hfma georgia chapter
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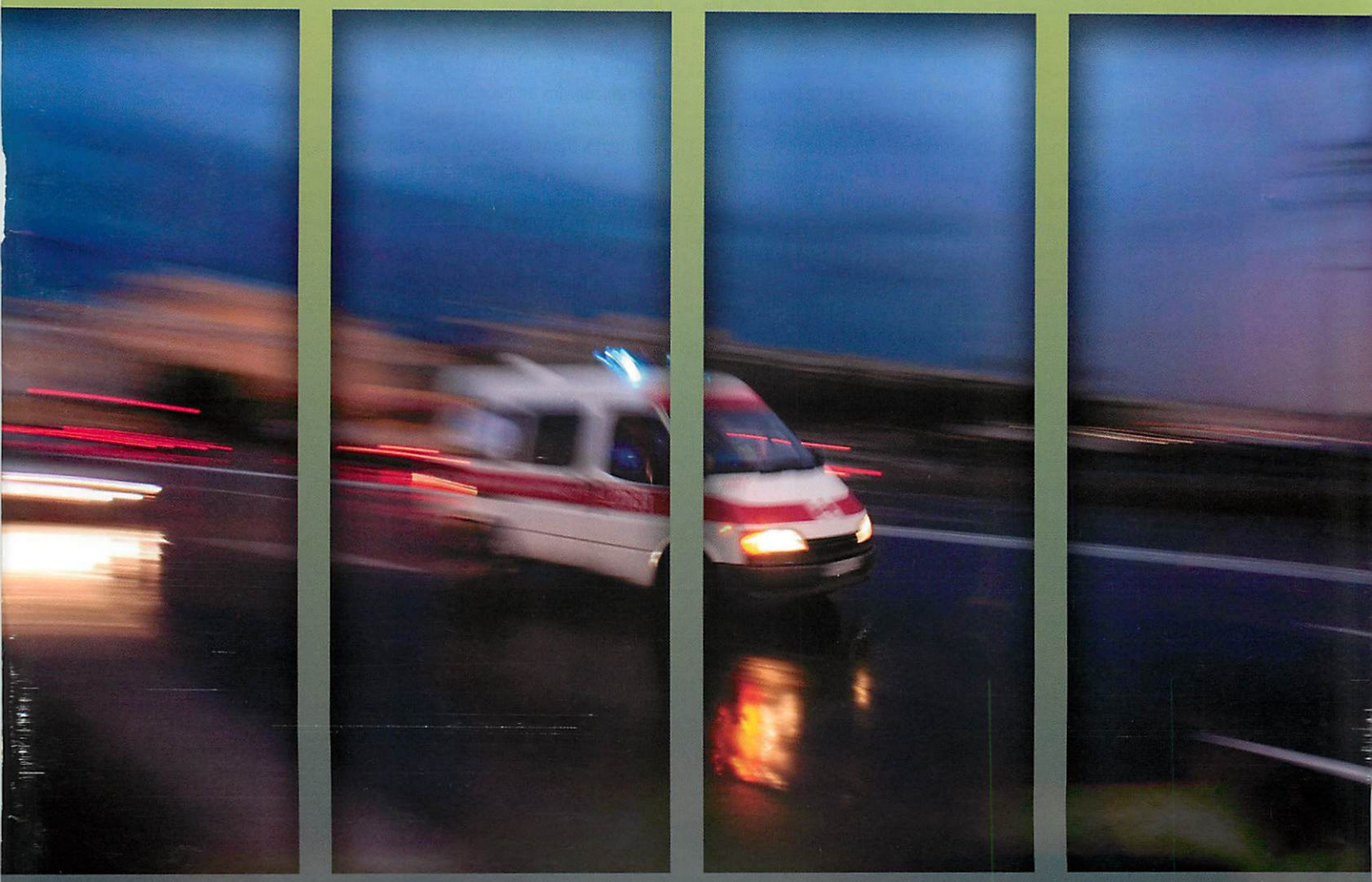

GEORGIA Scroll

SPRING 2010
VOLUME 44 NUMBER 4

LEARN ENGAGE LEAD THE WAY ACHIEVE DEVELOP

Patients Are Looking...

For Hospitals To Put In A Fast Lane

Georgia Scroll

PRESIDENT'S MESSAGE

As I write my last president's message, I reflect on the past year and the many people that I have met along my journey as President of the Georgia Chapter. During this last quarter of the 2009-2010 fiscal year, I have had the opportunity to attend many functions as your president. On January 8, despite the snowstorm, I, along with many of the GA HFMA Board of Directors and Officers, welcomed and congratulated our newly certified CPAR, CFC, CHFP and FHFMA members at the annual recognition luncheon. There were 150+ in attendance on that cold day with 40+ attending their first ACPAR sessions. The CPAR and CFC high scorers flew in from up north. Congratulations to all for accomplishing certification. We welcomed 200+ attendees at our Winter Institute as we networked and received education.

We also had 30+ vendors exhibit. Thank you to the education and registration committees for their ongoing ability to register everyone, coordinate education and handle logistics of the meeting. We talked about our Community Outreach program and invited a speaker from Operation Homefront. As part of the Region V initiative, we partnered with Operation Homefront in a fundraising effort. We raised $2500 to support the military troops and their families. Please consider continuing to donate to this worthy organization atwww.operationhomefront.com. I also had the opportunity to represent the Georgia chapter at Dixie Institute hosted by South Carolina. We had close to 80 Georgia members in attendance at the meeting in Charleston, SC despite the snow storms. I also want to thank our Georgia members who gathered at 4:30 am to feed the homeless at a nearby shelter. On another wintry snow filled evening, Georgia HFMA had the honor to co-host the National HFMA Post HIMSS Reception at The 191 Club. Despite the snow, many HIMSS attendees and GA HFMA members networked for the evening. As part of the Region V Certification initiative, we had 26 members participate in the recent day long National Certification Training Session. Thank you to all the attendees, the faculty , and Gail Hritz, National Certification Chairperson, for an excellent day filled with education. In addition the annual Past President's Dinner was held on March 11 and close to 20 past presidents and their spouses were in attendance. Rick Childs, GA HFMA Past President 2006-2007, shared information about the June 2011 First Region V Past President Reunion Cruise departing from Venice, Italy. Look for more details in the future as everyone is invited to join the fun away from all the snow!

Carmen Sessoms

It amazes me how fast time has flown and I can hardly believe that my year as the president of the Georgia Chapter of HFMA is coming to a close. I have enjoyed every moment! I have met so many new people and many of you have become my very close friends. GA HFMA is my "other" family and has been since 1993. You have seen my two children grow up in the chapter. As I become your next past president, I will celebrate my 20th wedding anniversary. My husband is looking forward to getting his wife back.

I envy Bill Eikost as he looks ahead to his year as president. It is a great experience and I wish him well in the upcoming year.

Thank you to all of you for sitting for exams, attending Institutes, and participating in committees to deliver excellent service, education and networking opportunities . Because of you, the Georgia Chapter of HFMA has continued to LEAD The Way!

Carmen Sessoms

LEARN ENGAGE LEAD THE WAY ACHIEVE DEVELOP

Reducing the Hospital Anesthesia Subsidy; an Administrator's Guide.

By Robert Cox

Most hospital administrators readily acknowledge that their facility couldn't survive without a high quality anesthesia service, since the operating room revenues account for as much as 40% of the overall facility revenues. However, the high cost of anesthesia care is beginning to get some renewed attention as it impacts the hospital bottom line. Abruptly replacing the anesthesia group is fraught with clinical and financial pitfalls that should be avoided at great cost. Administrators often feel disadvantaged in contract negotiations with their anesthesia group. It doesn't have to be that way. Administrators should gain perspective on three (3) fundamentals of the anesthesia contract and understand how to better negotiate each element. This will ensure more successful contracting and may yield a reduction in the anesthesia subsidy.

Figure 1 Fundamentals of an Anesthesia Subsidy

Fundamental	Controlled by
Service Level	Hospital
Billing & managed care contracting	Anesthesia Group
OR utilization	Hospital

Background: Over the past decade, the number of subsidies paid by hospitals to anesthesia groups has skyrocketed from 15% to 75%. Based on the lasted data from MGMA Anesthesia Cost Survey 2009, 75% of hospitals pay some form of subsidy to their contracted anesthesia service. 1 Subsidies are required because of 1)the inadequate levels of reimbursement from Medicare, Medicaid and other third parties for the anesthesia services, 2)escalating personnel cost for the anesthesia professionals and 3)underutilization of operating rooms. A continued manpower shortage of anesthesiologists and Certified Registered Nurse Anesthetist (CRNA) is causing salaries and benefits cost to increase at 11- 18% per year. The average subsidy paid to an anesthesia group practice has grown to $1.5 million dollars annually .1

Solution: Most anesthesia subsidy agreements have a clause that allows the hospital to periodically re-evaluate the need for the subsidy. The typical anesthesia subsidy agreement will have two components: 1) Service level and 2) Financial need. The service level outlines the services that are required to be delivered under the agreement. It may spell out exactly how many rooms will be open at 7am each morning and how the rooms will be closed as the day progresses. The service level will also outline the emergency coverage requirements.

The financial need can be calculated a number of ways including: cost based, market based, net of collections, etc. The most common subsidy calculation method is the "market- based cost minus the actual collections" method. Under this method the hospital supplies the service level it determines that it needs to meet the strategic goals for the surgical services it anticipates for the coming year. The anesthesia group then translates that service level into a staffing matrix (MDs and CRNAs) that will accomplish the anesthesia services required to deliver the service level. The third step is to calculate the reimbursement expected for the service level defined by the hospital. The difference between the market value of the anesthesia resources that must be employed and the expected reimbursement is the net amount of the subsidy that a hospital could expect to pay to the anesthesia group, each year.

Areas to validate are the market rates for anesthesia providers and the expected reimbursement from anesthesia services. Administrators have a good sense for labor cost and should ask for a thorough explanation of the make-up of the market cost. Administrators should also leverage their professional network to establish local or regional norms for the anesthesia subsidy. MGMA provides some good financial data on compensation for Anesthesia and other specialties. The administrator should ask that the group get an outside audit performed at least annually to validate that the expected and actual collections from anesthesia services is in line with industry standards. If not, the hospital is paying for every dollar of the underperformance.

Lastly, administrators that are truly interested in every avenue for cost improvement should look internally at the utilization of the operating rooms. Many hospitals surveyed have operating room utilization well below 50%. This means that in an effort to meet surgeon's satisfaction for operating room availability, the hospital is building in inefficiencies in staffing cost and anesthesia standby time. Administrators will always be tasked to balance surgeon satisfaction with operating room utilization percentages. A recent study of 35 hospitals revealed the following direct correlation between the subsidy amounts per operating room versus the utilized hours per operating room per day.

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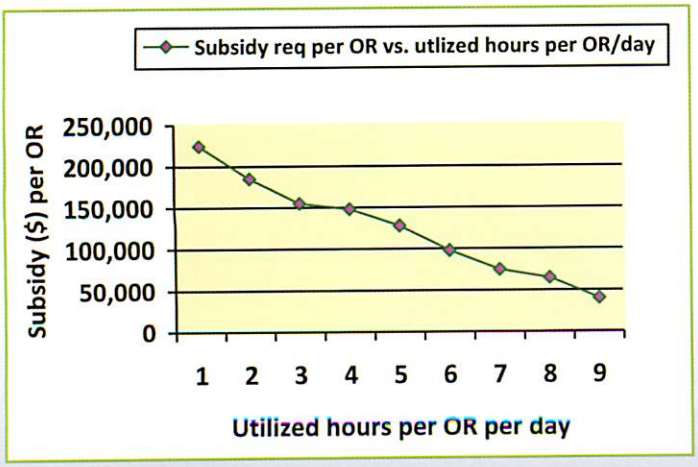
Figure 2 Subsidy per OR vs. Hours utilized per OR per day



One fundamental that the hospital controls that has the greatest impact on the anesthesia subsidy is the operating room utilization percentage. The fewer operating rooms that a hospital opens and runs to capacity, the higher utilization percentage which leads to lower anesthesia staffing cost and lower anesthesia standby time. There are also significant internal savings to be achieved by right sizing the operating room utilization percentage. A good hospital goal for operating room utilization is greater than 70%.[1]

Conclusion: Administrators will likely be faced with providing financial subsidies for their anesthesia group in the future. However, they should continually strive to minimize this subsidy in order to protect the hospital's bottom line. Administrators who better understand the three (3) contract fundamentals and are prepared for the negotiations will achieve better outcomes and will make reasonable progress toward reducing their anesthesia subsidy. Success shouldn't be defined by the size of the subsidy, but instead by the amount of value delivered per dollar spent.

Robert Cox is the president and managing partner in the practice management and consulting firm of Anesthesia Resources' Atlanta office. He can be reached at (678)478-6788 or via email at robertc@anesres.com.

References: 1. MGMA, Cost Survey for Anesthesia Practices, 2009 Report on 2008 Data