detroit Medical Center
Lalexand4@dmc.org

**Mark Glenn**
mglenn@mail.walshcollege.edu

**Keri M. Reffet,** Vice President/Partner
Ally Services, Inc.
kreffet@allyservicesinc.com

**Fang Gong,** Research Assistant
juliegon@umich.edu

**Brianne Dzwonek**
dzwonekb@umich.edu

**Jeffrey Rowe**, Associate
St. John Health System
jeffreydrowe@gmail.com

**Transfer from Northwest Ohio Chapter**

**Lawrence Kuk**
Larrykuk2000@yahoo.com

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# HFMA Night at Comerica Park

## The Detroit Tigers vs. the Texas Rangers

## DATE: Tuesday, July 20, 2010

## TIME: 7:05 pm start

**50 tickets will be available soon, on a first come-first serve basis**
**Networking session at Nemo's in the back room starting at 5:00**
**(includes a shuttle ticket to the ball park from Nemo's)**

**An email will be sent when tickets are available for purchase.**

# Retirement Luncheon November 4, 2009

Retirement luncheon attendees in the photo left to right:

- Jon Haber
- John Kelly
- Jack McClary
- Tim Grajewski
- Elyse Berry (current HFMA president)
- Ron Horwitz
- Cathy Brunkey
- Jerry McDonald
- Dennis Currier
- Frank St Onge
- George Kuliurgis
- Dave Flory

Bob Jarvis also attended, but is not in the picture. Please watch your email for the 2010 Retirement Luncheon. If you are retired and would like to be added to the listing, contact Susan Stokes at susan-stokes@comcast.net

# Newsletter Committee Member Profile – Jason Pulis

Organization works for: **Unified Revenue Organization for Trinity Health**

Title: **Senior Financial Analyst (Reimbursement)**

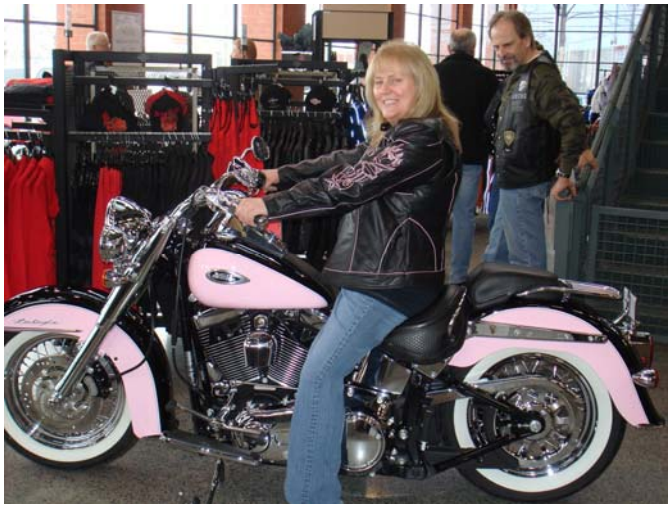
HFMA Member Since: **June 2009**

Years in Current Position: **10 Months**

Joined HFMA because: **Professional learning & Networking**

1. Top 3 songs on your iPod? **Imma Be, Hollywood Nights, Cowboy**
2. Greatest indulgence? **Dark Chocolate**
3. If I had time, I would like to learn: **Spanish**
4. If I had time, I would like to travel to: **Hawaii**
5. Favorite breakfast: **Bacon and eggs**
6. Restaurant we might bump into you: **Buddy's Pizza, Grand Azteca, or Firenze's**
7. Last book read: ***Takedown***

# Social Activities & Financial Accounting and Reporting Committee Member Profile – Sherrie White



Organization works for: **William Beaumont Hospital for Ambulatory**

Title: **Financial Analyst**

HFMA Member Since: **April 2007**

Years in Current Position: **9**

Joined HFMA because: **Networking**

"Get to Know You" questions:

1. Favorite soft drink? **I don't drink pop, but I love Starbucks Iced Green Tea**
2. Top 3 songs on your iPod? ***Something in your mouth*** **by Nickelback,** ***Wild Mountain Honey*** **by Steve Miller Band,** ***Kashmir*** **by Led Zeppelin**
3. Greatest indulgence? **Buying a motorcycle**
4. If I had time, I would like to learn: **To speak Spanish**
5. If I had time, I would like to travel to: **Hawaii**
6. Favorite midnight snack: **Cashews**
7. Three things you'll always find in my fridge: **Pickles, eggs, lettuce**
8. What is in your briefcase? **Nothing**
9. You would be surprised to know: **I went sky diving**
10. Greatest career achievement: **Getting my degree at the ripe old age of 40.**
11. In case of fire, I would grab my: **Cat**
12. Proudest moment: **I have two, my son Michael and my daughter Amber**
13. Favorite breakfast: **Eggs, turkey sausage and rye toast**
14. Restaurant we might bump into you: **Mr. B's**
15. Favorite saying: **Sorry can't say, my peers will be reading this**
16. Person I would like to meet: **Cher for she has stood the test of time**
17. Last book read: ***The Boleyn Inheritance*** **by Phillippa Gregory**
18. Dream automobile: **Jaguar**
19. Someday I hope to**: Take a trip out west on my motorcycle**

# Key Healthcare Reform Provisions Affecting Providers

*Article Submitted By: Plante & Moran, PLLC, 27400 Northwestern Highway, Southfield Mi 48034*
*Website: www.plantemoran.com*

The Senate is currently considering the Health Care and Education Affordability Reconciliation Act of 2010, also known as the Reconciliation bill (H.R. 4872), which is legislation intended to modify certain provisions to the Patient Protection and Affordable Care Act (H.R.3590) signed into law by President Obama on March 23, 2010.

**View a side-by-side comparison of the two bills on page 14 and 15.**

Here's a quick summary of the anticipated final legislation after reconciliation:

- 32 million additional Americans will be covered by healthcare insurance
- $940 billion estimated cost over 10 years ($69 billion more than H.R. 3590)
- $196 billion in reduced Medicare scheduled payments

Administrative simplification:
Simplify health insurance administration by adopting a single set of operating rules for eligibility verification and claims status (effective January 1, 2013), electronic funds transfers and health care payment remittance (effective January 1, 2014), health claims, enrollment and disenrollment in a health plan, health plan premium payments, and referral certification and authorization (effective January 1, 2016).

Medicare:

- Allow providers organized as accountable care organizations (ACOs) that voluntarily meet quality thresholds to share in the cost savings they achieve for the Medicare program. Shared savings program established January 1, 2012.
- Reduce Medicare payments to hospitals by specified percentages to account for preventable hospital readmissions for the three conditions with risk adjusted measures currently endorsed by the National Quality Forum. Effective October 1, 2012.
- Establish a national Medicare pilot program to develop and evaluate paying a bundled payment for acute, inpatient hospital services, physician services, outpatient hospital services, and post-acute care services for an episode of care. Effective date for establishing pilot program is January 1, 2013; expand program if approved by January 1, 2016.
- Create the Independence at Home demonstration program to provide high need Medicare beneficiaries with primary care services in their home and allow participating teams of health professionals to share in any savings if they reduce preventable hospitalizations, prevent hospital readmissions, improve health outcomes, improve the efficiency of care, reduce the cost of health care services, and achieve patient satisfaction. Effective January 1, 2012.
- Establish a hospital value-based purchasing program in Medicare to pay hospitals based on performance on quality measures and extend the Medicare physician quality reporting initiative

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beyond 2010. Effective October 1, 2012. Develop plans to implement value-based purchasing programs for skilled nursing facilities, home health agencies, and ambulatory surgical centers. Reports to Congress due January 1, 2011.
- Provide payments totaling $400 million in fiscal years 2011 and 2012 to qualifying hospitals in counties with the lowest quartile Medicare spending.

Medicaid:
- Create new demonstration projects in Medicaid to pay bundled payments for episodes of care that include hospitalizations (effective January 1, 2012 through December 31, 2016); to make global capitated payments to safety net hospital systems (effective fiscal years 2010 through 2012); to allow pediatric medical providers organized as accountable care organizations to share in cost-savings (effective January 1, 2012 through December 31, 2016); and to provide Medicaid payments to institutions of mental disease for adult enrollees who require stabilization of an emergency condition (effective October 1, 2011 through December 31, 2015).
- Provide states with new options for offering home and community-based services through a Medicaid state plan rather than through a waiver for individuals with incomes up to 300% of the maximum SSI payment and who have a higher level of need, and permit states to extend full Medicaid benefits to individuals receiving home and community-based services under a state plan. Effective October 1, 2010.
- Expands Medicaid to 133% of Federal Poverty Limit, and utilizes a revised definition of income to cover additional people.

Skilled Nursing Facility Requirements
- Require skilled nursing facilities under Medicare and nursing facilities under Medicaid to disclose information regarding ownership, accountability requirements, and expenditures. Publish standardized information on nursing facilities to a website so Medicare enrollees can compare the facilities. Effective dates vary.

Requirements for Non-Profit Hospitals
- Impose additional requirements on non-profit hospitals to conduct a community needs assessment every three years and adopt an implementation strategy to meet the identified needs, adopt and widely publicize a financial assistance policy that indicates whether free or discounted care is available and how to apply for the assistance, limit charges to patients who qualify for financial assistance to the amount generally billed to insured patients, and make reasonable attempts to determine eligibility for financial assistance before undertaking extraordinary collection actions. Impose a tax of $50,000 per year for failure to meet these requirements. Effective for taxable years following enactment.

Plante & Moran will be distributing more specific information regarding the implications of healthcare reform legislation for hospitals and health systems via our website in the coming days. www.plantemoran.com

| Area | Senate bill H.R. 3590 | Reconciliation bill H.R. 4872 Modifications |
|---|---|---|
| **Cost Containment** | | |
| **Administrative Simplification** | Simplify health insurance administration by adopting a single set of operating rules for eligibility verification and claims status (effective January 1, 2013), electronic funds transfers and health care payment remittance (effective January 1, 2014), health claims, enrollment and disenrollment in a health plan, health plan premium payments, and referral certification and authorization (effective January 1, 2016). | No adjustments. |
| **Medicare** | Reduce annual market basket updates for inpatient hospital, home health, skilled nursing facility, hospice and other Medicare providers. Effective dates vary. | Reduce the market basket reduction in addition to the productivity adjustment as follows: -0.3 in FY 14 and -0.75 in FY 17, FY 18 and FY 19. |
| | Reduce Medicare Disproportionate Share Hospital (DSH) payments initially by 75% and subsequently increase payments based on the percent of the population uninsured and the amount of uncompensated care provided. Effective fiscal year 2015. | Reduce Medicare Disproportionate Share Hospital (DSH) payments initially by 75% and subsequently increase payments based on the percent of the population uninsured and the amount of uncompensated care provided. Effective fiscal year 2014. |
| | Allow providers organized as accountable care organizations (ACOs) that voluntarily meet quality thresholds to share in the cost savings they achieve for the Medicare program. Share savings program established January 1, 2012. | No adjustments. |
| | Reduce Medicare payments to hospitals by specified percentages to account for preventable hospital readmissions for the three conditions with risk adjusted measures currently endorsed by the National Quality Forum. Effective October 1, 2012. | No adjustments. |
| | Reduce Medicare payments to certain hospitals for hospital-acquired conditions by 1%. Effective fiscal year 2015. | No adjustments. |
| **Medicaid** | Reduce a state's Medicaid DSH allotment by 50% or 25% for low DSH states once the state's uninsured rate decreases by at least 45%. DSH allotments will be further reduced, not to fall below 50% of the total allotment in 2012 if states' uninsured rates continue to decrease. Effective October 1, 2011. | Reduce aggregate Medicaid DSH allotments by $0.5 billion in 2014, $0.6 billion in 2015, $0.6 billion in 2016, $1.8 billion in 2017, $5 billion in 2018, $5.6 billion in 2019, and $4 billion in 2020. DSH reductions will be distributed in a manner that imposes the largest reduction in DSH allotments for states with the lowest percentage of uninsured or those that do not target DSH payments, and will impose smaller reductions for low-DSH states. Effective October 1, 2011. |
| | Prohibit federal payments to states for Medicaid services related to healthcare acquired conditions. Effective July 1, 2011. | No adjustments. |
| **Waste, fraud, and abuse** | Reduce waste, fraud, and abuse in public programs by allowing provider screening, enhanced oversight periods for new providers and suppliers, and enrollment moratoria in areas identified as being at elevated risk of fraud in all public programs, and by requiring Medicare and Medicaid program providers and suppliers to establish compliance programs. Develop a database to capture and share data across federal and state programs, increase penalties for submitting false claims, and increase funding for anti-fraud activities. Effective dates vary. | Reduce waste, fraud, and abuse in public programs by allowing provider screening, enhanced oversight periods for new providers and suppliers, including a 90-day period of enhanced oversight for initial claims of DME suppliers, and enrollment moratoria in areas identified as being at elevated risk of fraud in all public programs, and by requiring Medicare and Medicaid program providers and suppliers to establish compliance programs. Develop a database to capture and share data across federal and state programs, increase penalties for submitting false claims, strengthen standards for community mental health centers and increase funding for anti-fraud activities. Effective dates vary. |
| **Improving Quality / Health System Performance** | | |
| **Medicare** | Establish a national Medicare pilot program to develop and evaluate paying a bundled payment for acute, inpatient hospital services, physician services, outpatient hospital services, and post-acute care services for an episode of care. If the pilot program effectively improves or maintains quality while reducing costs, the program will be expanded. Effective date for establishing pilot program is January 1, 2013; expand program if approved by January 1, 2016. | No adjustments. |
| | Create the Independence at Home demonstration program to provide high need Medicare beneficiaries with primary care services in their home and allow participating teams of health professionals to share in any savings if they reduce preventable hospitalizations, prevent hospital readmissions, improve health outcomes, improve the efficiency of care, reduce the cost of health care services, and achieve patient satisfaction. Effective January 1, 2012. | No adjustments. |
| | Establish a hospital value-based purchasing program in Medicare to pay hospitals based on performance on quality measures and extend the Medicare physician quality reporting initiative beyond 2010. Effective October 1, 2012. Develop plans to implement value-based purchasing programs for skilled nursing facilities, home health | No adjustments. |

| | | |
|---|---|---|
| | agencies, and ambulatory surgical centers. Reports to Congress due January 1, 2011. | |
| **Medicaid** | Create new demonstration projects in Medicaid to pay bundled payments for episodes of care that include hospitalizations (effective January 1, 2012 through December 31, 2016); to make global capitated payments to safety net hospital systems (effective fiscal years 2010 through 2012); to allow pediatric medical providers organized as accountable care organizations to share in cost-savings (effective January 1, 2012 through December 31, 2016); and to provide Medicaid payments to institutions of mental disease for adult enrollees who require stabilization of an emergency condition (effective October 1, 2011 through December 31, 2015). | No adjustments. |
| **National quality strategy** | Develop a national quality improvement strategy that includes priorities to improve the delivery of health care services, patient health outcomes, and population health. Create processes for the development of quality measures and to select quality measures to be used in reporting to and payment under federal health programs. National strategy due to Congress by January 1, 2011. | No adjustments. |
| | **Long-Term Care** | |
| **Medicaid** | Provide states with new options for offering home and community-based services through a Medicaid state plan rather than through a waiver for individuals with incomes up to 300% of the maximum SSI payment and who have a higher level of need, and permit states to extend full Medicaid benefits to individuals receiving home and community-based services under a state plan. Effective October 1, 2010. | No adjustments. |
| | Create the State Balancing Incentive Program to provide enhanced federal matching payments to eligible states to increase the proportion of non-institutionally-based long-term care services. Selected states will be eligible for FMAP increases for medical assistance expenditures for non-institutionally-based long-term care services and supports. Effective October 1, 2011 through September 30, 2015. | No adjustments. |
| | Establish the Community First Choice Option in Medicaid to provide community-based attendant supports and services to individuals with disabilities who require an institutional level of care. Provide states with an enhanced federal matching rate of an additional six percentage points for reimbursable expenses in the program. Effective October 1, 2010. | Establish the Community First Choice Option in Medicaid to provide community-based attendant supports and services to individuals with disabilities who require an institutional level of care. Provide states with an enhanced federal matching rate of an additional six percentage points for reimbursable expenses in the program. Effective October 1, 2011. |
| **Skilled nursing facility requirements** | Require skilled nursing facilities under Medicare and nursing facilities under Medicaid to disclose information regarding ownership, accountability requirements, and expenditures. Publish standardized information on nursing facilities to a website so Medicare enrollees can compare the facilities. Effective dates vary. | No adjustments. |
| | **Other** | |
| **Medicaid coverage** | Expands Medicaid to 133% of the Federal Poverty Limit. | Expands Medicaid to 133% of Federal Poverty Limit, and utilizes a revised definition of income to cover additional people. |
| **Medicare** | Provide a 10% bonus payment to primary care physicians and to general surgeons practicing in health professional shortage areas, from 2011 through 2015 | No adjustments. |
| | No similar provision. | Provide payments totaling $400 million in fiscal years 2011 and 2012 to qualifying hospitals in counties with the lowest quartile Medicare spending. |
| **Requirements for non-profit hospitals** | Impose additional requirements on non-profit hospitals to conduct a community needs assessment every three years and adopt an implementation strategy to meet the identified needs, adopt and widely publicize a financial assistance policy that indicates whether free or discounted care is available and how to apply for the assistance, limit charges to patients who qualify for financial assistance to the amount generally billed to insured patients, and make reasonable attempts to determine eligibility for financial assistance before undertaking extraordinary collection actions. Impose a tax of $50,000 per year for failure to meet these requirements. Effective for taxable years following enactment. | No adjustments. |

# Save these Dates!

**April 27, 2010**
**Annual HFMA/MACPA Healthcare Conference**
**Click on link below for brochure and to register.**

**http://www.michcpa.org/Public/Conference/Description.aspx?courseID=10HCC**

Join Michigan's healthcare authorities to learn how the latest industry news from Washington will affect organizations here at home. Timely sessions on financial reporting, technology, operations and taxation are already in place, plus we've left room to include any potential reform developments.

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**Tuesday, May 25, 2010**
**Member Meeting**

Speakers: Richard A. Swenson, MD, Futurist
&
Terry Moore, President Emeritus of MidMichigan Health

Installation of Officers and Annual HFMA Awards

MSU Management Education Center, Troy, MI

1-5PM

Registration information will be emailed.

**May 26 – 28, 2010**
**HFMA MI Chapters**
**Spring Conference**
Soaring Eagle Conference Center
Mt. Pleasant, MI

**http://www.wmihfma.org/site/files/251/74171/277421/459080/Revised_Spring_Conference_Agenda_and_Registration_**

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**Thursday, June 10, 2010**
**HFMA Annual Golf Outing**
Tanglewood Golf Course, South Lyon, MI
Shot Gun Start 10:30AM

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**Tuesday, July 20, 2010**
Annual Tiger Game Outing
Detroit vs. Texas Rangers
Game Start 7:05
Networking at Nemo's before the game.
(See page 8 for details.)

# Healthcare Reform Law: Resident Rotation to Non-provider Setting

*By: Kenneth R Marcus*
*Honigman*
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Attention Teaching Hospitals

To provide flexibility, Section 5504 of the recently enacted health reform legislation permits two or more hospitals that share the proportional costs of training in the non-provider setting to receive Medicare IME and GME, provided that they have a written agreement which shows their proportional costs.

Thus, while the original "written agreement" requirement became optional as of October 1, 2004, it now has become effective for shared training arrangements.

The effective date is cost reporting periods beginning on or after July 10, 2010. The Centers for Medicare and Medicaid Services will issue regulations implementing this provision. As soon as possible, however, teaching hospitals are well advised to enter into a written agreement which reflects each hospital's proportional cost of a shared non-provider training program.

Note as well that, although stated obliquely in the legislation, for past cost reporting periods there may be an opportunity for "jurisdictionally proper pending appeals" to be favorably settled.

Click link below for Section 5504 of Healthcare Reform

http://hfmaemc.org/Documents/5504HealthReform.pdf

Click link below for Senate Finance Committee Report

http://hfmaemc.org/Documents/SenateFinCommReport.pdf

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