

HEALTHCARE INSURANCE AND REIMBURSEMENT METHODOLOGIES

Learning Objectives

After studying this chapter, readers will be able to

- Explain the overall concept of insurance, including adverse selection and moral hazard.
- Briefly describe the third-party payer system.
- Explain the different types of generic payment methods.
- Describe the incentives created by the different payment methods and their impact on provider risk.
- Describe the purpose and organization of managed care plans.
- Explain the impact of healthcare reform on insurance and reimbursement methodologies.
- Explain the importance and types of medical coding.

Introduction

For the most part, the provision of healthcare services takes place in a unique way. First, often only a few providers of a particular service exist in a given area. Next, it is difficult, if not impossible, to judge the quality of competing services. Then, the decision about which services to purchase is usually not made by the consumer but by a physician or some other clinician. Also, full payment to the provider is not normally made by the user of the services but by a healthcare insurer. Finally, for most individuals, health insurance from third-party payers is totally paid for or heavily subsidized by employers or government agencies, so many patients are partially insulated from the costs of healthcare.

This highly unusual marketplace for healthcare services has a profound effect on the supply of, and demand for, such services. In this chapter, we discuss the concept of insurance, the major providers of healthcare insurance, and the methods used by insurers to pay for health services.

Insurance Concepts

Healthcare services are supported by an insurance system composed of a wide variety of insurers of all types and sizes. Some are investor owned, while others are not-for-profit or government sponsored. Some insurers require their policyholders, who may or may not be the beneficiaries of the insurance, to make the policy payments, while other insurers collect partial or total payments from society at large. Because insurance is the cornerstone of the healthcare system, an appreciation of the nature of insurance will help you better understand the marketplace for healthcare services.

A Simple Illustration

To better understand insurance concepts, consider a simple example. Assume that no health insurance exists and you face only two medical outcomes in the coming year:

Outcome	Probability	Cost
Stay healthy	0.99	\$ 0
Get sick	0.01	20,000

Furthermore, assume that everyone else faces the same medical outcomes at the same odds and with the same associated costs. What is your expected healthcare cost— $E(\text{Cost})$ —for the coming year? To find the answer, we multiply the cost of each outcome by its probability of occurrence and then sum the products:

$$\begin{aligned}
 E(\text{Cost}) &= (\text{Probability of outcome 1} \times \text{Cost of outcome 1}) \\
 &\quad + (\text{Probability of outcome 2} \times \text{Cost of outcome 2}) \\
 &= (0.99 \times \$0) + (0.01 \times \$20,000) \\
 &= \$0 + \$200 = \$200.
 \end{aligned}$$

Now, assume that you, and everyone else, make \$20,000 a year. With this salary, you can easily afford the \$200 “expected” healthcare cost. The problem is, however, that no one’s actual bill will be \$200. If you stay healthy, your bill will be zero, but if you are unlucky and get sick, your bill will be \$20,000. This cost will force you, and most people who get sick, into personal bankruptcy.

Next, suppose an insurance policy that pays all of your healthcare costs for the coming year is available for \$250. Would you purchase the policy, even though it costs \$50 more than your expected healthcare costs? Most people would. In general, individuals are risk averse, so they would be willing to pay a \$50 premium over their expected costs to eliminate the risk of financial

ruin. In effect, policyholders are passing to the insurer the costs associated with the risk of getting sick.

Would an insurer be willing to offer the policy for \$250? If an insurance company sells a million policies, its expected total policy payout is 1 million times the expected payout for each policy, or $1 \text{ million} \times \$200 = \$200 \text{ million}$. If there were no uncertainty about the \$20,000 estimated medical cost per claim, the insurer could forecast its total claims precisely. It would collect $1 \text{ million} \times \$250 = \$250 \text{ million}$ in health insurance premiums; pay out roughly \$200 million in claims; and hence have about \$50 million to cover administrative costs, create a reserve in case realized claims are greater than predicted by its actuaries, and make a profit.

Basic Characteristics of Insurance

The simple example of health insurance we just provided illustrates why individuals would seek health insurance and why insurance companies would be formed to provide such insurance. Needless to say, the concept of insurance becomes much more complicated in the real world. Insurance is typically defined as having four distinct characteristics:

1. **Pooling of losses.** The pooling, or sharing, of losses is the heart of insurance. Pooling means that losses are spread over a large group of individuals so that each individual realizes the average loss of the pool (plus administrative expenses) rather than the actual loss incurred.
In addition, pooling involves the grouping of a large number of homogeneous exposure units—people or things having the same risk characteristics—so that the law of large numbers can apply. (In statistics, the law of large numbers states that as the size of the sample increases, the sample mean gets closer and closer to the population mean.) Thus, pooling implies (1) the sharing of losses by the entire group and (2) the prediction of future losses with some accuracy.
2. **Payment only for random losses.** A random loss is one that is unforeseen and unexpected and occurs as a result of chance. Insurance is based on the premise that payments are made only for losses that are random. We discuss the moral hazard problem, which concerns losses that are not random, in a later section.
3. **Risk transfer.** An insurance plan almost always involves risk transfer. The sole exception to the element of risk transfer is self-insurance, which is the assumption of a risk by a business (or an individual) itself rather than by an insurance company. (Self-insurance is discussed in a later section.) Risk transfer is transfer of a risk 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.

4. **Indemnification.** The final characteristic of insurance is indemnification for losses—that is, reimbursement to the insured if a loss occurs. In the context of health insurance, indemnification takes place when the insurer pays the insured, or the provider, in whole or in part for the expenses related to an insured’s illness or injury.

Adverse Selection

One of the major problems facing healthcare insurers is **adverse selection**. Adverse selection occurs because individuals and businesses that are more likely to have claims are more inclined to purchase insurance than those that are less likely to have claims. For example, an individual without insurance who needs a costly surgical procedure will likely seek health insurance if she can afford it, whereas an individual who does not need surgery is much less likely to purchase insurance. Similarly, consider the likelihood of a 20-year-old to seek health insurance versus the likelihood of a 60-year-old to do so. The older individual, with much greater health risk due to age, is more likely to seek insurance.

If this tendency toward adverse selection goes unchecked, a disproportionate number of sick people, or those most likely to become sick, will seek health insurance, and the insurer will experience higher-than-expected claims. This increase in claims will trigger a premium increase, which only worsens the problem, because the healthier members of the plan will seek insurance from other firms at a lower cost or may totally forgo insurance. The adverse-selection problem exists because of asymmetric information, which occurs when individual buyers of health insurance know more about their health status than do insurers.

In today’s world of health reform, ushered in by the Patient Protection and Affordable Care Act (ACA; introduced in Chapter 1), which requires insurers to take on patients regardless of preexisting conditions, the best strategy for healthcare insurers to combat adverse selection is to create a large, well-diversified pool of subscribers. If the pool is sufficiently large and diversified, the costs of adverse selection can be absorbed by the large number of enrollees.

Moral Hazard

Insurance is based on the premise that payments are made only for random losses, and from this premise stems the problem of **moral hazard**. The most common case of moral hazard in a casualty insurance setting is the owner who deliberately sets a failing business on fire to collect the insurance. Moral hazard is also present in health insurance, but it typically takes a less dramatic form; few people are willing to voluntarily sustain injury or illness for the purpose of collecting health insurance. However, undoubtedly there are people who purposely use healthcare services that are not medically required. For example, some people might visit a physician or a walk-in clinic for the social value of

Adverse selection

The problem faced by insurance companies because individuals who are more likely to have claims are also more likely to purchase insurance.

Moral hazard

The problem faced by insurance companies because individuals are more likely to use unneeded health services when they are not paying the full cost of those services.

human companionship rather than to address a medical necessity. Also, some hospital discharges might be delayed for the convenience of the patient rather than for medical purposes.

Finally, when insurance covers the full cost or most of the cost of healthcare services, individuals often are quick to agree to an expensive MRI (magnetic resonance imaging) scan or other high-cost procedure that may not be necessary. If the same test required total out-of-pocket payment, individuals would think twice before agreeing to such an expensive procedure unless they clearly understood the medical necessity involved. All in all, when somebody else is paying the costs, patients consume more healthcare services.

Even more insidious is the impact of insurance on individual behavior. Individuals are more likely to forgo preventive actions and embrace unhealthy behaviors when the costs of not taking those actions will be borne by insurers. Why stop smoking if the monetary costs associated with cancer treatment are carried by the insurer? Why lose weight if others will pay for the adverse health consequences likely to result?

The primary weapon that insurers have against the moral hazard problem is *coinsurance*, which requires insured individuals to pay a certain percentage of eligible medical expenses—say, 20 percent—in excess of the deductible amount. (Insurers also use *copayments*, which are similar to coinsurance but are expressed as a dollar amount: \$20 per primary care visit, for example.) To illustrate coinsurance, assume that George Maynard, who has employer-provided medical insurance that pays 80 percent of eligible expenses after the \$100 deductible is satisfied, incurs \$10,000 in medical expenses during the year. The insurer will pay $0.80 \times (\$10,000 - \$100) = 0.80 \times \$9,900 = \$7,920$, so George's responsibility is $\$10,000 - \$7,920 = \$2,080$. The purposes of coinsurance and copayments are to reduce premiums to employers

For Your Consideration

Who Should Pay for Health Services? Users or Insurers?

One of the most confounding questions that arises when discussing healthcare services is who should bear the responsibility for payment. Should the patient be responsible, or should some third party such as the government or an insurance company foot the bill?

Many people argue that when individuals bear the cost of their own healthcare, they will be responsible consumers and only pay for necessary services. In addition, they will choose providers on the basis of cost and quality and hence create the incentive for providers to offer better yet less expensive services. It is estimated that this action alone would reduce total healthcare costs in the United States by some 20–30 percent, or even more.

Other people argue that individuals cannot make rational decisions regarding their own healthcare because they do not sufficiently understand the nature of illness and injury. Furthermore, there is insufficient information about provider quality and costs available to guide individuals to good decisions. Finally, individuals would skimp on routine preventive healthcare services to save money, which would create healthcare problems down the road and ultimately lead to higher future costs.

What do you think? Should individuals be held more responsible for their own costs of healthcare services? What about the arguments stated above? Is there some way of balancing the need for more consumerism in healthcare service purchases with the need to protect individuals against the very high costs of many services?

and to prevent overutilization of healthcare services. Because insured individuals pay part of the cost, premiums can be reduced. Additionally, by being forced to pay some of the costs, insured individuals will presumably seek fewer and more cost-effective treatments and embrace a healthier lifestyle.

SELF-TEST QUESTIONS

1. Briefly explain the following characteristics of insurance:
 - a. Pooling of losses
 - b. Payment only for random losses
 - c. Risk transfer
 - d. Indemnification
2. What is adverse selection, and how do insurers deal with the problem?
3. What is the moral hazard problem, and how do insurers mitigate the problem?

Third-Party Payers

Up to this point in the chapter, we have focused on basic insurance concepts because a large proportion of the health services industry receives its revenues not directly from the users of their services—the patients—but from insurers known collectively as **third-party payers**. Because an organization's revenues are critical to its financial viability, this section contains a brief examination of the sources of most revenues in the health services industry. In the next section, the reimbursement methodologies employed by these payers are reviewed in more detail.

Health insurance originated in Europe in the early 1800s when mutual benefit societies were formed to reduce the financial burden associated with illness or injury. Since then, the concept of health insurance has changed dramatically. Today, health insurers fall into two broad categories: private insurers and public programs.

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 early 1900s. In this section, the major private insurers are discussed: Blue Cross/Blue Shield, commercial insurers, and self-insurers.

Blue Cross/Blue Shield

Blue Cross/Blue Shield organizations trace their roots to the Great Depression, when both hospitals and physicians were concerned about their patients' ability

Third-party payer

A generic term for any outside party, typically an insurance company or a government program, that pays for part or all of a patient's healthcare services.

to pay healthcare bills. One example is Florida Blue (formerly Blue Cross and Blue Shield of Florida), which offers healthcare insurance to individuals and families, Medicare beneficiaries, and business groups that reside in Florida.

Blue Cross originated as a number of separate insurance programs offered by individual hospitals. At that time, many patients were unable to pay their hospital bills, but most people, except the poorest, could afford to purchase some type of hospitalization insurance. Thus, the programs were initially designed to benefit hospitals as well as patients. The programs were all similar in structure: Hospitals agreed to provide a certain amount of services to program members who made periodic payments of fixed amounts to the hospitals whether services were used or not. In a short time, these programs were expanded from single hospital programs to communitywide, multihospital plans that were called *hospital service plans*. The Blue Cross name was officially adopted by most of these plans in 1939.

Blue Shield plans developed in a manner similar to Blue Cross plans, except that the providers were physicians instead of hospitals. Today, there are 37 Blue Cross/Blue Shield (the “Blues”) organizations. Some offer only one of the two plans, but most offer both plans. The Blues are organized as independent corporations, including some for-profit entities, but all belong to a single national association that sets standards that must be met to use the Blue Cross/Blue Shield name. Collectively, the Blues provide healthcare coverage for more than 100 million individuals in all 50 states, the District of Columbia, and Puerto Rico.

Commercial Insurers

Commercial health insurance is issued by life insurance companies, by casualty insurance companies, and by companies that were formed exclusively to offer healthcare insurance. Examples of commercial insurers include Aetna, Humana, and UnitedHealth Group. All commercial insurance companies are taxable (for-profit) entities. Commercial insurers moved strongly into health insurance following World War II. At that time, the United Auto Workers 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.

Self-Insurers

The third major form of private insurance is *self-insurance*. Although it might seem as if all individuals who do not have some form of health insurance are self-insurers, this is not the case. Self-insurers make a conscious decision to bear the risks associated with healthcare costs and then set aside (or have available) funds to pay future costs as they occur. Individuals, except the very wealthy, 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, the costs of which are paid directly by the state. Blue Cross/Blue Shield is paid a fee to administer the plan, but the state bears all risks associated with cost and utilization uncertainty.

Public Insurers

Government is a major insurer as well as a direct provider of healthcare services. For example, the federal government provides healthcare services directly to qualifying individuals through the medical facilities of the US Department of Veterans Affairs; the US Department of Defense and its TRICARE program (health insurance for uniformed service members and their families); and the Public Health Service, part of the *US Department of Health and Human Services (HHS)*. In addition, government either provides or mandates a variety of insurance programs, such as workers' compensation. In this section, however, the focus is on the two major government insurance programs: Medicare and Medicaid.

Medicare

Medicare was established by Congress in 1965 primarily to provide medical benefits to individuals aged 65 or older. About 50 million people have Medicare coverage, which pays for about 17 percent of all US healthcare services.

Over the decades, Medicare has evolved to include four major coverages: (1) Part A, which provides hospital and some skilled nursing home coverage; (2) Part B, which covers physician services, ambulatory surgical services, outpatient services, and other miscellaneous services; (3) Part C, which is managed care coverage offered by private insurance companies and can be selected in lieu of Parts A and B; and (4) Part D, which covers prescription drugs. In addition, Medicare covers healthcare costs associated with selected disabilities and illnesses, such as kidney failure, regardless of age.

Part A coverage is free to all individuals eligible for Social Security benefits. Individuals who are not eligible for Social Security benefits can obtain Part A medical benefits by paying monthly premiums. Part B is optional to all individuals who have Part A coverage, and it requires a monthly premium from enrollees that varies with income level. About 97 percent of Part A participants purchase Part B coverage, while about 20 percent of Medicare enrollees elect to participate in Part C, also called *Medicare Advantage Plans*, rather than Parts A and B. Part D offers prescription drug coverage through plans offered by private companies. Each Part D plan offers somewhat different coverage, so the cost of Part D coverage varies widely.

Medicare

A federal government health insurance program that primarily provides benefits to individuals aged 65 or older.

The Medicare program falls under HHS, which creates the specific rules of the program on the basis of enabling legislation. Medicare is administered by an agency in HHS called the *Centers for Medicare & Medicaid Services (CMS)*. CMS has eight regional offices that oversee the Medicare program and ensure that regulations are followed. Medicare payments to providers are not made directly by CMS but by contractors for 12 Medicare Administrative Contractor (MAC) jurisdictions.

Before we close our discussion of Medicare, note that many private insurers offer coverage called *Medicare supplement insurance*, or *Medigap*. Such insurance is designed to help pay some of the healthcare costs that traditional Medicare does not cover, such as copayments, coinsurance, and deductibles. In addition, some Medigap policies offer coverage for services that Medicare doesn't include, for example, medical care when traveling outside of the United States. When an individual buys Medigap coverage, Medicare will first pay its share of the Medicare-approved amount for covered costs, and then the Medigap policy pays its share.

Medicaid

Medicaid began in 1966 as a modest program to be jointly funded and operated by the states and the federal government that would provide a medical safety net for low-income mothers and children and for elderly, blind, and disabled individuals who receive 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 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 construct more limited programs. A mandatory nursing home benefit was added in 1972.

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 for nursing homes and other providers that treat large numbers of indigent patients. However, Medicaid expenditures have been growing at an alarming rate, which has forced both federal and state policymakers to search for more effective ways to improve the program's access, quality, and cost.

Medicaid

A federal and state government health insurance program that provides benefits to low-income individuals.

1. What are some different types of private insurers?
2. Briefly, what are the origins and purpose of Medicare?
3. What is Medicaid, and how is it administered?

SELF-TEST QUESTIONS

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Managed Care Plans

Managed care plan

A combined effort by an insurer and group of providers with the purpose of both increasing quality of care and decreasing costs.

Managed care plans strive to combine the provision of healthcare services and the insurance function into a single entity. Traditional plans are created by insurers who either directly own a provider network or create one through contractual arrangements with independent providers.

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 illnesses as to treat them. However, from a patient perspective, HMOs have several drawbacks, including a limited network of providers and the assignment of a primary care physician who acts as the initial contact and authorizes all services received from the HMO.

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 that 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*—those providers that have contracts (usually at discounted prices) with the PPO. Furthermore, PPOs do not require beneficiaries to use preselected gatekeeper physicians. In general, PPOs are less likely than HMOs to provide preventive services and do not assume any responsibility for quality assurance because enrollees are not constrained to use only the PPO panel of providers.

In an effort to achieve the potential cost savings of managed care plans, most insurance companies now apply managed care strategies to their conventional plans. Such plans, which are called *managed fee-for-service plans*, use preadmission certification, utilization review, and second surgical opinions to control inappropriate utilization.

Although the distinctions between managed care and conventional plans were once quite apparent, considerable overlap now exists in the strategies and incentives employed. Thus, the term *managed care* now describes a continuum of plans, which can vary significantly in their approaches to providing combined insurance and healthcare services. The common feature in managed care plans is that the insurer has a mechanism by which it controls, or at least influences, patients’ utilization of healthcare services.

SELF-TEST QUESTIONS

1. What is meant by the term *managed care*?
2. What are some different types of managed care plans?

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Healthcare Reform and Insurance

The ACA introduced a number of provisions to expand insurance coverage and improve insurance affordability and access. Here are some of the act's provisions that focus on healthcare insurance.

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 of premium dollars on health costs and claims instead of on administrative costs and profits. If the insurer violates this standard, it 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. If they do not maintain minimum essential coverage for themselves and their dependents, they face tax penalties assessed by the Internal Revenue Services at the end of each tax year.

Health Insurance Exchanges

Health insurance exchanges (HIEs) are an important part of ensuring that healthcare access is available to all Americans and legal immigrants. People who have no employer-sponsored insurance, the unemployed, or the self-employed can purchase coverage through an exchange. 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 participating insurance companies are required to post on HIEs the rates for their various health insurance plans. This mandate permits 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.

There are different types of HIEs. Public exchanges are created by state or federal government and are open to both individuals seeking personal insurance and 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 health insurance companies. Private HIEs are expected to increase in number over time as more employers offer defined healthcare contribution plans (discussed in a later section in this chapter) 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.

Health insurance exchange (HIE)

An online marketplace created primarily by the states or the federal government that insurers use to post plan details and consumers use to purchase healthcare insurance.

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.

High-Deductible Health Plans

Many individuals are now choosing *high-deductible health plans* (HDHPs) for their health insurance coverage. HDHPs are growing in popularity because they are among the least expensive options available on HIEs. In fact, the rate of enrollment in HDHPs has more than doubled since 2009. These plans have low premiums and high deductibles and are linked with savings accounts established to pay for healthcare services. HDHPs aim to provide individuals more control over their healthcare expenditures and hence may offer an incentive to control healthcare costs.

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 an entirely new, huge 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 (ACOs), 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.

1. Briefly describe the impact of the ACA on health insurance.
2. What is a health insurance exchange (HIE)?

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Generic Reimbursement Methodologies

Fee-for-service

A reimbursement methodology that provides payment each time a service is provided.

Capitation

A reimbursement methodology that is based on the number of covered lives as opposed to the amount of services provided.

Cost-based reimbursement

A fee-for-service reimbursement method based on the costs incurred in providing services.

Charge-based reimbursement

A fee-for-service reimbursement method based on charges (chargemaster prices).

Chargemaster

A provider's official list of charges (prices) for goods and services rendered.

Regardless of the payer for a particular healthcare service, only a limited number of payment methodologies are used to reimburse providers. Payment methodologies fall into two broad classifications: fee-for-service and capitation. In **fee-for-service** payment, of which many variations exist, the greater the amount of services provided, the higher the amount of reimbursement. Under **capitation**, a fixed payment is made to providers for each *covered life*, or *enrollee*, that is independent of the amount of services provided. In this section, we discuss the mechanics, incentives created, and risk implications of alternative reimbursement methodologies.

Fee-for-Service Methods

The three primary fee-for-service methods of reimbursement are cost based, charge based, and prospective payment.

Cost-Based Reimbursement

Under **cost-based reimbursement**, the payer agrees to reimburse the provider for the costs incurred in providing services to the insured population. Reimbursement is limited to *allowable costs*, usually defined as those costs directly related to the provision of healthcare services. Nevertheless, for all practical purposes, cost-based reimbursement guarantees that a provider's costs will be covered by payments from the payer. Typically, the payer makes *periodic interim payments (PIPs)* to the provider, and a final reconciliation is made after the contract period expires and all costs have been processed through the provider's managerial (cost) accounting system.

During its early years (1966–1982), Medicare reimbursed hospitals on the basis of costs incurred. Now most hospitals are reimbursed by Medicare, and other payers, using a per diagnosis prospective payment system (see the later subsection on this topic). However, *critical access hospitals*, which are small rural hospitals that provide services to remote populations that do not have easy access to other hospitals, are still reimbursed on a cost basis by Medicare.

Charge-Based Reimbursement

When payers pay *billed charges*, or simply *charges*, they pay according to a rate schedule established by the provider, called a **chargemaster**. To a certain extent, this reimbursement system places payers at the mercy of providers in regards to the cost of healthcare services, especially in markets where competition is limited. In the early days of health insurance, all payers reimbursed providers on the basis of billed charges. Some insurers still reimburse providers according to billed charges, but the trend for payers is toward other, less generous reimbursement methods. If this trend continues, the only payers that will be

expected to pay billed charges are self-pay, or private-pay, patients. Even then, low-income patients often are billed at rates less than charges.

Some payers that historically have reimbursed providers on the basis of billed charges now pay by *negotiated*, or *discounted*, charges. This is especially true for insurers that have established managed care plans. Additionally, many conventional insurers have bargaining power because of the large number of patients that they bring to a provider, so they can negotiate discounts from billed charges. Such discounts generally range from 20 to 50 percent, or even more, of billed charges. The effect of these discounts is to create a system similar to hotel or airline pricing, where there are listed rates (chargemaster prices for providers, and rack rates or full fares for hotels and airlines) that few people pay.

Prospective payment

In a **prospective payment** system, the rates paid by payers are established by the payer before the services are provided. Furthermore, payments are not directly related to either costs or chargemaster rates. Here are some common units of payment used in prospective payment systems:

- **Per procedure.** Under *per procedure* reimbursement, a separate payment is made for each procedure performed on a patient. Because of the high administrative costs associated with this method when applied to complex diagnoses, per procedure reimbursement is more commonly used in outpatient than in inpatient settings.
- **Per diagnosis.** In the *per diagnosis* reimbursement method, the provider is paid a rate that depends on the patient's diagnosis. Diagnoses that require higher resource utilization, and hence are more costly to treat, have higher reimbursement rates. Medicare pioneered this basis of payment in its *diagnosis-related group (DRG)* system, which it first used for hospital inpatient reimbursement in 1983.
- **Per day (per diem).** If reimbursement is based on a **per diem payment**, the provider is paid a fixed amount for each day that service is provided, regardless of the nature of the service. Note that per diem rates, which are applicable only to inpatient settings, can be *stratified*. 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. Stratified per diems recognize that providers incur widely different daily costs for providing different types of care.
- **Bundled.** Under **bundled payment**, payers make a single prospective payment that covers all services delivered in a single episode, whether the services are rendered by a single provider or by multiple providers. For example, a bundled payment may be made for all obstetric services

Prospective payment

A fee-for-service reimbursement method that is established beforehand by the third-party payer and, in theory, not related to costs or charges.

Per diem payment

A fee-for-service reimbursement method that pays a set amount for each inpatient day.

Bundled (global) payment

The fee-for-service payment of a single amount for the complete set of services required to treat a single episode.

For Your Consideration

Creating the Proper Provider Incentives

An article in the *Wall Street Journal* (February 18, 2015, page A1) describes how one patient in a Kindred Healthcare long-term care hospital was discharged after 23 days of treatment for complications from a previous knee surgery. According to family members, the timing of his release did not appear to be related to any improvement in his medical condition. However, it did result in a higher reimbursement that the hospital received for his stay.

According to billing documents, Kindred collected \$35,887.79 from Medicare for his treatment, the maximum amount it could earn for treating patients with his condition. Under Medicare's reimbursement rules, if the patient had left the hospital one day earlier, Kindred would have received a per diem rate that would have resulted in a total payment of roughly \$20,000. If he had stayed longer than 23 days, the hospital likely would not have received any additional reimbursement other than the \$35,887.79 single payment for an "extended" stay.

What do you think? What incentives are created for providers under the reimbursement method used by Medicare for long-term (as opposed to acute care) hospitals? Can you think of a payment system that would encourage long-term care hospitals to discharge patients at the appropriate time?

associated with a pregnancy provided by a single physician, including all prenatal and postnatal visits as well as the delivery. For another example, a bundled payment may be made for all physician and hospital services associated with a cardiac bypass operation. Finally, note that, at the extreme, a bundled payment may cover an entire population. In this situation, the payment becomes a *global payment*, which, in effect, is a capitation payment as described in the next section.

Capitation

Up to this point, the prospective payment methods presented have been fee-for-service methods—that is, providers are reimbursed on the basis of the amount of services provided. The service may be defined as a visit, a diagnosis, a hospital day, an episode, or in some other manner, but the key feature is that the more services that are performed, the greater the reimbursement amount. *Capitation*, although a form of prospective payment, is an entirely different approach to reimbursement and hence deserves to be treated as a separate category. Under capitated reimbursement, the provider is paid a fixed amount per covered life period (usually a month) regardless of the

amount of services provided. For example, a primary care physician might be paid \$15 per member per month for handling 100 members of an HMO plan.

Capitation payment, which is used primarily by managed care plans, dramatically changes the financial environment of healthcare providers. It has implications for financial accounting, managerial accounting, and financial management. Discussion of how capitation, as opposed to fee-for-service reimbursement, affects healthcare finance is provided throughout the remainder of this book.

SELF-TEST QUESTIONS

1. Briefly explain the following payment methods:
 - Cost based

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**SELF-TEST
QUESTIONS**

- Charge based and discounted charges
 - Per procedure
 - Per diagnosis
 - Per diem
 - Bundled
 - Capitation
2. What is the major difference between fee-for-service reimbursement and capitation?

Provider Incentives Under Alternative Reimbursement Methodologies

Providers, like individuals and businesses, react to the incentives created by the financial environment. For example, individuals can deduct mortgage interest from income for tax purposes, but they cannot deduct interest payments on personal loans. Loan companies have responded by offering home equity loans that are a type of second mortgage. The intent is not that such loans would always be used to finance home ownership, as the tax laws assumed, but that the funds could be used for other purposes, including paying for vacations and purchasing cars or appliances. In this situation, tax laws created incentives for consumers to have mortgage debt rather than personal debt, and the mortgage loan industry responded accordingly.

In the same vein, it is interesting to examine the incentives that alternative reimbursement methods have on provider behavior. Under cost-based reimbursement, providers are given a “blank check” in regards to acquiring facilities and equipment and incurring operating costs. 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 and hence lead to higher revenues.

Under charge-based reimbursement, providers have the incentive to set high charge rates, which lead to high revenues. However, in competitive markets, there will be a constraint on how high providers can go. But, to the extent that insurers, rather than patients, are footing the bill, there is often considerable leeway in setting charges. 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. Charge-based reimbursement does encourage providers to contain costs because (1) the spread between charges and costs represents profits, and the more the better, and (2) lower costs can lead to lower charges, which can increase volume. Still, the incentive to contain costs is weak because charges can be increased more easily than costs can be reduced. Note, however, that discounted charge reimbursement places additional pressure on profitability and hence increases the incentive for providers to lower costs.

Under prospective payment reimbursement, provider incentives are

altered. First, under per procedure reimbursement, the profitability of individual procedures varies 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 typically generates additional profit. The incentives under per diagnosis reimbursement are similar. Providers, usually hospitals, will seek patients with those diagnoses that have the greatest profit potential and discourage (or even discontinue) those services that have the least potential. Furthermore, to the extent that providers have some flexibility in selecting procedures (or assigning diagnoses) to patients, an incentive exists to *up code* procedures (or diagnoses) to ones that provide the greatest reimbursement.

In all prospective payment methods, providers have the incentive to reduce costs because the amount of reimbursement is fixed and independent of the costs actually incurred. For example, when hospitals are paid under per diagnosis reimbursement, they have the incentive to reduce length of stay and hence costs. Note, however, when per diem reimbursement is used, hospitals have an incentive to increase length of stay. Because the early days of a hospitalization typically are more costly than the later days, the later days are more profitable. However,

For Your Consideration

Value-Based Purchasing

Value-based purchasing rests on the concept that buyers of healthcare services should hold providers accountable for quality of care as well as costs. In April 2011, HHS launched the Hospital Value-Based Purchasing program, which marks the beginning of a historic change in how Medicare pays healthcare providers. For the first time, 3,500 hospitals across the country are being paid for inpatient acute care services based on care quality, not just the quantity of the services provided.

“Changing the way we pay hospitals will improve the quality of care for seniors and save money for all of us,” said former HHS Secretary Kathleen Sebelius. “Under this initiative, Medicare will reward hospitals that provide high-quality care and keep their patients healthy. It’s an important part of our work to improve the health of our nation and drive down costs. As hospitals work to improve quality, all patients—not just Medicare patients—will benefit.” The initial measures to determine quality focus on how closely hospitals follow best clinical practices and how well hospitals enhance patients’ care experiences. The better a hospital does on its quality measures, the greater the reward it will receive from Medicare.

What do you think? Should providers be reimbursed based on quality of care? How should “quality” be measured? Should the additional reimbursement to high-quality providers be obtained by reductions in reimbursement to low-quality providers?

as mentioned previously, hospitals have the incentive to reduce costs during each day of a patient stay.

Under bundled pricing, 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 pricing, 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 each provider separately attempting to minimize its treatment costs because lowering costs in one phase of treatment could increase costs in another.

Finally, capitation reimbursement totally changes the playing field by completely reversing the actions that providers must take to ensure financial success. Under all fee-for-service 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.

1. What are the provider incentives created under fee-for-service reimbursement? Under capitation?

SELF-TEST QUESTIONS

Medical Coding: The Foundation of Fee-for-Service Reimbursement

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

Medical coding
The process of transforming medical diagnoses and procedures into universally recognized numerical codes.

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case of inpatient settings) or the procedures performed on the patient (in the case of outpatient settings). Thus, a brief background on clinical coding will enhance your understanding of the reimbursement process.

Diagnosis Codes

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. Published by the World Health Organization, **ICD codes** are used internationally to record many types of health events, including hospital inpatient stays and death certificates. (ICD codes were first used in 1893 to report death statistics.)

The codes are periodically revised; the most recent version is ICD-10. However, US hospitals are still using a modified version of the ninth revision, called *ICD-9-CM*, where *CM* stands for *Clinical Modification*. The ICD-9 codes consist of three, four, or five digits. The first three digits denote the disease category, and the fourth and fifth digits provide additional information. For example, code 410 describes an acute myocardial infarction (heart attack), while code 410.1 is an attack involving the anterior wall of the heart. (However, it is expected that conversion to ICD-10 codes will occur October 1, 2015. The conversion process is consuming and costly because there are more than five times as many individual codes in ICD-10 as in ICD-9. Of course, the information provided by the new code set will be more detailed and complete.)

In practice, the application of ICD codes to diagnoses is complicated and technical. Hospital coders have to understand the coding system and the medical terminology and abbreviations used by clinicians. Because of this complexity, and because proper coding can mean higher reimbursement from third-party payers, ICD coders require a great deal of training and experience to be most effective.

Procedure Codes

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 and its corresponding codes are revised periodically to reflect current trends in clinical treatments. To increase standardization and the use of electronic health 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 codes be used for hospital inpatient services.)

International Classification of Diseases (ICD) codes

Numerical codes for designating diseases plus a variety of signs, symptoms, and external causes of injury.

Current Procedural Terminology (CPT) codes

Codes applied to medical, surgical, and diagnostic procedures.

To illustrate CPT codes, there are ten codes for physician office visits. Five of the codes apply to new patients, while the other five apply to established patients (repeat visits). The differences among the five codes in each category are based on the complexity of the visit, as indicated by three components: (1) extent of patient history review, (2) extent of examination, and (3) difficulty of medical decision making. For repeat patients, the least complex (typically shortest) office visit is coded 99211, while the most complex (typically longest) is coded 99215.

Because government payers (Medicare and Medicaid) as well as other insurers require additional information from providers beyond that contained in CPT codes, an enhanced version called the **Healthcare Common Procedure Coding System (HCPCS)**, commonly pronounced “hick picks”) was developed. This system expands the set of CPT codes to include nonphysician services and durable medical equipment such as ambulance services and prosthetic devices.

Although CPT and HCPCS codes are not as complex as the ICD codes, coders still must have a high level of training and experience to use them correctly. As in ICD coding, correct CPT coding ensures correct reimbursement. Coding is so important that many businesses offer services, such as books, software, education, and consulting, to hospitals and medical practices to improve coding efficiency.

1. Briefly describe the coding system used in hospitals (ICD codes) and medical practices (CPT codes).
2. What is the link between coding and reimbursement?

Healthcare Common Procedure Coding System (HCPCS)

A medical coding system that expands the CPT codes to include nonphysician services and durable medical equipment.

SELF-TEST QUESTIONS

Specific Reimbursement Methods

There are many specific reimbursement methods in use today. Typically, the methods differ from one insurer to another. In addition, insurers use different methods for different types of providers and services, such as hospitals versus physicians or even hospital inpatients versus outpatients. In this section, we discuss the specific methods used by Medicare to reimburse hospitals for inpatient services and physicians for all services. We discuss other specific reimbursement methods used by Medicare in the chapter supplement.

Hospital Inpatient Services

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

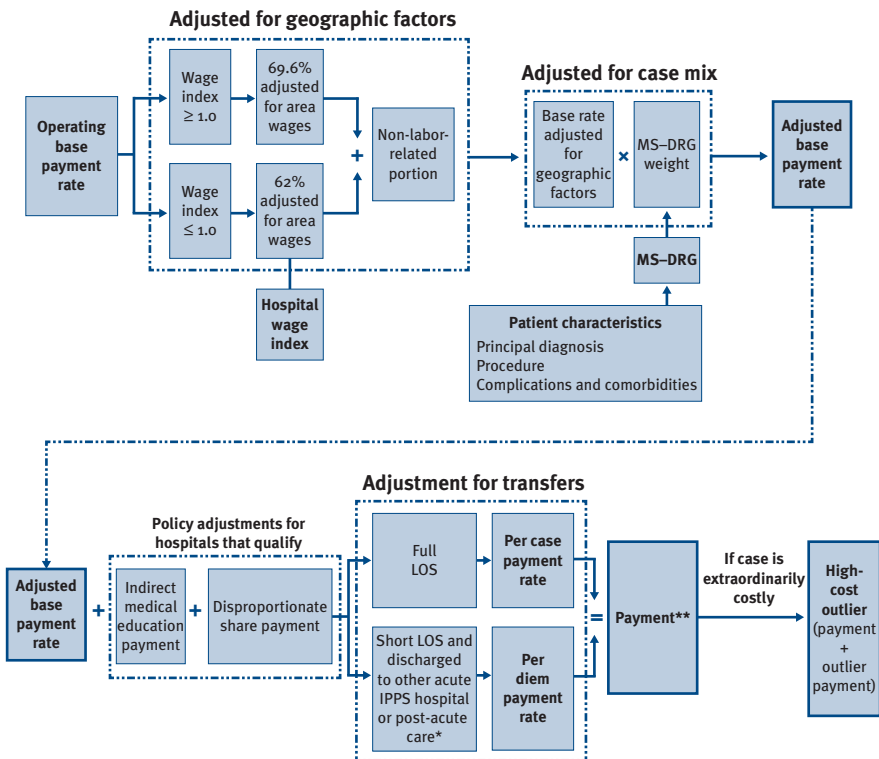
Inpatient prospective payment system (IPPS)

The method, based on diagnosis, that Medicare uses to reimburse providers for inpatient services.

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 (Exhibit 2.1).

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

EXHIBIT 2.1
Medicare
Hospital Acute
Inpatient Services
Payment
System



Note: MS-DRG (Medicare severity diagnosis-related group), LOS (length of stay), IPPS (inpatient prospective payment system). Capital payments are determined by a similar system.

* Transfer policy for cases discharged to post-acute care settings applies for cases in 275 selected MS-DRGs.

** Additional payment made for certain rural hospitals.

Source: Reprinted from MedPAC. 2014. "Hospital Acute Inpatient Services Payment System." Figure 1. Revised October. www.medpac.gov/documents/payment-basics/hospital-acute-inpatient-services-payment-system-14.pdf?sfvrsn=0.

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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.

The IPPS rates are intended to cover the costs that reasonably efficient providers would incur in providing high-quality care. If the hospital is able to provide the services for less than the fixed reimbursement amount, it can keep the difference. Conversely, if a Medicare patient's treatment costs are more than the reimbursement amount but do not meet the definition of an outlier, the hospital must bear the loss.

Physician Services

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

Relative value unit (RVU)

A relative weight that indicates the amount of physician work, practice expenses, and liability costs associated with a particular service.

Industry Practice

Using RVUs for Physician Compensation

Traditionally, there have been a number of ways of estimating physician productivity when tying compensation to performance. For many years, productivity was measured by volume-based metrics such as number of patients seen or amount of revenue billed. Today, however, physician productivity measures and compensation models are rapidly moving toward models based on relative value units (RVUs).

Work RVUs, which are one of three components of RVUs, measure the relative level of time, skill, training, and intensity required of a physician to provide a given service. As such, they are a good proxy for the training required and volume of work expended by a physician in treating patients. A routine well-patient visit, for example, would be assigned a lower RVU than an invasive surgical procedure would. Given this relative scale, a physician seeing two or three complex or high-acuity patients per day could accumulate more RVUs than a physician seeing ten or more low-acuity patients per day. Thus, the nature of the work, rather than number of patients or billings, is being measured and hence used for compensation levels.

According to the Medical Group Management Association (MGMA), well over half of all physicians are compensated, at least in part, on the basis of productivity as measured by work RVUs. Usually, work RVUs are combined with other productivity and quality measures in determining productivity and compensation, but there is little doubt that they have the dominant role.

provider characteristics, geographic designations, and other factors. The provider is paid the final amount, less any beneficiary coinsurance (Exhibit 2.2).

SELF-TEST QUESTIONS

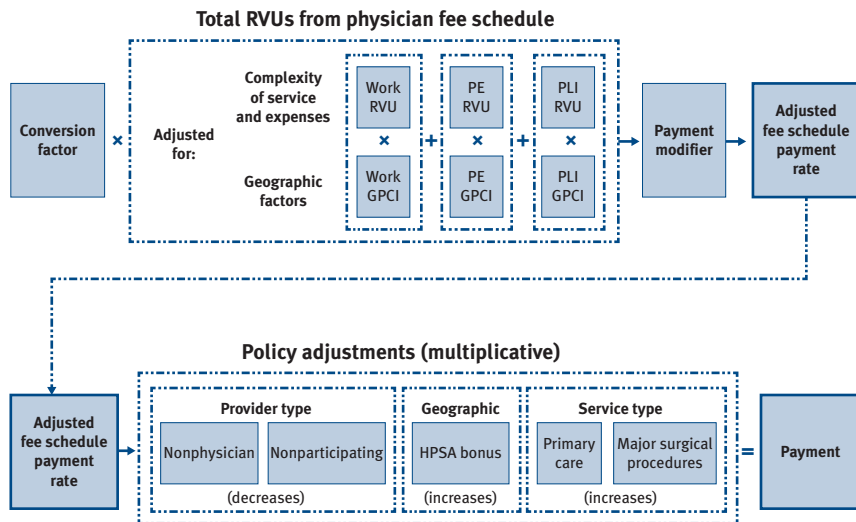
1. Briefly describe the method used by Medicare to reimburse for inpatient services.
2. Explain the method used by Medicare to reimburse for physician services.

Healthcare Reform and Reimbursement Methods

In addition to improving healthcare delivery through focusing on access and quality, 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 that based on the amount of services provided (volume) to that based on value and better outcomes.

EXHIBIT 2.2

Medicare Physician Services Payment System



Note: RVU (relative value unit), GPCI (geographic practice cost index), PE (practice expense), PLI (professional liability insurance), HPSA (health professional shortage area). This figure depicts Medicare payments only. The fee schedule lists separate PE RVUs for facility and nonfacility settings. Fee schedule payments are reduced when specified nonphysician practitioners bill Medicare separately, but not when services are provided “incident to” a physician.

Source: Reprinted from MedPAC. 2014. “Physician and Other Health Professionals Payment System.” Figure 1. Revised October. <http://medpac.gov/documents/payment-basics/physician-and-other-healthprofessionalspayment-system-14.pdf?sfvrsn=0>.

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The new payment methods are specifically designed to accomplish the following:

- Encourage providers to deliver care in a high-quality, cost-efficient manner
- Support coordination of care among multiple providers
- Adopt evidence-based care standards and protocols that result in the best outcomes for patients
- Provide accountability and transparency
- Discourage overtreatment and medically unnecessary procedures
- Eliminate or reduce the occurrence of adverse events
- Discourage cost shifting

The sections that follow describe a few of the important implications for provider payments.

Value-Based Purchasing

Value-based purchasing (VBP) is a Medicare initiative that rewards acute care hospitals with incentive payments for providing high-quality care to Medicare beneficiaries toward promoting better clinical outcomes for all hospitalized Medicare patients. 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 quality goals, and how much it improved on each measure compared to its performance during the baseline period. Note that some VBP programs are paired with shared savings programs (discussed later) to reward cost reduction as well as quality of care.

Value-based purchasing (VBP)
An approach to provider reimbursement that rewards quality of care rather than quantity 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 reimbursement 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 the 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 excessive 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 they rank in the top 25 percent of hospital-acquired conditions for all hospitals in the previous year.

SELF-TEST QUESTIONS

1. Briefly describe the impact of the ACA on payments to providers.

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Key Concepts

This chapter covers important background material related to healthcare insurance and provider reimbursement. The key concepts of this chapter are as follows:

- Health insurance is widely used in the United States because individuals are risk averse and insurance firms can take advantage of the *law of large numbers*.
- Insurance is based on four key characteristics: (1) *pooling of losses*, (2) *payment for random losses*, (3) *risk transfer*, and (4) *indemnification*.
- *Adverse selection* occurs when individuals most likely to have claims purchase insurance, while those least likely to have claims do not.
- *Moral hazard* occurs when an insured individual purposely sustains a loss, as opposed to a random loss. In a health insurance setting, moral hazard is more subtle, producing such behaviors as seeking more services than needed and engaging in unhealthy behavior because the costs of the potential consequences are borne by the insurer.
- Most provider revenue is not obtained directly from patients but from healthcare insurers known collectively as *third-party payers*.
- Third-party payers are classified as *private insurers* (Blue Cross/Blue Shield, commercial, and self-insurers) and *public insurers* (Medicare and Medicaid).
- *Managed care plans*, such as health maintenance organizations (HMOs), strive to combine the insurance function and the provision of healthcare services.
- Third-party payers use many different payment methods that fall into two broad classifications: *fee-for-service* and *capitation*. Each payment method creates a unique set of incentives and risk for providers.
- When payers pay *billed charges*, they pay according to a schedule of rates established by the provider called a *chargemaster*.
- *Negotiated charges*, which are discounted from billed charges, are used by insurers with sufficient market power to demand price reductions.
- Under a *cost-based reimbursement system*, payers agree to pay providers certain allowable costs incurred when providing services to the payers' enrollees.

(continued)

(continued from previous page)

- In a *prospective payment system*, the rates paid by payers are determined in advance and are not tied directly to reimbursable costs or billed charges. Typically, prospective payments are made on the basis of the following service definitions: (1) *per procedure*, (2) *per diagnosis*, (3) *per diem* (per day), or (4) *bundled pricing*.
- *Capitation* is a flat periodic payment to a physician or another healthcare provider; it is the sole reimbursement for providing services to a defined population. Capitation payments are generally expressed as some dollar amount per member per month, where the word *member* typically refers to an enrollee in some managed care plan.
- *Medical coding* is the foundation of fee-for-service reimbursement systems. In inpatient settings, *ICD* codes are used to designate diagnoses, while in outpatient settings, *CPT* codes are used to specify procedures.
- Medicare uses the *inpatient prospective payment system (IPPS)* for hospital inpatient reimbursement. Under IPPS, the amount of the payment is determined by the patient's *Medicare severity diagnosis-related group (MS-DRG)*.
- To provide some cushion for the high costs associated with severely ill patients within each diagnosis, IPPS includes a provision for *outlier payments*.
- Physicians are reimbursed by Medicare using the *resource-based relative value system (RBRVS)*. Under RBRVS, reimbursement is based on *relative value units (RVUs)*, which consist of three resource components: (1) *physician work*, (2) *practice expenses*, and (3) *malpractice insurance expenses*. The RVU for each service is multiplied by a dollar conversion factor to determine the payment amount.
- The ACA has is having a significant impact on health insurance and on the way providers are reimbursed. More people now have access to insurance coverage, and the new provider payment methods emphasize value and patient outcomes over volume.

Because the managers of health services organizations must make financial decisions within the constraints imposed by the economic environment, the insurance and reimbursement concepts discussed in this chapter will be used over and over throughout the remainder of the book.

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Questions

- 2.1 Briefly explain the following characteristics of insurance:
 - a. Pooling of losses
 - b. Payment only for random losses
 - c. Risk transfer
 - d. Indemnification
- 2.2 What is adverse selection, and how do insurers deal with the problem?
- 2.3 What is the moral hazard problem?
- 2.4 Briefly describe the major third-party payers.
- 2.5
 - a. What are the primary characteristics of managed care plans?
 - b. Describe different types of managed care plans.
- 2.6 What is the difference between fee-for-service reimbursement and capitation?
- 2.7 Describe the provider incentives under each of the following reimbursement methods:
 - a. Cost based
 - b. Charge based (including discounted charges)
 - c. Per procedure
 - d. Per diagnosis
 - e. Per diem
 - f. Bundled payment
 - g. Capitation
- 2.8 What medical coding systems are used to support fee-for-service payment methodologies?
- 2.9 Briefly describe how Medicare pays for the following:
 - a. Inpatient services
 - b. Physician services
- 2.10 What are some features of the ACA that affect healthcare insurance and reimbursement?

Resources

*For the latest information on events that affect the healthcare sector, see *Modern Healthcare*, published weekly by Crain Communications Inc., Chicago.*

Other resources pertaining to this chapter include

- Beagle, J. T. 2010. "Episode-Based Payment: Bundling for Better Results." *Healthcare Financial Management* (February): 36–39.
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ADDITIONAL MEDICARE PAYMENT METHODS

Introduction

In Chapter 2, we discussed the inpatient prospective payment system (IPPS) and the resource-based relative value scale (RBRVS) system used by Medicare to reimburse hospitals for inpatient services and physicians for all services. In this supplement, we provide information on the other primary reimbursement methods used by Medicare.

More Medicare Reimbursement Methods

Outpatient Hospital Services

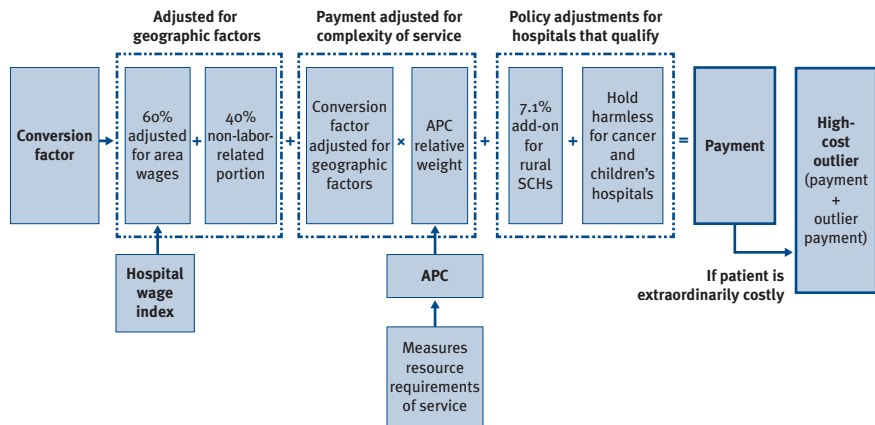
The *outpatient prospective payment system (OPPS)* is essentially a fee schedule. The unit of payment under the OPPS is the individual service as identified by the Healthcare Common Procedure Coding System (HCPCS), which contains codes for about 6,700 distinct services. Medicare groups services into *ambulatory payment classifications (APCs)* on the basis of clinical and cost similarity. Each APC has a relative weight that measures the resource requirements of the service and is based on the median cost of services in that APC. The Centers for Medicare & Medicaid Services (CMS) sets payments for individual APCs using a conversion factor that translates the relative weights into dollar payment rates with adjustments for geographic differences in input prices. Hospitals also can receive additional payments in the form of outlier adjustments for extraordinarily high-cost services and pass-through payments for selected new technologies (Exhibit S2.1).

Ambulatory Surgery Centers

Medicare pays for surgery-related facility services provided in ambulatory surgery centers (ASCs) based on the individual surgical procedure. Each of the nearly 3,600 approved procedures is assigned an APC from the same payment groups as used for hospital outpatient services. The relative weights for most procedures in the ASC payment system are the same as the relative weights used in the OPPS. Like the OPPS, the ambulatory surgical center payment system sets payments for individual services using a conversion factor and adjustments for geographic differences in input prices. Note that the payment for facilities services is separate from the payment for physician services.

EXHIBIT S2.1

Medicare
Outpatient
Hospital
Services
Payment
System



Note: APC (ambulatory payment classification), SCH (sole community hospital). The APC is the service classification system for the outpatient prospective payment system. Medicare adjusts outpatient prospective payment system payment rates for 11 cancer hospitals so that the payment-to-cost ratio (PCR) for each cancer hospital is equal to the average PCR for all hospitals. *Source:* Reprinted from MedPAC. 2014. "Outpatient Hospital Services Payment System." Figure 1. Revised October. www.medpac.gov/documents/payment-basics/outpatient-hospital-services-payment-system.pdf?sfvrsn=0.

Inpatient Rehabilitation Facilities

Inpatient rehabilitation facilities are paid predetermined, per discharge rates based primarily on the patient's condition (diagnoses, functional and cognitive status, and age) and market area wages. Discharges are assigned to one of 92 intensive rehabilitation categories called *case-mix groups (CMGs)*, which are groups of patients with similar clinical problems. Within each of these CMGs, patients are further categorized into one of four tiers on the basis of comorbidities, with each tier having a specific payment that reflects the costliness of patients in that tier relative to others in the CMG.

Psychiatric Hospital Services

Medicare uses the inpatient psychiatric facility prospective payment system for psychiatric hospital services, which is based on a per diem rate plus additional payments for ancillary services and capital costs. A base per diem payment is adjusted to account for cost-of-care differences related to patient characteristics, such as age, diagnosis, comorbidities, and length of stay, and facility characteristics, such as local wages, geographic location, teaching status, and emergency department status.

Skilled Nursing Facility Services

Medicare uses a prospective payment system for skilled nursing facilities (SNFs) that pays facilities a predetermined daily rate for each day of care, up to 100

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days. The rates are expected to cover all operating (nursing care, rehabilitation services, and other goods and services) and capital costs that efficient facilities would incur in providing SNF services. Various high-cost, low-probability ancillary services are covered separately. Patients are assigned to one of 66 categories, called *resource utilization groups (RUGs)*, on the basis of patient characteristics and services used that are expected to require similar resources. Nursing and therapy weights are applied to the base payment rates of each RUG. Daily base payment rates are also adjusted to account for geographic differences in labor costs.

Home Health Care Services

Medicare uses a prospective payment system that pays home health agencies a predetermined rate for each 60-day episode of home health care. If fewer than five visits are delivered during a 60-day episode, the home health agency is paid per visit by visit type. Patients who receive five or more visits are assigned to one of 153 home health resource groups, which are based on clinical and functional status and service use as measured by the *Outcome and Assessment Information Set (OASIS)*. The payment rates are adjusted to reflect local market input prices and special circumstances, such as high-cost outliers.

Critical Access Hospitals

The Balanced Budget Act of 1997 created a new category of hospitals called *critical access hospitals (CAHs)*, which operate primarily in rural areas. Each of the approximately 1,300 CAHs is limited to 25 beds, and patients are limited to a four-day length of stay. The limited size and short length of stay requirements are designed to encourage CAHs to focus on providing inpatient and outpatient care for common, less complex conditions while referring more complex patients to larger, more distant hospitals. Unlike most other acute care hospitals (which are paid using prospective payment systems), Medicare pays CAHs on the basis of reported costs. As of this writing, each CAH receives 99 percent of the costs it incurs in providing outpatient, inpatient, laboratory, and therapy services and post-acute care. The cost of treating Medicare patients is estimated using cost accounting data from Medicare cost reports. The purpose of the different reimbursement system for CAHs is to enhance the financial performance of small rural hospitals and thus reduce hospital closures.

Hospice Services

Medicare pays hospice providers a daily rate for each day a beneficiary is enrolled in the hospice program, regardless of the amount of services provided, even on days when no services are provided. The daily payment rates are intended to cover costs of providing services included in patients' care plans. Payments are made according to a fee schedule for four different categories of care: routine home care, continuous home care, inpatient respite care, and general inpatient

care. The four categories of care differ by the location and intensity of the services provided, and the base payments for each category reflect variation in expected input cost differences.

Ambulance Services

Medicare pays for ambulance services using a dedicated fee schedule, which has set rates for nine payment categories of ground and air ambulance transport. Historical costs are used as the basis to establish relative values for each payment category. These relative values are multiplied by a dollar amount that is standard across all nine categories and then adjusted for geographic differences. This amount is added to a mileage payment to arrive at the total ambulance payment amount. Medicare payments for ambulance services may also be adjusted by one of several add-on payments based on additional geographic characteristics of the transport.



FINANCIAL ACCOUNTING

Part I discusses the unique environment that creates the framework for the practice of healthcare finance. Now, in Part II, we begin the actual coverage of healthcare finance by discussing financial accounting, which involves the preparation of a business's financial statements. These statements are designed to provide pertinent financial information about an organization both to its managers and to the public at large.

The coverage of financial accounting extends over several chapters. Chapter 3 begins the coverage with an introduction to basic financial accounting concepts and an explanation of how organizations report financial performance, specifically revenues, expenses, and profits. Then, in Chapter 4, the discussion is extended to the reporting of financial status, which includes an organization's assets, liabilities, and equity. In addition, Chapter 4 covers the way in which organizations report cash flows. Finally, note that Chapter 17 is related to financial accounting in that it also discusses financial statements, but the focus is on how interested parties use financial statement data to assess the financial condition of an organization. That material has purposely been placed at the end of the book because the nuances of financial statement analysis can be better understood after learning more about the financial workings of a business. Part II and Chapter 17, taken together, will provide readers with a basic understanding of how financial statements are created and used to make judgments regarding the operational status and financial condition of health services organizations.