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healthcare financial management association

HealthCents

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Chapter Web site: www.hfmaemc.org

President's Message

By: Maria Abrahamsen, JD

MEMBER SATISFACTION SCORES ARE IN!

Greetings Chapter Members:

In order to improve member communication and feedback, HFMA National is now surveying a sample of Chapter members annually (rather than biennially). We just received the results and are very happy to see that 60% of Eastern Michigan respondents gave the Chapter an overall score of "extremely satisfied" or "very satisfied." National's standard is that Chapters receive such high marks from at least 49% of their members. Thank you to those members who took the time to complete the survey.

We are especially proud of the quality of our local educational programming which received very high marks on the survey. The Program Committee, chaired by Rhonda Main and Diane Justewicz, is working very hard to bring high quality and high value programs to Eastern Michigan HFMA. Please check out our next member programs: ICD-10 Seminar, February 22 a.m. at Providence Southfield Also, be sure to block off the morning of March 24 on your calendar – that's the annual Insurance & Reimbursement Update – still in Novi, but at a new location – the Hilton Garden Inn.

Many thanks to our educational committees – Financial Accounting & Reporting, Financial Analysis, Insurance & Reimbursement, Managed Care, and Revenue Cycle – for the meaningful topics being shared in committee meetings, which provide attendees up-to-the-minute information about Michigan and local developments and practices. If you are not already a committee member, please contact the co-chair of a committee that interests you, or attend a committee meeting to see if it's for you (see calendar on Chapter web site for meeting information).

As mentioned above, we appreciate all those who participated in HFMA National's survey. We'd also be happy to hear from you at any time with suggestions, new ideas, and "constructive criticism." The Chapter Board and Committee Co-Chairs value your input.

Best wishes for 2011!

Maria

Inside This Issue

STEP Up

HFMA Certification Changes – The Process is More Convenient – Consider Becoming Certified

Become CHFP Certified

The CHFP Certification Program is Online January 2011

HFMA's CHFP (Certified Healthcare Financial Professional) certification is intended for mid-level healthcare professionals with a minimum of 3-5 years experience. Becoming certified distinguishes you a leader as well as a role model in the healthcare finance community. Earning the CHFP credential enhances your credibility, supports your professional development, demonstrates a high level of commitment to the field, and validates your skills and knowledge.

We've made the process of certification more convenient. Beginning January 2011 the requirements to becoming CHFP certified are:

- Active regular or advanced HFMA membership*
- The title Manager and above or equivalent
- The successful completion of one comprehensive certification exam

Also new for 2011, CHFP preparation and study materials will now be available online.

To learn more about becoming certified, visit **www.hfma.org/certification.**

To review FAQs about the program changes, visit **www.hfma.org/certificationFAQ.**

**The two year HFMA membership requirement has been dropped.*

hfma

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 March 25, 2011.

How 3 Hospitals Reduced OR Inventory Costs

The following article originally appeared in HFMA's Healthcare Cost Containment newsletter (www.hfma.org/hcc).

Learn how three organizations worked with clinicians to improve distribution and utilization of supplies—and achieved significant savings.

As one of the busiest and most strategic departments of a hospital, the operating room (OR) presents plenty of opportunity not only to generate revenue, but also to generate costs. As such, the OR is ripe with opportunity for cost savings, especially in the supply chain, where inefficient processes in distribution and utilization can add multiple thousands of dollars to inventory costs.

Medical centers that are part of the University HealthCare Consortium's Supply Chain Performance Excellence Collaborative offer examples of how their supply chain departments have helped reduce costs in the OR.

Case Example: University of Wisconsin Hospital and Clinics

Once upon a time at University of Wisconsin Hospital and Clinics (UWHC), Madison, clinicians were responsible for supply chain functions in the OR. Nurses and technicians would often put in requisitions for six months' worth of supplies to minimize the number of times they had to reorder and to ensure they would not run out of items. The result was an inefficient process in which supplies were improperly stored, sometimes having never been removed from the box in which they were shipped, and multiples of one item were purchased unnecessarily. Some items were stored so long that they expired.

Eight years ago, the health system's materials management department took over all supply chain functions in the OR—from ordering items to setting par levels—and slowly transformed the process, allowing clinicians to focus on caring for patients.

The hospital's materials management department hired eight full-time-equivalent employees (FTEs), who also manage inventory in interventional radiology and the cardiac catheterization laboratory. The new staffers began by working with OR nurse managers who were open to the idea of turning supply chain over to materials management. They shadowed nurses to see how they performed supply chain functions, taking note of what processes seemed inefficient (asking why, for example, 100 quantities of a certain item were ordered when 20 would do). Under the careful watch of the clinicians, materials management staff then began performing those functions. Eventually, materials management took over full control of supply chain responsibilities in these areas, working in an administrative area within the surgical services department and even wearing scrubs.

Materials management staff removed many items from the OR, such as expired orthopedic implants, and reduced the quantities of other items, such as heart valves (worth about $6,000 each), to more appropriate quantities. Some items were able to be returned to the supplier for credit. Removing the clutter enabled clinicians to get a better handle on what supplies they needed, but formerly did not store and now had the space to do so.

Nurses have come to rely fully on materials management to supply the medical center's 37 operating rooms, which handle 25,200 cases annually. "They just tell us, 'We want this,' and then they walk away," says Robert C. Scheuer, director of materials management/distribution for UWHC.

Using materials management staff, rather than more expensive clinical staff, to perform supply chain

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functions proved to be cost-effective as well. For example, an OR nurse is paid nearly twice as much as a materials management employee. Formerly, three clinicians ordered the same product from three different vendors; as part of this initiative, materials management staff consolidated vendors and obtained reduced costs through volume pricing. Improved planning on shipments has also reduced the cost of expedited freight charges.

Today, materials management staff handles everything from cutting purchase orders to deciding how much inventory to carry, determining necessary lead times, and weighing the value of expedited shipments. “It just does not make financial sense to have anyone but materials management staff perform materials management services,” Scheuer says.

Case Example: Denver Health

As a Level 1 trauma center, Denver Health needs to carry a full range of trauma and orthopedic implants for emergency cases. But the health system’s implant inventory became out of control, representing about three-fourths of total inventory dollars in the OR.

Two years ago, two materials management FTEs took over the supply chain functions for implants in the OR. These supply chain consultants paired their expertise in supply chain with clinical expertise to identify items that had low turnover or were unnecessary and could be reduced or eliminated.

Materials management began by tracking the use of all implants and related items in the OR over a four-month period. Then the data were analyzed to develop recommendations for par levels. Over about a year, the internal supply chain consultants worked closely with the chief of orthopedics, who reviewed each recommendation. “He basically authorized and approved our inventory levels,” says Phil Pettigrew, director of materials management for Denver Health, which has 12 operating rooms and handles 20,000 surgical cases annually.

For example, the chief of orthopedics helped identify about $250,000 worth of items such as screws, rods, and plates that were no longer needed because surgeons were using updated versions with new technology. Materials management then worked with suppliers in securing credit for the unused items.

The chief also helped materials management right-size inventory by exchanging implants in sizes that were infrequently used for implants in sizes that were used much more frequently. Materials management increased the inventory of the more frequently used sizes and reduced the frequency of ordering such items, creating a more streamlined process.

“We had the data, but we didn’t have the clinical expertise to know exactly what the inventory levels needed to be,” Pettigrew says.

In addition, materials management recently instituted a policy that all new orthopedic instrument sets stocked at Denver Health be on consignment. Overall, the initiative reduced inventory by 25 percent, for a savings of about $800,000.

Case Example: Wake Forest Baptist Medical Center

About four years ago, Wake Forest University Baptist Medical Center, Winston-Salem, N.C., began using an internal package-tracking system to track inventory deliveries—including supplies for its 40 operating rooms, in which 34,000 surgeries are performed annually. The computerized system is

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similar to the systems used by national shipping companies. Upon delivery of an item, its bar code number is scanned into the materials management information system. That number is then used to track the package to the specific area/department where it has been delivered. A handheld computer is used to record electronic signatures when the item is received. When an item is delivered to the OR, for example, the computer system notes who signed for it.

The tracking system makes distribution faster and more efficient. “It’s a more professional way of doing business,” says Sallie Simpson, RN, director of materials management for the medical center.

This same tracking system is also used to trend supply utilization. Using the electronic data, materials management staff can more easily note the frequency with which items are being ordered and determine if that amount can be changed to streamline the process. For example, if an item is being ordered every other day, materials management can meet with the OR supply manager to determine if it makes more sense to simply increase the quantity of the item, thereby reducing the number of orders. Conversely, if an item is not being replenished often, par levels may be able to be reduced.

Materials management also can more easily monitor freight expenses. For instance, if there is a pattern of certain items being ordered for overnight delivery, it may be beneficial to keep stock on hand and eliminate the expedited freight charges. Also, high-usage items are categorized with certain numbers within the materials management information system, which enables staff to more easily run queries on order and usage patterns. Before the computerized tracking system was implemented, such data had to be obtained manually—a challenging task that was only performed sporadically.

“The tracking system gives us an objective, numeric way of looking at usage trends by product,” Simpson says.

Because supply inventory is being better managed in the OR, the cost per case is now routinely within budget. If, for example, during one month more supplies were ordered than actually needed for the surgical caseload, the cost per case (the amount of supplies purchased for one month divided by the number of procedures performed that month) was artificially inflated.

Work With, Not Against, Physicians

A few years ago, in light of escalating supply costs, Wake Forest decided to consider capping costs for total knee and total hip replacements. Materials management at first tried to limit the number of vendors that sell these supplies to the organization to just two vendors, but physicians resisted, preferring to stick with the vendors they had been using.

Working with the medical center’s Total Joints Committee, materials management decided on a different approach. The Committee meets quarterly to work on issues regarding utilization, vendor and product standardization, best practices, and outcomes. In addition to Simpson, the committee includes Jonathan Kepley, the assistant manager for contracts in procurement services; a business manager from orthopedics; a clinical manager and an inventory manager from the OR; and four orthopedic surgeons.

The Committee devised a plan for reducing supply costs that would allow physicians to use their preferred vendor, if that vendor agreed to meet a certain price. Materials management sent a memo informing vendors of the rules of the new pricing structure. Orthopedic surgeons signed the memo,

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giving Wake Forest the leverage it needed to obtain vendor acceptance. “It showed that there was a partnership between physicians and materials management,” says Kepley.

The number of total joint suppliers was maintained at six vendors. The medical center saved more than $800,000 the first year the pricing structure was implemented. Surgeons have now begun making their own suggestions to improve processes and save money; one involves standardizing cement suppliers. “We’re now partners with our physicians in efforts to reduce supply costs, rather than adversaries,” Simpson says.

For more information about University HealthSystem Consortium, contact Jake Groenewold, Senior Vice President, Supply Chain, at groenewold@uhc.edu, or visit www.uhc.edu.

Membership Committee News

By: Michael Berryman & Jeana Hobart, Co-Chairs, Membership & Retention Committee

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.

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Assessing the Impact of Healthcare Reform – Insurance & Reimbursement Committee Recap

By: Jeff Ewald, CPA, MBA
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On October 28, 2011 the Insurance & Reimbursement Committee hosted an informative presentation on assessing the impact of healthcare reform. Steve Loree, Vice President of Strategic Financial Planning; hospital employer presented his reform impact model (in an Excel format) which could be used for any hospital to compute the impact on it of the Patient Protection & Affordable Care Act (H.R. 3590) signed into law in March 2010. His model first identified the inpatient payment rate reductions with a breakdown by category (DRG, DSH, Capital). It showed that market basket adjustments would be increasing at a decreasing rate, with a 4.9% overall decrease for the years 2010 to 2019 and an 11% decrease in the full market basket in 2019 alone.

The model also quantified the incremental net revenue increases related to the influx of formerly uninsured patients who would now qualify for Medicaid and insurance exchanges. These increases were based on Congressional Budget Office (CBO) estimates. Unfortunately, this additional net revenue was not enough to offset the rate decreases for the sample model hospitals that were presented. Steve also factored in the Blue Cross negative impact related to the inherent decrease in bad debt.

Next, Tony Colarossi, Partner at Plante & Moran, PLLC presented his version of a reform impact model which took Steve's model a step further beyond Medicare and Medicaid rate reductions by attempting to quantify additional potentially negative impacts for payor mix shifts, Value-Based Purchasing, Hospital Acquired Conditions, bundled payments and readmissions. Tony's model used state, county and zip code data and presented a sensitivity analysis displaying the negative impacts of patient shifts from high reimbursement payors, such as Blue Cross and commercial, to lower reimbursing exchanges. It was interesting to see his payor mix shift analysis as most of this data used may not be readily available to providers.

Tony like Steve, concluded that most hospitals will experience negative impacts from this reform legislation for years to come and must formulate plans with their financial leaders in order ready themselves. Tony explained that hospitals should strongly consider joining an Accountable Care Organization (ACO) and formulate subcommittees around the areas of bundled payments, continuing care, and readmissions.

Steve may be contacted at sloree@dmc.org and Tony at Anthony.v.colarossi@plantemoran.com with questions. In addition, Steve has made is model available to providers who desire to calculate their own impacts. Please contact Jeff Ewald at jbewald@botsford.org in order to receive a copy of Steve's Excel model.

RING IN THE NEW YEAR AS A NEW MEMBER SPONSOR AND WIN AN IPAD

For every new or former member you recruit, who begins their membership between January 1, 2011, and February 28, 2011, **you will receive one entry into a drawing for a brand new iPad!** The drawing will be held in March, and the winner will be contacted.

HERE'S HOW THE 2010-2011 MEMBER-GET-A-MEMBER PROGRAM WORKS:

- Recruit one or two new members who begin their membership between June 1, 2010, and April 30, 2011, or former* HFMA members who reactivate their membership between August 1, 2010, and April 30, 2011, and you will win your choice of an HFMA apparel item (approximate retail value of $25) or a $25 Visa® Fuel Card.** Fuel cards can be used at the gas station of your choice or anywhere Visa debit cards are accepted worldwide.
- Recruit three or four new and/or former* HFMA members and you will receive a $100 Visa prepaid card good anywhere Visa debit cards are accepted worldwide. You will also be entered into a drawing among all those recruiting three or four to receive a $1,000 cash prize.
- Recruit five or more new and/or former* members and you will receive a $150 Visa prepaid card. You will also be entered into a drawing among all those recruiting five or more to receive a $2,500 cash prize.

MEMBER-GET-A-MEMBER MAKE A DIFFERENCE GRAND PRIZE

For every new or former* member you recruit, you will receive one entry into the drawing for the Member-Get-A-Member Make A Difference Grand Prize worth $5,000. You will receive $3,000 in cash for yourself and a $2,000 donation in your name to the charity organization of your choice.

You will receive one entry in the drawing for each new member or former* HFMA member you bring in (or bring back).

*Sponsors will receive credit in the Member-Get-A-Member campaign for former members who reinstate (reactivate) their memberships between August 1, 2010, and April 30, 2011. Sponsors will also continue to receive credit in the Member-Get-A-Member campaign for new members who join (or have joined) between June 1, 2010 and April 30, 2011.

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Preparing the 990 Tax Return, Schedule H – Financial Accounting & Reporting Committee Recap

By: Terry Smith
Member, Financial Accounting & Reporting Committee
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The Eastern Michigan HFMA Financial Accounting and Reporting Committee October's Chapter meeting invited Tony Pittiglio, of Wolinski & Company, CPA, PC to discuss the revised Form 990 which was released by the IRS late in 2007 and features the newly released Schedule H. The purpose of Schedule H is to allow tax exempt hospitals a uniform methodology to report charity care and other community benefits. One of the primary goals of Schedule H is to provide transparency and improve tax compliance.

Tony provided a detailed analysis of Schedule H. The key points discussed during the meeting were as follows:

- Schedule H Is very comprehensive as evidenced by its length. The form is four pages long and is accompanied by 15 pages of instructions.
- Charity care is the primary focus of this form. Prior to 2008, this was not an emphasis.
- Consistency is the key in the preparation of Schedule H and at first may prove to be very difficult.
- Part I focuses on and asks detailed questions on whether the preparing organization has a policy with respect to charity care and, if so, is it written?
- Another area of disclosure involves whether the organization prepares a community benefit report and whether this report is made available to the public.
- This form poses the question of what types of criteria are used to determine poverty levels. Tony provided a copy of a Schedule H illustrating the various incomes utilized by the Federal Poverty Guidelines (FPG) to determine eligibility for charity care.
- Another focus is the calculation and disclosure of the amounts contributed by patients for care.
- Medicare shortfalls and bad debt expense are excluded from the calculation of community benefit.
- Part III addresses the amount (if any) of bad debt written off by the organization and whether the organization has written policies regarding collection practices.
- The preparation of Part III necessitates a reconciliation involving the organization's total Medicare program costs. This is because several line items exclude certain Medicare revenues and expenses. As such, full disclosure is necessary to illustrate the differences between the amounts.
- Part IV involves the disclosure and allocation of all management companies and joint ventures related to the organization. Any ownership which is in excess of 10% should be identified.
- No passive investment income should be included.
- Planning is the key prior to submission of the 990 Schedule H. Tony indicated that the cost of compliance both internally and externally will probably increase significantly.
- Part VI should be utilized for disclosure purposes (i.e. supplemental information). Part VI can be duplicated in the event that more space is needed.

The State of Healthcare in Michigan – October 21, 2010 Member Meeting Recap

By: Christina Wong
HFMA-EMC Board Member
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At the HFMA EMC's conference, The State of Healthcare in Michigan on October 21, 2010, three expert speakers shared their perspectives on health reform.

Dr. Paul Harkaway, President of the Huron Valley Physicians Association

Dr. Harkaway shared a physician's perspective and concerns with implementation of the health care reform. He spoke of barriers in the system including: conflicting incentives stemming from liability concerns and current payment systems; the need, costs, and quality of electronic medical records and opportunity for physician input/creation of these systems; and the historical mistrust between physician and hospital groups.

He recommended focusing on patient-centered care, quality cost redesign of the healthcare system with focus on chronic disease, and the goal of customizing IT systems. He also spoke about the need for hospitals to work with physicians, under new and innovative structures outside of current medical staff models.

Christopher Priest, Director of the Bureau of Medicaid Policy and Actuarial Services in the Michigan Department of Community Health

Mr. Priest recently returned to Michigan after working two years in policy in Washington DC. His work currently focuses on implementing health reform in Michigan, as these changes are being clarified. Among changes to occur include:

- As Michigan has seen increases in the uninsured. Approximately 1.6 million residents will be eligible for either Medicaid or an Exchange.
- On 9/23/2010, under the "Affordable Care Act," insurance rules changed such that children up to age 26 can stay on parents' policies; preventative care plans, such as immunizations, are free.
- On 10/1/2010, a temporary "high-risk" pool was granted to PHP as a "covered bridge" for insurance to these enrollees to 2014.
- In 2014 large scale changes are planned to occur, including:

  (1) Insurance companies cannot discriminate,
  (2) Individuals will be mandated to buy insurance or face penalties,
  (3) Large employers are required to cover or will face penalties if goes to Exchanges,
  (4) Smaller employers will be exempt from insurance coverage requirement,

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(5) Medicaid will be expanded (to <65 years to 133% of poverty – approximately 400K people, mostly parents and childless adults) – benefits package still being clarified, and measures will no longer be based on income and assets, instead based on modified adjusted gross income,
(6) Medicare will be tied to Exchanges, and
(7) As the uninsured numbers decrease, then DSH will also decrease (expect drops in charity care.)

- Exchanges will be a new marketplace for healthcare – a single point of entry. The federal government will make tax credits available for eligible persons. Talks are continuing regarding federal-program versus non-federal program exchanges, as this will be a challenging structure. The federal government will test readiness of exchange on 1/1/2013 or else may take over. Questions are continuing about self-sustaining exchanges (via technology, etc.) in 2015 and beyond.
- New dollars will be available from the Federal government, including for FQHCs. The Michigan Primary Care Association is reviewing this and also the opportunity for the state to partner with other groups.
- For two years, 2013 to 2014, primary care providers will have Medicaid rates increased to 100% of Medicare and will be funded by the government.
- Changes in coding are expected.
- Governor Granholm created a healthcare reform group for strategic planning efforts. One million dollars has been earmarked in the state budget for Exchange planning.

David S. Finkbeiner, Senior Vice President, Advocacy, Michigan Health and Hospital Association

Mr. Finkbeiner walked the group through the legislative issues in which the Michigan Health and Hospital Association is involved. The following topics were discussed:

1. Cope with Federal Health Reform
2. Retain critical Medicaid funding
3. Protect the balance of power on the Supreme Court

Healthcare is the largest private-sector industry employer in Michigan. The healthcare outlook shows that more hospitals are joining health care systems, with the number of independent hospital dropping from 236 in 1990 to 144 in 2010. At the same time, beginning 2008, physicians are looking to hospital/health systems for economic support. Estimate that 51 million uninsured, while insurance premiums have increased 131% in past ten years.

The Michigan budget shortfall is projected to be $525 million in 2011, and healthcare funds are dependent on the negotiations surrounding the shortfall. Medicaid cuts represent opportunity loss with federal matching funds.

He also talked about the state election and the stands of different candidates or office. The election is going to re-elect all 15 Michigan seats in the U.S. House, though a seat will likely be lost due to population decline. To wrap up, several websites were givento the group, including his organization's (www.mha.org) related to updates on the Michigan hospital community.

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