

The Buckeye Connection

April 2004



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Interested in assisting with the newsletter? Please contact Tara -Ann McElhearn (229-5165) or Johanna Matheny (233-5617).

Avoiding Cost Bias in Acquisition of High Cost Drug Therapies

Recent Study Highlights Role of Financial Leaders

By: F. Randy Vogenberg, R.Ph., Ph.D., Leo K. Lichtig, Ph.D.
Aon Consulting's Clinical Effectiveness Initiative

Within the next few years billions of dollars worth of genetically engineered, or biotechnology (Biotech) medications will enter the marketplace. These therapies are the true "miracle" drugs of the future. They have the potential not only to improve clinical outcomes, but to save lives and give new hope to millions of patients and their families.

Paying for these new drugs, however, will not be cheap. Some of the newest drugs to treat hospitalized patients cost thousands of dollars a day to acquire and administer, potentially adding billions to the nation's already skyrocketing healthcare costs.

Unfortunately, the quest to manage expenditures for these drugs is challenging and may lead to cost bias. Especially if the approach does not take into account non-drug related costs that may influence the total cost of care (i.e., length of stay, staff resources, laboratory costs, etc.), an organization could potentially make a more costly decision to exclude a medication rather than include it and realize significant benefits.

Avoiding Cost Bias (continued)

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▲ Balancing Clinical and Financial Demands

Balancing financial demands with clinical needs is never an easy task in the healthcare community. Chief Financial Officers, charged with ensuring the profitability and overall viability of an organization by looking at its overall needs, often find themselves at odds with clinicians who have available to them drugs that are newer and often more expensive (but for appropriately selected patients may be safer and more effective) than older drug therapies. Clinicians want to provide the best outcomes for their patients and often choose newer medications to meet these needs. Additionally, they are typically in a better position to judge whether or not a newer, more expensive medication will ultimately save money by being more effective, but usually lack the hospital-wide data to quantify potential benefits.

An example of the challenges faced by healthcare leaders today is the treatment of deep vein thrombosis (DVT), the formation of a blood clot within a deep vein which can block the flow of blood and lead to “throwing” a potentially lethal embolism to the lungs. It’s estimated that a majority of hospital admissions—including patients with cardiovascular disease, orthopedic surgeries, cancer and other illnesses—are at risk for thrombosis. Despite these risks, nearly half of such patients in hospitals studied did not receive prophylactic drug treatment even though it may be clinically proven to reduce the risk of DVT. This potentially presents a significant liability for clinicians and hospitals. A Clinical and Financial Tool Recognizing the need to merge the

goals of clinical and financial healthcare leaders, a national practice of Aon Consulting, Life Sciences Consulting, developed the Clinical Effectiveness Initiative (CEI). CEI focuses on high cost clinical areas such as the acquisition and delivery of new technology drugs and on financial strategies that can help organizations better quantify the cost and potential benefits of today’s most promising drugs and technologies.

(Continued on Page 6)

What's New?


We want to know what's new with you.

Remember to keep National HFMA informed whenever you:

- get promoted
- move to a new organization
- get a new business address
- move to a new home
- work for a different department, unit, etc.
- anything new about you or your organization

To receive a Member Record Update Form and instructions, call Fax-It, 800/839-HFMA, and request document no. 200002.

Or call HFMA's Member Service Center at 800/252-HFMA, ext. 350.



One Person's Journey with HFMA

By: Luke Brown, President,
Central Ohio Chapter

Dear Chapter Members:

As my term as President of the Central Ohio Chapter comes to a close, I've decided to share with you some of my experiences with HFMA. In doing so, I hope to make this interesting for you to read, and to give some reasons to consider becoming more active in the organization, either nationally, at the chapter level, or both. I know it's a cliché, but you do "get out of it what you put into it". Anyway, here goes....

When I became employed by Children's Hospital, I registered for HFMA membership at the suggestion of Eric Young, who was assisting Children's with our finance department's management transition at the time. Eric was in chapter leadership, and he encouraged me to attend educational events, which I did. The events were informational, and provided me with the opportunity to network with other healthcare financial professional within the Central Ohio marketplace. As importantly, Eric and I have become good friends, and this may not have occurred without the HFMA organization drawing us closer together. Thanks "E"!!.

My progression within HFMA continued, as I was asked to become active in the Central Ohio chapter as an officer about 4 ½

years ago. As you may know, to become an officer for the Central Ohio chapter is a four year time commitment, as you progress from Treasurer to Secretary to President-Elect and finally to President. At first glance, this tour of duty may appear a bit daunting. I won't kid you; there have been times when it was difficult. However, the value I've gained from being a chapter officer for HFMA has far surpassed the investment of personal time and resources. Let me give you a couple examples:

- I've had the opportunity to work with a terrific group of individuals as part of the chapter leadership team, including Pat Robertson, George Gevas, Craig Bjerke, John Miller and Lola Purdef. These folks taught me a lot about leadership and the value of organizational skills. In addition, we've managed to have some fun along the way. I want to specially acknowledge Lola for all her hard work related to the 03/04 chapter educational programs. Lola, you're the best!
- I've traveled to Dallas, Phoenix, Chicago, Detroit and Traverse City, Michigan to participate in a variety of national and regional leadership conferences. (Unfortunately,

my timing was bad and I missed out on San Francisco this year L). At these conferences, I've met people from throughout our region and the country, developed contacts through the networking opportunities, and learned about the depth and breadth of services provided to our membership by folks in the HFMA national office. What an experience!

I would be remiss in not thanking senior leadership at Children's Hospital, and especially my boss, Tim Robinson, for providing me with the support and flexibility to develop my professional skills in working as a chapter leader for HFMA. I believe much of what I've learned during the last four years, I've been able to use in becoming a more effective member and leader within the Children's management team.

Please contact any of our incoming officers or myself if you are interested in becoming active in the Central Ohio chapter. In addition to the officer rotation, there are many opportunities to serve in leadership or membership capacities within various chapter committees. I hope to see many of you at our upcoming golf outing on May 24th at **Riviera Country Club**.

President's Message

CMS Releases Physician Referral Regulations, Phase II

Today's *Federal Register* includes the long-awaited second phase of rules establishing new exceptions to the physician referral regulations and permissible physician investment and compensation arrangements. The referral regulations pertain to designated health service entities with which the physician (or a physician's family member) has a financial relationship. Additionally, the regulations prohibit an entity from billing for services as a result of an improper referral.

Provisions of today's interim final rule include:

- Creation of safe harbors for valuation of physician practices and different types of hourly compensation
- A revised definition of compensation that is "set in advance" to permit certain common percentage compensation arrangements
- Greater flexibility for the academic medical centers exception than what was established in phase I
- Expansion of the medical staff incidental benefits exception to include facilities other than hospitals
- Elimination of a proposed restriction on productivity bonuses
- An exception for communitywide health information systems to encourage provider use of electronic health records

In addition, the rule relaxes requirements for the reporting of entities' financial relationships with physicians. Instead of periodic reports by providers, entities need only make the information available only upon HHS/CMS request. The 18-month moratorium on specialty hospitals is also reflected in the rule's provisions.

The interim final rule will become effective on July 24, 2004. Comments are due June 24.

- Read the [interim final rule on physician referrals, phase II](#).
- Read the [CMS announcement of phase II of the physician self-referral interim final rule](#).
- Get [HFMA's highlights of phase I of the physician self-referral rules](#).

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FASB PROPOSES MMA GUIDANCE ON RETIREE HEALTH BENEFITS

The FASB has issued a proposed staff position, FSP FAS 106-b, to provide supplemental guidance to Statement 106, "Employers' Accounting for Postretirement Benefits Other than Pensions," which calls for employers to recognize the cost of future healthcare benefits provided to their retirees as those individuals render services as employees. The proposal responds to accounting and disclosure questions that were raised as a result of the drug benefits enacted in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). MMA introduces an unprecedented subsidy to some plan sponsors for continuing postretirement drug coverage. The March 22 Wall Street Journal reported the MMA could provide savings of as much as \$11.8 billion in benefit costs to 18 large companies over time.

Comments will be accepted on the proposed FSP until April 12, 2004.

- [Read FSP FAS 106-b, 'Employers' Accounting for Postretirement Benefits Other than Pensions.'](#)

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FASB Proposes MMA Guidance on Retirement Health Benefits

Avoiding Cost Bias (continued)

Beginning in 2002, the first CEI program with Atlantic Health System in New Jersey focused on the treatment of hospitalized patients with or at risk for DVT. The CEI program was expanded to 15 hospitals nationwide, including the Cleveland Clinic Northeast Region (Euclid Hospital in Euclid, Hillcrest Hospital in Mayfield Heights, Huron Hospital in Cleveland, and Southpointe Hospital in Warrensville).

Under CEI, the first step was to gather and analyze patient-level clinical and billing data from administrative (UB-92) data systems at a participating hospital. Researchers compared total costs for similar patients receiving one of two drugs – unfractionated heparin (UFH) or a newer, low molecular weight heparin (LMWH). They analyzed savings (reduced costs) and losses (increased costs) by key cost center such as Medical/Surgical Acute, Pharmacy and Laboratory for various patient categories relevant to prevention and treatment of DVT (i.e., long-stay medical patients and hip replacement patients) and by individual diagnosis related groups (DRGs).

Another initial step was an interview process used to help hospitals identify areas that could benefit from the information. During the interview process, hospital financial personnel, administrators, physicians, pharmacists, quality management personnel and nurses were interviewed, providing valuable information on the procedures and guidelines they followed when identifying, preventing and treating DVT as well as where they thought improvements could be made.

A key finding of the interviews was that while financial leaders understood the cost to acquire drugs to prevent and treat DVT, they were unaware of the associated costs of delivering the drugs. For example, UFH – the traditional method of treatment for DVT – costs less than \$1 a day to acquire but requires multiple lab tests per day plus nurses' time to administer and check on the dosages, which are typically administered intravenously.

Alternatively, the newer form of thrombosis prevention and treatment, which uses LMWH, costs about \$26 a day to acquire, but typically requires dosing only once a day with no lab testing or IV administration, thus reducing nursing care and other expenses. These

reductions more than offset the acquisition costs for most types of patients. In addition, the data showed that there are often savings in length of stay especially in the ICU.

While the data clearly showed savings across a broad cross-section of admission categories for patients receiving LMWH versus UFH, it also showed that LMWH was more advantageous in certain therapeutic areas than others. With the information gathered for participating hospitals by CEI, hospital staff were better equipped to make decisions about the cost-effectiveness of these drugs.



THE QUALITY MANAGEMENT
CONSULTING GROUP, LTD.

100 South Third Street

Columbus, Ohio

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Finally, CEI offers an actuarial modeling tool to predict what the financial impact might be from any changes in practice patterns that clinicians may consider. The tool helps hospitals calculate the impact of potential changes in practice patterns, taking into account regional cost differences, payment methodology and a hospital's case mix.

Results from the initial study were compiled in late 2003 and included data from more than 720,000 hospital admissions. The program has shown that on average, the 15 hospitals have already saved (\$8.4 million, \$538 per case) and have the potential to save an additional \$3.2 million per year (or \$151 per case on average) by using a LMWH instead of a UFH. Individual hospital results vary depending on their own volume and case mix. Most importantly, the CEI helped to highlight to financial leaders the difference between drug acquisition cost and total patient care costs.

The message of this initiative for financial leaders is that in their effort to manage overall costs and improve outcomes, they play an important role in helping to ensure that when evaluating newer therapies, overall costs and outcomes are always measured and taken into consideration. When based on quantifiable data, the result of a more integrated clinical and financial approach to acquiring new therapies, will be lower costs and better outcomes.

Note: Aon is recruiting an additional 50 hospitals to participate in this next phase of the CEI thrombosis management project. There is no cost to the hospital; the project is funded by an unrestricted educational grant from Aventis Pharmaceuticals. Hospitals would provide Aon with UB-92 data and recent Medicare Cost Report data. All data handling is HIPAA compliant and the data remains confidential and the property of the participating hospital. Hospitals interested in participating in the program should contact Barbara Hodge at 518-893-2451 or Barbara.Hodge@aoncons.com.

About Aon Consulting:

Aon Consulting is a worldwide leader in insurance, pharmaceutical and employee benefit consulting. Aon's Consulting Life Sciences Practice offers the healthcare industry a multidisciplinary approach to addressing the clinical and financial challenges of today. More information is at www.aon.com/lifesciences.

About the Authors:

F. Randy Vogenberg, R.Ph., Ph.D., is vice president of Aon Consulting's Life Sciences Practice.

Leo K. Lichtig, Ph.D., is vice president of Aon Consulting's Life Sciences Practice. He is also a member of HFMA's Northeastern NY chapter.

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Mark Bainbridge
614.229.5002
mark.bainbridge@ey.com

Lynne Parrott
614.229.5110
lynneparrott@ey.com

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Avoiding Cost Bias (continued)

CMS Provides Details on Specialty Hospital Moratorium

CMS published a one-time notification explaining the moratorium on specialty-hospital physician investment and referral, mandated by MMA. Under the moratorium, a physician may not refer a patient to certain specialty hospitals in which the physician has an ownership or investment interest, and the hospital may not bill Medicare or any other entity for services provided as a result of a prohibited referral. The moratorium is effective from enactment of the MMA December 8, 2003, through June 8, 2005, and it applies to hospitals that are primarily or exclusively engaged in the care and treatment of patients with cardiac or orthopedic conditions, surgical patients, and patients receiving other specialized types of services that CMS may designate.

According to CMS, specialty hospitals under development as of November 18, 2003, are excluded from the moratorium. To determine whether a hospital was under development as of that date, CMS said entities could request an advisory opinion under existing advisory opinion procedures. Specialty hospitals with Medicare provider agreements in effect as of November 18, 2003, are considered to have been in operation as of that date and do not need to request a CMS determination.

- Read about the moratorium on physician investment in specialty hospitals.



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IMPORTANT HFMA MEMBER NEWS: FOUNDERS PROGRAM CHANGES

HFMA is about to implement some important changes to the Founders Merit Award program, to bring it back to its original purpose of recognizing volunteer efforts at the chapter, regional, and national levels. The changes are the work of HFMA's Regional Executive Council, at the request of the HFMA Board of Directors.

Starting June 1, 2004, HFMA members will earn Founders points for volunteer activities, such as writing articles for national or chapter publications, participating in a program, and volunteering for a chapter committee. Members will not receive points for attending educational programs. The amounts of points required to earn Founders Merit Awards have been adjusted to reflect the new award levels. HFMA certification maintenance requirements have been adjusted to provide for non-volunteer activities that used to earn Founders points, as well as for participating in other non-HFMA sponsored education events.

- **Learn more about changes in the Founders Program.**



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Founders Program Changes

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Featured Speaker: Bruce Hallowell, MBA

Denials Management and How to Improve Revenue Realization

Spring Golf Outing

Monday, May 24

Riviera Country Club

HFMA's Annual National Institute

June 27-July 1

Nashville, Tennessee



Newsletter Editors

Tara-Ann McElhearn

(614) 229-5165

tara.mcelhearn@ey.com

Johanna Matheny

(614) 233-5617

johanna.matheny@ey.com

Newsletter Design and Layout

Laura Dutton

(614) 229-5279

laura.dutton@ey.com

Ernst & Young LLP
1100 Huntington Center
41 South High Street
Columbus, Ohio 43215

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Central Ohio Chapter
Healthcare Financial Management Association
Ernst & Young
1100 Huntington Center
41 South High Street
Columbus, Ohio 43215