Healthcare Revenue Cycle 101
A – B – C

Friday, March 20, 2015
Dallas, TX
Objectives

- Introduce attendees to the basics of healthcare finance
- Provide relevant information attendees can take back to their work environment
- Have interactive participation among attendees
- Share supporting materials for additional learning post class participation
- Enjoy The Day – Have Fun!
<table>
<thead>
<tr>
<th>Time</th>
<th>Agenda</th>
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<tbody>
<tr>
<td>8:45 – 10:30 AM</td>
<td>Healthcare Basics, including</td>
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<td>- Industry overview</td>
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<td>- The healthcare delivery system</td>
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<td>- Affordable Care Act</td>
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<td>10:30 – 10:45 AM</td>
<td>Break</td>
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<td>10:45 – 12:00 Noon</td>
<td>Revenue Cycle, continued</td>
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<td>12:00 – 1:00 PM</td>
<td>Lunch</td>
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<td>1:15 – 3:30 PM</td>
<td>Reimbursement, including</td>
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<td>- Medicare</td>
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<td>- Medicaid</td>
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<td>- Other payors</td>
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<td>- Government Cost Reporting</td>
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<td>- Hospital v OP v Physician Key Reimbursement concepts</td>
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<td>Healthcare Finance Basics, including</td>
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<td>- Concepts and Terminology</td>
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<td>- Key Financial Statements</td>
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<td>- Planning, Budgeting, Internal Controls</td>
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<td>A Glimpse into the Future</td>
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</table>
Revenue Cycle 101
Healthcare Industry Information

- Composed of two main sectors: (Global Industry Classification Standard 2014)
  - Health care equipment and services
  - Pharmaceuticals & Biotechnology

- Many roles:
  - Medical and Health Services Managers, Healthcare Practitioners and Technical Occupations, and Healthcare Support Occupations

- From September 2013 to September 2014 healthcare has added an average of 20,000 jobs per month (Bureau of Labor Statistics October 3, 2014)
Healthcare – What’s Unique?

- Most “customers” don’t choose to become a customer
- Hospitals and professionals seldom paid by the “customer”
- Cost continue to rise faster than cost for other industries and general inflation
- Hospitals and Long-Term Care Facilities require 24x7 staffing
- Collections can be difficult since you can’t “repossess” the service performed
- Credentials and certifications required for clinical staff
Healthcare Acronyms

“Imagine what it’s like to be suddenly injured or ill. You or your family member calls 911. EMTs arrive and take you to the nearest ER or ED. You or someone in your family is given a lot of paperwork, including HIPAA notification. The doctors and nurses say you need an IV, MRI, and CT scan. And all this before you are admitted to the ICU.”

The healthcare industry has its own language and it is usually understood only by those in healthcare. Sometimes the same acronyms can have multiple meanings (*i.e.* ADA has 26 meanings)

Other common acronyms examples:

- IV, MRI = Medical conditions/procedures
- APHA, AAAHC, HFMA = Professional organizations
- FHFMA, CRCR = Certifications
- MD, NP, PA RN, LPN = Credentials
- HIPAA, ACA, CDC, CMS = Regulations
- AP, AP, GL = Financial functions

The Healthcare Delivery System

- Various Settings, including:
  - Hospitals – general acute care or specialty facilities
    - Not-for-profit
    - For profit
    - Government Owned or Public
  - Ambulatory or outpatient care facilities, including Home Care
  - Long-term care facilities, including SNFs, ICFs, residential care facilities
- Diversification has led to Integrated Delivery Systems
The “Regulated Business Side” of Healthcare

- Heavily regulated by governmental and other standards
- Department of Health and Human Services (www.hhs.gov)
  - HIPAA (Health Insurance Portability and Accountability Act)
  - Protection of Human Research Subjects
  - Health Information Technology Standards
  - Additional Laws and Regulations
Regulations

- Civil and Privacy Rights
- Food & Drugs
- Fraud Prevention & Detection
- Freedom of Information Act & Privacy Act
- Certificate of Need (CON) – state level
- Medical & Health Care
  - Centers for Disease Control and Prevention (www.cdc.gov)
- Medicare/Medicaid
  - Centers for Medicare and Medicaid Services (www.cms.gov)
Affordable Care Act

- Patient Protection and Affordable Care Act signed into law March 23, 2010
- Individual Mandate
- Employer Requirements
- Expansion of Public Programs
- Premiums and cost-sharing subsidies to individuals
- Premium Subsidies to Employers
- Tax Changes related to health insurance or financing health reform
- Health Insurance Exchanges
The Uninsured 2013

Source: Kff.org/other/state-indicator/total-population/#
Most recent data available

Texas – 20%

4% - 7%  8% - 12%  12% - 16%  16% - 20%

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Health Insurance Coverage in the US 2013

Total = $313.4 million

- Uninsured, 13%
- Medicaid/Other Public, 18%
- Medicare, 15%
- Employer-Sponsored Insurance, 48%
- Private Non-Group, 6%

Source: http://kff.org/other/state-indicator/total-population Most recent data available
Employers Already Scaling Back Coverage

Erosion of Employer-Sponsored Coverage Well Underway

Individuals Covered by ESI¹
Non-elderly Population

<table>
<thead>
<tr>
<th>Year</th>
<th>Percentage</th>
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</thead>
<tbody>
<tr>
<td>2000</td>
<td>69.7%</td>
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<tr>
<td>2011</td>
<td>59.5%</td>
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</tbody>
</table>

11.5M fewer individuals

Contribution to Insurance Premiums
Coverage for Family of Four

Employer

<table>
<thead>
<tr>
<th>Year</th>
<th>Premium</th>
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<tbody>
<tr>
<td>2002</td>
<td>$5,866</td>
</tr>
<tr>
<td>2012</td>
<td>$11,429</td>
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</table>

Worker

<table>
<thead>
<tr>
<th>Year</th>
<th>Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002</td>
<td>$2,137</td>
</tr>
<tr>
<td>2012</td>
<td>$4,316</td>
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</table>

95% growth
102% growth

25%
Insured non-elderly adults with deductibles $1,000 or higher, 2012

23%
Employers planning to offer CDHP² as only plan option, 2014

¹ Employer-sponsored insurance.
² Consumer-directed health plan.

The federal poverty level was $23,050 or a family of four in 2012. Data may not total 100% due to rounding.

SOURCE: KCMU/Urban Institute analysis of 2013 ASEC Supplement to the CPS. Most recent data available
Uninsured Rates Among the Nonelderly by State, 2012

Most recent data available

SOURCE: KCMU/Urban Institute analysis of 2013 ASEC Supplement to the CPS.

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How does lack of insurance affect access to healthcare?

- Health providers can choose to not provide care to uninsured
- Only Emergency departments required by federal law to screen and stabilize
- Uninsured receive less preventive care and screenings
- Less likely to receive follow up care for chronic conditions leading to a decline in health
- In addition, uninsured twice as likely as those with health insurance coverage to have trouble paying medical bills
Question

Will the Affordable Care Act make a difference?
Moody’s Industry Outlook – 2014

- Moody’s issued negative outlook for nonprofit hospital sector for the 6th straight year late November last year.

- Major Factors Supporting Negative Outlook
  - Lower Medicare payments
  - Falling Disproportionate Share Hospital payments
  - Patient volumes shifting to outpatient from inpatient
  - Lower increases in Commercial payer rates
  - Heavy health IT investments
  - Changing reimbursement models
  - Impact of Patient Protection and Affordable Care Act (PPACA)

- For-profit hospitals received positive outlook in February 2014 largely due to expected decrease in Bad Debt expense as more individuals become insured under ACA


Source: [https://www.moodys.com/research/Moodys-Outlook-for-US-for-profit-hospitals-has-been-changed--PR_292719](https://www.moodys.com/research/Moodys-Outlook-for-US-for-profit-hospitals-has-been-changed--PR_292719)
Revenue Cycle

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What is Revenue Cycle?

- All the administrative and clinical functions, processes, and software applications that contribute and manage the registration, charging, billing, payment and collections tasks associated with a patient encounter.

- Revenue Cycle is the process that begins when a patient comes into the system and includes all those activities that have occurred in order to have a zero balance.

- In other words, think… Zero to Zero!
Understanding Revenue Cycle – Simple?
The Revenue Cycle

Front End

Patient Access
  Scheduling & Registration
  Ins. Verification & Cash Collection

Middle

In-House Activities
  Pricing
  Charge Structure
  Charge Capture
  Documentation
  Coding
  3rd Party Reimbursement

Back End

Business Office
  Accounts Receivable Management
  Claims Processing

PEOPLE, PROCESS & TECHNOLOGY

Efficiency    Effectiveness    Accuracy    Completeness    Adaptability

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## Revenue Cycle

<table>
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<tr>
<th>25% FRONT END</th>
<th>55% MIDDLE</th>
<th>20% BACK END</th>
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<tbody>
<tr>
<td>Registration</td>
<td>Charge Capture &amp; Pricing</td>
<td>Claims Processing, A/R Management</td>
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<tr>
<td>Patient Access</td>
<td>Denial Management</td>
<td>Late Charge Analysis, EDI Editing and Billing, DNFB Reduction*</td>
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<tr>
<td>• Scheduling</td>
<td>• Inpatient Documentation</td>
<td>• Recording: A/R, Cash, Contractual</td>
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<tr>
<td>• Pre-registration</td>
<td>• Outpatient Documentation</td>
<td>• Bad debts</td>
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<tr>
<td>• Insurance Verification</td>
<td>• Medical Records assembly process</td>
<td>• Denial Management</td>
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<tr>
<td>• Point-of-Service Collections</td>
<td>• QA functions</td>
<td>• Self-Pay Collections Management</td>
</tr>
<tr>
<td>• Call Center Technology</td>
<td>• DNFB reduction</td>
<td>• Agency Management</td>
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<tr>
<td>• Registration Points</td>
<td>• Charge Capture</td>
<td>• Payer Appeal/dispute resolution</td>
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<tr>
<td>• Prior Balance Adjudication</td>
<td>• Reconciliation</td>
<td>Patient Access Redesign</td>
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<td>• Rate Setting</td>
<td>CDM Standardization</td>
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<tr>
<td></td>
<td>• Managed Care Pricing / Contracting</td>
<td>Cash Acceleration</td>
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<tr>
<td></td>
<td>• Late Charge Analysis</td>
<td></td>
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<tr>
<td></td>
<td>• Case Management</td>
<td>Efficiency, Effectiveness, Accuracy, Completeness, Adaptability</td>
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<tr>
<td></td>
<td>• Appeals Process</td>
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<tr>
<td></td>
<td>• Staffing Deployment</td>
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</tr>
<tr>
<td>Patient Access Redesign</td>
<td>CDM Standardization</td>
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</table>

### Efficiencies
- Efficiency
- Effectiveness
- Accuracy
- Completeness
- Adaptability

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The Stages of Revenue Cycle

Evolving

- "Planning" mentality
- More integrated with other operational units
- Best practices in a few areas
- Evolving metrics and targets
- Seen as the responsibility of all areas

Mature

- "Anticipatory" planning
- Use of leading edge technologies to drive value
- Best practice metrics as targets for staff and management
- Demonstrating year-over-year net margin enhancements from revenue cycle initiatives
- Best practices in several key areas
- All areas understanding and striving to results
- Low cost to collect

Emerging

- "Reactive" mentality
- Limited integration and use of leading edge technologies
- Lack of targets and KPIs
- Best practices in one or two areas
- Viewed culturally as a Finance or PFS only responsibility
- High cost to collect

Margin Enhancing
The Revenue “Cycle”

The Revenue Cycle diagram illustrates the various stages involved in the revenue process within healthcare finance. It includes key components such as:

- **Billing**
- **CDMP**
- **Scheduling**
- **Registration**
- **Insurance Verification**
- **CPT Coding**
- **Case Management/QUR**
- **CDM/Charge Capture**
- **Medical Records**
- **Cash Posting**
- **Post Payment Review**
- **Self Pay Collections**
- **Third Party Follow-Up**
- **Customer Service**
- **Denials Management**
- **Financial Counseling**
- **Financial Clearance**
- **Point of Service Collections**
- **Customer Expectations**
- **Regulations**
- **Technology**
- **Payers**

These components are interconnected, highlighting the cyclical nature of the revenue process in healthcare finance.
People, Process and Technology - no operation can succeed without their planned integration.
Revenue Cycle – Where Does the Information Come From?

Required Billing Elements - Where do they come from?
50% - Patient Access, Registration
15% - Charge Entry Areas
15% - Medical Records
20% - Billing

Required Elements:

Patient Demographic Data
- Patients last name, first name, and middle initial
- Patient address
- Birth date
- Male (M) or Female (F)
- Marital Status
- Admission date or start of care date

Encounter Specific
- Hour patient was admitted for inpatient or outpatient care
- Occurrence Codes
- Code indicating the priority of admission—1 indicates emergency; 2 urgent; 3 elective; 4 newborn; and 9 information not available.
- Code indicating the source of admission or outpatient service
- Provider has patient signature on file permitting release of data (Y or N)
- Principal Diagnostic Coding (ICD-9-CM code)
- Admitting Diagnostic Coding (ICD-9-CM code)

Insurance Information
- The name and number identifying each payer that payment is expected
- Assignment of benefits (Y) yes; (N) no
- The name of the patient or insured individual
- Relationship of the insured (person having insurance) to the patient
- Insured's identification number assigned by the payer organization
- The group name/plan through which the insurance coverage is provided
- The insurance group number
- Employment status code
- Employer's name and address
Patient Access

- The Focus Has Shifted from “Back End” to “Front End”
  - Customer Focus (First Impressions)
  - Scripting with Marketing Focus
  - Staff Well-informed – Handle Any Question
  - Decrease Wait Times
  - Pre-Registration Focus
  - Positive Experience with Every Contact
Changing Role of Registrars

- Functions performed and information gathered in Access include:
  - Scheduling services (surgery generally not included)
  - Verifying of Insurance
  - Obtaining Authorizations and certifications
  - Gathering patient demographics and insurance information
  - Identifying the referring physician
  - Informing the patient on instructions for the date of service, referral process, etc.
  - Responsible for 50% of claims data
Changing Role of Registrars

- Establish ability to pay
- Communicate hospital collection policy
- Obtain info about ALL 3rd party resources
- Calculate the estimated self pay responsibility
- Notify the responsible party of their obligation
- Request payment in full
- Establish acceptable repayment arrangements or refer for Financial Counseling or Medicaid eligibility
- Complete all Pre-Admission paperwork
Access Metrics

- Registration accuracy rate
- Denials
  - No Authorization
  - Not Eligible
- Telephone Statistics
  - Hold Times
  - Abandonment Rates
  - Other
- Point of Service Collections
- “Red Flags” – Incorrect Claim Demographics
Access Metrics Defined

- **Pre-Registration Rate**
  - Numbers of Patient Encounters Pre-Registered / Total Patient Encounters Scheduled
  - ? Target Rate

- **Insurance Verification Rate**
  - Total Number Of Verified Encounters / Total Number Of Registered Encounters
  - ? Target Rate

- **Service Authorization Rate**
  - Number Of Encounters Authorized / Number Requiring Authorization
Health Information Management

Health information management (HIM) is the practice of maintenance and care of health records by traditional and electronic means in hospitals, physician's office clinics, health departments, health insurance companies, and other facilities that provide health care.

The important functions and information gathered in HIM include:

- Providing and Managing Transcription Services
- Coding services documented by Physicians
  - CPT codes (procedures)
  - ICD-9 (diagnosis)
  - HCPCS (supplies, drugs, etc.)
  - ASC Codes
Health Information Management

- Ensure Codes accurately reflect patient services
- Acts as a Liaison between all areas
- Serves as Subject Matter Experts in HIPAA, Documentation and Coding
- Educates, presents, and trains on opportunities to improve
  - Case Mix Index (CMI)
- Oversees and responds to Defensive Audits
- Manages storage and retrieval of medical records
- Implementation of Electronic Health Record System
- Building the Compliant Documentation Management Program (CDMP)
HIM Metrics

- Discharges Not Final Billed (DNFB)
- Turnaround Times
  - Dictation/Transcription
- Record Requests & TAT
- CDMP
  - Queries Rate
  - Response Rate
  - Agreement Rate
- RAC
  - Audits & Timeliness
  - Responses
HIM Metrics Defined

- Days In Total Discharged Not Final Billed (DNFB)
  - Gross Dollars In AR (Not Final Billed) / Average Daily Gross Revenue
    - ? Target Rate
  - ? Impact Of Hold Days
Patient Financial Services (PFS)

- Patient Financial Services is the “cash machine” of the hospital.
- The important functions and information gathered in PFS include:
  - Charge Master/Revenue Integrity
  - Billing
  - Overseeing Claims Edits to ensure “Clean Claim Submissions”
  - Employing tools to ensure accuracy in charge capture
  - Follow-Up with Insurance companies
    - Appeals
    - Denials
    - Unpaid Claims
Patient Financial Services (PFS)

- Customer Service
- Collections
- Cash Posting
- Subject Matter Experts
  - Government Billing
  - Commercial and Managed Care Billing
- Employs and Oversees systems and vendors to enhance
  - Services provided to patients
  - Revenue
  - Cost to Collect
PFS Metrics

- Cash Expected Reports
- Days in A/R
- Aging Analysis by Payer
- Unbilled Accounts Receivable
- Late Charge Postings by Service Area
- Claim Denial Volumes / Amounts / Types
- Bad Debt / Bad Debt Recovery Levels
- Cost to Collect
Revenue Cycle KPI – Definitions

- Gross Days In Accounts Receivable =
  - Total Gross AR / Average Daily Gross Revenue

- Net Days In Accounts Receivable =
  - Total Net AR / Average Net Daily Patient Service Revenue
    - Both Use 90 Day Average For Revenue
    - ? Credit Balances

- Days In Total Discharged Not Submitted To Payer (DNSP) =
  - Gross Dollars In DNFB + Gross Dollars In FBNS / Average Gross Daily Revenue
Revenue Cycle KPI – Definitions

- Late Charges As % Of Total Charges =
  - Charges With Post Date Greater Than 3 Days From Service Date / Total Gross Charges
  - ? System Hold Days or Bill Hold Days

- Net Days In Credit Balances =
  - Dollars In Credit Balances / Average Daily Net Patient Services Revenue

- Cost To Collect
  - Total RC Cost / Total Cash Collected
Value Of KPIs

A/R Days Example

Provider A – Patient Service Revenue

- Month 1 = $21,381,229
- Month 2 = $19,005,700
- Month 3 = $21,874,789
- Current Outstanding A/R = $31,260,135

AR Days = ?

Is That Good or Bad?
Value Of KPIs

- **A/R Days Example**
  - **Provider A – Patient Service Revenue**
    - Month 1 = $21,381,229
    - Month 2 = $19,005,700
    - Month 3 = $21,874,789
  - Current Outstanding A/R = $31,260,135
  - **AR Days = 45.17**
  - Is That Good or Bad?

  **It Depends**
Value of KPIs

- A/R Days Further Defined
  - Current Outstanding A/R By Payor
    - Medicare = $14,830,090
    - Medicaid = $3,133,659
    - Comm/Mgd Care = $6,022,028
    - SP = $6,313,607
    - Other = $960,750

ADR = $691,797

AR Days = ?

Is That Good or Bad?
Value Of KPIs

- A/R Days Further Defined
  - Current Outstanding A/R By Payor
    - Medicare = $14,830,090 (21.43)
    - Medicaid = $3,133,659 (4.53)
    - Comm/Mgd Care = $6,022,028 (8.70)
    - SP = $6,313,607 (9.13)
    - Other = $960,750 (1.34)
  - ADR = $691,797
  - AR Days = 45.1
  - Is That Good or Bad?
    - Again It Depends
Chargemaster

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Charge Master or Charge Description Master (CDM)

- A list of all items for which the healthcare organization has established specific prices

- Services provided flow directly to billing through the capture and posting of charges
  - “Charge slips” in a manual mode
  - Direct order entry or bar code readers when automated

- Information from medical record and charge master flow into actual claim
Codes and Charge Master

- Six Common Elements
  - Charge Code
  - Item Description
  - Department Number
  - Charge/price
  - Revenue code
  - CPT/HCPCS code
Principles of Pricing

- Desired Net Income
  - Net Income = Revenues - Expenses
- Competitive Position
- Market Structure
Competitive Position

- Perceived quality may allow more favorable payment terms with major health plans
- Lower-cost providers can typically have lower prices
- Market share provides negotiating leverage
- Capital intensity
Charge Master

- A comprehensive listing of hospital charges
- The Revenue Integrity team are a critical component to billing compliance and charge capture and is often considered the "life blood" to a Hospital's Revenue Cycle by touching almost every department within the facility.
  - Standardization of charge master
  - Department level review of all processes and charges with management staff to ensure all billable charges are represented on the CDM
  - CDM reviews and updates to ensure compliance for all payors
  - Market pricing, transparency and defensibility strategies
  - Revenue cycle system mapping to ensure charge capture and compliant billing
  - Acuity-based charging methodology development and implementation
  - Maintenance strategies, controls and tools for maintaining an accurate and compliant CDM
  - Educational and training tools
The Importance of Charge Capture

- A key part of the Revenue Cycle but often does not report to Revenue Cycle
- “Bill what you do” – the process where services provided are entered into the system; charges and expected reimbursements are calculated

The important functions and information gathered include:
- Keyers and coders enter data automatically from a charge master or manually input
- Claims Manager software scrubs entries for correctness
- Problems sent to department work file for processing or corrections
- Reconciliation performed to insure all entries received and entered into the system
- Accuracy of service and charge
- Appropriate edits to scrub data
- Charge entered timely for prompt payment
- Daily Charge Logs Reviewed
Charges, Payments, and Cost

- **Charges** are the amount the hospital lists as the price for services. Very few pay this “sticker price.”

- **Payment or Reimbursement** is the amount the hospital actually receives in cash for its services.
  - Private insurers, public insurers, Self Pay and the uninsured all pay different amounts for the same services. Payment can be either more or less than what it costs the hospital to provide a given service.

- **Cost** is what it actually costs the hospital to provide the services.
Coding

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HIPAA designated two specific coding systems

- International Classification of Diseases, 9\textsuperscript{th} revision, Clinical Modification (ICD-9-CM)
  - Diagnosis Codes (10\textsuperscript{th} revision scheduled in future)
    - Three digits (primary diagnosis) followed by a decimal point with two additional digits (exact condition)
  - Procedure Codes for inpatient services

- Healthcare Common Procedure Coding System (HCPCS)
  - Procedure Codes outpatient services (two digits followed by two digits)
ICD-9 and DRG

- ICD-9 very important in assignment of DRG (Diagnosis Related Grouping)
- DRG used by Medicare and others
- Critical link to provider payment
Two Tiers in HCPCS coding:

- Level I: Current Procedure Terminology (CTP) codes from the AMA
  - Six Main Categories:
    - Evaluation & Management
    - Anesthesia
    - Surgery
    - Radiology
    - Pathology and Laboratory
    - Medicine
HCPCS and CPT

- Level II: developed by CMS to report
  - Services
  - Supplies
  - Procedures not present in Level I
- Two Groups:
  - Permanent
  - Temporary (used to meet a temporary need for a new code and can exist for a long time)
Where does the Money Come From?
Revenue Stream

- Commercial, 40%
- Medicare, 31%
- Medicaid, 21%
- Other, 8%

Source: OHA 2010
Insurance by Percentage Enrolled

- PPO, 57%
- HMO, 17%
- POS, 8%
- Indemnity, 1%
- HDHP, 17%

Source: Kaiser Family Foundation 2010
Charity, Indigent, Bad Debt

- **Charity care** is provided services where it is never expected to result in cash flow. Charity care results from a provider’s policy to provide healthcare services free of charge to individuals who meet certain financial criteria.

- An **indigent** patient is one that has no means of paying for the medical services or treatments and is not eligible for benefits under Medicaid or any other Public Assistance program.

- **Bad debt** is an uncollectible account resulting from the extension of credit. Examples:
  - Patients who default from payment arrangements,
  - Patients that skip
  - Patients that file bankruptcy without assets,
  - Insolvent estates, and
  - Guarantors that refuse to pay
Market Conditions Impact Revenue Cycle Operations and Outcomes
Market Conditions - NC

- State budget issues continue
  - Traditional Medicaid/Medicaid Managed Care wanting relief
- More NC residents are living below the poverty level
- High Penetration of Self-Insured Employers
- Shifts of health care costs to Consumers
  - Increases in Deductibles
  - Increases in Co-Pays
  - But, still coverage offered from employers
- Most markets are dominated by few payors
- Smaller Payors being closed out of the Market
- Aggressive Managed Care payors
- Movements to more complicated contracts
Market Conditions

- Reimbursement Variances
  - Commercial Payors Continue to Subsidize Government Payors

- High Deductible Health Plans Increase
  - Deductibles increasing as well

- Quality Scores tied to Contract Increases Consumerism

- Multi-Year Contracts with Payors

- Transparency Growing
A Greater Burden for Individual Patients

Patient Obligations Grow with High-Deductible Insurance Plans

High-Deductible Health Plan (HDHP) Enrollment

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<td>6.1 M</td>
<td>8.0 M</td>
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IRS Definition: High-Deductible Health Plan (HDHP)

- HDHPs are health plans with a minimum deductible of $1,200 for self-only coverage and $2,400 for self-and-family coverage.
- The HDHP maximum out-of-pocket limit for in-network care is $5,950 for self-only coverage and $11,900 for self- and-family coverage (no legal limit is established for out-of-network services if the plan uses a network of providers).
Individuals Gravitating Toward Leaner Plans

Metal Tiers of Plans Chosen on Public Exchanges

October 2013 to April 2014


Average Monthly Premiums By Metal Tier
27-Year-Old Before Financial Assistance

$129
$163
$203
$240

Catastrophic
Bronze
Silver
Gold

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NOTE: SMI is Supplementary Medical Insurance. Out-of-pocket spending includes SMI (Part B and Part D) premiums and out-of-pocket cost-sharing expenses for SMI covered services.

Bad debts are increasing as percent of revenues as well as those eligible for financial assistance.

Source: Moody’s May 21, 2014 report
No Silver Bullets

Process Enhancements Needed to Maximize Benefits of Technology

- Source: Financial Leadership Council interviews and analysis

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<th>Percentage of Patients Making Payments</th>
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- Source: Financial Leadership Council interviews and analysis
Medicare
General Overview

- Title XVII of Social Security Act of 1965
- Administered by Centers for Medicare and Medicaid
- Provides coverage to individuals 65 and older, or who meet certain other criteria (e.g., ESRD)

- Part A
  - Covers inpatient stays and other specific services
  - Funded through payroll tax

- Part B
  - Covers outpatient services such as imaging procedures, lab tests
  - Enrollees pay premium
General Overview cont...

- **Part C**
  - Gives beneficiaries option to have benefits administered by a third party
  - Commonly known as Medicare Advantage Plans
  - Administered by managed care companies, not CMS

- **Part D**
  - Beneficiaries can choose certain prescription drug plans administered by third parties
  - Federal government assists to a certain limit, depending on plan
  - “Donut hole” – beneficiaries capped at $2,400 in expenditures until they meet out of pocket
Beneficiary Cost Sharing

- **Premiums**
  - Most people do not pay Part A premiums but if you do $419/month (2015)
  - Part B premiums $104.90/month for most people (2015)
  - Part C premiums vary by plan

- **Deductibles**
  - Part A inpatient stay $1,260 (2015) per *benefit period* (60 days)
  - Patient could incur more than one deductible in a year
Co-Insurance/Co-Payment

- If a beneficiary receives inpatient services for more than 60 days, co-insurance is equal to $1/4 of the inpatient hospital deductible per day for the 61st through 90th day spent in the hospital - $315/day (2015)
- Each beneficiary has 60 lifetime reserve days – $1/2 of inpatient hospital deductible per day for 91st to 150th day - $630/day (2015)
- 60 days of regular and 30 days of co-insurance replenish 61 days after discharge
- Lifetime reserve can only be used once
- SNF stays also subject to a co-insurance after 20 days - $157.50/day (2015)
Other

- **Medicare Supplemental Policies, i.e., Medigap**
  - Sold and administered by insurance companies
  - For expenses not covered by Medicare, or to pay co-pays and deductibles
  - Cannot be used by Part C beneficiaries

- **Advanced Beneficiary Notice (ABN)**
  - If medical services not “reasonable and necessary” to diagnose or treat hospital must inform beneficiary of their financial responsibility before service is performed

- **Medicare Secondary Payer (MSP)**
  - Medicare can be secondary payer if the patient has other insurance coverage
  - Hospital is responsible for determining if MSP applies
Inpatient Prospective Payment System (IPPS)

- Prior to 1983 hospitals reimbursed at cost
- IPPS introduced 1983
  - Hospital receives fixed amount regardless of resources used
- All patients classified into Diagnosis Related Group (DRG)
  - Based on their principal diagnosis/procedure
- 2008 Medicare Severity – DRG (MS-DRG) introduced
  - Introduced secondary diagnosis codes
Example: DRG 75 Major Chest Procedure
- MS-DRG 163 Major Chest Procedure W Major Complication/Comorbidity (MCC)
- MS-DRG 164 Major Chest Procedure W Complication/Comorbidity (CC)
- MS-DRG 165 W/O CC or MCC

In general the higher the acuity of the patient’s condition, the higher the assigned weight which drives reimbursement (more later)

MS-DRGs range from 001-999 with unused numbers to accommodate future expansion

In 2015 there are 751 MS-DRGs
Case Mix Index (CMI)

- Average DRG weight for all of a hospital’s Medicare volume
- Reflects clinical complexity and diversity of hospital services
- \( \text{CMI} = \frac{\# \text{Medicare inpatient cases for a DRG} \times \text{DRG weight}}{\text{total number of Medicare inpatient cases}} \)
- A decrease in CMI negatively affects operating income
- Can use CMI to monitor changes in surgical and medical volumes
- As more inpatient procedures move to an outpatient basis, CMI will slowly increase
  - Do you know why?
Medicare Blended Rate

- Every hospital has its own ‘blended IPPS rate’
- Starts with a ‘standardized rate’ set yearly by the federal government
- Standardized rate is adjusted annually
  - If a hospital does not submit required Quality Data 2% penalty
- Separated into labor related portion and non-labor related portion
- Combined to form ‘wage-adjusted’ base operating rate
- ‘Wage-adjusted’ base operating rate is multiplied by DRG weight
- Series of add-on payments/adjustments applied to come up with “hospital-specific blended rate”
Acute Care Hospital Inpatient Prospective Payment System
Operating Base Payment Rate

Adjusted for geographic factors

\[
\left( \text{Wage index} \times \text{Labor-related portion} \right) + \left( \text{Nonlabor-related portion} \times (\text{COLA, if applicable}) \right) \rightarrow \begin{align*}
\text{Wage index} > 1.0000 & \rightarrow 68.8\% \text{ of labor-related portion is adjusted for area wages} \\
\text{Wage index} \leq 1.0000 & \rightarrow 62\% \text{ of labor-related portion is adjusted for area wages}
\end{align*}
\]

Adjusted for case mix

Base rate adjusted for geographic factors \times DRG weight \rightarrow DRG

Policy adjustments for qualifying hospitals:

I. Additional operating amounts

Adjusted base payment rate + IME payment + Disproportionate share payment \rightarrow \begin{align*}
\text{Hospital VBP payment amount} & \rightarrow \text{Hospital Readmissions Reduction Program payment amount}
\end{align*}

II. Adjustments for transfers

Full LOS \rightarrow \begin{align*}
\text{Per case rate}
\end{align*}

Short LOS and discharged to another acute care IPPS hospital or post-acute care \rightarrow \begin{align*}
\text{Adjusted per diem payment rate}
\end{align*}

III. If case is extraordinarily costly

High-cost outlier (payment + outlier payment)

IV. If case qualifies for new technology add-on

New technology add-on (payment + new technology payment)

Acute Care Hospital Inpatient Prospective Payment System

**Capital Base Payment Rate**

- Capital base rate
- Capital wage index
- Capital COLA (if applicable)
- Base rate adjusted for geographic factors

Policy adjustments for qualifying hospitals (Hospital VBP and Hospital Readmissions Reduction Programs adjustments do not apply to capital payments)

- Adjusted for case mix
  - DRG weight
  - Adjusted base payment rate
  - Capital disproportionate share payment
  - Capital IME adjustment

Adjustments for transfers

- Full LOS
- Per case payment rate
  - If case is extraordinarily costly
  - High-cost outlier (payment + outlier payment)

- Short LOS and discharged to another acute care PPS hospital or post-acute care
  - Adjusted per diem payment rate

Medicare Disproportionate Share (DSH) Add-on

- Paid to hospitals for treating a disproportionate share of low-income patients
- Medicare Fraction + Medicaid Fraction
- Medicare Fraction = Days for Patients *Entitled* to Medicare Part A and Entitled to SSI Benefits/Days for Patients *Entitled* to Medicare Part A
- Medicaid Fraction = Days for Patients *Eligible* for Medicaid and not Entitled to Medicare Part A/Total Days for Patients in Acute Care Areas including Nursery
  - Include in numerator ‘dual eligible’ whether paid or not
- If Medicare Fraction + Medicaid Fraction < 15% (the “Disproportionate Patient Percentage” or DPP), no operating DSH add-on
Medicare Disproportionate Share (DSH) Add-on cont...

- If DPP > 20.2% “Super-DSH” payment
- Hospitals can also qualify for capital DSH
  - $e$ raised to the power of $(.2025 \times \text{DPP})$ where $e = 2.71828$
DSH Payments Starting in 2014

- Affordable Care Act (ACA) requires reduction to and redistribution of DSH funding starting FFY2014
- Hospitals will continue to be paid 25% of DSH calculated under traditional method
- Remaining 75% will be reduced to reflect the impact of insurance expansion and will be redistributed to hospitals as a new uncompensated care payment
- 75% payment will be based on each hospital’s ratio of uncompensated care relative to uncompensated care provided by all DSH-eligible hospitals
DSH – WHAT CHANGED EFFECTIVE 10/1/13

As long as hospital meets minimum DSH threshold for traditional DSH, in current year, it can also receive an uncompensated care payment.

Payment is based on Medicare and Medicaid SSI volumes reported in prior year (most recent CR data in HCRIS database).

Payment is fixed amount per claim based on dividing hospital’s pool amount by a three year average of Medicare discharges.

Why do you need to know this?

- The 75% pool is based on unaudited data.
- Originally CMS was going to use S-10 worksheet as source of hospital’s uncompensated care amount. Instead using Medicaid days as proxy.
- The pool amount is not subject to change or appeal. You need to identify Medicaid eligible days at the time of filing of CR or if a 9/30 or 12/31 amend soon thereafter, although there is still a question as to whether CMS will incorporate amended returns into the calculation of the pool amount.

What can you do?

- Look at as-filed and audited Medicaid eligible days to determine trend and file incorporating trend. You do not want to understate days.
- If you are currently capped at 12% under traditional DSH, note that the uncompensated care pool DSH amount is not capped. As with uncapped hospitals, you should attempt to identify all Medicaid eligible days that can be supported
- Continue to pay attention to traditional DSH calculation and amend cost reports if necessary. Traditional DSH will continue to be calculated and settled on CR, subject to audit of Medicaid eligible days and the impact of updated SSI%
- Uncompensated care DSH payment cannot exceed hospital’s pool amount. Hospital will be settled to the pool amount.

And the S-10?

- Ensure you are filing accurate information. If and when CMS decides to use S-10 you may not have time to make any adjustments. Do not put DSH dollars at risk if CMS moves away from current Medicaid days and SSI calculation to S-10 reported uncompensated care.
DSH and 340B Drug Pricing Program

- DSH % determines if hospital eligible for this program
- Requires drug manufacturers to provide eligible health care organizations drugs at significantly reduced prices
- Can save hospitals estimated 20%-50% on the cost of outpatient drugs if DSH% > 11.75%
  - Criteria different for different types of hospitals
- Only available to not-for-profit and governmental hospitals
- Hospitals must certify eligibility annually
- Strict compliance requirements
Capital Portion of Blended Rate

- Capital costs are fixed costs incurred in treating patients
- Stating point is geographically adjusted national capital rate
- There are also capital add-on payments related to DSH and IME
  - Percentages determined from cost report are multiplied by the capital federal payment
  - Medicare capital DSH only paid to hospitals >100 beds
- Total capital payment is sum of federal capital payment + capital DSH add-on + capital IME add-on
- Total DRG Blended Rate
  - Sum of operating and capital payments times DRG weight = reimbursement for each hospital admission
    - Before other adjustments
Total DRG Blended Rate

- Sum of operating and capital payments times DRG weight = reimbursement for each hospital admission
  - Before other adjustments
Outlier Payments

- Patient may require extensive stay or need unusual amount of supplies or other items
- Federal government sets a cost outlier threshold so the hospital will not incur excessive loss
- Hospital-specific cost-to-charge ratios are applied to the covered charges for a case to determine whether the costs of the case exceed the fixed-loss outlier threshold.

Outlier Payment = \((.80) \times [(\text{charges} \times \text{cost/charge ratio}) - (\text{DRG} + \text{IME} + \text{DSH} + \text{threshold})]\)

- CMS publishes the outlier threshold in the annual PPS Final Rule
Medicare Eligible Days

- Concept of *spell of illness* is used to describe time period when beneficiaries may receive Part A benefits
- Financial implications for patients
- Patient is responsible for deductible for 60 days, coinsurance up to 30 days, then lifetime reserve up to 60 days.
  - Beyond that patient pays for all non-diagnostic services
Shadow Billing

- Medicare HMOs do not pay the Indirect Medical Education (IME) add-on.
- Hospital has to bill Medicare Administrative Contractor (MAC) separately for the payment that is part of the blended rate in traditional fee-for-service Medicare payment.
Other Factors Impacting Medicare Rate

- Readmissions Penalty
  - ACA requires CMS to reduce payments to hospitals with excess readmissions beginning 10/1/2012
  - Readmission is defined as admission to a hospital within 30 days of discharge from same or another hospital
  - Payment Adjustment amount = [Base Operating DRG payment amount x readmissions factor] - Base operating DRG payment amount
Other Factors Impacting Medicare Rate

- Value Based Purchasing Adjustment
  - VBP program ties hospital performance based on clinical and patient satisfaction metrics directly to reimbursement rates on Medicare patients
  - Hospitals are scored on how well they perform against other hospitals in the industry and how they improve over time
  - Funded by reducing base operating payments - 1.0% FY13, 1.25% FY14, 1.5% FY15, 1.75% FY16 and 2% FY17 and subsequent years
Other Factors Impacting Medicare Rate

- **Sequestration**
  - Effective 4/1/2013 a 2% across the board cut in Medicare provider payments
  - Sequester is not applied to the payment rate; instead, it is applied to Medicare claims after determining co-insurance, any applicable deductibles, and any applicable Medicare secondary payment adjustments.
  - Other Medicare payment lines such as GME, bad debt, DSH and electronic health record (EHR) incentives are also affected by the sequester reductions

- **Coding Adjustments**
  - Designed to offset perceived ‘code creep’ from change to MS-DRGs in 2008
Indirect Medical Education Add-On

- Applied to wage-adjusted base operating rate of teaching hospitals
  - \[\left(\frac{\# \text{ FTE resident}}{\# \text{ open beds}}\right) \times 1\]^{0.405}
  - Payment is geographically adjusted
  - Intended to cover higher costs associated with having residents
  - Trued up on annual Medicare cost report
  - To increase ratio remove from service beds not being used due to maintenance or clinical issues

- Medicare HMOs do not pay the Indirect Medical Education (IME) add-on
  - Hospital has to bill Medicare Administrative Contractor (MAC) separately for the payment that is part of the blended rate in traditional fee-for-service Medicare payment
Other Reductions from Patient Protection and Affordable Care Act (PPACA)

- Multi-Factor Productivity Adjustment based on 10 year rolling average of annual economy wide private nonfarm business multi-factor productivity
- Statutory Adjustment Factor – reduction to market basket update
- Hospital Acquired Conditions (HACs) – beginning with discharges on or after 10/1/2008 Medicare does not assign an inpatient hospital discharge to a higher paying MS-DRG if a HAC was not present on admission.
  - Case is paid as if secondary diagnosis not present
  - In 2015 hospitals will face an additional 1% reduction in Medicare inpatient payments if the hospital falls into the top 25% of national risk-adjusted HAC rates for all hospitals in the previous year
Transfer Payments

- “Transfer DRGs” – refers to the Medicare post-acute transfer (PACT) policy
- Payment reduction occurs only if all of the following conditions are met:
  - Patient is in a Transfer DRG
  - Patient was a “short-stay” or early discharge (LOS+1<GMLOS)
  - Patient was transferred to either a SNF, home health care, rehab hospital, or LTC hospital
- Started with 10 Transfer DRGs in 1999; now applies to almost all DRGs
Transfer Payments

- Started with 10 Transfer DRGs in 1999; now applies to almost all DRGs
- ‘Standard Rule’ versus ‘Special Rule’ – complicated calculation
- Objective is to protect CMS from paying twice for the same care – once as part of MS-DRG and once as separate payment for post-acute care
Medicare Hospital Designations

- Sole Community Hospital (SCH) must meet one of the following criteria:
  - Located at least 35 miles from other like hospitals;
  - Rural, located between 25 and 35 miles from other like hospitals, AND meets ONE of the following criteria: No more than 25% of residents who become hospital inpatients or no more than 25% of the Medicare beneficiaries who become hospital inpatients in the hospital’s service area are admitted to other like hospitals located within a 35-mile radius of the hospital or, if larger, within its service area; or has fewer than 50 beds and would meet the 25% criterion if not for the fact that some beneficiaries or residents were forced to seek specialized care outside of the service area due to the unavailability of necessary specialty services at the hospital;
Medicare Hospital Designations

- Rural and located between 15 and 25 miles from other like hospitals but because of local topography or periods of prolonged severe weather conditions, the other like hospitals are inaccessible for at least 30 days in each of 2 out of 3 years; or
- Rural and because of distance, posted speed limits, and predictable weather conditions, the travel time between the hospital and the nearest like hospital is at least 45 minutes
Medicare Hospital Designations

- Medicare Dependent Hospital (MDH)
  - IPPS hospital located in a rural area, <100 beds, cannot be SCH
  - Must meet a threshold test – at least 60% discharges Medicare
  - Pays hospital based for inpatient operating costs based on the Federal rate or, if higher the Federal rate plus 75% of the amount by which the hospital specific rate exceeds the Federal rate
  - Not capped for DSH add-on
  - Designation set to expire 3/31/15
Medicare Hospital Designations

- Rural Referral Center (RRC)
  - Rural, >275 beds, at least 5,000 annual discharges, not capped for DSH
  - Qualifies for 340B Program with 8% DSH

- Critical Access Hospital (CAH)
  - No more than 25 beds, average length of stay < 4 days
  - Must provide 24 hour emergency services
  - Reimbursed at 101% allowable Medicare costs
Outpatient Prospective Payment System

- National Ambulatory Payment Classification (APC) fee schedule for hospitals introduced in 2000
- Services listed independently and as bundled group
- Medicare OP APC Payment = National Fee Schedule Payment x Geographic Adjustment % x Wage Index %
- Clinical lab work has a separate fee schedule
- ‘Three Day Payment’ Window
  - Effective 7/1/2012 when a physician furnishes services to a beneficiary in a ‘wholly owned or operated hospital entity’ all procedures and services performed on an outpatient basis are combined with the inpatient charges if performed within 3 days of admission
  - Applies to all diagnostic services furnished, and any non-diagnostic services that are clinically related to the inpatient admission
Skilled Nursing Facilities

- Paid a comprehensive prospective per diem rate which includes cost of all services – routine, ancillary, and capital
  - except costs associated with operating approved educational activities and
  - costs of SNF Consolidated Billing (CB) excluded services which are billed under Part B (e.g. Physician Services, Emergency Services)

- Per diem rate is case-mix adjusted using a resident classification system known as Resource Utilization Group IV (RUG IV)

- Labor portion of the federal rate is adjusted using the hospital wage index
Home Health Agencies

- Prospective base payment
  - Case-mix adjusted for health condition and needs of beneficiary using Outcome and Assessment Information Set (OASIS)
  - Adjusted for geographical differences in wages for HHAs across the country
- Payment is made for each 60-day episode of care for each beneficiary
  - At the end of the first episode of care a second episode can begin
- No limits to the number of episodes of care as long as the beneficiary remains eligible for home health benefits
- Outlier payments are made for beneficiary’s who incur unusually large costs
Physician Reimbursement

General Professional Reimbursement Models

- Fee-for-Service
  - Physicians are paid for every service and test that they provide based on the usual and customary charges of physicians in the local area

- Capitation
  - A fixed amount of money per patient per unit of time paid in advance to the physician for the delivery of health care services. The actual amount of money paid is determined by the ranges of services that are provided, the number of patients involved, and the period of time during which the services are provided.
  - Capitation payments are used by managed care organizations to control health care costs.
  - Capitation payments control use of health care resources by putting the physician at financial risk for services provided to patients.

- Salary
Physician Reimbursement

- Traditional Medicare
  - Fee-for-service based on two primary factors: RBRVS and SGR
  - **(RBRVS)** Resource based relative value scale
    - Medicare payment rates broken out by CPT or HCPCS code
    - Rates are a result of three relative values – work, practice expense, and malpractice, which are multiplied by a regional cost index
  - **(SGR)** Sustainable growth rate system
    - Formula limits growth in spending for physicians’ services by linking updates to target rates of spending growth
  - Medicare also differentiates by setting
    - A procedure performed in a hospital involves a payment to the hospital as well as the physician
Physician Reimbursement

- Physicians have choice when dealing with Medicare patients
- Accept Medicare as payment in full (participating or PAR)
  - A participating physician agrees to accept assignment on every Medicare patient treated
  - Can only bill patient for copayment portion
- Treat Medicare patients but not accept payment in full from Medicare (non PAR)
  - Limiting charge is 95% of approved Medicare fee schedule
  - Maximum fee for a non PAR physician equals 115% of approved fee for non PAR
  - Payment comes directly from patient
  - Can accepts assignment on a case-by-case basis but limited to the non Par fee schedule
Physician Reimbursement

- Health Professional Shortage Area
  - Incentive payment of 10% more than what otherwise would be paid under the fee schedule

- Physicians can also enter into private contracts with patients (do not bill Medicare)
  - Concierge Medicine (retainer medicine)
    - relationship between a patient and a primary care physician in which the patient pays an annual fee or retainer. This may or may not be in addition to other charges
Medicaid
General Introduction

- Title XIX of Social Security Act of 1965
- Administered by each state to provide health coverage to low income families
- Eligibility rules vary by state
- Funded at Federal and state level
  - States responsible for bulk of Medicaid funding
  - Federal government shares in costs
  - Federal Medical Assistance Percentage (FMAP) – federal participation in funding set annually based on each state’s per capita income
General Introduction

- States required by federal government to cover certain mandatory groups and have option to cover other populations
  - Mandatory coverage is general for physician services, hospital IP and OP services; lab services; early and periodic screening, diagnosis, and treatment services for children < 21 years old; family planning services and supplies; nursing facility services for adults >21 years, HH care; and transportation services

- States must also cover:
  - Services provided by federally qualified health centers, rural health clinics, pediatric and family nurse practitioners, and nurse midwives
  - Medicaid covers hospital services medically necessary for the maintenance, improvement, or protection of the patient’s health
  - Cosmetic procedures typically not covered
Section 30(A) of the Medicaid Act

“Provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1396b(i)(4) of this title) as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.”
Medicaid Payments

- Inpatient Reimbursement
  - Inpatient Stays typically paid under DRG or per-diem
    - Non-frequent services typically paid per-diem
  - States do their own blended rate calculation
  - Discharge base rate and capital-add on are set for each hospital based on historical data for that hospital
  - Like Medicare, each state has a weight listing of all possible Medicaid DRG reimbursed procedures
  - Per-diem rates are adjusted by a hospital specific-multiplier

- Outpatient Reimbursement
  - Typically fee schedule for all services – surgical or non-surgical
Medicaid Payments

- Medicaid Add-on Payments
  - DME – paid on claim as part of blended rate
    - Based on data in previous year’s cost report
    - \((\text{Total hospital Medical Education costs} \times \text{Medicaid Utilization Rate})/\text{Number of Medicaid claims}\)
    - Some states may add other variables
  - IME – usually based on the same computation as in the Medicare blended rate
    - Using # of Medicaid claims instead of Medicare claims
  - Teaching Supplement
    - Some states have add-on payments for teaching of physicians who treat Medicaid patients
Medicaid

- Dual Eligibles
  - An individual who qualifies for both Medicare and Medicaid benefits
  - Medicare will always be primary
  - Most states pay the allowed amount less the reimbursement paid by Medicare or the coinsurance/deductible amount (whichever is less)
Medicaid

- Medicaid Cost Settlement
  - Goal of traditional Medicaid is to pay hospitals at cost for treating Medicaid patients
  - Annual cost report is method of settlement
  - Most states initially reimburse at 75%-80% of costs
  - Cost report is used to determine Cost to Charge Ratio (CCR) which is applied to Charges to get cost
    - Cost is compared to what the hospital has already been paid resulting in initial settlement
    - Final settlement occurs after independent audit
  - Effective 1/1/14 NC settles outpatient at 70% of costs
Medicaid DSH

- Most hospitals have a Medicaid DSH program in addition to the traditional fee-for-service program
- Paid to hospitals for Medicaid and all indigent patients
- Most not-for-profit hospitals in the state will pay an “assessment” to initially fund both traditional and DSH payments
- The assessment is used by the state to draw down matching Federal funds
  - May be doubled or even tripled by Federal government but subject to a state specified cap
- Each state has its own model for paying out DSH money
  - Funds are disbursed pro rata if the available DSH money does not cover the total cost of care to indigent patients
State Children’s Hospital Insurance Program (SCHIP)

- Covers children under 18 years where parents do not qualify for government program
- Cannot be covered under SCHIP if covered under Medicaid
- Example NC Health Choice for Children. Children must be:
  - Between the ages of 6 through 18;
  - Be ineligible for Medicaid, Medicare, or other federal government-sponsored health insurance;
  - Be uninsured;
  - Be in a family whose family income is above one hundred percent (100%) through two hundred percent (200%) of the federal poverty level;
  - Be a resident of this State and eligible under federal law; and
  - Have paid the Program enrollment fee required under this Part
Government Cost Reporting

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Medicare Cost Report

- Mandatory for hospitals participating in Medicare program
  - Similar to a tax return
  - May be prepared internally or outsourced
- Due 5 months after hospital’s fiscal year-end
  - Extensions only in extraordinary circumstances beyond provider’s control
- Penalty for not filing timely is withholding of 100% of payments and interest
- Uses a step-down methodology to find the costs of performing hospital services
  - Allocates support costs to other support departments and operating departments
  - No reverse allocation
Medicare Cost Report cont..

- Reflects the activity of the hospital in that fiscal period
- Certain expenses excluded, i.e., Part B Physician-related expenses
- Source for all costs is hospital general ledger
- Expenses classified as allowable or nonallowable
- Cost-to-charge ratios created from data for treating all patients, not just Medicare and Medicaid
- Primary purpose is to determine cost of providing care to Medicare and Medicaid patients
- Federal government uses CR to determine gap between payment and cost
- Impacts future reimbursement rates
Information in CR used by managed care companies to negotiate rates with hospitals

States used to reimburse at cost for treating Medicaid patients

The MAC audits and settles the Medicare CR

The State contracts auditing to an outside firm

Tentative settlement usually 60 days after filing if the hospital is owed money

If the hospital owes money, payment must accompany the CR

Medicaid auditors focus on cost data since states reimburse primarily based on costs

Medicare auditors will primarily focus on Bad Debt and DSH

- And Education costs, if teaching hospital
Medicare Bad Debt

- If certain conditions met, federal government will reimburse hospitals for a portion of their Medicare Bad Debt
- Reimbursement is 65% in 2015
- Medicare Bad Debt must be:
  - Debt must be related to covered services and derived from deductible and co-insurance amounts
  - Provider must be able to establish that reasonable collection efforts were made
  - Debt was actually uncollectible when claimed as worthless
  - Sound business judgment established that there is no likelihood of recovery at any time in the future
Medicare Bad Debt cont...

- Cannot claim:
  - Deductibles and coinsurance from professional fees such as CRNA & physician services.
  - Deductibles and coinsurance resulting from non-allowable services
  - Deductible and coinsurance owed by patients of Medicare HMOs are not included in Medicare Bad Debt
Medicare Bad Debt cont...

Reasonable Collection Efforts

- Collection efforts must continue for at least 120 days after the date the first bill was mailed
- Any payment restarts the 120 day clock
- If accounts sent to an outside collection agency (OCA) can only be claimed as Medicare Bad Debt when returned from the OCA
- Must apply similar collection efforts to Medicare and non-Medicare Bad Debt
- Must return Medicare and non-Medicare Bad Debt using same criteria
Medicare Bad Debt cont…

- Regular Medicare Bad Debt
  - Not crossovers or charity care bad debt
  - Subject to reasonable collection rules

- Crossover Medicare Bad Debt
  - Dual eligible
  - Not subject to reasonable collection effort rules
  - Must bill Medicaid

- Charity Care Medicare Bad Debt
  - Indigent patients
  - Not dual eligible
  - Not subject to reasonable collection effort rules
Audit Issues

- Auditors want to see copies of written policies at the beginning of the Medicare Bad Debt audit
- MACs are requiring asset, liability, income and expense tests as part of hospital’s determination of charity
- Collection Agencies being asked to provide patient transaction history to document collection efforts
- Auditors analyzing Medicare and Non-Medicare accounts to determine all payers being treated equally and hospitals are abideing by written collection policies
- Hospitals must ensure Fee Schedule and Professional coinsurance and deductible excluded from Bad Debt claimed
- Auditors are looking closely at recoveries and requesting a reconciliation to total recoveries in the G/L
Audit Issues

- MACs are disallowing any coinsurance or deductible if the hospital did not bill in a timely manner after Medicare paid. The regulations state “timely manner” but auditors are using 45 days as their guideline.
- Error rates are being extrapolated based on statistical samples that do not appear to be statistically valid.
- Size of audit samples is often too small to provide any reasonable level of confidence in results.
- Auditors are grouping bad debt listings by the amount claimed which can generate different error rates.
Medicare DSH Calculation

- **DSH Patient Percentage (DPP)**
  - \((\text{Medicare SSI Days/Total Medicare Days}) + (\text{Medicaid, Non-Medicare Days/Total Patient Days})\)
  - If DPP >15%, or >20.2% (“super” DSH), hospital is eligible for DSH payment based on statutory formula based on hospital status and number of beds
  - Actual computation depends on hospital status
    - “Primary Qualifying Method”
    - Special Exception for ‘Pickle’ hospitals

- **Medicaid days**
  - Hospital must determine whether the patient was eligible for Medicaid under a State plan approved under Title XIX on the day of service.
  - If the patient was eligible, the day counts in the DSH calculation.
<table>
<thead>
<tr>
<th>STATUS/LOCATION NUMBER OF BEDS</th>
<th>THRESHOLD</th>
<th>ADJUSTMENT FORMULA</th>
</tr>
</thead>
<tbody>
<tr>
<td>URBAN HOSPITALS</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| 0 - 99 Beds                   | ≥15%, ≥20.2% | 2.5% + [.65 x (DPP − 15%)]  
|                               |           | Not to Exceed 12%   |
|                               | ≥20.2%    | 5.88% + [.825 x (DPP − 20.2%)]  
|                               |           | Not to Exceed 12%   |
| 100 or More Beds              | ≥15%, ≥20.2% | 2.5% + [.65 x (DPP − 15%)]  
|                               |           | No Cap              |
|                               | ≥20.2%    | 5.88% + [.825 x (DPP − 20.2%)]  
|                               |           | No Cap              |
| RURAL REFERRAL CENTERS        | ≥15%, ≥20.2% | 2.5% + [.65 x (DPP − 15%)]  
|                               |           | No Cap              |
|                               | ≥20.2%    | 5.88% + [.825 x (DPP − 20.2%)]  
|                               |           | No Cap              |
| OTHER RURAL HOSPITALS         |           |                    |
| 0 - 499 Beds                  | ≥15%, ≥20.2% | 2.5% + [.65 x (DPP − 15%)]  
|                               |           | Not to Exceed 12%   |
|                               | ≥20.2%    | 5.88% + [.825 x (DPP − 20.2%)]  
|                               |           | Not to Exceed 12%   |
| 500 or More Beds              | ≥15%, ≥20.2% | 2.5% + [.65 x (DPP − 15%)]  
|                               |           | No Cap              |
|                               | ≥20.2%    | 5.88% + [.825 x (DPP − 20.2%)]  
|                               |           | No Cap              |
Medicare DSH Calculation

- Focus is on patient’s eligibility for Medicaid benefits as determined by State, not the hospital’s eligibility for Medicaid payment
- Patient must be eligible for medical assistance under an approved Title XIX State Plan, not assistance under a State-only program
- Medicaid days includes all days for which patient is eligible, even if Medicaid did not make payment
## Medicare DSH Calculation

<table>
<thead>
<tr>
<th>Included Title XIX Eligible Days</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actual 1902(r)(2) and 1931(b) Days</td>
<td>Days for patients eligible under a State plan based on a 1902(r)(2) or 1931(b) election. These patients are Medicaid-eligible under the Title XIX State plan under the authority of these provisions, which is exercised by the State in the context of the approved State plan.</td>
</tr>
<tr>
<td>Medicaid Optional Targeted Low Income Children (CHIP-related) Days</td>
<td>Days for patients who are Title XIX-eligible and who meet the definition of &quot;optional targeted low income children&quot; under section 1905(u)(2). The difference between these children and other Title XIX children is the enhanced FMAP rate available to the State. These children are fully Medicaid-eligible under the State plan.</td>
</tr>
<tr>
<td>1915(c) Eligible Patient (the &quot;217&quot; group) Days</td>
<td>Days for patients in the eligibility group under the State plan for individuals under a Home and Community Based Services waiver. This group includes individuals who would be Medicaid-eligible if they were in a medical institution. Under this special eligibility group, they are Medicaid-eligible under the State plan.</td>
</tr>
<tr>
<td>Retroactive Eligible Days</td>
<td>Days for patients not enrolled in the Medicaid program at the time of service, but found retroactively eligible for Medicaid benefits for the days at issue. These patients are Medicaid-eligible under the State plan.</td>
</tr>
<tr>
<td>Medicaid Managed Care Organization Days</td>
<td>Days for patients who are eligible for Medicaid under a State plan when the payment to the hospital is made by an MCO for the service. An MCO is the financing mechanism for Medicaid benefits, and payment for the service through the MCO does not affect eligibility.</td>
</tr>
</tbody>
</table>
Medicare DSH Calculation

- Source of Medicaid Days
  - MARS report or state issued PS&R
  - All Medicaid secondary bills

- Patient must be eligible for medical assistance under an approved Title XIX State Plan, not assistance under a State-only program

- Medicaid days includes all days for which patient is eligible, even if Medicaid did not make payment

- Hospital bears the burden of proof and must verify with the State that the patient was eligible under one of the allowable categories during each day of the patient's stay.
Medicare Subproviders

- Medical services reimbursed separately from traditional DRG methodology
  - PPS diagnosis related groups do not accurately account for the resource costs for the types of patients treated in those facilities, e.g., rehabilitation and psychiatric care

- Hospital can choose to create subprovider distinct units and report on the cost report
  - Otherwise services are included in traditional IPPS methodology

- IRF Methodology
  - Separate DRG listing for rehab services
  - To qualify to be paid under IRF PPS must meet ‘75% rule” – 75% of patients must qualify for 1 of 13 specified medical rehabilitation condition
Medicare Subproviders

IPF Methodology

- Federal per diem rates include inpatient operating and capital-related costs (including routine and ancillary services) and are determined based on Geographic factors, Patient characteristics, and Facility characteristics.
- The per diem base rate excludes pass-through costs such as bad debts and graduate medical education.

Clinics

- *Provider-Based* – part of the hospital, classified as an outpatient service, bills for services using outpatient fee schedule, costs are included on the cost report.
- Patient gets two bills – one from hospital and one from physician.
- Specific requirements to be Provider-Based.
- *Freestanding* – separate entity from the hospital, costs not reported on the cost report.
Medicaid Cost Report

- Mandatory for hospitals participating in Medicaid program
  - Prepared at the same time as the Medicare Cost Report
  - Difference related to allowed costs under Medicaid versus Medicare
Financial & Other Reporting Requirements
Financial Statements
Financial Statements

- Not-for Profit and Government Hospitals
  - Statement of Operations
  - Statement of Financial Position
  - Statement of Changes in Net Assets - 501(c)(3) only

- For Profit
  - Income Statement
  - Balance Sheet
  - Statement of Changes in Equity

- All
  - Statement of Cash Flows
  - Financial Statement Notes
Accrual basis

Common structure: revenue - expenses = net income
  - Overall purpose is to report profitability in a period of time

Considered the most significant FS for performance evaluation

Gross Revenue
  - All inpatient and outpatient revenues before any deductions
  - Gross charges are uniform no matter what the payer classification or patient’s ability to pay
  - Revenue usually classified by payer type or service rendered
Net Revenue

- Reduction to net takes place through contractual or reserve analysis
  - Contractual adjustment is critical in hospital accounting because different insurance plans reimburse at different amounts
  - Additional adjustments take into consideration the aging of the accounts
  - Must also consider patients still in beds at end of accounting period or Discharged Not Final Billed (DNFB)

- Reduction of gross patient service revenue for bad debt expense

- Charity care revenue
  - A hospital does not expect to receive any cash from a charity care patient therefore the net revenue for a charity care patient is always zero (contractual = gross revenue)

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1 FASB's guidance, ASU 2011-07: If healthcare providers are required to treat patients because they do not have the ability to assess patients' credit risk (healthcare providers with emergency departments) — then they will classify their bad debt expense as a reduction of gross patient revenue. Previously shown on hospital income statements as operating expense.
Statement of Operations/Income Statement

- **Other Revenue**
  - Non-patient revenue, i.e., cafeteria sales, gift shop
  - Classified below the net revenue line
    - Patient related but not patient driven

- **Operating Expenses**
  - Salaries and Supplies largest component in a hospital (~80%)
Statement of Financial Position/Balance Sheet

- Compiles information about the hospital’s assets, liabilities, and equity (net assets)
  - Records data at a period in time
- Cash - most critical – must constantly evaluate to determine if appropriate balance is being maintained
- Accounts Receivable – second largest asset for a hospital
  - Always presented at net balance or net realizable value
- Inventory – hospital must keep sufficient inventory to meet patient needs and unexpected volumes
  - Manage using supply chain distribution and inventory control
Investments

- For profit will classify as:
  - Held to maturity securities – presented at amortized cost
  - Trading securities – presented at fair value, record unrealized holding gains or losses in earnings
  - Available for sale securities – presented at fair value, record changes in fair value in a separate component of equity
- Not-for-profit will classify all investments at fair value and all unrealized gains or losses are reported as changes in net assets
Property and Equipment (Fixed Assets)

- Grouped into Land, Land Improvements, Buildings, Major Moveable Equipment, Minor Equipment
- Fixed Assets are unique in that they depreciate over time
  - Depreciation is presented as an operating expense even though no cash is disbursed

Intangible Assets (no physical form)

- These assets are amortized versus depreciated

Accounts Payable

- Represents the need for use of credit as payment for goods in all industries
Long-Term Debt

- Primary source of funding to expand operations and upgrade buildings, etc. as neither not-for-profit or governmental hospitals have retained earnings or the ability to issue stock
- Significant benefit of being 501(c)(3) hospital is the ability to qualify for tax-exempt long-term debt (longer maturity period and lower interest
- Majority is revenue bonds, secured by the hospital’s revenues
- Bond liability is reported as current liability (12 months) and long term (remaining balance)
- Bond covenant – as a requirement of tax-exempt bond financing hospital required to restrict cash and maintain certain financial ratios

Other Liabilities

- e.g., Medical Malpractice suits
Statement of Financial Position/Balance Sheet

- Net Assets
  - Significant difference between for profit and not-for-profit hospitals
  - Net assets similar to equity reported by for profits
  - Not-for-profits and governmental hospitals segregate net assets into three categories primarily to monitor compliance with donor restrictions
    - Unrestricted net assets – contributions given to the hospital to use as it sees fit
    - Temporarily restricted net assets – considerations dictated by time or purpose
    - Permanently restricted net assets – restrictions not removed by the passage of time or the actions of the hospital (e.g. permanent endowment fund)
  - Information on nature and amount can be found in Notes to F/S or in Statement of Changes in Net Assets
Other Financial Statements

- **Statement of Changes in Net Assets**
  - 501(c)(3) only
  - Breakdown and classification of increases and decreases if fund balances listed in Statement of Financial position
  - Aggregated information, not individual funds

- **Statement of Changes in Equity**
  - For profit
  - Lists hospital profit/loss and comprehensive income
    - Comprehensive income is the sum of net income and other financial items that have not been realized, such as foreign currency gains/losses

- **Statement of Cash Flows**
  - Flow of cash for that period divided into operating, investing, financing
Other Financial Statements

- Financial Statement Notes
  - Considered part of financial statements
  - Provide additional detail of many of the amounts listed
Planning & Budgeting
Planning & Budgeting

Planning focuses on the long-term future

- **Strategic** plan addresses the ‘what’ - the organization’s mission and objectives
- **Operating** plan addresses the ‘how’
  - Usually five year horizon
  - Details accountability and timelines

Budgeting is offshoot of planning process

- Budgets are managerial tools that address planning for the short-term and as are a control mechanism to ensure current performance is consistent with long-term plans

Conventional approach to budgeting is to use the previous budget as the starting point

Zero-based budgets require all amounts to be justified each budget period
Planning & Budgeting

Different types of budgets

- Statistics
- Revenue
- Expense
- Operating (revenue and expense combined)
- Cash
- Capital

Budgeting as a control function

- Variance Analysis – what happened versus what was planned
- Static versus flexible budgets
  - Flexible budgets tell us what the results would have been under the volume level actually attained, assuming all other budgeting assumptions held constant
Planning & Budgeting

Budgeting - Process

- Determine the budget calendar
- Distribute budget instructions, input forms, and projected inflation rates
- Obtain historical data on costs and volumes by accounting periods
- Analyze internal and external forces that could affect historical patterns
- Project the volume of activities (patient visits, tests, surgeries) using all the above information — a total budget will include statistics, operations defining expense and revenues, capital, and cash flows
- Project expenses and revenues
- Determine the other capital needs (equipment, debt service, and working capital)
- Establish revenue and rates schedule, net of reductions from revenue required to generate sufficient cash to cover the operating costs and capital needs
- Submit the budget if required to others for final approval
Planning & Budgeting

- Budgeting – Functional focus
  - Data collection & analysis
  - Projections
  - Capital planning
  - Cash flow
  - Budget analysis & monitoring
  - Financing options
Cash management principles

- Increase speed of collections on receivables
- Keep inventory low
- Delay payment of liabilities
- Plan the timing of major expenses
- Invest idle cash
Disbursements & Internal Controls
Disbursement Function

Functional focus

- Payroll
  - Regulatory employee and contractor financial data collection (e.g. I-9; W-4, W-9)
  - Work load data collection

- Purchasing
  - Requisitions
  - Authorizations
  - Procurement
  - Verification/approval
  - Payment processing/posting
Internal Control Functions

- Functional focus
  - Segregation of duties
  - Safeguarding of assets
  - Safeguarding of data
  - Regulatory compliance
  - Billing compliance
  - IT systems validation
Internal Controls Function

- Internal control is most effective when controls are built into the entity’s infrastructure and are an essential element of the enterprise.
- Management is ultimately responsible for an organization’s system of internal controls.
Internal Controls Function – Corporate Compliance

- Failure to comply with regulations and statutes may result in charges
  - Criminal or Civil Penalties

- Regulations
  - Healthcare is governed by many regulations and standards.
  - Health information management (HIM) department contends with many of the regulations, standards and regulatory entities.
Internal Control Functions

HIM must ensure:

- Patient information is protected from unauthorized access, safeguarded against destruction and tampering
- Integrity of the data
- Timely access to authorized individuals
- Information is released in accordance with governmental and organization policies and procedures (internal control system)
- Internal control of computerized and other financial and patient information
Managed Care & General Contracting

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Contract Management Function

- What makes a contract valid?
  - Provisions
  - Price
  - Authority
  - Legal services and products

- Assessing a contract
  - Understand legal terms
  - Read the contract for the financial benefits it offers
  - Summarize the ‘gives’ and ‘takes’ of the proposal
  - Identify loopholes
## Contract Management Function

<table>
<thead>
<tr>
<th>Boilerplate Provisions</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Choice of law</td>
</tr>
<tr>
<td>• Modification of Agreement</td>
</tr>
<tr>
<td>• Severability of Agreement</td>
</tr>
<tr>
<td>• Separate Exhibits</td>
</tr>
<tr>
<td>• Survival</td>
</tr>
<tr>
<td>• Confidentiality</td>
</tr>
<tr>
<td>• Representation/Signatories</td>
</tr>
<tr>
<td>• Notice</td>
</tr>
<tr>
<td>• Entire Agreement</td>
</tr>
<tr>
<td>• Execution</td>
</tr>
<tr>
<td>• Force Majeure</td>
</tr>
<tr>
<td>• Necessary Acts</td>
</tr>
<tr>
<td>• Survival</td>
</tr>
<tr>
<td>• Ambiguities</td>
</tr>
</tbody>
</table>

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Contract Management Function

- Common Uses of Contracts in Healthcare Finance
  - Services of an external auditor
  - Health plan/payer contracts
  - Banking services
  - Collection agency
  - Contracting for temporary billers or other staff
  - Engaging a scanning company to scan files and destroy paper files
  - Equipment maintenance (shredders, copiers, printers and other equipment)
  - Maintaining applications by providing upgrades to and education for the software used
Are Charges the Same for Everyone?

"If I promise to come back several times, can I get the group rate?"
Evolution of Managed Care

- Significant drivers
  - 20th Century
    - Medical Specialization
    - Group Medical Practices
    - Corporate Management of Medical Practices
  - Medicare & Medicaid Changes in 1960s
    - Realigning the payment process
    - HMO Act
    - Advent of employer-based insurance

Source: http://www.pbs.org/healthcarecrisis/history.htm
HMOs and PPOs

- Health Maintenance Organizations (HMOs)
  - Type of Managed Care Organization (MCO) that provides health insurance through hospitals, doctors and other providers with which HMO has contract
  - Preferred Provider Organizations (PPOs) provide covered services at a discounted cost for subscribers who use network providers
HMOs and PPOs

- Each type of managed care plan provide services at a reduced rate and covers:
  - primary care visits
  - preventive services
  - copayments for prescription drugs
  - PPOs allow the enrollee to choose his or her physician
  - HMOs maintain a list of plan-approved doctors
Four Major Models of HMOs

- **Staff Model**
  - Either the physicians are employees of the HMO or they provide most of their services to HMO members through a contractual relationship.

- **Group Model**
  - The HMO contracts with one or more medical groups to provide all necessary services to HMO members.

- **IPA Model**
  - A much looser affiliation of independent physicians - the IPA contracts with the HMO for needed medical services.

- **Network Model**
  - A hybrid of the three previous forms—key to success is the ability to access a pool of cost-effective physicians who can manage care.
Conventional or Indemnity Plans

- Provide their members with the greatest access to healthcare providers
  - Doctors
  - Hospitals

- No restriction to members on who they can see—freedom of choice
Point-of-Service (POS) Plans

- Hybrid form of an HMO
  - Can choose out of network but will cost more in forms of deductibles, higher copayments, or both
Provider-Payer Relationships and Terms To Know

- Deductibles
- Coinsurance
- Copayments
- Out-of-pocket maximums
- Incentives and disincentives
- Reinsurance recovery
- Coordination of Benefits (COB)
Provider Reimbursement Methods

- Percent-of-Charge
- Per Diem Payments
- Case Rate Payments
- Global Per Case Payments
- DRGs
- APGs
- APCs
Professional Reimbursement Methods

- Fee-for-Service, negotiated fee schedules
- Resource Based Relative Value System (RBRVS)
- Capitation
- Indemnity vs. Managed Care

Source: http://www.agencyinfo.net/iv/medical/types/indemnity-managed.htm
Important Areas of Health Plan Contract Language

- Remove Contract Ambiguity
- Eliminate Retroactive Denials
- Establish a Reasonable Appeal Process
- Define Clean Claims
- Remove Most Favored Nation Clauses
- Definition of Day in Per Diem Contracts
- Prohibit Silent Preferred Provider Organization Arrangements
- Include Terms for Outliers or Technology-Driven Cost Increases
- Establish Ability to Recover Payment After Termination
- Preserve the Ability to be Paid for Services
- Definition of Emergency Services

Source: Cleverly, Song, and Cleverly p. 150
Common Health Plan Contract Provisions and Definitions

- Incorporation of other documents
- Access to data
- Unilateral changes
- Cost of living rate adjustments
- Retrospective Payment Denial
- Dispute resolution
- Allowance/prohibitions against litigation
- Appeals
Evaluating Health Plan/Payer Contracts

- Contract language
- Reimbursement levels
- Financial, operational and legal parameters acceptable to both parties
Contract Evaluation Model

- Payment rates
- Covered lives
- Claim complexity
- Preapproval/utilization review requirements
- Carve-outs
- Risk for the provider
Contract Management Function

- Contracts with Health Plans & Payers
  - Indemnity/commercial insurers
  - Preferred provider organizations (PPOs)
  - Managed care organizations (MCOs) such as health maintenance organizations (HMOs), exclusive provider organizations (EPOs), and accountable health plans (AHPs)
  - Other health plan/payer related entity
Contract Management Function

- Common Health Plan Contract Provisions and Definitions
  - Claims submission requirements
  - Clean claim
  - Claims payment requirements
  - Definition of day in per diem contracts
  - Definition of emergency services
Looking Forward
Looking Forward

- **Insurance Expansion**
  - Impact of State decisions about whether to implement ACA Medicaid expansion

- **Increased focus on primary care**
  - PPACA eliminated cost-sharing for certain preventive care services

- **Rewarding Quality Outcomes**
  - The current system is moving from a fee-for-service approach to an approach that rewards quality outcomes and promotes care coordination among all providers along the continuum of care

- **Center for Medicare & Medicaid Innovation (CMI)**
  - Broad mandate as Medicare’s “laboratory” to test new delivery system approaches and fold them into the Medicare and Medicaid programs
Accountable Care Organizations (ACOs)

- Groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their Medicare patients
- Goal is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors.
- When an ACO succeeds both in delivering high-quality care and spending health care dollars more wisely, it will share in the savings it achieves for the Medicare program.
ACO Risk Sharing Models

- Shared Savings
- Shared risk and savings, pay for performance for selected performance metrics
- Bundled payments, case management fee
- Partial capitation, targeting high-risk chronic disease population
- Full capitation, population-based risk

Adapted from Delbanco et al. Promising Payment Reform: Risk Sharing with ACOs. The Commonwealth Fund. 2011
Looking Forward

- **Bundled Payments**
  - Discards the conventional method of paying health care professionals individually and directly for the care they provide in favor of offering one lump sum payment to be divided among all who participate in a defined episode of care.

- **Patient Centered Care**
  - Principle behind the growing movement toward patient-centered care is that you can improve the quality of health care and reduce the costs at the same time.
  - Medicare Medical Home Demonstration Project attempts to redesign the health care delivery system to provide targeted, accessible, continuous and coordinated, family–centered care by a personal physician practicing in a medical home to Medicare beneficiaries with qualifying chronic conditions.
Thank you for your attention

Questions?

My head can’t hold any more information!