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The complete instructor materials include the following:

- Solutions for the end-of-chapter questions and problems
- PowerPoint slides covering the essential issues of each chapter
- Test bank

This sample includes the end-of-chapter solutions and PowerPoint slides for Chapter 2, “Healthcare Insurance and Reimbursement Methodologies.”

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11/4/15

ANSWERS TO END-OF-CHAPTER QUESTIONS

- 2.1a.** Pooling of losses means that losses are spread over a large group of individuals so that each person pays the average or expected loss of the entire group (plus administrative expenses), rather than paying the actual loss incurred. Pooling losses in this way protects individuals from catastrophic (very large) losses that could result in bankruptcy. In order for pooling of losses to be financially feasible, future losses must be predictable with some accuracy. This requires the pooling of losses over a large number of people with relatively homogeneous risk so the law of large numbers will apply.
- b.** Payment only for random losses means that insurance payments are made only for losses that cannot be foreseen (i.e., losses that cannot be controlled or affected by the insured individual). Moral hazard, discussed later, describes circumstances under which losses are not random.
- c.** Risk transfer is the transfer of a risk of loss from an insured to an insurer, which typically is in a better financial position to bear the risk than the insured because of the law of large numbers.
- d.** Indemnification is the reimbursement of the insured person if a loss occurs (i.e., payment of a claim). In the context of health insurance, indemnification takes place when the insurer pays the insured individual or the provider for the covered portion of the expenses related to an insured illness or injury.
- 2.2** Adverse selection occurs because individuals or businesses that are more likely to incur losses (i.e., have a greater risk of loss) are more likely to purchase insurance than those that are less likely to have claims. Adverse selection arises because there is asymmetric information between the insured and insurer, where the insured knows more about his or her risk of loss than the insurer. Among other strategies, one way insurers deal with the problem of adverse selection is by creating large, well-diversified risk pools so that the costs of adverse selection can be absorbed by the large number of enrollees.
- 2.3** The moral hazard problem describes circumstances under which individuals are more likely to incur losses because of personal behaviors (i.e., the losses are not random). For example, in the context of health insurance, individuals may be more likely to use unneeded health services when they are not paying the full cost of those services.
- 2.4** Third-party payers, the organizations that provide most of the revenues to healthcare providers, are classified as either private insurers or public insurers.

Private Insurers

In the United States, the concept of public, or government, health insurance is relatively new, while private health insurance has been in existence since the turn of the century. The major private insurers are Blue Cross/Blue Shield, commercial insurers, and self-insurers.

Blue Cross/Blue Shield organizations trace their roots to the Great Depression, when both hospitals and physicians were concerned about their patients' ability to pay healthcare bills. *Blue Cross* originated as a number of separate insurance programs offered by individual hospitals, which were ultimately consolidated into larger programs. The states, one by one, passed enabling legislation that provided for the founding of not-for-profit hospital service

corporations that were exempt both from taxes and from the capital requirements mandated for other insurers. However, state insurance departments had—and continue to have—oversight over most aspects of the plans' operations. *Blue Shield* plans developed in a manner similar to that of the Blue Cross plans, except that the providers were physicians instead of hospitals. The Blues are organized as local or statewide corporations, but all belong to a single, national association that sets standards that must be met to use the Blue Cross/Blue Shield name. Historically, the Blues have been not-for-profit corporations that enjoyed the full benefits accorded to that status, including freedom from taxes. In 1986, however, Congress eliminated the Blues' tax exemption on the grounds that they operated commercial-type insurance activities. In 1994, the national association lifted its traditional ban on member plans becoming investor-owned companies. Since that time several plans have converted to for-profit status.

Commercial health insurance is issued by life insurance companies, by casualty insurance companies, and by companies that were formed exclusively to write health insurance. Commercial insurance companies can be organized either as stock or mutual companies. *Stock* companies are shareholder owned and can raise capital by selling shares of stock, just like any other for-profit company. Furthermore, the stockholders assume the risks and responsibilities of ownership and management. A *mutual* company has no shareholders; its management is controlled by a board of directors elected by the company's policyholders. Regardless of the form of ownership, commercial insurance companies are taxable entities. Commercial insurers moved strongly into health insurance following World War II. At that time, the United Auto Workers (UAW) negotiated the first contract with employers in which fringe benefits were a major part of the contract. Like the Blues, the majority of individuals with commercial health insurance are covered under *group policies* with employee groups, professional and other associations, and labor unions.

The third major form of private insurance is *self-insurance*. Self-insurers make a conscious decision to bear the risks associated with healthcare costs and then set aside funds to pay future costs as they occur. Individuals are not good candidates for self-insurance because they face too much uncertainty concerning healthcare expenses. On the other hand, large groups, especially employers, are good candidates for self-insurance. Today, most large groups are self-insured. For example, employees of the State of Florida are covered by health insurance that is administered by Blue Cross/Blue Shield of Florida, but the actual benefits to plan members are paid directly by the state. Blue Cross/Blue Shield is paid for administering the plan, but the state bears all risks associated with cost and utilization uncertainty.

Public Insurers

The two major government third-party payers are Medicare and Medicaid.

Medicare is a federal program that was established by Congress in 1965 primarily to provide medical benefits to individuals aged 65 or older. Medicare also covers healthcare costs associated with selected disabilities and illnesses (such as kidney failure) regardless of age. Medicare includes four major coverages: (1) Part A provides hospital and some skilled nursing home coverage; (2) Part B covers physician services, ambulatory surgical services, outpatient services, and other miscellaneous services; (3) Part C (Medicare Advantage) is a managed care option offered by private insurance companies that can be selected in lieu of Parts A and B; and (4) Part D covers prescription drugs. The Medicare program falls under the *Department of Health and Human Services (HHS)*, which creates the specific rules of the program on the basis of enabling legislation. Medicare is administered by an agency under HHS called the *Centers for Medicare & Medicaid Services (CMS)*.

Medicaid began in 1966 as a modest program to be jointly funded and operated by the states and the federal government to provide a medical safety net for low-income mothers and children and for elderly, blind, and disabled individuals receiving benefits from the Supplemental Security Income (SSI) program. Congress mandated that Medicaid cover hospital and physician care, but states were encouraged to expand on the basic package of benefits either by increasing the range of benefits or by extending the program to cover more people. States with large tax bases were quick to expand coverage to many groups, while states with limited abilities to raise funds for Medicaid were forced to establish more limited programs. Over the years, Medicaid has provided access to healthcare services for many low-income individuals who otherwise would have no insurance coverage. Furthermore, Medicaid has become an important source of revenue for healthcare providers, especially those that treat large numbers of indigent patients. However, Medicaid expenditures have been growing at an alarming rate, and hence both federal and state policymakers are struggling to find effective ways to improve the program's access, quality, and cost.

- 2.5a.** Managed care plans strive to combine the provision of healthcare services and the insurance function into a single entity, with the joint goals of increasing quality of care and decreasing costs. Traditionally, such plans have been created by insurers, who either directly own a provider network or create one through contractual arrangements with independent providers. There is variation in the approaches used by managed care plans to combine financing and delivery of healthcare, but a common feature is that the insurer has some mechanism by which it controls or influences patients' utilization of healthcare services.
- b.** One type of managed care plan is the *health maintenance organization (HMO)*. HMOs are based on the premise that the traditional insurer/provider relationship creates perverse incentives that reward providers for treating patients' illnesses while offering little incentive for providing prevention and rehabilitation services. By combining the financing and delivery of comprehensive healthcare services into a single system, HMOs theoretically have as strong an incentive to prevent as to treat illnesses.

Another type of managed care plan, the *preferred provider organization (PPO)*, evolved during the early 1980s. PPOs are a hybrid of HMOs and traditional health insurance plans. They use many of the cost-saving strategies developed by HMOs. PPOs do not mandate that beneficiaries use specific providers, although financial incentives are created that encourage members to use those providers that are part of the *provider panel*, which are those providers having discounted-fee contracts with the PPO. Unlike HMOs, PPOs do not require beneficiaries to use preselected gatekeeper physicians who serve as the initial contact and authorize all services received. PPOs are less likely than HMOs to provide preventive services. PPOs also do not assume any responsibility for quality assurance, because the enrollees are not constrained to use only the PPO panel of providers.

Finally, *managed fee-for-service plans* use preadmission certification, utilization review, second surgical opinions, and other managed care strategies to control inappropriate utilization.

- 2.6** The primary difference between fee-for-service and capitation reimbursement is that under *fee-for-service* each encounter creates additional revenue for the provider. The encounter may be defined as a visit, a diagnosis, a hospital day, or in some other manner, but the key feature is that the more services that are performed, the greater the reimbursement amount. Under *capitation*, the provider is paid a fixed amount per covered life per period (usually a month) regardless of the amount of services provided.
- 2.7a.** Under *cost-based* reimbursement, providers are given a "blank check" in regards to acquiring assets and incurring operating costs (although only allowable costs are

- reimbursed, usually defined as those costs directly related to the provision of healthcare). If payers reimburse providers for all costs, the incentive is to incur costs. Facilities will be lavish and conveniently located, and staff will be available to ensure that patients are given “deluxe” treatment. Furthermore, as in billed charges reimbursement, services that may not truly be required will be provided because more services lead to higher costs, which mean higher revenues. Cost-based reimbursement is the least risky for providers because payers more or less ensure that costs will be covered, and hence profits will be earned. Few hospitals currently receive cost-based reimbursement. The exception is critical access hospitals—small rural hospitals—which are reimbursed on a cost basis by Medicare.
- b. Under *charge-based* reimbursement, providers have the incentive to set high charge rates, which leads to high revenues. However, in highly competitive markets, there will be a constraint on how high providers can go. Because billed charges is a fee-for-service type of reimbursement, in which more services result in higher revenue, a strong incentive exists to provide the highest possible amount of services. In essence, providers can increase utilization, and hence revenues, by *churning*—creating more visits, ordering more tests, extending inpatient stays, and so on. Although charge-based reimbursement does encourage providers to contain costs, the incentive is weak because charges can be more easily increased than costs can be reduced. Note, however, that *discounted-charge* reimbursement places additional pressure on profitability and hence creates an increased incentive for providers to lower costs. In charge-based systems, providers typically can set charges high enough to ensure that costs are covered, although discounts introduce uncertainty into the reimbursement process. Providers bear the cost-of-service risk, in that costs can exceed revenues. However, if providers set charge rates for each type of service provided, they can most easily ensure that revenues exceed costs.
 - c. *Per procedure* reimbursement is one form of prospective payment, where rates paid by payers are established before the services are provided. Under per procedure reimbursement, a separate payment is made for each procedure performed on a patient. Because of the high administrative costs that would be incurred by using this form of payment with very complex patients, per procedure reimbursement is more common in outpatient than in inpatient settings. Under *per procedure* reimbursement, the profitability of individual procedures will vary depending on the relationship between the actual costs incurred and the payment for that procedure. Providers, usually physicians, have the incentive to perform procedures that have the highest profit potential. Furthermore, the more procedures, the better, because each procedure generates additional revenue. Prospective payment adds a second dimension of risk to reimbursement contracts because the bundle of services needed to treat a particular patient may be more extensive than that assumed in the payment. However, when the prospective payment is made on a per procedure basis, risk is minimal because each procedure will produce its own revenue.
 - d. *Per diagnosis* reimbursement is a second form of prospective payment, where the provider is paid a rate that depends on the patient’s diagnosis. Medicare pioneered this basis of payment in its diagnosis-related group (DRG) system, first used for hospital inpatient reimbursement in 1983. The incentives under per diagnosis reimbursement are similar to those under per procedure reimbursement. Providers, usually hospitals, will seek patients with those diagnoses that have the greatest profit potential, and they will discourage (even discontinue) those services that have the least potential. Furthermore, to the extent that providers have some flexibility in assigning diagnoses to patients, an incentive exists to *up code* diagnoses to another one that provides greater reimbursement. When prospective payment is made on a per diagnosis basis, provider risk is increased relative to cost- or charge-based reimbursement. If, on average, patients require more intensive treatments, and for hospitals, a longer length of stay (LOS), than assumed in the prospective payment amount, the provider must bear the added costs.

- e. A third form of prospective payment is *per diem* (per day) reimbursement. Under per diem reimbursement, the provider is paid a fixed amount for each day that service is provided, regardless of the nature of the services. Per diem rates may be stratified by the type of care; for example, a hospital may be paid one rate for a medical/surgical day, a higher rate for a critical care unit day, and yet a different rate for an obstetrics day. Per diem rates may also vary over the course of a patient's stay. For example, the early days of a stay may be paid at higher rates than the later days in order to recognize that service intensity is highest when the patient is first admitted. Per diem reimbursement applies only to inpatient settings, for example, Medicare's inpatient psychiatric facility prospective payment system. Because providers are paid per day, per diem reimbursement creates an incentive to extend patients' length of stay as long as the per diem reimbursement rate is higher than the cost of providing a day of care. Because the early days of a hospitalization are typically more costly to the provider than the later days, the later days are more profitable. When prospective payment is made on a per diem basis, even when stratified, one daily rate usually covers a large number of diagnoses. Because the nature of the services provided could vary widely, due to both varying diagnoses and intensity differences within a single diagnosis, the provider bears the risk that costs associated with the services provided on any day exceed the per diem rate. Although patients with complex diagnoses and greater intensity tend to remain hospitalized longer, the additional days of stay (and hence reimbursement) may be insufficient to make up for the increased resources consumed. In addition, providers bear the risk that the payer, through the utilization review process, will constrain length of stay and hence increase intensity during the days that a patient is hospitalized.
- f. Under *bundled payment*, providers do not have the opportunity to be reimbursed for a series of separate services, which is called *unbundling*. For example, a physician's treatment of a fracture could be bundled, and hence billed, as one episode, or it could be unbundled with separate bills submitted for diagnosis, x-rays, setting the fracture, removing the cast, and so on. The rationale for unbundling is usually to provide more detailed records of treatments rendered, but often the result is higher total charges for the parts than would be charged for the entire package. Also, bundled payment, when applied to multiple providers for a single episode of care, forces involved providers (e.g., physicians and a hospital) to jointly offer the most cost-effective treatment. Such a joint view of cost containment may be more effective than when each provider separately attempts to minimize its treatment costs, because lowering costs in one phase of treatment could increase costs in another. Under bundled payment, a more inclusive set of procedures, or providers, are included in one fixed payment. Clearly, the more services that must be rendered for a single payment—or the more providers that have to share a single payment—the more providers are at risk for intensity of services.
- g. *Capitation* reimbursement totally changes the playing field by completely reversing the actions that providers must take to ensure financial success. Under all prospective payment methods, the key to provider success is to work harder, increase utilization, and hence increase profits; under capitation, the key to profitability is to work smarter and decrease utilization. As with prospective payment, capitated providers have the incentive to reduce costs, but now they also have the incentive to reduce utilization. Thus, only those procedures that are truly medically necessary should be performed, and treatment should take place in the lowest-cost setting that can provide the appropriate quality of care. Furthermore, providers have the incentive to promote health rather than just treat illness and injury, because a healthier population consumes fewer healthcare services. Under capitation, providers assume utilization and actuarial risks that traditionally have been an insurance function. In the traditional fee-for-service system, the financial risk of providing healthcare is shared between purchasers and insurers. Hospitals, physicians, and other providers bear negligible risk because they are paid on the basis of the amount of services provided. Insurers bear short-term risk in that in any year, payments to providers can exceed the amount of premiums collected. However, poor profitability by insurers in one

year usually can be offset by premium increases to purchasers the next year, so the long-term risk of financing the healthcare system is borne by purchasers. Capitation, however, places the burden of short-term utilization risk on providers.

2.8 *Medical coding*, or medical classification, is the process of transforming descriptions of medical diagnoses and procedures into code numbers that can be universally recognized and interpreted. The diagnoses and procedures are usually taken from a variety of sources within the medical record, such as doctor's notes, laboratory results, and radiological tests. In practice, the basis for most fee-for-service reimbursement is the patient's diagnosis (in the case of hospitals) or the procedures performed on the patient (in the case of outpatient settings). The *International Classification of Diseases* (most commonly known by the abbreviation ICD) is the standard for designating diseases plus a wide variety of signs, symptoms, and external causes of injury and are used internationally to record many types of health events, including hospital inpatient stays. While ICD codes are used to specify diseases, *Current Procedural Terminology (CPT) codes* are used to specify medical procedures (treatments). CPT codes were developed and are copyrighted by the American Medical Association. The purpose of CPT is to create a uniform language (set of descriptive terms and codes) that accurately describes medical, surgical, and diagnostic procedures. CPT terminology and codes are revised periodically to reflect current trends in clinical treatments. To increase standardization and the use of electronic medical records, federal law requires that physicians and other clinical providers, including laboratory and diagnostic services, use CPT for the coding and transfer of healthcare information. (The same law also requires that ICD-9-CM [Clinical Modification] codes be used for hospital inpatient services. Conversion to ICD-10 is expected in 2015.) The *Healthcare Common Procedure Coding System (HCPCS)* extends CPT codes to include nonphysician services and durable medical equipment.

2.9a The Medicare *inpatient prospective payment system (IPPS)* is a prospective payment methodology based on an inpatient's diagnosis at discharge. It starts with two national base payment rates (operating and capital expenses), which are then adjusted to account for two factors that affect the costs of providing care: (1) the patient's condition and treatment and (2) market conditions in the facility's geographic location. Discharges are assigned to one of 751 *Medicare severity diagnosis-related groups (MS-DRGs)*, which designate the diagnoses of patients with similar clinical problems and, hence, who are expected to consume similar amounts of hospital resources. Each MS-DRG has a relative weight that reflects the expected cost of inpatients in that group. The payment rates for MS-DRGs in each local market are determined by adjusting the base payment rates to reflect the local input price level and then multiplying them by the relative weight for each MS-DRG. The operating and capital payment rates are increased for facilities that operate an approved resident training program or that treat a disproportionate share of low-income patients. Rates are reduced for various transfer cases, and *outlier payments* are added for cases that are extraordinarily costly to protect providers from large financial losses due to unusually expensive cases. Both operating and capital payment rates are updated annually.

b. Medicare pays for physician services using a *resource-based relative value scale (RBRVS)* system. In the RBRVS system, payments for services are determined by the resource costs needed to provide them as measured by weights, called relative value units (RVUs). RVUs consist of three components: (1) a work RVU, which includes the skill level and training required along with the intensity and time required for the service; (2) a practice expense RVU, which includes equipment and supplies costs as well as office support costs, including labor; and (3) a malpractice expense RVU, which accounts for the relative risk and cost of potential malpractice claims. To illustrate, the (total) RVU is 0.52 for a minimal office visit, 1.32 for an average office visit, and 3.06 for a comprehensive office visit. Furthermore, the average office visit RVU is composed of a work RVU of 0.67, a practice expense RVU of 0.62, and a malpractice expense RVU of 0.03. The RVU values then are

adjusted to reflect variations in local input prices, and the total is multiplied by a standard dollar value—called the conversion factor—to arrive at the payment amount. Medicare's payment rates may also be adjusted to reflect provider characteristics, geographic designations, and other factors. The provider is paid the final amount, less any beneficiary coinsurance.

- 2.10** The ACA introduced a number of provisions to expand insurance coverage and improve insurance affordability and access. In addition, the ACA has significantly changed the way providers are reimbursed. The key reforms include a move from a fee-for-service model to a prospective payment model, which may include bundled payments or capitation. These new payment methods aim to move reimbursement from one based on the amount of services provided (volume) to one based on value and better outcomes. The insurance and payment provisions of the ACA are described below.

Insurance Provisions

Insurance Standards. A number of new insurance standards have been specified in the ACA. In terms of coverage, these include the following:

- Children and dependents are permitted to remain on their parents' insurance plans until their twenty-sixth birthday.
- Insurance companies are prohibited from dropping policyholders if they become sick and from denying coverage to individuals due to preexisting conditions.
- Individuals have a right to appeal and request the insurer to review denial of payment.

In terms of costs, the standards include the following:

- Insurers are required to charge the same premium rate to all applicants of the same age and geographic location, regardless of preexisting conditions or sex.
- Insurers are required to spend at least 80 percent to 85 percent of premium dollars on health costs and claims instead of on administrative costs and profits. If this is violated, then the insurer must issue rebates to policyholders.
- Lifetime limits on most benefits are prohibited for all new health insurance plans.

In terms of care, the standards include the following:

- All plans must now include essential benefits, such as ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services; prescription drugs; laboratory services; preventive and wellness services; and chronic disease management and pediatric services, including oral and vision care.
- Preventive services, such as childhood immunizations, adult vaccinations, and basic medical screenings, must be available to patients free of charge.
- Individuals are permitted to choose a primary care doctor outside the plan's network.
- Individuals can seek emergency care at a hospital outside the health plan's network.

Individual Mandate. All eligible individuals (US citizens and legal residents) who are not covered by an employer-sponsored health plan, Medicaid, or Medicare are required to have a health insurance policy or face tax penalties. Individuals are required to maintain minimum essential coverage for themselves and their dependents. Individuals who do not have minimum levels of coverage and do not qualify for an exemption are required to pay a penalty to the Internal Revenue Service at the end of each tax year.

Health Insurance Exchanges. People who have no employer-sponsored insurance, the unemployed, or the self-employed can purchase coverage through *health insurance exchanges (HIEs)*. HIEs are online marketplaces, where people can research and review their options and purchase health insurance. It is estimated that more than 25 million people are using HIEs to buy healthcare insurance coverage. To ensure price

transparency, all insurance companies are required to post on HIEs the rates for their various health insurance plans. This will permit individuals and businesses shopping for insurance to compare all plans and rates side by side and select plans that are affordable and meet their needs. Public exchanges are created by state or federal government and are open to both individuals seeking personal insurance and to small-group employers seeking insurance for their workers. All plans listed on an HIE are required to offer core benefits—called *essential health benefits*—such as preventive and wellness services, prescription drugs, and hospital stays. Private exchanges, on the other hand, are created by private-sector firms, such as a health insurance company. Private HIEs are expected to increase in number over time as more employers offer defined healthcare contributions to their employees who then must purchase health insurance on their own.

Medicaid Expansion. One of the provisions of the ACA is the expansion of Medicaid. Nearly all US citizens and legal residents between the ages of 19 and 64 who have household incomes below 133 percent of the federal poverty level now qualify for Medicaid. This expansion benefits childless adults who previously did not qualify for Medicaid regardless of their income level, as well as low-income parents who previously did not qualify even if their children did qualify. As a result, it is estimated that an additional 16 million people will receive coverage through Medicaid. Originally, under the ACA, Medicaid expansion was mandatory for all states; states that did not comply were to be penalized by the federal government. However, the US Supreme Court ruled that states can opt out of the Medicaid expansion, leaving this decision to participate in the hands of the state's leaders. As of 2014, 26 states have participated in the Medicaid expansion program. The managed Medicaid market may be an area of high growth potential for insurance companies as more states move Medicaid beneficiaries into managed care plans.

New Insurance Markets. Before health reform, the health insurance industry focused on selling group plans to employers. Now it must re-create itself to cater to a huge, entirely new market of individual consumers. Many insurers have little idea how costly it is to provide coverage to these new customers, many of whom are not working and have not been insured for a long time (or even at all). One of the biggest challenges that insurance companies will face is attempting to accurately price and administer these plans without dramatic premium increases. Another problem is that the newly insured often need education about how to use their health plan effectively and how to access different types of care.

Focus on Chronic Care. As insurers and providers continue to partner in new accountable care organizations, the shared savings programs will likely increasingly focus on consumers with chronic conditions. That means implementing more patient-centered medical homes that aim to manage chronic conditions with specific care pathways that address behavioral health needs and decrease hospital admissions and emergency department visits. ACOs and medical homes will also increasingly make use of personal health coaches, who motivate patients on a one-on-one basis and help coordinate patient care with all caregivers.

Payment Provisions

Value-Based Purchasing. *Value-based purchasing (VBP)* is a Medicare initiative that rewards acute care hospitals with incentive payments for the quality of care they provide to Medicare beneficiaries. VBP aims to promote better clinical outcomes for all hospitalized Medicare patients. To that end, hospitals are encouraged to improve the quality and safety of the care they provide to Medicare beneficiaries as well as other patients during inpatient stays by receiving bonus payments. The amounts of these payments are based on how closely the institution followed best clinical practices, how well it enhanced patients' care experiences, how well it achieved a quality measure, and how much it has improved on each measure compared to its performance during the baseline period. Note that some

VBP programs are paired with shared savings programs (discussed below) to reward cost reduction as well as quality of care.

Quality-Based Clinician Compensation. In addition to VBP for hospitals, the ACA requires Medicare to factor quality into payments for physicians and most other clinicians. Quality-based compensation is part of Medicare's effort to shift medicine away from the volume-based focus, where clinicians are paid for each service regardless of quality. Clinicians can earn additional compensation based on the quality of care they provide to their patients. Bonuses and penalties are calculated on the basis of performance on quality measures, which vary by specialty. As with VBP programs for hospitals, quality-based clinician programs can be paired with shared savings programs.

Shared Savings Programs. *Shared savings* is an approach to reducing healthcare costs and, potentially, a mechanism for encouraging the creation of ACOs. Under shared savings, if a provider reduces total healthcare spending for its patients below the level that the payer expected, the provider is then rewarded with a portion of the savings. The benefits are twofold: (1) The payer spends less than it would otherwise, and (2) the provider gets more revenue than it expected. The savings can arise from more efficient, cost-effective use of hospital or outpatient services that enhance quality, reduce costs over time, and improve outcomes. It can be applied to hospital episodes of care, including physician services, or to physician office care.

New Bundled Payment Models. Bundled payment models are a form of fee-for-service reimbursement in which a single sum covers all healthcare services related to a specific procedure. The objective of bundled payments is to promote more efficient use of resources and reward providers for improving the coordination, quality, and efficiency of care. If the cost of services is less than the bundled payment, the physicians and other providers retain the difference. But if the costs exceed the bundled payment, physicians and other providers are not compensated for the difference. In some circumstances an ACO may receive the bundled payment and subsequently divide the payment among participating physicians and providers. In other situations, the payer may pay participating physicians and providers independently, but it may adjust each payment according to negotiated, predefined rules to ensure that the total payments to all the providers do not exceed the total bundled payment amount. This type of reimbursement is called *virtual bundling*. For providers, the challenges of bundled payments include determining who owns the episode of care and the apportioning of the payment among the various providers.

Readmission Reduction Program. With the passage of the ACA, Medicare now has the authority to penalize hospitals if they experience excess readmission rates compared to expected levels of readmission. The readmissions are based on a 30-day readmission measure for heart attack, heart failure, and pneumonia.

Hospital-Acquired Conditions. In a relatively new initiative, hospitals will be penalized by Medicare for hospital-acquired conditions. Hospital-acquired conditions include bedsores, infections, complications from extended use of catheters, and injuries caused by falls. Hospitals will face a 1 percent reduction in Medicare inpatient payments for all discharges if the hospital ranks in the top 25 percent of hospital-acquired conditions for all hospitals in the previous year.

CHAPTER 2

Healthcare Insurance and Reimbursement Methodologies

Although some provider revenues come directly from patients, the vast majority come from insurers and other entities known collectively as **third-party payers**. Because revenues are essential to financial success, health services managers must understand the healthcare insurance system and the methodologies that payers use to reimburse providers.

Insurance Concepts

- For insurance to “work,” it must have these *basic characteristics*:
 - Pooling of losses
 - Payment only for random losses
 - Risk transfer
 - Indemnification

- However, two problems often arise in insurance programs:
 - Adverse selection
 - Moral hazard

Adverse Selection

- **Adverse selection** means those with greater risk are more likely to purchase insurance.
 - The problem exists because of *asymmetric information*; insurance applicants have better knowledge of their health status than insurers have.
 - In the past, insurance companies used **underwriting provisions** to minimize adverse selection.
- **Cross-subsidies** often exist among different groups.

Underwriting Provisions

- There are two opposing positions that insurers have taken in the past regarding underwriting:
 - Community rating
 - Experience rating
- Under the ACA, insurers are required to use *community ratings*.
- Historically, insurance included *preexisting condition* clauses, but these are now banned by the ACA. In essence, health insurers are required to take all applicants, regardless of health condition, gender, occupation, or age.

Moral Hazard

- **Moral hazard** is the overuse of health services or forgoing of prevention because the insured does not bear the full cost of the consequences.
- Insurers use the following techniques to protect themselves (as limited by the ACA):
 - Deductibles
 - Copayments
 - Coinsurance
 - Stop-loss limits
 - Policy restrictions

Third-Party Payers

- For the most part, provider revenues come from **third-party payers** rather than from patients.
- Private insurers
 - Blue Cross/Blue Shield
 - Commercial insurers
 - Self-insurers
- Public insurers
 - Medicare
 - Medicaid

Managed Care Plans

- **Managed care plans** strive to combine both the provision of healthcare services and the insurance function in a single organization.
- There are many types of plans
 - Health maintenance organizations (HMOs)
 - Preferred provider organizations (PPOs)
 - Point-of-service (POS) plans
- ? In general, the purpose of managed care plans is to control costs. How?

Health Reform and Insurance

- **New insurance standards**
- **Individual mandate to have insurance**
- **Establishment of federal/state **health insurance exchanges****
- **Medicaid expansion**
- **Price transparency**
- **High-deductible health plans**
- **New (individual) insurance markets**
- **Increased focus on chronic care**

Generic Reimbursement Methodologies

- Regardless of payer, there are a limited number of payment methodologies.
- These fall into two broad categories:
 - **Fee-for-service (FFS)**, where payment is tied to the *amount of services provided*.
 - Charge based
 - Cost based
 - Prospective payment
 - **Capitation**, where payment is tied to the *size of the covered population* (number of enrollees).

FFS: Charge-Based Reimbursement

- Payer pays **billed (gross) charges** for services rendered.
- Historically, all third-party payers reimbursed providers on the basis of billed charges.
- Some payers still use billed charges as the payment method, but often negotiate a **discount** from gross charges ranging from 20 to 50 percent (or more).
- ? What should the uninsured pay for healthcare services?

FFS: Cost-Based Reimbursement

- Payer pays all *allowable costs* incurred in providing services.
- Typically, **periodic interim payments** are made, with a final reconciliation at the end of each year.
- Medicare used this method for all hospitals in its early years (1966–1983).
- Used rarely today. One example is Medicare payment to **critical access hospitals (CAHs)**.

FFS: Prospective Payment

- **Prospective payment** methods have a fixed payment determined beforehand that is, at least in theory, unrelated to either costs or charges.
- Prospective payment may be on a:
 - Per procedure basis
 - Per diagnosis (DRG) basis
 - Per diem (per day) basis
 - Bundled (episodic) pricing basis

Capitation

- **Capitation** is entirely different from FFS reimbursement.
 - Payment is not tied to utilization, but rather to the number of **covered lives**.
 - Payment to providers usually is made on a **per member per month (PMPM)** basis.
 - Used primarily by managed care plans.
- The impact of capitation will be examined throughout the course.

Discussion Item

Assume that you are the CEO of a hospital. What are the incentives to the organization under:

- **Charge-based reimbursement?**
- **Cost-based reimbursement?**
- **Per diagnosis (DRG) reimbursement?**
- **Per diem reimbursement?**
- **Bundled reimbursement?**
- **Capitation?**

Medical Coding

- **Medical coding** is the first step in the reimbursement process.
- Coding is performed by administrative personnel (**coders**) on the basis of clinicians' notes.
- There are three different types of codes commonly used by providers.
 - ICD codes
 - CPT codes
 - HCPCS codes

ICD Codes

- **International Classification of Diseases (ICD)** codes are used to specify diseases, symptoms, or injuries.
- The codes currently consist of 3, 4, or 5 digits. The greater the number, the more detailed the information. For example:
 - 410 is heart attack
 - 410.0 specifies the anterior wall
- ICD codes are used by hospitals to specify inpatient diagnoses. **ICD-9** was used up until **October 2015**, but **ICD-10**, with many more codes, is now required.

CPT Codes

- **Current Procedural Terminology (CPT) codes** are used to specify medical procedures (treatments).
- **The codes are 5 digits. For example:**
 - 99211 is a simple (short) office visit
 - 99215 is a complex (long) office visit
- **CPT codes are used by physicians (and other clinicians) to specify procedures performed on patients.**

HCPCS Codes

- Because government payers wanted more information than found in CPT codes, they use an expanded system: the **Healthcare Common Procedure Coding System (HCPCS)**.
- This system expands the set of CPT codes to include nonphysician services, ambulance services, and durable medical equipment such as prosthetic devices.

Medicare Reimbursement Methods

- **Different methods are used for different providers.**
 - **Most use a method of classifying patients into groups based on clinical data.**
 - **Patient groups are weighted to reflect different use of resources with the weights frequently updated.**
- **We will illustrate with three examples.**
- **More information can be found at the Medicare Payment Advisory Commission (MedPAC) website (www.medpac.gov).**

Hospital Acute Inpatient Services

- **The Inpatient Prospective Payment System (IPPS) is used.**
- **Each discharge is assigned to a Medicare severity diagnosis related group (MS-DRG).**
- **Payment rates are calculated using a base dollar amount, first adjusted for local input prices, then multiplied by the MS-DRG relative weight.**

Outpatient Hospital Services

- **The Outpatient Prospective Payment System (OPPS) is used.**
- **Each discharge is assigned to an ambulatory payment classification (APC).**
- **Payment rates are calculated using a base dollar amount, first adjusted for local input prices, then multiplied by the relative weight for each APC.**

Physician Services

- The **Physician Fee Schedule** is used.
- Each service has a **relative value unit (RVU)** assigned that reflects amount of physician work, practice expenses, and liability insurance costs.
- Payment rates are calculated using an RVU value, first adjusted for local input prices, then multiplied by a standard dollar amount (the **conversion factor**).

Health Reform and Reimbursement Methods

- **Emphasis on value-based purchasing**
- **New models of bundled payment**
- **Shared savings programs**
- **Quality-based clinician compensation**
- **Readmission reduction program**
- **Program to reduce hospital-acquired conditions (HACs)**

Conclusion

- This concludes our discussion of ***Chapter 2*** (Healthcare Insurance and Reimbursement Methodologies).
- Although not all concepts were discussed in class, you are responsible for all of the material in the text.
- ? Do you have any questions?