hfma healthcare financial management association

first illinois speaks

A Newsletter from HFMA's First Illinois Chapter

January 2009

The Healthcare Environment in Russia Today

BY MIKE GRADY, FIRST ILLINOIS CHAPTER HFMA, DAVE TIMPE, SOUTH DAKOTA CHAPTER HFMA, RONALD TIMPE, IOWA CHAPTER HFMA

making connections

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In early September 2008, 26 members of the United States and six members of the United Kingdom Healthcare Financial Management Association toured, met and observed various components of the Russian Healthcare Delivery System as part of the USA sponsored People to People Program. HFMA delegates met with several members of the **National Research Institute of Public Health of the Russian Academy of Medical Services** and the **Federal Compulsory Medical Insurance Fund,** both agencies located in Moscow. The delegation toured the **Vsevolozhsk Central District Hospital** in Leningradsky Region and a private **MEDI Clinic** that specializes in Dentistry, Plastic Surgery, Cosmetology and Laser Vision correction, both located in the Saint Petersburg area.

Authors Left to Right: Ron Timpe (Iowa Chapter), Mike Grady (First Illinois Chapter) and Dave Timpe (South Dakota Chapter)

The meeting with National Research Institute of Public Health of the Russian Academy of Medical Services was very informative as to how the Russian healthcare delivery system has functioned over the past 40 years. They informed us that the Academy was formed in 1944 with a main objective to improve the health of the Russian people. The academy staff provided us with numerous healthcare statistics on life expectancies in Russia at this time. Some of the key statistics are:

- Income distribution has shifted from 80% of the populace sharing 80% of the total national revenue in the early 1980s to 40%

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Letter from the President

As we enter the new year, let it not be said that we don't live in interesting times. Our country is undergoing monumental stresses as well as monumental changes. We now have new leadership in Washington with a decidedly Chicago connection. We may see the largest change in healthcare policy in decades. As leaders of the healthcare community in one of the largest metropolitan areas in the country, we have the opportunity to influence the changes that may be coming. If and when opportunity knocks, rise to the challenge. It's our chance to make a difference, to make healthcare better, to make this country better!

The leadership of First Illinois Chapter HFMA has been working hard on several programs to help keep you educated and current on what's happening in the industry. Save the following dates:

January 22– Acct Reimbursement/Revenue Cycle – Naperville Holiday Inn Select

February 19–Medical Group/Physician Committee – University Club, Chicago

March 19–Managed Care Committee – University Club, Chicago

The CFO committee is planning its Education Session/Golf Outing for May 7, 2009 at Medinah Country Club. The theme will be healthcare reform this year. One never knows who might show up. One thing is certain: the weather will be nice, even if the President's golf score isn't so nice. Making connections on the golf course will be different this year. The chapter golf outing has a new date and venue! The outing will be Thursday, June 4, 2009 at Gleneagles Country Club in Lemont. There will be a shotgun start in the morning with a late afternoon sit down dinner for everyone to mix and mingle. It should be a great day to put the stresses of life behind us and have some fun with our many friends.

So, please be a leader when your chapter or your country calls upon you in this pivotal year in our nation's history. Be a part of the solution, not a part of the problem. Use your connections. Make new connections. Renew old connections.

Making connections! Let us work together to make our healthcare system in Chicago and Illinois as well as the nation more connected and better functioning.

Guy R. Alton, FIHFMA, CPA
2008 – 2009 Chapter President

First Illinois Chapter News, Upcoming Chapter Events and Committee Updates

Golf Committee

'09 Golf Outing Update

The planning is almost complete for the 2009 event. Gleneagles Country Club in Lemont will be the host site and we have moved the date to Thursday, June 4, 2009. The 9:00 a.m. shotgun start will be followed by a cocktail hour and dinner banquet. On course shot contests, free golf giveaways, and one of the biggest prize tables you have ever seen will highlight the event. Save the date now and look for sponsorship opportunities and registration materials soon.

Carl Pellettieri and Ross Stebbins

Managed Care Committee

HFMA Managed Care Meeting 2009

Oh the election! A new president and a new administration. What will happen to healthcare? Please join your colleagues to discover: Here are the major topics:

- An expert's understanding of needed National Healthcare Policy Reform - David Dranove, MBA, Ph.D., a Professor of Management and Strategy at Northwestern University Kellogg School of Management, and author of "Code Red: An Economist Explains How to Revive the Healthcare System without Destroying It" will present and will also be available for book signing.
- What is new in Springfield? Elena Butkus from the IHA will update us.
- What does Gary Pickens, Ph.D., Senior Vice President and Chief Research Officer of Thomson Reuters say about the major clinical trends?
- What are the changes large area employers are making that will affect providers? A senior person from Mercer will share key data and insights.
- Find out how the top leaders of Chicago's key payers answer some pretty hard questions.
- Take home some administrative and contractual tools that just might help you be more efficient.

We are excited about the great speakers and topics. Please attend and invite your colleagues and friends!

Meeting Specifics

Date: March 19, 2009

Location: University Club, Chicago, Illinois

Presented By: The Managed Care Committee

First Illinois Chapter HFMA

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In Memoriam

In Memory of Gail Walker

It is with sad hearts, we regret to inform you that fellow HFMA member Gail Walker passed away on December 15, 2008. Gail was the registration chair for our HFMA chapter and a member for many years. She will be missed by many.

"I was deeply saddened to learn of Gail Walker's passing. When she handled registration for my annual Medical Groups and Physicians Committee program, it was a pleasure dealing with her. She was thorough and always, always pleasant. She went out of her way to make sure that on the day of the program everything would go smoothly. She was a great asset to our Chapter. Gone too soon."

~Elaine Scheye

Gail Walker
1947-2008

Founders Merit Awards for 2008

BY BRIAN SINCLAIR, CHAIRPERSON, AWARDS COMMITTEE

Congratulations are in order for the recipients of the 2008 Founders Merit Awards. National HFMA recognizes that its strength lies in the volunteers who contribute their time, ideas and energy to serve the healthcare industry and their local chapter. The Founders Merit Award program was established to acknowledge the contributions made by individual HFMA members.

The awards program is a merit plan, which assigns a range of point values to specific chapter activities, such as committee participation, educational presentations, and serving as a chapter officer. The Follmer Bronze Award is awarded when a member has accrued 25 points, the Reeves Silver Award is earned after an additional 25 points are accumulated, and the Munice Gold Award is presented after a final 50 points are earned. A fourth award, the Founders Medal of Honor, may be conferred by nomination of the Chapter Board of Directors to qualifying members. This award recognizes significant continuous service after completing the medal program.

Each of these award recipients will receive a personalized inscribed plaque from HFMA to officially recognize their achievements. The First Illinois Chapter officers and directors also extend their congratulations and appreciation for the support and participation of the award recipients.

Please refer to your chapter membership directory for more information regarding the awards series, scoring details and a listing of all former recipients. If you have any questions regarding the awards or your current point status, please call Brian Sinclair, Chairperson, Awards Committee, at 630-207-7308.

The 2008 award recipients are:

Follmer Bronze Award
Gordon R. Holtby
Elise M. Lauer
Eleanor M. Michalek
Brian M. Washa

Reeves Silver Award
Susan D. Aaron
Janet E. Blue
Charles F. MacKelvie

Muncie Gold Award
Grace Daigel, FHFMA, JD, MBA
K. Michael Nichols, FHFMA, CPA
James J. Unland
James L. Watson

Letter from the Editor

Happy New Year! It's a time for new beginnings and new life. Speaking of new life, I proudly announce the long awaited arrival of my first daughter! Isabella Grace Springborn was born Saturday, November 1, 2008, at 1:19 p.m. She was 7 pounds 15 ounces and 19 inches long. To see the world through the eyes of a child again!

I have really enjoyed editing the newsletter and would not be able to do it without the help of others. I want to thank everyone who continually submits articles, helps edit and of course those who always get me last minute information that I need. I don't think I could meet the deadlines without them. I would also like to thank all of the committee chairs for submitting the promotions and recaps of their committee events on time. Without everyone's support, it would simply be a newsletter that changed colors each quarter.

As many of you probably realized, there was a caption misprint in the October issue. The picture that stated "Medal of Honor Recipient-David Golom" was actually David Chabala who received a certification award. Both pictures with the correct captions, I hope, are reprinted in this newsletter. I apologize to both gentlemen.

As always, if you have an article for future newsletters, please forward them to my attention.

Amanda Springborn
amanda.springborn@rsmi.com

Isabella Grace Springborn

Interpreter Act Ensures Safety for Deaf and Hard of Hearing in Medical Settings

BY DAN YUNKER

In September of 2007, the Interpreter for the Deaf Licensure Act of 2007 was signed into law in the State of Illinois. This bill established important statewide licensing standards for registered interpreters, protecting the deaf and hard of hearing by establishing accountability for the profession.

As we enter into 2009, the law will go into full swing; all interpreters are required to have a license in order to provide interpreting services. Proficiency levels include intermediate, master and advanced. For hospitals and medical settings, the type of license an interpreter has determines where he or she can provide services:

Proficiency Level	Location
Intermediate	■ Nursing and personal care (nursing homes) Non-clinical routines
Master	■ Clinical appointments ■ Emergency room ■ Obstetrics ■ Life-threatening medical situations ■ Psychiatry (routine clinical, crisis intervention, hospitalization)
Advanced	■ All of the above

Due to interpreter shortages, some exceptions were built into the bill that allows individuals to fill in for a licensed interpreter when necessary. Most importantly for hospitals and healthcare providers, according to the bill, unlicensed individuals may interpret "in an emergency situation involving healthcare services in which the consumer and healthcare provider or professional agree that the delay necessary to obtain a licensed interpreter is likely to cause injury or loss to the consumer."

Previously, sign language interpreters were required to register with the Illinois Deaf and Hard of Hearing Commission; however, due to a lack of standards, a deaf or hard of hearing individual could have varying experiences. This law not only established standards, but allows for deaf and hard of hearing individuals to file complaints against interpreters, allowing for discipline. Institutions that do not comply with the law are subject to disciplinary hearings and fines of up to $2,500 for each offense.

In hospitals settings, where communication is key to health and well-being, it is imperative that the deaf and hard of hearing receive accurate medical interpretation so that the patient can not only understand their ailment, but make an educated treatment decision. As the hospital industry and the nation head into tough economic times, it may be fiscally impossible for some hospitals to hire a full-time licensed interpreter for their facility.

However, there are other ways for hospitals to ensure that they fully comply with this law. Services are available today that use call center technology to create a reliable network of advanced-licensed sign language interpreters. As a resource to Illinois hospitals, the Metropolitan Chicago Healthcare Council, has developed such a tool, the Illinois Video Interpreter Network for Healthcare (IVIN-H), which allows hospitals to access qualified interpreters from a network formed by participating hospitals. Currently, the network can provide advanced-licensed sign language interpreters.

Through innovative programs, hospitals can ensure that their deaf and hard of hearing patients receive quality interpretation services without a huge added expense. For a copy of the Act or to learn more information about IVIN-H, go to www.mchc.org.

Editor's Corrections to the October Issue

Certification Award, David Chabala

Merit of Honor Award, David Golom

HFMA Events

Managing UB-04 Data

BY GUY ALTON

On November 12, 2008, a new chapter program was held at the Lindner Center in Lombard. The program was geared toward educating members and potential members with the nuts and bolts of the UB-04 billing form and changes needed and coming in the near future. While many billers of varying experience were in attendance, there were also many attendees from other parts of the revenue cycle, from admitting to denials management.

Suzanne Lestina from HFMA National was our guest lecturer. As always she was a very dynamic and insightful presenter and has remained one of the most knowledgeable presenters on the UB-04. She not only taught the ins and outs of the UB-04, but how it takes an entire hospital to create a clean claim and how to calculate the true cost of denials.

Suzanne also updated attendees with changes coming to the X12 8371 005010 to support ICD-10-CM and other changes needed to the standard.

The half day program stressed what HFMA is all about – education and networking. If you missed this year's program watch for future programs. This program was designed as a reasonably priced education program for providers with staff new to billing or other parts of the revenue cycle. We promise to give better driving directions and hope to see many of you there!

Suzanne Lestina, Presenter

Audience, Managing UB-04 Data

First Illinois Chapter News, Upcoming Chapter Events and Committee Updates

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aIPAM Spring Conference

Save the Date!

The Palace of Access Delights

Thursday, March 12, 2009

Come join your friends and Patient Access peers for the aIPAM Spring Conference at Alhambra Palace Restaurant in Chicago. Become enchanted by knowledgeable speakers, be thrilled by exotic belly dancing, get connected to key healthcare professionals who can influence your career.

Details will be available soon. Visit **aIPAM.net** for updates.

Katherine Murphy

Patient Access – We're Lovin' It!

BY FRED FALLER

The Fall aIPAM Conference, "Patient Access – We're Lovin' It!" was held at the Hyatt on McDonald's campus in Oak Brook, Illinois on October 2, 2008. Attendees enjoyed good food, engaging vendor exhibits and lunchtime entertainment from a nimble, harmonica-playing juggler.

The nearly 200 attendees were treated to informative presentations including: a look at the revenue cycle of the future, leadership philosophy and associate loyalty, advancements in scheduling, and a panel discussion on timely healthcare issues. The keynote speaker, Rob Peck, entertained the group with astounding feats of juggling and deeply touching stories of human interaction.

This year, the aIPAM Torch Award for service excellence at the front-line went to Cheryl Crutchfield from Delnor Hospital. Robin Speaks from Children's Memorial Hospital in Chicago received the Allegiance Award for her unyielding leadership and advocacy in Patient Access. The aIPAM Scholarship Award went to Annette Hicks from Carle Hospital in Urbana, Illinois, which entitled her to attend the fall conference free of charge.

Following the presentations the cocktail hour included an exciting raffle and classic McDonald's hamburgers and cheeseburgers. This group clearly knows how to have a great time!

Fred Faller is a marketing manager with Nebo Systems, Inc. He can be reached by e-mail at fred@nebo.com

Allegiance Award, Robin Speaks

Panel Speakers, Angela Willmot, Denise LaDoice, Suzanne Lestina, Jean Kummerer, Sandra Joe and Eleanor Michalek

Scholarship Award, Annette Hicks

Torch Award, Cheryl Crutchfield

HFMA and MCHC Deliver Knockout Finance Sessions at Second Annual Conference and Exhibition

BY DAN YUNKER

More than 600 healthcare professionals and industry leaders gathered at MCHC's 2nd Annual Conference & Exhibition on October 30, 2008, to learn, explore and network in the exhibition hall as well as attend numerous educational sessions.

HFMA and MCHC paired up to offer the following finance-related sessions which all received high marks:

- The RAC is Knocking: Are You Ready to Answer the Door?
- Understanding IRS Form 990 and Related Schedules: Part 1 and 2
- Healthcare Delivery and the Revenue Cycle—Future Shock?
- Hospital Financial Management for the Non-Financial Manager, Part 1 and 2
- National Managed Care Payer Trends—What May Shock You

Morning keynote speaker Geraldine Ferraro, former Congresswoman and vice-presidential candidate, discussed her battle with multiple myeloma, including her drug regimen, how the diagnosis affected her family and her efforts to create awareness about her disease. Ferraro also analyzed the presidential nominee's healthcare plans, discussed the issue of the uninsured and indicated her intentions to assist the new president with healthcare reform.

"No matter which candidate wins, I will be contacting Senator Hillary Clinton, my Senator, and offering my assistance with healthcare reform," Ferraro said.

Ethicist Jack Gilbert, the afternoon keynote speaker, provided an indepth look at the role of ethics in society and the workplace. Using current and historical examples, Gilbert explained how attitudes affect reality as well as how companies can stay true to their missions by aligning it with their margins.

Dr. Gilbert's award winning book, *Productivity Management: A Step-By-Step Guide for Healthcare Professionals,* has been used widely by healthcare managers. Over the course of working with hundreds of executives, business leaders, and employees, he has observed the phenomenon of ethical erosion. Research shows that it is the small steps and small decisions that lead individuals and their organizations into ethical conflicts, a slippery slope that can ultimately undermine the organization's viability and credibility.

Both speeches touched on important issues that are currently affecting the U.S. healthcare system.

Geraldine Ferraro, Guest Speaker, MCHC

David Hammer, Session Presenter

Brian Sinclair, Jim Ventrone, Tammy Rowland, and Al Staidl

The Obama Presidency and Healthcare Issues

Excerpted from *metroHealth*, vol. 17, no. 8, a publication of the Metropolitan Chicago Healthcare Council

President-elect Barack Obama will take office with Democratic majorities in the House and Senate. Obama and key congressional leaders, with the 2010 mid-term elections looming around the corner, will want to demonstrate that they are governing effectively by achieving early legislative victories. Because Obama is assuming control of the presidency during a time of war and recession, and overseeing a massive rescue of the financial services industry, the Obama administration and congressional Democrats will have to make hard choices of where to focus their reform efforts. During his campaign, Obama proposed an ambitious healthcare plan, which includes a mandate that all U.S. children have health insurance coverage, a "play-or-pay" requirement on most businesses, and large investments in health information technology (HIT) and preventive health programs. Estimates suggest that Obama's healthcare reform plan could cost as much as $1.6 trillion over 10 years.

The reality is that the Obama administration will face a number of challenges, not the least of which are a weak economy and a record federal budget deficit exacerbated by the $700 billion rescue of the financial services industry. Obama's campaign also promised fiscal relief for the middle class. Massive healthcare reform may be put on the back burner, with Democrats choosing a more incremental approach to overhauling the system.

The new administration may pass a second economic stimulus package that includes federal medical assistance percentage (FMAP) relief as well as the reauthorization and expansion of the State Children's Health Insurance Program (SCHIP). SCHIP provides federal financial support for Illinois' All Kids program which is scheduled to expire in March 2009. In the past, Democrats have supported an increase to the federal tobacco tax as a way to pay for SCHIP reauthorization and a modest program expansion. Any large expansion in SCHIP may compete with the funding priorities of hospitals and other providers.

Other incremental healthcare initiatives under consideration include legislation to increase the proliferation of HIT, which is supported by both parties. Investments in HIT would help reign in healthcare costs and reduce medical errors, but sticking points over funding and privacy remain. Congress will likely consider increased funding for embryonic stem cell research and legislation to bring generic versions of some biotech drugs to market more quickly.

The Outlook for Medicare and Medicaid

Could 2009 be the year for major Medicare and Medicaid legislation? A key issue for the Obama administration and the 111th Congress is to ensure that both programs can be financed to support current and future generations of beneficiaries. In 2007, Medicare spending exceeded $430 billion, doubling since 2001. For its part, Medicaid spending is projected to grow at nearly double the rate of inflation over the next 10 years. Taken together, Medicare and Medicaid now comprise more than 20 percent of the federal budget. Medicare's trustees are likely to report that, by 2013, at least 45 percent of the program's funding will

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October 30, 2008, MCHC HFMA Conference

The Obama Presidency and Healthcare Issues (continued from page 9)

come from general revenues. By law, the report will force the administration to recommend program cuts.

Should Congress and the next presidential administration choose to tackle Medicare reform, hospitals may have an opportunity to present their issues with the Medicare system. On the other hand, the struggling economy, the record federal budget deficit and competing priorities may force hospitals to defend against significant payment cuts. With the 2010 midterm congressional elections looming, larger changes to address Medicare's finances, such as raising beneficiaries' cost-sharing, limiting benefits or increasing payroll taxes are not likely to be politically viable. Constraining or reducing provider payments will be the more politically safe option. Areas of vulnerability for hospitals will likely include: freezing or providing less-than-full payments updates for inpatient, outpatient and other services; further expanding Medicare policies on transfers and non-payment; and reducing add-on payments for medical education, disproportionate share hospitals, bad debt and capital.

In addition to protecting federal Medicaid funding, hospitals must urge the 111th Congress and the Obama administration to refrain from implementing seven Medicaid regulations which, taken together, could reduce federal funding for Illinois' Medicaid program by $2.5 billion over five years. The current moratorium on these regulations is scheduled to expire in March 2009.

The 111th Congress and the Illinois Congressional Delegation

The Illinois congressional delegation will have some new members in the 111th Congress. The delegation will include 14 Democrats and seven Republicans. Senator Richard Durbin was easily re-elected and will continue his role as Senate Majority Whip and the second highest ranking Democrat in the U.S. Senate. Likewise, Representative Jan Schakowsky will maintain her leadership position within the House Democratic Caucus. Only two seats changed hands. State Senator Debbie Halvorson (D) won the 11th District to replace retiring Jerry Weller (R) and State Representative Aaron Schock (R) won the 18th District to replace retiring Ray LaHood (R). Additional changes are likely. Illinois Congressman Rahm Emanuel (D-5th) is Obama's Chief of Staff and others are expected to follow him to the White House. Obama's own U.S. Senate seat will be vacant as a result of his election to the presidency.

The 2008 Elections and the Impact on Local Government

Changing demographics in Congress and the presence of Obama at the top of the ticket had a significant impact on many local races throughout the metropolitan Chicago area. As a result, Democrats either gained a foothold or expanded their numbers in many jurisdictions, especially in those that have been traditional Republican strongholds. Suburban Democrats won five seats on the Lake County Board. Democrats also swept all countywide offices and picked up four board seats in Will County and two seats each on the boards of commissioners for DuPage, Kane and McHenry counties. Democrats also won their first-ever seats on the Grundy and Kendall county boards. On the flip side, Kankakee County voters increased the Republican majority on the Kankakee County Board.

Looking ahead, reports indicate that Obama is considering several Illinois elected officials in addition to Representative Emanuel to serve in his administration. Those appointments and the subsequent special elections they would cause could dramatically impact the political landscape at the local, state and federal levels in Illinois.

Beware of Increased Bundling in 2009 Final OPPS Rules

BY ALLWYN J. BAPTIST

The 2009 Medicare Outpatient Prospective Payment System (OPPS) final regulations, which were issued by CMS on October 30, 2008, contain a number of provisions that accelerate the trend toward the bundling of services into composite APCs (Ambulatory Payment Classification). Under the bundling concept, which began in 2008, Medicare remits to providers a lump sum payment, referred to as a composite APC, for groups of services that are typically provided together. In prior years, these same services were reimbursed separately based on the individual APC rates for each service.

Medicare's rationale for reimbursing providers using composite APCs is that hospitals achieve savings when they provide multiple services to a Medicare patient during a single encounter. This is similar to the rationale used since the inception of the OPPS, which initially called for discounted reimbursement rates on surgical procedures when two or more procedures are done during the same operative session. Medicare states that the development and implementation of an increasing number of bundled payment rates is a long term goal for the OPPS. They believe that this payment model will encourage hospitals to "manage their resources with maximum flexibility by monitoring and adjusting the volume and efficiency of services themselves."

In the final OPPS regulations for 2008, Medicare established four composite APCs: Extended Assessment and Management, Low Dose Rate (LDR) Prostate Brachytherapy, Cardiac Electrophysiological Evaluation and Ablation, and Mental Health Services. This list has been expanded to eleven composite APCs in 2009, effectively splitting some of the 2008 APCs and adding five new composite APCs for imaging services.

The following is the complete list of composite APCs for 2009, along with their national unadjusted payment rates:

- APC 8000 Cardiac Electrophysiological Evaluation and Ablation $9418.24
- APC 8001 LDR Prostate Brachytherapy $3035.05
- APC 8002 Level 1 Extended Assessment and management composite $375.70
- APC 8003 Level 2 Extended Assessment and management $674.73
- APC 8004 Ultrasound $192.69
- APC 8005 CT and CTA without Contrast $415.76
- APC 8006 CT and CTA with Contrast $635.10
- APC 8007 MRI and MRA without Contrast $711.05
- APC 8008 MRI and MRA with Contrast $990.32
- APC 0172 Level 1 Partial Hospitalization (3 services) $161.05
- APC 0173 Level 2 Partial Hospitalization (4 or more services) $204.78

There are specific criteria that apply to each claim before it can be categorized as a composite APC. The Outpatient Coding Editor will determine whether combinations of procedures will qualify for composite APC payments or will be paid under standard/individual APC rates.

Medicare has been attempting to implement a multiple imaging discount policy for hospital and physician payments since 2005. Since 2006, payments to physicians have been reduced by 25 percent for the second and any subsequent imaging procedure performed on contiguous body areas during a single session if they fall within the same family of imaging procedures. There are 11 such families that apply to physicians. In proposing the five composite imaging APCs for hospitals in 2009 (see APC 8004 to 8008 above), Medicare has finally caught hospital reimbursement methodology up to the methodology they have been using for physicians since 2006. They consolidated 11 families into five families and performed an analysis of prior year hospital claims to establish the composite rates.

Under current OPPS policy, hospitals receive a full APC payment for each imaging service on a claim, regardless of how many procedures are performed during a single session using the same imaging modality or whether the procedures are performed on contiguous body areas. Under the proposed rules CMS will reimburse hospitals one composite APC payment for all procedures within a single imaging family that are on a single date of service.

To demonstrate the potential financial impact to hospitals of composite APCs, let us examine the application of APC 8006 CT and CTA with Contrast Composite. If a hospital performs a CT pelvis without and with dye (CPT 72194) and a CT chest spine without and with dye (CPT 72130) on the same patient on the same date of service, the composite payment rate would be $635.10. The individual payment rates are $340.96 for each procedure, or a total of $681.92. This means the hospital will be paid $46.82 less using the composite APC methodology than it would have using individual APCs, a difference of roughly 7 percent. Furthermore, if more than two services are performed on the same date, the single composite rate is still applied and the financial impact is even greater.

It is worth mentioning that there are many other procedures listed within this particular family, such as CT head/brain with dye (CPT 70460) and CT soft tissue neck with dye (CPT 70491). If performed on the same day, these procedures would be reimbursed at the composite rate of $635.10. The individual payment rates are $307.80 for these procedures. As a result, or a total of $615.60. This would result in increased reimbursement of $19.50, or a surplus of 3 percent.

There are several things hospitals can do to be successful under the composite APC payment structure, namely:

- Understand which services are bundled and which are not.
- Periodically analyze the hospital's delivery pattern for potentially bundled services.
- Calculate the potential reimbursement loss or gain under the proposed rules.
- Compare costs of bundled services to the composite APC rates.
- Educate affected physicians and department managers/supervisors about the new rules and their potential impact.
- Develop and articulate internal strategies to manage under these new rules.

We had four composite APCs in 2008. In 2009, there will be 11, and this number is sure to continue to grow in the future. Hospitals must monitor this trend carefully and develop and update appropriate strategies for each composite APC. If this trend continues we will someday likely have composite APCs for most outpatient encounters.

The Healthcare Environment in Russia Today (continued from page 1)

of the populace sharing 80% of the total national revenue today

- Life expectancy for Russian men averages 60 years and for Russian women averages 70 years with some variation depending on the geographic location, usually downward. As an example in the Novgorod area the men live an average of 58 years.
- Major mortality causes are:
  - Cardio Vascular – blood infections and circulatory problems believed caused by the significant number of people that smoke and consume excessive amounts of alcohol
  - Cancer
  - Other – auto accidents, lung problems and missed diagnoses issues (198.5 deaths per 1,000 die in auto accidents or related events)
- 20% of the total populace or 32 million Russians are hospitalized annually
- 85% of hospital beds occupied annually – 100 beds available per 10,000 people
- 5,000 hospitals and 6,000 clinics exist in Russia and all are maintained by government
- One-tenth of bed capacity is used for Medical Health Services and one-twentieth of the bed capacity is used for Tuberculosis Services
- Length of stay approximates 13 to 14 days, which includes admission, treatment plan and convalescence
- 20% of the patients die during the length of stay period while 80% die at home, in the streets or in auto accidents
- 3,000 hospitals and clinics have closed over the past 15 years

The Academy also shared with us what they considered some of the problems and their goals for improving the health of the Russian population over the next ten-year period. They stated the most significant problem at this time is access to high quality medical care in all the geographic regions of Russia. Some of the Academy's goals over the next ten years include:

- Improving the mortality for both men and women by 10 years – men to 70 years and women to 80 years
- Reducing preventable deaths because of Cardio Vascular problems
- Developing a National Health Policy
- Initiating inter-agency cooperation between the different healthcare agencies in Russia
- Reviewing and implementing the excellent features of other nations' healthcare systems in order to implement the necessary plans for improving the healthcare of the Russian populace

The Academy has recommended that the Russia Federation commit an additional 1.0 trillion rubles or $39.2 million USD to the health system for improving the healthcare delivery system, especially the mortality rate.

The Academy staff also provided the following financial information:

- 5.2% of the total federal budget is spent on healthcare which represents an estimated 60% of the total annual healthcare expenditures; the other 40% is funded by the 85 health defined regions - 20% from other sources

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including patients

- Total federal budgetary overlays for 2006 were 4.5 trillion rubles or $180.0 million USD or 5% of the total national budget.
- Average federal outlay per capita is approximately 10,000 rubles or $400 USD
- 0.5 trillion rubles or approximately $20.0 million USD were funded by the patients, which varies significantly from region to region with the highest being 30,000 rubles or $1,200 USD per person to 1,500 rubles or $60 USD per person

We also learned that patients pay "extra" or "unofficial gratuities" to receive better medical services, such as quicker, or even to obtain access to sophisticated medical equipment such as CAT, MRI and PET scanners, or for extra drugs including many brand names. We learned in an informal conversation at the Compulsory Medicare Insurance Ministry that the "extra" patient payments may be as high as 40% of the total healthcare financial outlays.

Russia's healthcare financial mechanism also includes a Compulsory Medical Insurance Component. The insurance is funded by employer companies and self employed individuals. A social tax of 3.1% is leveled on total salaries and wages of which 1.1% goes directly to the Compulsory Insurance Fund and 2.0% goes to the regions to assist them in providing healthcare coverage to the unemployed, the retired and the children in the region. Approximately 60% of the total Russian populace, excluding the military and the police forces, are unemployed or unemployable, retired or children.

The Compulsory Medical Insurance present budget is 175.0 billion rubles or $7.0 billion USD. The Russia Federation provides the funds for high technology, bricks and mortar. Medical expenses consume 4.5% of the Gross Domestic Product (GDP) while in the United States medical expenses consume approximately 16% of the GDP.

The Compulsory Medical Insurance Ministry has established several immediate needs for the Russian Healthcare system. They include:

- Moving from financing healthcare institutions, including the salaries of medical professionals in state owned facilities, to financing medical services

Members of Delegation from First Illinois Chapter Left to Right Back Row: Larry Damron, Charlotte Damron & Mike Grady Front Row: Mary Grady, Joe Abel & Patrick McDermott

- Establishing methods for measuring and monitoring medical quality care through economic standards and defined benchmark costs
- Ensuring that the medical service payments cover all medical costs for necessary services so that the present "extra" patient payment system could be eliminated
- Improving the integrated information technology personal medical record system for monitoring and measuring medical outcome results for supporting healthcare reform
- Reviewing the requirements of certain population groups for determining the appropriate medical subsidiaries
- Reducing cost in the healthcare delivery system without effecting quality of care by 25.0 billion rubles or $1.0 billion USD annually
- Working with the Russian Minister of Health in developing a strategic plan for the healthcare delivery system for the Russian citizens for the period 2008 to 2020

The Compulsory Medical Insurance does not cover Mental Healthcare. Mental Healthcare is covered entirely at the national federation.

The Russian healthcare delivery system faces many challenges, as each citizen is guaranteed access to medical care by their national constitution. This constitutional mandate presents many budgetary issues as the methods for financing the healthcare access mandate are not defined and results in several different interpretations which result in "soft" budgets. What is not being covered by the federation is paid as out-of-pocket expense by the citizens (patients).

As a group we visited the Vsevolozhsk Central District Hospital outside Saint Petersburg. This facility serves 217,000 people who live in a variety of villages and suburban areas in the hospital service area. The central district is arranged into three zones with one hospital in each zone. The zones also include a number of clinics of which 13 serve the area surrounding the Vsevolozhsk facility.

The Vsevolozhsk Hospital receives funding from three sources, Compulsory Medical Insurance (60%), regional budget allocation (15%), and other sources including patent payments and receipt of charitable donations (25%). The hospital's budgeted expenditure allocations are distributed 75% to salaries and wages, 10% to medical supplies and drugs, 10% to dietary and the remaining 5% to administration. These percentages exclude the average of 7% for fines imposed by the nation federation for failing to meet medical standards which are poorly defined and vary from region to region. The local hospital's budget does not include any capital or information technology budgetary outlays.

(continued on page 14)

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The hospital's funding for 2007 was 30.0 million rubles or $1.2 million USD received from the federal sources, 12.0 million rubles or $0.48 million USD received from local governments and 8.0 million rubles or $0.32 million USD provided by other revenue sources. The hospital and the supporting clinics provide most medical services including those of medical specialists with the exception of Pediatrics and Physicists. In addition, critically ill patients are transferred to another hospital in the zone that has more equipment to handle such cases.

The hospital is launching a "day hospital program" to attempt to reduce cost. This model provides medical care for the patient during the day, excluding meals. They are addressing "home visits" (house calls) by physicians, which is a carryover from the old Soviet times that shifts revenue from the hospital and is generally funded by "extra" patient payments. The hospital is considering outsourcing certain services, such as housekeeping, to reduce expenses. Some of us found the hospital, built in the 1980s, to be both dilapidated and ill equipped for providing medium to high level medical services.

The last medical facility the group visited was a MEDI clinic in Saint Petersburg. This clinic is part of a group of clinics that specialize in preserving beauty for the patient. The clinic provides dental care and manufactures dental prosthetics and inlays. The MEDI clinic firm also provides post-graduate training, publishes articles and performs research for the professional society of dentists.

The MEDI clinics are funded through employers that provide private (voluntary) insurance and certain self-insured and self-funded clients. The clinic has three levels of service determined by the patient's ability to pay. They include premium service, business service and economy service. The price range for the different services is from 100,000 rubles or $4,000 USD to 250,000 rubles or $10,000 USD. The MEDI clinics also provide dermatology and cosmetic surgery services to enhance the beauty of the patients.

The Russian healthcare delivery system appears to be in the post Medicare era in the United States. We found the visit to the various healthcare agencies and facilities very interesting and informative. In conclusion, we believe that the U.S. healthcare delivery system far exceeds the system presently operating in Russia.

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A broad topical article may be 1000-1500 words in length. Shorter, "how-to" or single subject articles of 500-800 words are also welcome. Authors should suggest titles for their articles. Graphs, charts, and tables **(PDF or JPG only)** should be provided when appropriate. Footnotes should be placed at the end of the article. Authors should provide their full names, academic or professional titles, academic degrees, professional credentials, complete addresses, telephone and fax numbers, and e-mail addresses. Manuscripts should be submitted electronically, on computer disk or by e-mail as a Microsoft Word or ASCII document.

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Chapter Education Calendar 2008/2009

Thursday, January 22, 2009
Accounting & Reimbursement / Revenue Cycle
Holiday Inn Select, Naperville

Thursday, February 19, 2009
Medical Group & Physicians
University Club, Chicago

Thursday, March 19, 2009
Managed Care
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