Eye on Washington

Gail R. Wilensky

It matters little who wins the White House or controls Congress after the 2012 election—healthcare providers will still face many of the same challenges they are facing today.

That’s not to say the outcome of the 2012 election will not make a difference. A lot could happen starting in 2013. The nature and amount of legislation that will be passed in the years to come will certainly depend on whether President Obama is reelected, whether the country continues with split government, whether the House and Senate are controlled by the same or different parties, and whether the majorities are larger or smaller than they are today.

But 2012 is a different story. From what we have seen of the campaign season to date, it seems clear that 2012 will mostly be a year of posturing and stalemate. Generally speaking, not much tends to happen legislatively during politically contentious election years. And that describes 2012 rather well.

Politics aside, some issues will need to be resolved soon—like “the doc fix,” which would reduce Medicare payments to physicians by 27 percent if not resolved by March, or an extension of the payroll tax cut, which the Congressional Budget Office has judged to be one of the more effective policies to stimulate the economy in the near term.

It’s unlikely, however, that we will see much legislative action to address three important challenges facing healthcare providers: the need to change the incentives in health care, the need to reform the delivery system, and the need for entitlement reform—particularly as it relates to future Medicare spending growth.

The Need to Change Incentives

There is widespread agreement that if the United States is to slow the growth rate of spending on health care and improve the value for what is spent, the current incentives implicit in the nation’s healthcare payment system must be changed. Most healthcare payment today involves some form of fee-for-service, which is notorious for encouraging the provision of more volume and more complex services.

In Medicare, for most services, other than those provided by physicians, there has been a move to bundled payment, where a single payment covers multiple services that are typically delivered over multiple days, or even weeks (as with home care, for example). The use of a bundled payment encourages efficiency within the bundle of services, but like all fee-for-service payment, it encourages greater volume (i.e., more bundles), which is at the root of the Medicare program’s concern with hospital readmissions. There is also currently no incentive or reward for producing higher quality “bundles of care,” and to the extent that higher quality may reduce the likelihood of reoccurrence, there is actually an implicit penalty.

For physicians, the incentives are even worse. The relative value scale uses a disaggregated fee schedule that rewards neither efficiency nor quality.

Continued on page 13
PUBLICATION POLICIES

The Great Lakes Gazette is the official publication of the Great Lakes Chapter Healthcare Financial Management Association. Our objective is to provide members with information regarding Chapter and national activities, with current and useful news of both national and local significance to healthcare financial professionals, and serve as a forum for the exchange of ideas and information.

Opinions expressed in articles or features are those of the author and do not necessarily reflect the view of the Great Lakes Chapter, the Healthcare Financial Management Association, or the Editor. The Editor reserves the right to edit material and accept or reject contributions whether solicited or not. All correspondence is assumed to be released for publication unless otherwise indicated.

Address communications to:

William Roche
Hutchinson, Shockey, Erley & Co.
200 Maple Park Blvd., Suite 204
St. Clair Shores, Michigan 48081
Telephone: 586-782-7058
E-mail: wroche@hsemuni.com

GREAT LAKES CHAPTER OFFICERS AND DIRECTORS
June 1, 2011 - May 31, 2012

OFFICERS

PRESIDENT
Pamela Sanborn
Director, Business Intelligence and Medical Economics
HealthPlus of Michigan
2050 S. Linden Rd.
Flint, MI 48532
810-600-8015

PRESIDENT-ELECT
Amy Bilyea
Otsego Memorial Hospital
825 N. Center Ave.
Gaylord, MI 49735-1560
989-731-2210

SECRETARY
Chad Gutzman
Central Michigan Community Hospital
1221 South Drive
Mount Pleasant, MI 48858
989-772-6741

TREASURER
Melissa Grew
St. Mary’s of Michigan
1015 S. Washington Ave, 3rd Flr
Saginaw, MI 48601
989-907-7556

PAST PRESIDENT
Shari Glynn
Vice President of Finance/Chief Financial Officer
Eaton Rapids Medical Center
1500 S. Main Street
Eaton Rapids, MI 48827

DIRECTOR - NORTHERN MICHIGAN
Tabitha Rudolph
Controller
Charlevoix Area Hospital
14700 Lake Shore Dr.
Charlevoix, MI 49720-1999
231-547-8508

DIRECTOR - UPPER PENINSULA
Gerald David Artman, Jr., CHFP
Reimbursement Specialist
Helen Newberry Joy Hospital
502 W. Harrie
Newberry, MI 49868-109
906-293-9164

BOARD MEMBERS

Josh Wiggins
MidMichigan Medical Center-Clare
703 N. McEwan St.
Clare, MI 48617
989-802-5103

Mary LaLonde
Helen Newberry Joy Hospital
502 W Harrie St
Newberry, MI 49868
906-293-9164

Lori Swarts
Mercy Hospital - Grayling
Mercy Hospital - Cadillac
400 Hobart Street
Cadillac, MI 49601
231-876-7387

Robert L. Lutz
St. Mary’s of Michigan
800 S. Washington
Saginaw, MI 49601
989-907-7561

COMMITTEE CHAIRS

Mentoring
Lori Swarts, Chair
231-876-7387

Membership
Mike Graham, Chair
989-839-3268

Newsletter
William Roche, Chair
586-782-7058

Certification
Mark Thompson, Chair
989-907-2021

Program/Networking
Jason Hunt, Chair
989-839-3329

Publication & Membership
Elizabeth Linn, Chair
906-776-5323

Sponsorship
Brent Smith, Chair
810-262-9748

Financial Review
Lindy Beldyga, Chair
517-332-6200

Attention Advertisers

Remember that the Great Lakes Gazette will reserve space in the next issue for your ad

| 9-1/2 x 8 (1 page) | Per Issue | $200.00 | All Three Issues | $500.00 |
| 5 x 7 (1/2 page)  | $150.00   | $400.00 |
| 4 x 5 (1/4 page)  | $ 75.00   | $200.00 |
| 2 x 5 (1/8 page)  | $ 50.00   | $125.00 |

Please Contact:
William Roche 586-782-7058
Kathryn Huskin 586-782-4532

PUBLICATION SCHEDULE
Published 3 Times a Year!

Deadline      Issue

June 1, 2012  Summer 2012
October 1, 2012 Fall 2012
March 1, 2013  Spring 2013
EDITOR’S MESSAGE
William M. Roche, Editor

We are always looking for articles, job openings or jokes for the newsletter. Please feel free to call, fax or email your materials to me or my assistant Kathryn Huskin.

Sincerely,

William M. Roche, Editor
586-782-7058
wroche@hsemuni.com
Fax: 586-778-3548

Kathryn Huskin, Assistant Editor
586-782-4532
khuskin@hsemuni.com
HFMA Announces Nominees for 2012-13 Board Leadership

HFMA is pleased to announce that the Association’s Board of Directors has nominated Steven P. Rose, FHFMA, CPA, and Kari S. Cornicelli, FHFMA, CPA, to stand for election to the Board for the positions of Chair-Elect and Secretary/Treasurer for 2012-13.

Rose is CFO at Conway Regional Health System, Conway, Ark., and a member of HFMA’s Arkansas Chapter. Since joining HFMA in 1985, he has served the Association nationally on HFMA’s Board of Directors and as a member of the Executive Committee, Audit & Finance Committee, Strategic Planning Committee, and Revenue Cycle KPI Task Force. Rose also has served as president, secretary, and treasurer for the Arkansas Chapter, and as chair of the Regional Executive Council.

Cornicelli is vice president and CFO of Sharp Grossmont Hospital, La Mesa, Calif., and a member and past president of HFMA’s San Diego Imperial Chapter. A member of HFMA since 1986, she has served the Association nationally on HFMA’s Board of Directors from 2000-03, and as a member of the Audit & Finance Committee and the National Advisory Council.

Three HFMA members also have been chosen to stand for election as 2012-15 Directors:

**Carol A. Friesen**, FHFMA, is president and CEO, Crete Area Medical Center, Crete, Neb.

**Michael P. Freed**, CPA, is executive vice president, corporate resources, and CFO, Spectrum Health, Grand Rapids, Mich.

**Michael M. Allen**, FHFMA, CPA, is treasurer/CFO, Winona Health Services, Winona, Minn.

Board elections will take place in April 2012.

Posted on 12/13/2011 11:08:56 AM
Education Programs

********

May 16, 2012
Chapter Planning Meeting
(Mini LTC)
Bay Valley Resort
9 am to 3 pm

May 23—25, 2012
Annual Spring Conference
& Golf Outing
Soaring Eagle Casino & Resort

*******

CHECK WEBSITE FOR NEW INFO

http://www.greatlakeshfma.org/

We strive to bring members of the Great Lakes Chapter of HFMA educational seminars that address current issues and are presented by renowned healthcare speakers.

Job Postings

If you want any job postings listed on the web site please email the information to Kathryn Huskin at: khuskin@hsemuni.com

This is a free service for Healthcare members with at least one member in the Great Lakes Chapter.

If a Hospital does not have any member in the Great Lakes Chapter the cost is $125.00 per posting. Checks should be mailed to the attention of:

William Roche
Hutchinson, Shockey, Erley & Co.
200 Maple Park Blvd., Suite 204
St. Clair Shores, MI 48081
Spring arrived early for us this season and as we look forward to the coming months. We have had a great year so far with many new members joining our chapter and continued educational opportunities. As we look towards the end of this chapter year I am reminded of the great team of leaders this chapter has and the many new faces that have joined in a leadership role. I had challenged all of us at the beginning of the year to look at HFMA as an opportunity for personal and professional growth and many of you took that challenge!

The next couple of months we have several key activities happening:
- Leadership team traveling to the HFMA National Leadership conference
- Chapter strategic planning
- HFMA ANI conference in June
- Remaining educational sessions and webinars – Virtual Conference last live session is April 11th

Reminder of our Chapter Goals for the year
Education @ 13.6 hours/Member – we are moving towards that mark, but need your help and commitment to meet that goal.

Membership – we have met our goal but need to maintain our current membership through the end of our year

Member Satisfaction - 55% very or extremely satisfied. We did not meet our goal - our satisfaction score was 50% very or extremely satisfied. We will be focusing on your feedback on how to improve in this area with regards to educational offerings, location of education and networking opportunities.

Thank you for your continued support of our chapter!
WELCOME NEW MEMBERS

Andrea Curtis
Senior Auditor
Munson Healthcare

Mike Lahaie
Regional Sales Director
Phytel

Karen M. Fleming
Staff Accountant
Schneider, Larche, Haapala & Co., PLLC

David E. Elston
Director of Accounting
Memorial Healthcare

Barbara K. Trombley
Director of Financial Services
Munising Memorial Hospital

Cheryl Thiem, RN
Hurley Medical Center

Heidi Gustine
Director
Munson Medical Center

Rebecca J. Lawson
Financial Analyst
Bell Hospital

Robert K. Gillis
Treasury Manager
MidMichigan Health

Marilyn K. Skrocki
Assoc. Professor Health Sciences
Saginaw Valley State University

Meghan Recla
Revenue Cycle Process Improvement
Dickinson County H/C System

Julie Zwerk
Consultant
Collaborative Data, Inc.

Jaime Miller
PlanteMoran

Spring's New Members - 2012
GREAT LAKES CHAPTER HFMA
2011 - 2012 SPONSORS

Gold

advomas
A strong and multisourced financial advocate for hospitals and their patients

LJROSS

The Rybar Group
Healthcare Financial Consultants

Silver

A/R=E/S
Account Receivable Solutions, Inc.

CFMA
A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

Plante Moran

WIPFLi LLP
CPAs and Consultants

Bronze

Avadyne Health

CBM Services, Inc.

Fifth Third Bank

HSE & Co
Hutchinson Shockey Erley & Co

Hall Render
Killian Heath & Lyman

Lubaway Masten & Company, Ltd.

Mesirow Financial

Lancaster Pollard

L&S Associates, Inc.

Hurley Medical Center
With more than 1,000 associates and 22 offices in the United States and India, Wipfli LLP (Wipfli) ranks among the top 30 accounting and business consulting firms in the nation. For more than 81 years, Wipfli has provided private and publicly held companies with industry-focused assurance, accounting, tax and consulting services to help clients overcome their business challenges today and plan for tomorrow. Through the firm’s membership in PKF North America, Wipfli can draw upon the resources of 264 firms in 120 countries around the world.

Wipfli’s national health care practice has 17 partners and approximately 100 associates dedicated to serving hospitals and health systems, critical access and rural hospitals, physician practices, long-term care organizations, dental practices, and health plans. Wipfli can advise in all areas of business, from finance and operations to human resources, information technology, and reimbursement.

We believe our value comes from a comprehensive approach led by experienced consultants who all have service line management experience and have been in the trenches dealing with the some of the same or similar issues your organization is facing right now. So whatever the entry point, we bring a broad understanding of how to solve the upstream issues, as well as an ability to be reflective of where the market is heading and what you need to be anticipating in the future. For more information, visit www.wipfli.com/healthcare.

Experts in eligibility for the uninsured and third party claims resolution

advomas

A strong and multisourced financial advocate for hospitals and their patients

335 East Big Beaver, Suite 100
Troy, Michigan 48083
Phone: 248-989-4200
Fax: 248-989-4201
E-mail: c.korpela@advomas.com
Web: www.advomas.com
NCQA Announces ACO Accreditation Standards

The National Committee for Quality Assurance announced it will begin accreditation of accountable care organizations by evaluating healthcare organizations’ ability to coordinate care in seven domains.

NCQA, which accredits and certifies healthcare organizations, said the ACO accreditation will look at organizations to see if they meet the following critical areas: structures and operations, access to needed providers, patient-centered primary care, care management, care coordination and transitions, patient rights and responsibilities, and performance and quality improvement.

NCQA said using evidence-based standards will help to identify the ACOs that are likely to deliver on healthcare savings and improved outcomes. A point system will determine levels of ACO readiness, according to NCQA.

Posted on 11/15/2011 3:06:26 PM

Community Hospitals Report Disparity in Financial Health

Nearly half of community hospitals in the U.S. report operating margins of 2 percent or less, according to a survey by Anthelio Healthcare Solutions.

The survey of more than 60 community hospitals found that 22 percent of respondents had negative operating margins and 27 percent reported operating margins under 2 percent. Approximately 23 percent of the hospitals reported healthy operating margins over 4 percent, the survey found.

Disparity also was reported in days cash on hand, as approximately 67 percents of community hospitals had more than 80 days cash on hand, compared to 23 percent of hospitals that had less than 60 days cash on hand and 12 percent that reported under 30 days of cash on hand, according to the survey.

The survey was conducted between July and September based on an e-mail survey sent to community hospitals with fewer than 300 acute care beds.

Posted on 11/10/2011 3:22:05 PM
Keynote Speakers Announced for ANI: The 2012 HFMA National Institute

Pilot and bestselling author Chesley B. Sullenberger III, who safely guided a U.S. Airways jetliner to an emergency landing on the Hudson River in New York, will deliver the keynote address at the opening session of HFMA’s 2012 ANI: The Healthcare Finance Conference, scheduled for June 24-27 in Las Vegas, Nev.

The four-day conference also will feature keynote presentations from U.S. Olympic track and field star Carl Lewis, former U.S. Comptroller General David Walker, and best-selling authors Kevin and Jackie Freiberg.

Sullenberger gained international acclaim as the pilot of the “Miracle on the Hudson” U.S. Airways jetliner, which he safely landed on the Hudson River after the plane hit a large flock of birds. Sullenberger will discuss the importance of passion for excellence and preparedness and the need to lead by example.

Lewis, who participated in five Olympics, will discuss what it takes to win, overcome the odds, and develop a champion mindset in the healthcare arena and beyond. Lewis will show how determination, dedication, and a focus on goals help turn dreams into realities.

Former U.S. Comptroller General David Walker will present facts and proposed solutions to rein in out-of-control government spending and reform the country’s healthcare system. Walker has authored three books, including Comeback America: Turning the Country Around and Restoring Fiscal Responsibility.

The concluding day of the conference features a keynote presentation by Kevin and Jackie Freiberg, authors of Nanovation: How a Little Car Can Teach the World to Think Big. Experts in leadership and innovation, the Freibergs will discuss how to create a culture where healthcare teams are inspired to find ways to overcome healthcare challenges.
Data Trends
Rural hospitals have historically received special payment provisions to preserve access and address rural health disparities. With the increasing belt-tightening of public budgets, these special payments are increasingly questioned. The Dartmouth Atlas of Health Care, which has a well-established process to define hospital service areas (HSAs), earlier this year published a new dataset that makes an adjustment for cost-of-living differences among regions, along with their historical adjustments for age, sex, and race. The Dartmouth data for Medicare Parts A and B reimbursements per beneficiary provide the basis for the following analysis of the differences in spending between rural and urban HSAs. The data show significant variation among different regions—a finding consistent with Dartmouth’s historical research. Nationally, spending in rural HSAs is 4.5 percent lower than in urban HSAs, on average. With 6.45 million rural Medicare beneficiaries, this differential totals $2.76 billion, which includes the Medicare special payment provisions to rural providers.

Exhibit 1

<table>
<thead>
<tr>
<th>HSA</th>
<th>Urban Costs</th>
<th>Rural Costs</th>
<th>Difference</th>
<th>Rural Medicare Beneficiaries</th>
<th>Rural Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>New England</td>
<td>$6,869</td>
<td>$7,309</td>
<td>$430</td>
<td>298,927</td>
<td>$3,327</td>
</tr>
<tr>
<td>Middle Atlantic</td>
<td>$9,241</td>
<td>$9,649</td>
<td>$408</td>
<td>514,423</td>
<td>$6,244</td>
</tr>
<tr>
<td>South Atlantic</td>
<td>$9,208</td>
<td>$8,730</td>
<td>$478</td>
<td>496,027</td>
<td>$5,728</td>
</tr>
<tr>
<td>East North Central</td>
<td>$9,329</td>
<td>$8,675</td>
<td>$654</td>
<td>1,031,445</td>
<td>$7,214,478</td>
</tr>
<tr>
<td>East South Central</td>
<td>$9,502</td>
<td>$10,413</td>
<td>$911</td>
<td>845,825</td>
<td>$6,213,928</td>
</tr>
<tr>
<td>West North Central</td>
<td>$8,316</td>
<td>$8,030</td>
<td>$286</td>
<td>901,260</td>
<td>$2,580,030</td>
</tr>
<tr>
<td>West South Central</td>
<td>$10,218</td>
<td>$10,145</td>
<td>$73</td>
<td>845,825</td>
<td>$6,213,928</td>
</tr>
<tr>
<td>Mountain</td>
<td>$8,276</td>
<td>$7,397</td>
<td>$879</td>
<td>410,890</td>
<td>$3,153,302</td>
</tr>
<tr>
<td>Pacific</td>
<td>$8,346</td>
<td>$7,002</td>
<td>$1,344</td>
<td>445,660</td>
<td>$5,541,692</td>
</tr>
<tr>
<td>Total</td>
<td>6,448,845</td>
<td>6,762,963</td>
<td>3,254,142</td>
<td>30,437,645</td>
<td>$2,762,891,603</td>
</tr>
</tbody>
</table>

Source: Data from the Dartmouth Atlas of Health Care, 2008.

The Dartmouth HSA approach includes the payments for Medicare beneficiaries residing in the area, regardless of where they received services, as long as the services were delivered predominantly within the HSA. The differential identified in this analysis represents a conservative estimate of spending differences, given that many rural providers do not provide advanced and more costly services. Yet this outmigration is still captured in the cost picture for the HSA.

More research is needed on reasons for the differences between rural and urban spending. Dartmouth data on end-of-life care, however, suggest that in rural HSAs, spending during the last six months of life is 18 percent lower than in urban HSA, and the rural HSAs see 17 percent lower use of ICU/CCU services (See The Dartmouth Atlas: Selected Measures of Inpatient Utilization During the Last Six Months of Life by HSA, 2007).

Many rural providers believe they are already operating within the coordinated Medical Home-type approach that promises to reduce healthcare costs. Even with the special payment provisions, this analysis supports that contention.

Exhibit 2

This analysis was developed by Eric Shell and Brian Haapala, principals, and Kristina Hahn, consultant, Stroudwater Associates, Portland, Maine. For more information, contact Eric Shell at eshell@stroudwater.com.

Publication Date: Monday, January 02, 2012
The problem is that there is no consensus on how best to redesign the payment system. To address this problem, the Innovation Center within the Centers for Medicare & Medicaid Services (CMS) is sponsoring several bundling demonstrations focusing on bundled payment for hospital and post-acute care, with and without physician services, and for the hospital stay, encompassing all services including physician services. Unfortunately—and, to me, inexplicably—there are no demonstrations designed to test different ways of paying physicians independently from the hospital.

There also are many interesting demonstrations under way in the private sector involving performance-based pay, patient-centered medical homes, episode-based payments, and global fees. The hope is that what is learned from these various pilots and demonstrations will be sufficient to guide efforts to design the next generation of payment systems.

The Need to Reform the Delivery System

There is also widespread agreement that payment reform needs to be accompanied by delivery system reform that will facilitate the delivery of the higher-quality, more efficient care that payment reform aims to reward. Fee-for-service payment in a fragmented delivery system has been responsible for many of the well-known problems with the nation’s health care. Having the majority of physicians practice in small, single-specialty practices that are independent from the hospital facilities that they use also complicates the move toward more integrated, coordinated care.

Some have wondered whether payment reform should precede or be preceded by delivery system reform. This is an open question. My view is that payment reform will help drive delivery system change and should be strongly pursued, in any event, wherever the opportunity presents itself. Both types of reform clearly are needed.

The Need for Entitlement Reform

It will be hard to fix the debt and deficit without resolving issues relating to entitlement reform, particularly Medicare and Medicaid. Entitlements represent 55 percent of the budget. Social Security constitutes a large portion and, like Medicare, needs to be put on a fiscally sustainable basis. But with Social Security, the changes are much easier—at least at a policy level. For Medicaid, the main challenge involves dealing with issues around long-term care, which the Community Living and Assistance Services and Support (CLASS) Act clearly has been unsuccessful in addressing.

Reforming Medicare poses a bigger challenge because there is no clear consensus on what “reform” means. Perhaps it will be clearer after the 2012 election, but it may take a greater crisis to force the nation to come to some agreement about what types of changes are acceptable even to consider.

The Affordable Care Act has alleviated some of Medicare’s short-term fiscal pressures. The legislated reductions in payments for providers of all services to Medicare and a general slowing in healthcare spending have produced unusually slow rates of spending growth, to quite dramatic effect, although questions remain as to why healthcare spending, both in Medicare and overall, has slowed to the extent that it has and whether the phenomenon is likely to continue. The Part A Trust Fund is currently projected to remain solvent until 2024—five years sooner than was projected in 2010, but far off in the future, especially for most politicians.

Current law projections show Medicare spending through the rest of the decade growing on an annual per capita basis at 3.6 percent—about the rate of growth of the economy. But even this slow per capita growth rate translates to an annual growth rate of 6.6 percent when retiring baby boomers are taken into account. It is unclear whether the legislated changes will negatively affect access as some have predicted and whether that undermines their future viability.

The real question is what will happen after 2020, when the currently budgeted reductions expire. Democrats have set GDP plus 1 as their spending goal, to be achieved by reducing provider payments as needed, with the reductions being enforced by the yet-to-be-created Independent Payment Advisory Board. Republicans have suggested the same spending goal, but want to achieve it by converting Medicare to a premium support program. Whatever strategy is chosen will mean a resource-constrained environment for providers both in the current decade and the decade to come.

Gail R. Wilensky, PhD, is a senior fellow at Project HOPE; a former administrator of HCFA, now CMS; and a former chair of the Medicare Payment Advisory Commission (gwilensky@projecthope.org).

Publication Date: Thursday, March 01, 2012