Healthcare Reimbursement in an Era of Reform

Presenters

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Presenter Bio

Lisa G. Han, Esq., is a partner in the Columbus office of Jones Day. Ms. Han focuses her practice on transactional and regulatory matters for the health insurance and healthcare industries. She represents publicly traded and privately held health insurance companies, employers, PEOs, TPAs, PBMs, and other entities providing insurance support services in the health insurance and employee benefits area.

Ms. Han also has significant experience representing healthcare clients in the formation of strategic alliances between hospitals and physicians, complex managed care contract negotiations, reimbursement issues between providers and payers, product and network issues, prompt payment compliance, audits and recovery, and regulatory compliance and audit.

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Presenter Bio

Todd A. Zigrang, MBA, MHA, FACHE, ASA is the President of **HEALTH CAPITAL CONSULTANTS** (HCC), where he focuses on the areas of valuation and financial analysis for hospitals, physician practices, and other healthcare enterprises. Mr. Zigrang has over 20 years of experience providing valuation, financial, transaction and strategic advisory services nationwide in over 1,000 transactions and joint ventures involving acute care hospitals and health systems; physician practices; ambulatory surgery centers; diagnostic imaging centers; accountable care organizations, managed care organizations, and other third-party payors; dialysis centers; home health agencies; long-term care facilities; and, numerous other ancillary healthcare service businesses. Mr. Zigrang is also considered an expert in the field of healthcare compensation for physicians, executives and other professionals.

Mr. Zigrang is the co-author of the soon-to-be released "*Adviser's Guide to Healthcare – 2nd Edition*" (AICPA, 2015), numerous chapters in legal treatises and anthologies, and peer-reviewed and industry articles such as: *The Accountant's Business Manual* (AICPA); *Valuing Professional Practices and Licenses* (Aspen Publishers); *Valuation Strategies*; *Business Appraisal Practice*; and, *NACVA QuickRead*. Additionally, Mr. Zigrang has served as faculty before professional and trade associations such as the American Bar Association (ABA); the National Association of Certified Valuators and Analysts (NACVA); Physician Hospitals of America (PHA); the Institute of Business Appraisers (IBA); the Healthcare Financial Management Association (HFMA); and, the CPA Leadership Institute.

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As a comprehensive body, the ASA pursues accurate valuation for all classes of property and hence examines multiple levels of economic activity. As such, the ASA seeks to foster cooperation between professionals of several valuation disciplines, and this spirit of cooperation may help engender multidisciplinary approaches to the art and science of valuation.

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The *Healthcare Special Interest Group* (HSIG) is a Subcommittee of the ASA's International Education Committee and dedicated to the advancement of multidisciplinary education in healthcare valuation.

HSIG views the field of healthcare valuation as a complex area affecting multiple disciplines and requiring unique approaches for study and solutions. At the same time, the field also holds much promise for those willing to pursue new, multidisciplinary answers in this ever-changing healthcare market environment.

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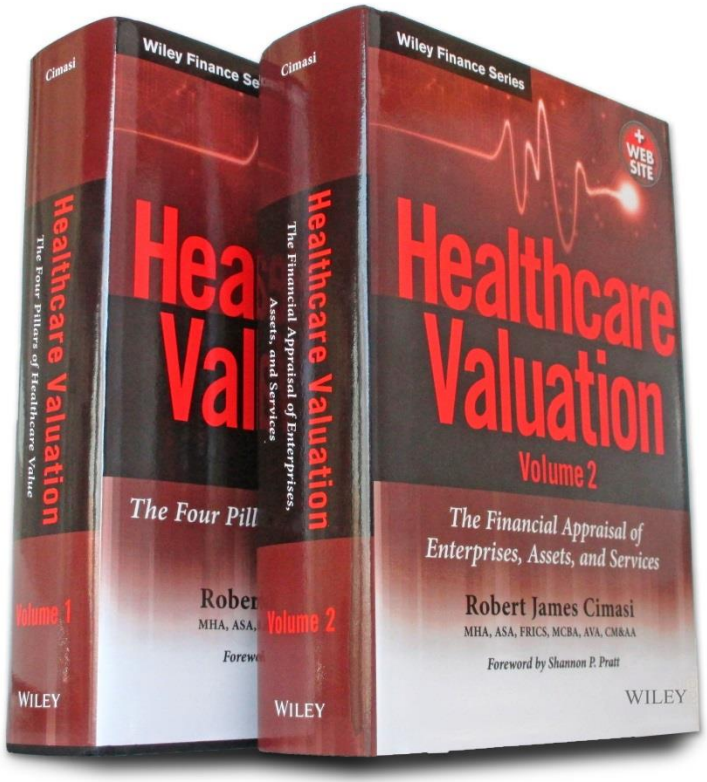
In-Person Course Session Textbook



The course session textbook page reference appears, for your reference, at the top left-hand corner of each slide.

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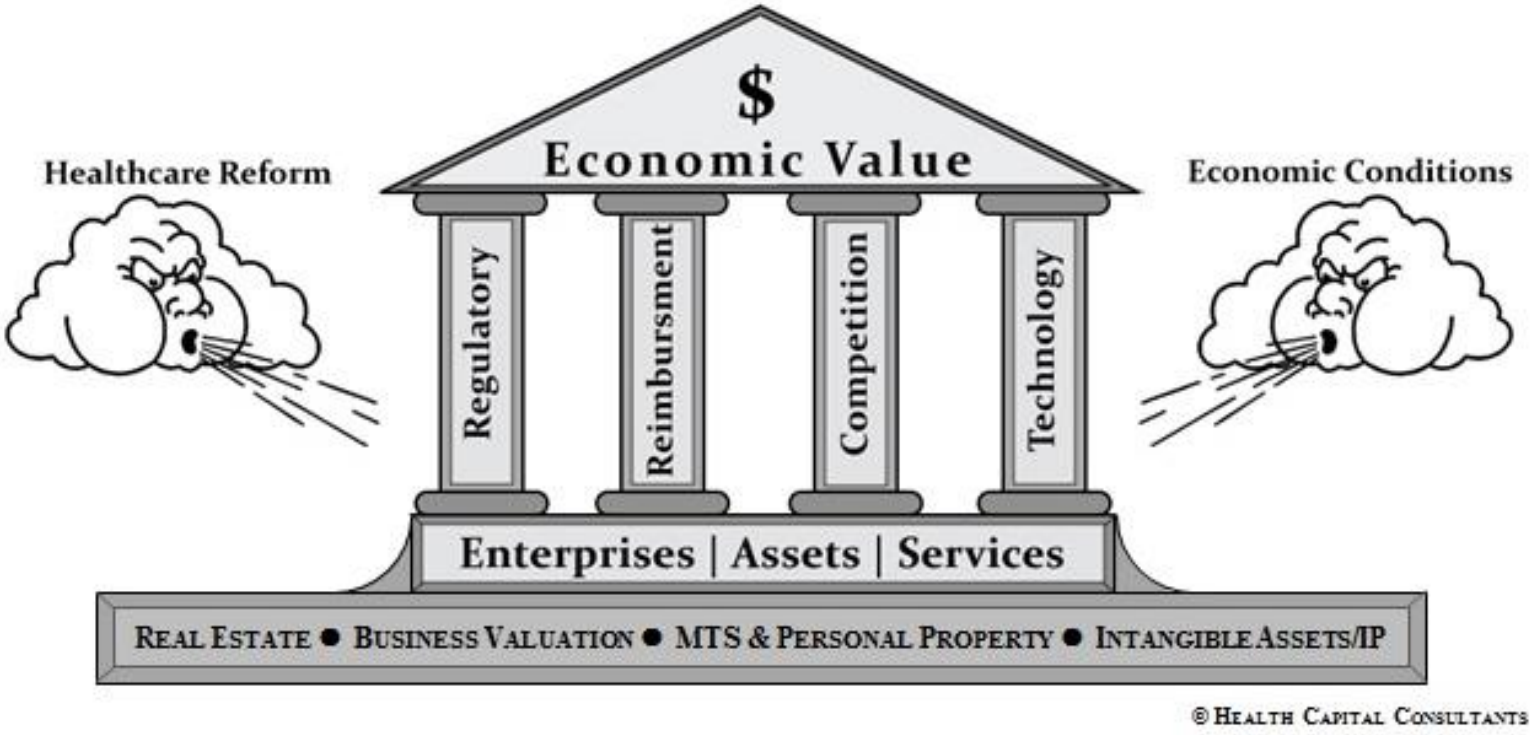
Overview of Presentation

- The Healthcare Revenue Cycle
- The Current Reimbursement Environment
  - Types of Payors
- Methods of Reimbursement
- Current and Emerging Reimbursement Trends
- Impact of Healthcare Reform
- Concluding Remarks

Healthcare Trends: *The Four Pillars*



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The Healthcare Revenue Cycle

The Healthcare Revenue Cycle

The process by which providers:

- Schedule patients
- Diagnose, code, and document patient clinical conditions presented
- Bill both primary and secondary payors
- Complete claims resolution
- Pursue the collection of revenue from billable charges for goods and services rendered from both third party payors and patients

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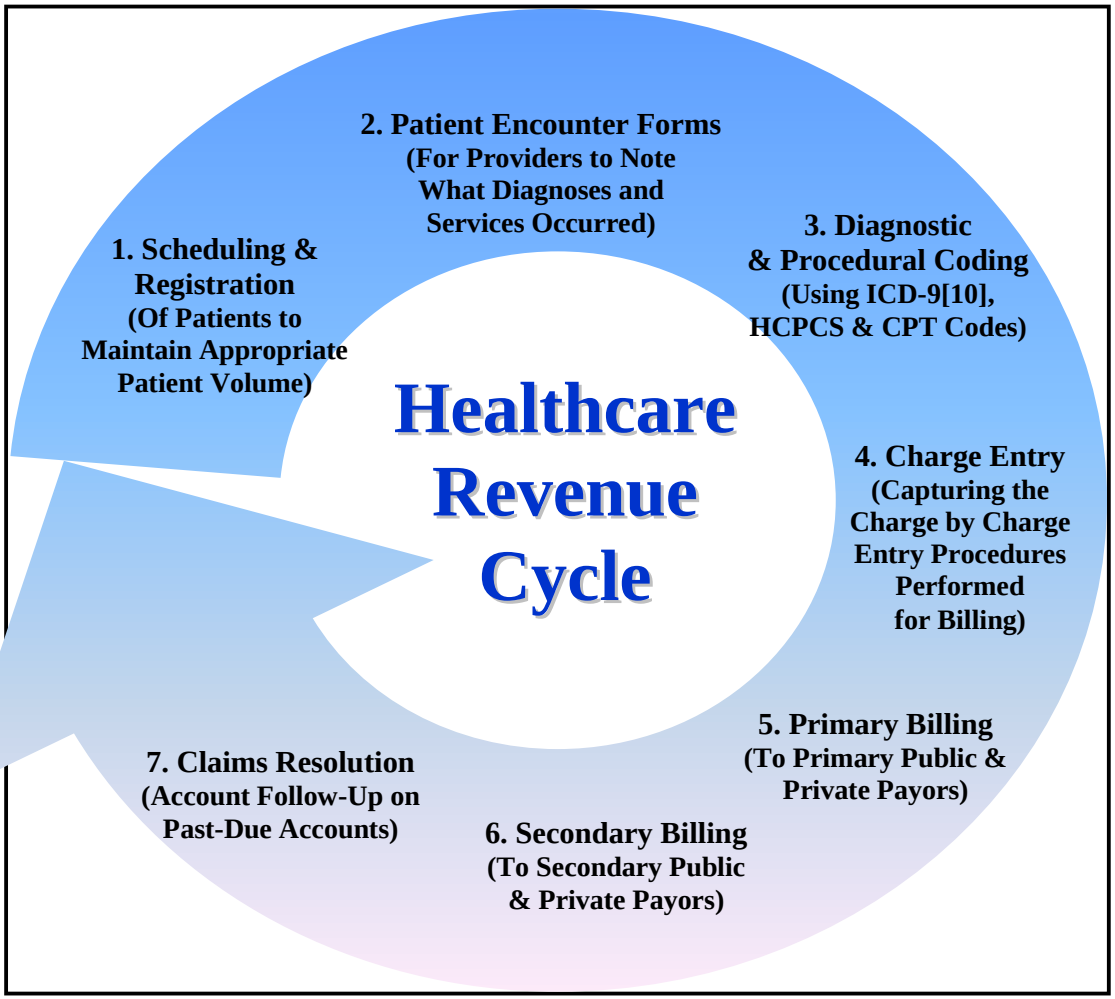
"Financial Management of the Medical Practice" By Max Reiboldt, Second Edition, Chicago, IL: American Medical Association, 2002, p. 12-14.

The Healthcare Revenue Cycle



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The Healthcare Revenue Cycle

Step 1: Scheduling and Registration

- When patients schedule their appointment with a caregiver
- Key Element: Effective registration system that **accurately** collects patient information
  - Erroneous or omitted information could delay reimbursement
- Verify at each patient encounter:
  - Patient's demographic information
  - Patient's eligibility status
  - Patient's pre-authorization requirements

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The Healthcare Revenue Cycle

Step 2: Patient Encounter Forms

- Must note principal and related diagnoses
- Specifically document the nature and scope of services rendered during patient encounter

Step 3: Diagnostic and Procedural Coding

- The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires providers to identify and classify both *diagnoses* and *clinical procedures*, choosing between several coding systems

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"Overview: Transaction Code Sets Standards" Centers for Medicare and Medicaid, April 26, 2009, http://www.cms.hhs.gov/TransactionCodeSetsStands/ (Accessed 09/18/2013).

Diagnostic Coding

Diagnostic Code: A numerical representation of the provider's *observations* and *conclusions* as to what health problem(s) or diagnoses the patient presents with during a particular patient encounter

- If a patient is treated for more than one condition, there may be both a primary and a secondary diagnosis
  - If the secondary condition affects the treatment or recovery of the primary diagnosis, it is classified as a coexisting condition
- Established within the International Classification of Diseases and Related Health Problems 9th Revision (ICD-9)
- Replaced by the ICD-10 on October 1, 2015

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Shift from ICD-9 to ICD-10 Coding

- ICD-9 excludes many recently discovered diseases, conditions, and treatments currently utilized
  - Produces limited data about a patient's medical conditions and hospital inpatient procedures
- 2009 HHS Final Rule - Replacement of current *ICD-9 code* with *ICD-10 code*
  - Hospitals with less than 100 beds expected to pay $100,000 - $250,000 for conversion
  - Hospitals with more than 400 beds expected to pay $1.5 million - $5 million for conversion
  - Implementation of *ICD-10* recently delayed until October 1, 2015

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"ICD-10 Cost, Timing Concerns Explain AMA Vote" By Cheryl Clark, HealthLeaders Media, November 17, 2011, http://www.healthleadersmedia.com/print/TEC-273412/ICD10-Cost-Timi (Accessed 11/18/2011). "Administrative Simplification: Adoption of a Standard for a Unique Health Plan Identifier; Addition to the National Provider Identifier Requirements; and a Change to the Compliance Date for the International Classification of Diseases, 10th Edition (ICD-10-CM and ICD-10-PCS) Medical Data Code Sets: Final Rule" 45 CFR Part 162 (Pre-Federal Registrar Publication), August 24, 2012.
"Engage Your Bottom Line: Understanding the Financial Implications of ICD-10" By Denise Hall and June St. John, Healthcare Information and Management Systems Society, Virtual Briefing, October 12, 2011, p. 6; citing "HIPAA Administrative Simplification: Modifications to Medical Data Code Set Standards To Adopt ICD-10-CM and ICD-10-PCS: Final Rule" Federal Register, Vol. 74, No. 11 (January 16, 2009).

CMS's Annual Initially Estimated Costs over 7 Years for ICD-10 (in millions)

Cost		Year						
		2011	2012	2013	2014	2015	2016	2017
Training	**Coders - Inpatient**	**$0**	**$0**	**$32**	**$159**	**$21**	**$0**	**$0**
	Coders - Outpatient	$0	$0	$12	$96	$12	$0	$0
	Code Users	$0	$0	$4	$33	$4	$0	$0
	Physicians	**$0**	**$0**	**$104**	**$835**	**$104**	**$0**	**$0**
	Subtotal	$0	$0	$152	$1,123	$141	$0	$0
Productivity Losses	**Coders - Inpatient**	**$0**	**$0**	**$0**	**$10**	**$0**	**$0**	**$0**
	Coders - Outpatient	$0	$0	$0	$9	$0	$0	$0
	Physician Practices	$0	$0	$0	$12	$0	$0	$0
	Improper and returned claim	**$0**	**$0**	**$0**	**$0**	**$329**	**$165**	**$49**
	Subtotal	$0	$0	$0	$31	$329	$165	$49
System Changes	**Providers**	**$23**	**$45**	**$75**	**$8**	**$0**	**$0**	**$0**
	Software vendors	$17	$35	$58	$6	$0	$0	$0
	Payors	$30	$59	$99	$10	$0	$0	$0
	Government	$77	$154	$256	$26	$0	$0	$0
	Subtotal	$147	$293	$488	$50	$0	$0	$0
Total Cost (in millions)		**$147**	**$293**	**$640**	**$1,204**	**$470**	**$165**	**$49**

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"Engage Your Bottom Line: Understanding the Financial Implications of ICD-10" By Denise Hall and June St. John, Healthcare Information and Management Systems Society, Virtual Briefing, October 12, 2011, p. 6.

Diagnostic Coding

ICD-10 will:

- Increase the number of procedure codes from 4,000 to 72,000
- Increase the number of diagnostic codes from 14,000 to 69,000
- Change the coding structure from a five-digit numeric code to a seven-digit alphanumeric code, resulting in more specific coding and documentation of medical conditions and procedures than ICD-9

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"ICD-10: Mandate and Opportunity" By Marianne Aiello, HealthLeaders Media, November 2011, http://www.healthleadersmedia.com/content/MAG-272629/ICD10-Mandate-and-Opportunity (Accessed 12/2/11), p. 56.

Benefits & Concerns of Adopting ICD-10

Benefits:

- Facilitate quality data reporting
- Support pay-for-performance payment methodologies
- Improve billing accuracy
- Allow for international comparison of the incidence and spread of disease

Concerns:

- Requires complete EHR implementation
- Will most likely require substantial capital spending

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"HHS Issues Final ICD-10 Code Sets and Updated Electronic Transaction Standards Rules" Centers for Medicare and Medicaid Services, News Release (January 15, 2009), Accessed at http://www.hhs.gov/news/press/2009pres/01/20090115f.html, (Accessed 08/09/09).

ICD-10 Progress

- 2014 HIMSS survey of healthcare IT professionals – 69% identified ICD-10 conversion as top IT priority
  - 92% of respondents indicated their conversion would be complete by October 2014
- October 2013 HRAA Hospital Survey:
  - 76% of respondents had initiated ICD-10 CM training for coding staff
  - 64% of respondents had initiated ICD-10 PCS training for coding staff
  - 68% of respondents had begun document improvement education for medical staff

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"25th Annual HIMSS Leadership Survey," HIMSS, February 24, 2014, http://himss.files.cms-plus.com/FileDownloads/2014-HIMSS-Leadership-Survey.pdf (Accessed 4/11/2014); "One Year from ICD-10 Transition, Small- and Mid-Sized Hospitals Increased Staff Training Programs but Lag in Payer Preparations, Financial Modeling and Denial Strategies," HRAA, October 1, 2013, http://www.healthrevenue.com/news/one-year-icd-10-transition-small-and-mid-sized-hospitals-increased-staff-training-programs-lag (Accessed 4/11/2014).

Procedural Coding

Procedural Codes: Used to *identify* and *classify* medical services

- Examples: Surgical procedures and diagnostic tests, evaluation and management (E/M) codes for patient visits and examinations

Depends on:

- Whether designated provider is a physician or a facility
- When a facility provider, whether service was performed in an inpatient or outpatient setting
  - Services submitted for payment must be *linked* by an appropriate *procedure code* that corresponds to the *diagnostic reasoning* behind the claim
    - Used by payors to evaluate *medical necessity* of reported charges

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"From Patient to Payment: Insurance Procedures for the Medical Office" By Cynthia Newby, Third Edition, Columbus, OH: Glencoe/McGraw-Hill, 2002, p. 48. "Essentials of Health Care Finance" By William O. Cleverley and Andrew E. Cameron, Sixth Edition, Sudbury, MA: Jones and Bartlett Publishers, 2007, p. 17.

Procedural Coding

Most commonly implemented procedural coding systems:

- The *Healthcare Common Procedure Coding System (HCPCS)* - Classifies ancillary services and procedures
- The *Current Procedural Terminology (CPT)* - For physician procedures in both inpatient and outpatient settings
- The *ICD-9 Procedure Coding System (ICD-9-PCS)* - For procedure reporting in hospital inpatient settings
- The *National Drug Codes (NDC)* - Provides a list of all pharmaceuticals
- The *Current Dental Terminology (CDT)* - For dental procedures

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"National Drug Code Directory" U.S. Food and Drug Administration, September 18, 2013, http://www.fda.gov/Drugs/InformationOnDrugs/ucm142438.htm (Accessed 9/18/2013). "Overview: Transaction Code Sets Standards" Centers for Medicare and Medicaid, April 17, 2013, http://www.cms.hhs.gov/TransactionCodeSetsStands/ (Accessed 09/18/2013).

Current Procedural Terminology (CPT)

- Developed and published by the American Medical Association (AMA) in 1966
- Used by providers to report information to payors about the services and procedures provided to patients
- Required to be used for all Medicare billing

CPT Process How a Code Becomes a Code: How Was CPT Developed?" The Centers for Medicare and Medicaid Services, http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/cpt/cpt-process-faq/code-becomes-cpt.page (Accessed 8/27/2012). "Medicare Rules & Regulations: A Survival Guide to Policies, Procedures and Payment Reform" By Denise L. Knaus, Los Angeles, CA: PMIC, 1998, p. 4, 106.

Current Procedural Terminology (CPT)

Divides established codes among 6 sections that differentiate between various *types of procedures* (Category I codes):

- Evaluation and management (E/M)
  - Type of service
  - Place of service
  - Patient status (new or established)
- Anesthesiology
- Surgery
- Radiology, including nuclear medicine & diagnostic ultrasound
- Pathology & laboratory
- Medicine, excluding anesthesiology

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"Current Procedural Terminology: Professional Edition 2012" By Michelle Abraham, et al., 4th Edition, Revised, Chicago, IL: American Medical Association, 2011, p. 4.

E/M Code Subdivisions

All E/M Codes

Office Services
- New Patient
- Established Patient

Hospital Observation
- Observation Care Discharge Services
- Initial Observation Care
- Subsequent Observation Care

Inpatient Hospital Services
- Initial Hospital Care
- Subsequent Hospital Care
  - Observation or Inpatient Care Services
  - Hospital Discharge Services

Consultations
- Office or Other Outpatient Consultation
- Inpatient Consultations

Emergency Dept. Services
- Other Emergency Services

Critical Care Services

Nursing Facility Services
- Initial Nursing Facility Care
- Subsequent Nursing Facility Care
- Nursing Facility Discharge Services
- Other Nursing Facility Services

Other E/M Code Subdivisions Include:
- Special Evaluation & Management Services
- Newborn Care Services
- Inpatient Neonatal Services
- Other Evaluation & Management Services
- Case Management Services
- Care Plan Oversight Services
- Preventative Medicine Services
- Non-Face-to-Face Physician Services
- Prolonged Services
- Domiciliary, Rest Home, or Custodial Care Services
- Domiciliary, Rest Home, or Home Care Plan Oversight Services
- Home Services

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""Current Procedural Terminology: Professional Edition 2012" By Michelle Abraham, et al., 4th Edition, Revised, Chicago, IL: American Medical Association, 2011, p. 11-41.

Current Procedural Terminology (CPT)

- Determining current coding for each E/M service requires providers to determine the level of complexity required for establishing a diagnosis or selecting a care management option (each level has its own CPT code)
- Determinants of complexity:
  - Number of options available
  - Amount of, and complexity of, patient's medical record/history
  - Risk of complications, morbidity, mortality, and/or comorbidities with the patient's current condition, the diagnosis, or the selected care management option

Assignment of a Complexity Level for E/M Services

Level of Complexity	Number of Options Available	Amount of, and Complexity of, the Data to be Reviewed	Risks Associated with a Particular Case
Straightforward	Minimal	None - Minimal	Minimal
Low Complexity	Limited	Limited	Low
Moderate Complexity	Multiple	Moderate	Moderate
High Complexity	Extensive	Extensive	High

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"Current Procedural Terminology: Professional Edition 2012" By Michelle Abraham, et al., 4th Edition, Revised, Chicago, IL: American Medical Association, 2011, p. 10.

CPT Category Codes

- Category II and III codes are supplementary
  - Category II Codes
    - Optional
    - Account for performance assessment and quality improvement activities with a four digit numerical code
    - Describe patient characteristics with an alphabetic fifth character
  - Category III Codes
    - Temporary, and are assigned to emerging medical technologies, services and procedures

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CPT Modifiers

- Providers may bill using *modifiers* if procedure was:
  - Performed more than once
  - Performed by more than one physician
  - Exclusively for a professional service
  - Discontinued due to threats to the patient's health
- Often multiple combinations of HCPCS and CPT codes for a particular procedure
- *National Correct Coding Initiative Coding Policy Manual for Medicare Services* - Providers not allowed to separate, or *"unbundle,"* codes for different components of a comprehensive procedure if there is a code for the entire procedure

"National Correct Coding Initiative Policy Manual for Medicare Services," Centers for Medicare and Medicaid Services, 2012, http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/Downloads/NCCI_Policy_Manual.zip (Accessed 8/20/12) p. I-1. "Introduction," in "National Correct Coding Initiative Policy Manual for Medicare Services," Centers for Medicare and Medicaid Services, 2008, p. xii. "Medicare Rules & Regulations: A Survival Guide to Policies, Procedures and Payment Reform" By Denise L. Knaus, Los Angeles, CA: PMIC, 1998, p. 135-144.

The Link Between Diagnostic & Procedural Coding

HIPAA Designated Coding

		Inpatient		Outpatient	
		Diagnosis	**Procedure**	**Diagnosis**	**Procedure**
1	**Physician**	ICD-10-CM	CPT	ICD-10-CM	CPT
2	**Facility**	ICD-10-CM	ICD-10-CM	ICD-10-CM	HCPCS (CPT & HCPCS Level II)

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"Essentials of Health Care Finance" By William O. Cleverley and Andrew E. Cameron, Sixth Edition, Sudbury, MA: Jones and Bartlett Publishers, 2007, p. 18.

Step 4: Charge Entry

- The transfer of the provider's coding and documentation to an actual bill or claim
- May capture the charge through:
  - Computerized provider charge entry (CPCE) system
  - Paper form
  - Staff hired to review hospital charts onsite and retrospectively charge capture
  - Central billing departments that organize and submit captured information
- May also be included in a provider's computerized physician order entry (CPOE) system

"The Revenue Cycle" In "Financial Management of the Medical Practice, Second Edition" By Max Reiboldt, CPA and The Coker Group, American Medical Association, 2002, p. 13. "The Physician Billing Process: Avoiding Potholes in the Road to Getting Paid" By Deborah L. Walker, Sara M. Larch and Elizabeth W. Woodcock, Medical Group Management Association, 2004, p. 51. "Capturing Charges on the Go: Billing Software Saves Money When it Complements Hospitalists Workflow" By Susan FitzGerald, ACP Hospitalist.org, May 2009, http://www.acphospitalist.org/archives/2009/05/software.htm, (Accessed on August 26, 2009). "Optimizing Advanced Practitioner Charge Capture in High-Acuity Surgical Intensive Care Units" By Karyn L. Butler, et al., Archives of Surgery, vol. 146, No. 5, May 2011, p. 552.

Step 5: Primary Insurance Billing

"Bill of Exchange" submitted (usually electronically) to the payor

- Medicare will not accept paper claims
  - Exception: From a physician practice with fewer than 10 full time equivalent (FTE) employees, or institutions with fewer than 25 FTEs
- Typically uploaded to a *clearinghouse*, or electronic data interchange (EDI), which assesses each claim for errors and securely forwards the bill of exchange to the correct payor
- Providers first submit charges to the patient's primary payor, often an insurance company

"Say Goodbye to Paper: Noncompliant Medicare Claims Oct. 1" By Joyce Frieden, Family Practice News, September 1, 2005, p. 6.

Step 5: Primary Insurance Billing

To ensure the *effectiveness* of the billing process, many providers:

- Implement computerized management systems to process claims electronically
- Work to maintain relationships with payors
- Develop internal information system processes
- Require continued staff education and training

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"The Revenue Cycle" In "Financial Management of the Medical Practice, Second Edition" By Max Reiboldt, CPA and The Coker Group, American Medical Association, 2002, p. 13.

Step 6: Secondary Insurance Billing

- Once primary payors have been billed, and co-payments and deductibles have been paid by the patient, any remaining amount can be billed to a *secondary payor*
- Secondary insurance may be available from:
  - The benefit plan held by a spouse or parent
  - An alternative public payor for which the patient is eligible
  - Supplemental insurance that was purchased to cover gaps in primary insurance coverage
- Billing procedure and timeline for secondary insurance differs based on the type and scope of coverage/benefits

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Step 7: Patient Responsibility

- Any co-payment or any portion of the charge not paid at the patient encounter or by a primary or secondary insurer may be sent to the patient
- Providers prohibited under the Social Security Act from billing *qualified Medicare beneficiaries* for Medicare cost-sharing, including deductibles, coinsurance, or copayments
- Several payors prohibit providers from **balanced billing**, where the provider bills the patient for the amount between the provider's charge and the payor's allowable fee rate

"Prohibition on Balance Billing Qualified Medicare Beneficiaries (QMBs)" Centers for Medicare and Medicaid Services, MLN Matters« Number: SE1128, Revised, July 25, 2012, p. 2. "From Patient to Payment: Insurance Procedures for the Medical Office" By Cynthia Newby, Third Edition, Columbus, OH: Glencoe/McGraw-Hill, 2002, p. 140.

Step 8: Claims Resolution

- Even correct coding, timely billing and aggressive claims resolution efforts are not always sufficient to ensure ultimate payment
- Cases resulting in overdue accounts often require follow-up activities to encourage payment or to correct billing errors

"The Revenue Cycle" In "Financial Management of the Medical Practice, Second Edition" By Max Reiboldt, CPA and The Coker Group, American Medical Association, 2002, p. 14.

Step 9: Collections

- Providers must maintain a process for tracking payments received
- When providers cannot resolve an account balance, he or she will likely write-off the *"balance [of] the accounts receivable as bad debt"*
  - Bad debt accounts can also be outsourced to a collection agency that will attempt to recover the balance for a fee

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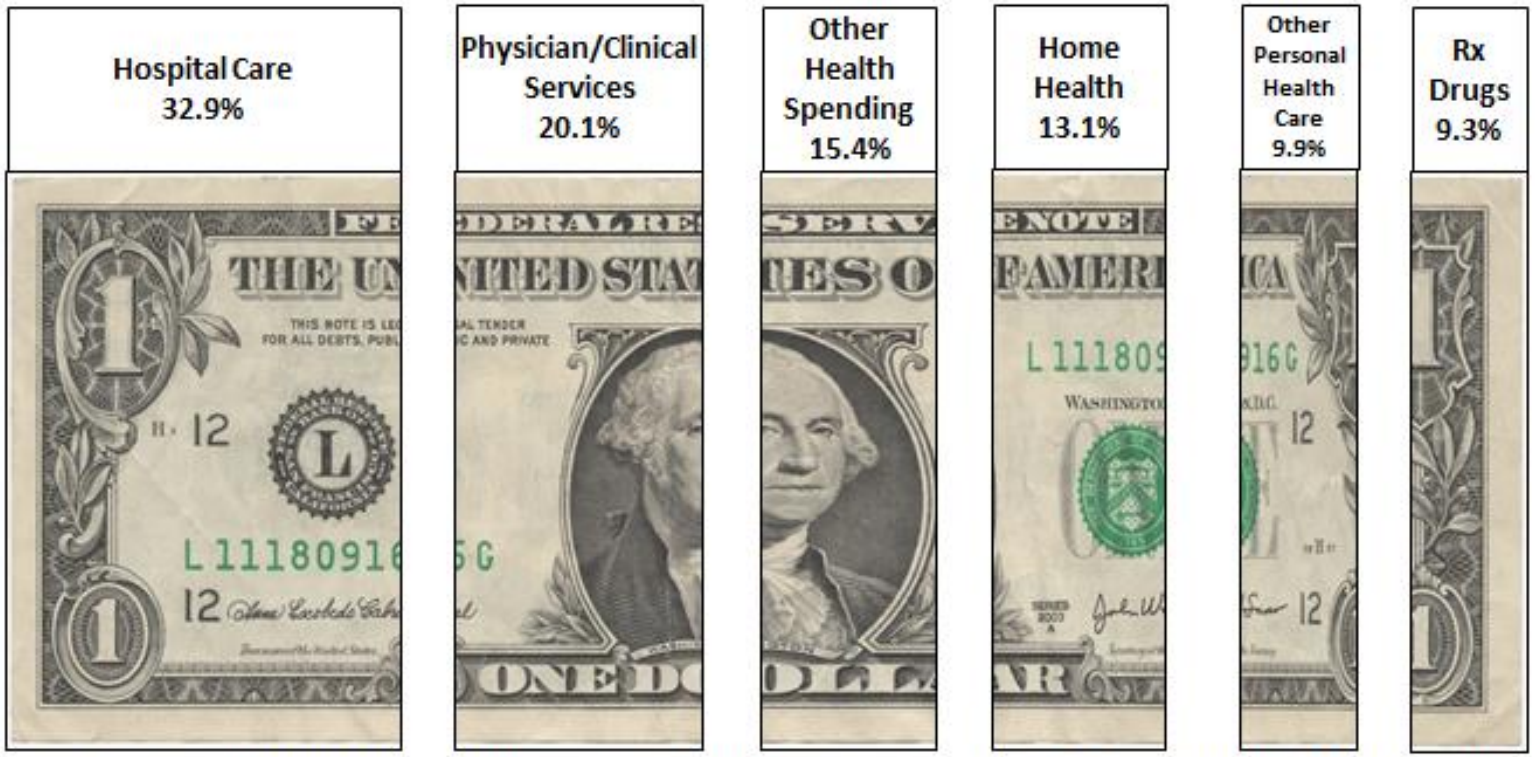
"The Physician Billing Process: Avoiding Potholes in the Road to Getting Paid" By Deborah L. Walker, Sara M. Larch and Elizabeth W. Woodcock, Medical Group Management Association, 2004, p. 137.

The Current Reimbursement Environment

The Current Reimbursement Environment

- The elaborate set of relationships between *providers* and *payors* comprises the infrastructure of the healthcare reimbursement environment
- The nature of any specific relationship is characterized by:
  - The type of service being provided
  - The location where that service is provided
  - The type of payor for the service
  - The method of reimbursement
  - The type of reimbursement model being utilized

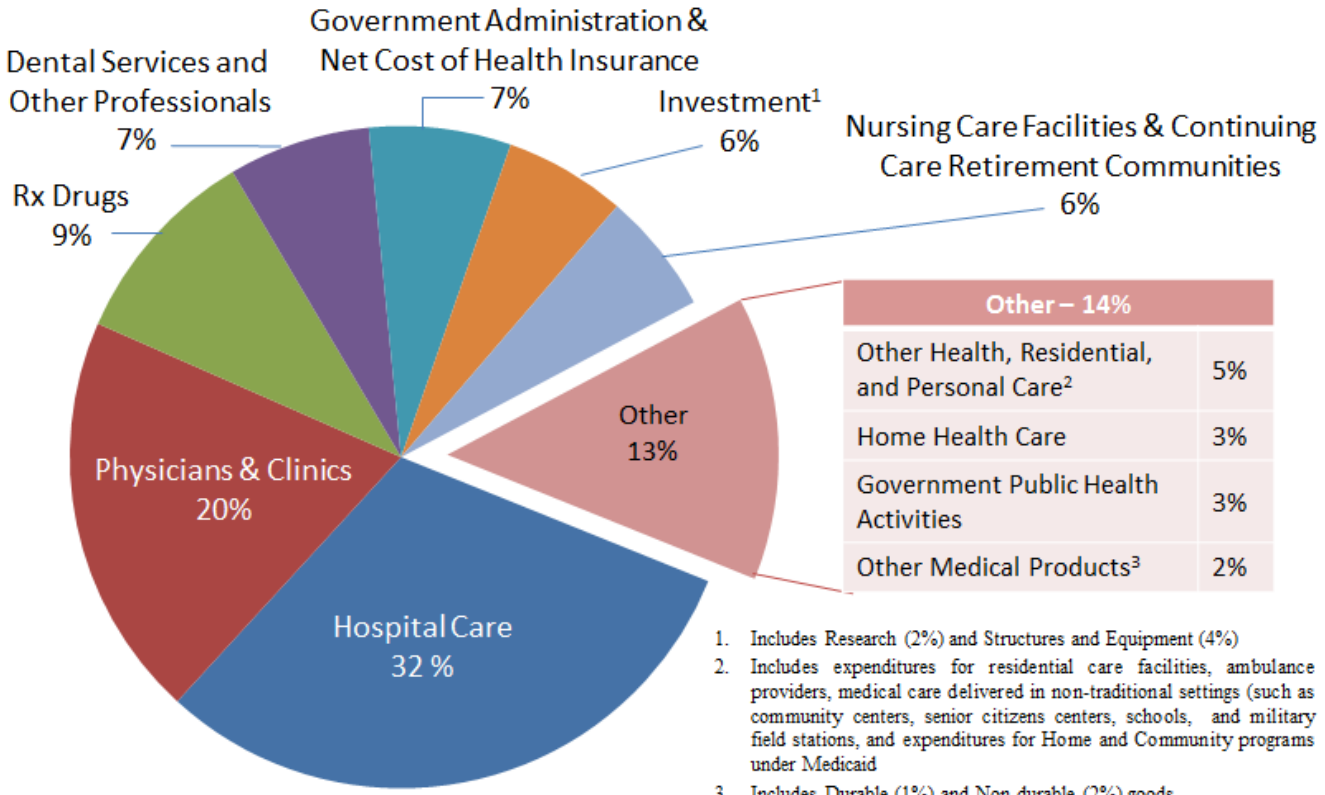
Allocation of 2013 Healthcare Expenditures by Type of Service – the Almighty Dollar



*Note: Other Personal Health Care includes dental and other professional health services, as well as durable and non-durable medical equipment. Other Health Spending includes administration and net cost of health insurance, public health activity, research, as well as structures and equipment.

"National Health Expenditures by Type of Service and Source of Funds, CY 1960-2013" Centers for Medicare & Medicaid Services, http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/NHE2013.zip (Accessed 2/24/2015).

Allocation of 2012 Healthcare Expenditures



Other – 14%	
Other Health, Residential, and Personal Care[2]	5%
Home Health Care	3%
Government Public Health Activities	3%
Other Medical Products[3]	2%

1. Includes Research (2%) and Structures and Equipment (4%)
2. Includes expenditures for residential care facilities, ambulance providers, medical care delivered in non-traditional settings (such as community centers, senior citizens centers, schools, and military field stations, and expenditures for Home and Community programs under Medicaid
3. Includes Durable (1%) and Non-durable (2%) goods

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"National Health Expenditures; Aggregate and Per Capita Amounts, Annual Percent Change and Percent Distribution; Selected Calendar Years 1960-2012," Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group.

Reimbursement Based on Location

Medicare Physician Fee Schedule (MPFS) differentiates between these two distinct revenue streams for diagnostic services:

- **Technical Component**
  - When providers execute diagnostic and testing functions
- **Professional Component**
  - When providers interpret (read) the results of those tests or write reports

"CCH Medicare Explained: §860" Editor Pamela K. Carron and Nicole T. Stone, Chicago, IL: CCH, 2012, p. 410.
"Professional and Technical Component Modifiers" By Donna Tyler, The American College of Obstetricians and Gynecologists, 2009, http://www.acog.org/departments/dept_notice.cfm?recno=6&bulletin=4672 (Accessed 08/31/09).

Reimbursement Based on Location

Facility-Based Reimbursement Rates

- Providers reimbursed at different rates depending on whether charges are submitted under Part A or Part B
- Outpatient procedures under Medicare Part B reimbursed at different rates based on the site of service, e.g., physician office-based or hospital-based
- Hospitals are reimbursed an average, qualified, predetermined amount in advance for each patient treated with a similar diagnosis
  - Defined by a **Diagnostic Related Group (DRG)** – Classifies patients based on the average per discharge cost of caring for their particular diagnosis

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Reimbursement Based on Location

The federal government has developed a prospective payment system (PPS) for:

- Ambulatory surgery centers (ASC)
- Home healthcare
- Hospital outpatient services
- Rehabilitation facilities
- Skilled nursing facilities

"Medicare Primer," By Patricia A. Davis, Congressional Research Service, July 1, 2010, Accessed at http://aging.senate.gov/crs/medicare1.pdf (Accessed 8/23/12), p. 7-13.

Hospital Inpatient Reimbursement

Hospitals are reimbursed for Medicare Part A under the Inpatient Prospective Payment System (IPPS) using DRGs

- Reimburses hospitals at per-discharge rates based on two factors:
  - The patient's condition and related treatment strategy
  - Market conditions in the facility's location
- Each DRG is assigned a relative rate based on its average cost, which is then multiplied by the input-price level of each geographic market to determine the payment rate for the DRG

"Hospital Acute Inpatient Services Payment System," MedPAC Payment Basics, October 2008, p.1, http://www.medpac.gov/documents/MedPAC_Payment_Basics_08_hospital.pdf (Accessed 9/24/09). "How Medicare Pays for Services: An Overview" Medicare Payment Advisory Commission, Report to the Congress: Medicare Payment Policy, 2002 Washington, D.C., March 2002, p. 10.

Inpatient PPS Calculations

Key

DRG = Diagnosis Related Groups

MSA = Metropolitan Statistical Area

IME = Indirect Medical Education Add-On (for approved teaching hospitals)

DSH = Disproportionate Share Hospital Adjustment (for hospitals that treat a large portion of low-income patients)

VBP = Hospital value based purchasing payments or penalties

HRR = Hospital readmissions reduction program penalties

Federal Rate for Operating Costs:

Payment = DRG Relative Weight x [(Wage Index x Labor Related Portion) + Nonlabor Related Portion x Cost of Living Adjustment] x (1 + IME + DSH ± VBP - HRR)

Federal Rate for Capital Costs:

Payment = DRG Relative Weight x (Capital Base Rate x Capital Wage Index x Cost of Living Adjustment) x (1 + DSH + IME)

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"Acute Care Hospital Inpatient Prospective Payment System" Centers for Medicare & Medicaid Services, Medicare Learning Network, http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/AcutePaymtSysfctsht.pdf (Accessed 2/21/2015), p. 4. Note that outlier payments and adjustments for transfers are not included in the displayed formula.

Determining the Prospective Payment

- Payments for inpatient care to certain hospitals are increased:
  - For hospitals with academic medical centers
  - For hospitals which serve a disproportionate amount of low-income patients
- Outlier payments may be paid for patients who require particularly expensive treatment, due to either:
  - The acuity of their illness or condition
  - The existence of co-morbidity factors
- To qualify, a hospital's specific operating and capital costs for a given patient must exceed a fixed loss outlier threshold set by CMS

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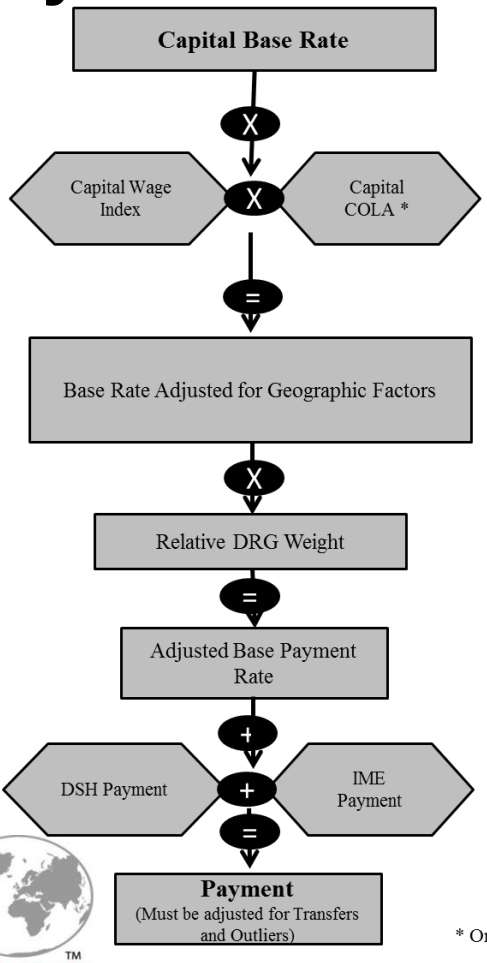
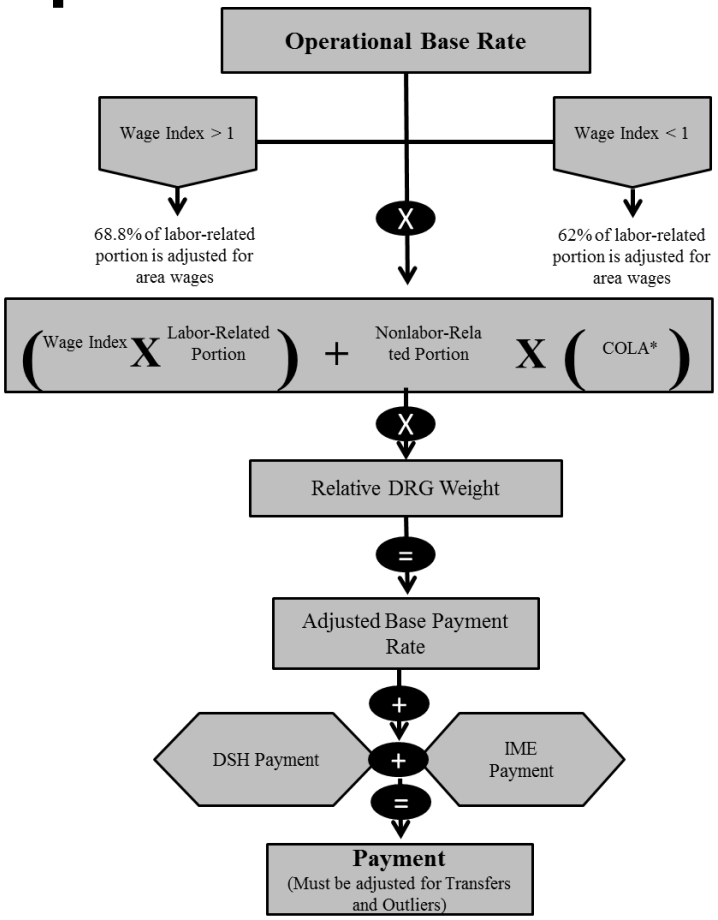
"Hospital Acute Inpatient Services Payment System," MedPAC Payment Basics, October 2008, p.1, http://www.medpac.gov/documents/MedPAC_Payment_Basics_08_hospital.pdf (Accessed 9/24/09).

Determination of IPPS Capital and Operating Payments for Hospital Reimbursement





* Only if applicable

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"Acute Care Hospital Inpatient Prospective Payment System" Centers for Medicare and Medicaid Services, Payment System Fact Sheet Series February 2012, p. 3-4; "Hospital Acute Inpatient Services Payment System" Medicare Payment Advisory Commission, Payment Basics, October 2012, p. 2.

Two-Midnight Rule

- Patient hospital stays of less than *two midnights* will be reimbursed as outpatient, under Medicare Part B
  - Patient will be admitted under an *"observation"* status
- Patient hospital stays of more than *two midnights* will be reimbursed as inpatient, under Medicare Part A

"Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Fiscal Year 2014 Rates; Quality Reporting Requirements for Specific Providers; Hospital Conditions of Participation; Payment Policies Related to Patient Status," Federal Register, Vol. 78, No. 160 (August 19, 2013), p. 50496.

Hospital Outpatient Reimbursement

Based on the Hospital Outpatient Prospective Payment System (HOPPS)

- Payments are based on several elements, including:
  - A set of relative weights
  - A conversion factor
  - An adjustment for geographic differences in input prices
- Includes an outlier adjustment for extraordinarily high cost services and pass-through payments for new technologies

"How Medicare Pays for Services: An Overview" Medicare Payment Advisory Commission, Report to the Congress: Medicare Payment Policy, 2002 Washington, D.C., March 2002, p. 18.

Ambulatory Payment Classifications (APC)

- CMS grouped outpatient procedures that were clinically similar and used comparable resources into approximately 750 Ambulatory Payment Classifications (APC)
  - Services are assigned CPT codes, which are classified into APCs and assigned a specific payment rate
    - Each classification group is bundled
- The payment reimbursed to the hospital is intended to cover the hospital's operating and capital costs
  - Determined by multiplying the relative weight for a given APC by a designated conversion factor

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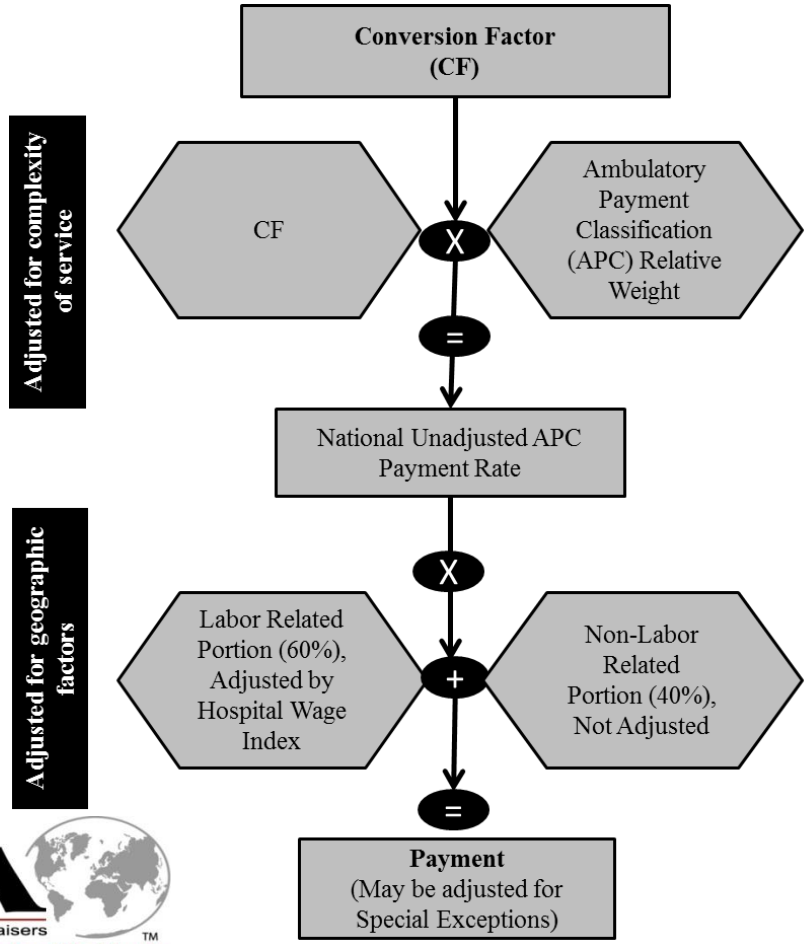
"APC Desk Reference" Ingenix, St. Anthony Publishing/Medicode, January 2004, p. 4-40. "How Medicare Pays for Services: An Overview" Medicare Payment Advisory Commission, Report to the Congress: Medicare Payment Policy, 2002 Washington, D.C., March 2002, p.123-124.

Determination of OPPS Payments for Hospital Outpatient Department (HOPD) Reimbursement



Special Exceptions

If the service is exceptionally costly (1.75 times the APC payment rate)	→	Payment + High cost outlier
If a rural sole community hospital	→	Payment x 1.071
If a cancer or children's hospital is eligible for transitional outpatient payment	→	Payment + Transitional outpatient payment

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"Hospital Outpatient Prospective Payment System: Payment System Fact Sheet Series," Department of Health and Human Services, Centers for Medicare & Medicaid Services, December 2012, p. 4-6.

ASC Reimbursement – HOPD v. Freestanding

- Medicare distinguishes between services provided at hospital ASCs and freestanding ASCs, partly because of patient demographic differences
- Reimbursement for freestanding ASCs is set at a percentage of the OPPS for HOPD with annual adjustments based on inflation

Freestanding ASCs are reimbursed at the lower of:

- The ASC rate
  - Calculated as the product of the conversion factor and the ASC relative payment weight for a given service or procedure
- The actual charge

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"Ambulatory Surgical Centers Fee Schedule" Centers for Medicare and Medicaid Services, Payment System Fact Sheet Series, December 2011, p. 5.

ASC Reimbursement – HOPD v. Freestanding

- The ***Conversion Factor*** - The main distinguishing component between freestanding ASC payments and HOPD payments
  - Established from different indexes
    - *Freestanding ASCs* - Consumer price index for all urban consumers (CPI-U) (based on prices for energy & housing)
      - The only healthcare entity where the conversion factor is dictated by the CPI-U
    - *HOPDs* – Hospital market basket (driven by goods and services purchased by healthcare facilities)

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"H.R. 4700, the Transparency in All Health Care Pricing Act of 2010; H.R. 2249, the Health Care Price Transparency Promotion Act of 2009; and H.R. 4803, the Patients Right to Know Act" Testimony of Ambulatory Surgery Center Advocacy Committee before the U.S. House of Representatives Committee on Energy and Commerce Subcommittee on Health, May 6, 2010.
"Ambulatory Surgical Centers Fee Schedule" Centers for Medicare and Medicaid Services, Payment System Fact Sheet Series, December 2011, p. 5.

ASC Reimbursement – HOPD v. Freestanding

- Beginning in 2008, new, office-based procedures performed in ASCs are covered by Medicare Part B, but are not reimbursed at the OPPS percentage
  - Reimbursed at whichever rate is lower:
    - The ASC rate (i.e., the percentage of the OPPS rate)
    - The practice expense portion of the MPFS payment rate that would have applied if the procedure had been performed in a physician office

"Ambulatory Surgical Centers Payment System," Medicare Payment Advisory Commission, Payment Basics, October 2011, p. 2.

Skilled Nursing Facility Reimbursement

- Medicare only covers about 22% of all nursing home expenditures
  - Paid approximately $26.4 billion to skilled nursing facilities in 2010
- Neither Medicare Part A nor B covers *custodial care*, i.e., care that helps residents with daily activities

"Skilled nursing facility services payment system" MedPAC, October 2011, http://www.medpac.gov/documents/MedPAC_Payment_Basics_11_SNF_v2.pdf (Accessed 8/17/12).
"CCH Medicare Explained: §244" Editor Pamela K. Carron and Nicole T. Stone, Chicago, IL: CCH, 2012, p. 60.

Skilled Nursing Facility Reimbursement

Medicare Part A will only pay for daily skilled nursing or rehabilitation services under the following scenario:

- The patient had a prior stay in a general acute care hospital (for 3 consecutive days)
- Admission to a skilled nursing facility was within a short time period after hospital discharge
- The patient is receiving treatment for the same condition that was being treated in the hospital
- A medical professional certified the need for daily skilled nursing or rehabilitative care

"CCH Medicare Explained: §230, §625" Editor Pamela K. Carron and Nicole T. Stone, Chicago, IL: CCH, 2012, p. 50-52, 301.

Skilled Nursing Facility Reimbursement

Skilled nursing days covered by Medicare Part A are limited to 100 days per benefit period

- The first 20 days covered at 100%
- A co-payment of $144.50 per day is required for days 21 through 100
- After the 100-day benefit is exhausted, Medicare Part B benefits continue to reimburse for physician services and other Part-B covered services, but the patient is liable for all other costs

"Medicare & You 2012" Centers for Medicare and Medicaid Services, 2012, http://www.medicare.gov/publications/pubs/pdf/10050.pdf (accessed 8/21/2012), p. 35. "Medicare Beneficiary Access to Skilled Nursing Facilities, 2001," Report OEI-02-01-00160, U.S. Office of Inspector General, July 2001, p.1; "Prospective Payment for Post-Acute Care: Current Issues and Long-Term Agenda," Report to the Congress: Medicare Payment Policy, MedPAC, March 2001, p. 91.

Skilled Nursing Facility Reimbursement

PPS Definitions

- ***Market Basket Index**:* An adjustment factor made for inflation
- ***Case-Mix Index**:* Accounts for different levels of care required by individual patients
  - To determine the appropriate case-mix, skilled nursing facilities assign patients into one of 66 Resource Utilization Groups (RUGs), which are then divided into the following 6 major categories:
    - Special rehabilitation
    - Extensive services
    - Special care
    - Clinically complex
    - Impaired cognition
    - Reduced physical function

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"Medicare Beneficiary Access to Skilled Nursing Facilities, 2001," Report OEI-02-01-00160, U.S. Office of Inspector General, July 2001, p. 2. "Skilled Nursing Facility Services Payment System" Medicare Payment Advisory Commission, Payment Basics, October 2011, p. 1-2.

Home Health Reimbursement

- Section 1861 of the Social Security Act authorizes Medicare Part A payments for home health services
- Part A will reimburse for home healthcare only when:
  - A physician has certified that home healthcare is necessary
  - The beneficiary has been confined to their home
  - The beneficiary requires services covered by Medicare
    - Physical and occupational therapy
    - Speech language pathology services
    - Medical social services
    - Home health aide services for personal care related to the treatment of the beneficiary's illness or injury

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Home Health Reimbursement

- If a beneficiary does not have Medicare Part A coverage, home health services may also be reimbursed from available Medicare Part B benefits
  - Part B also covers the cost of medical supplies and durable medical equipment (DME)
- The Omnibus Budget Reconciliation Act of 1980 transformed Medicare home health benefits into an unlimited benefit serving:
  - Chronic needs of patients
  - Short term recuperative care after a hospital stay

"Variation Among Home Health Agencies in Medicare Payments for Home Health Services" Department of Health and Human Services Office of Inspector General, (July 1995), p. 1. "Requirements for Home Health Services" 42 CFR CH. IV §424.22 (October 1, 2004), p. 996. "Medicare from the Start to Today" By Tom Dowdal, National Bipartisan Commission of the Future of Medicare, http://rs9.loc.gov/medicare/history.htm (Accessed 8/29/2012).

Home Health Reimbursement

The Balanced Budget Act of 1997

- Required implementation of a PPS for home healthcare services covered under Medicare and aggregate, *per patient cost caps,* on amount agencies were reimbursed for home healthcare patients
- Home health agencies received a pre-determined pay rate for each 60-day episode of care based upon several elements, including:
  - Patients' conditions and service usage
  - Geographic area
  - Case mix
  - Number of visits

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"Medicare Home Health Care: Prospective Payment System Could Reverse Recent Declines in Spending" GAO Report to the Chairman, Subcommittee on Health, Committee on Ways and Means, House of Representatives, September 2000, Accessed at http://www.gao.gov/new.items/he00176.pdf, (Accessed 7/13/07), p. 23. "Home Health Care Services Payment System" MedPAC, October 2011, Accessed at http://medpac.gov/documents/MedPAC_Payment_Basics_11_HHA.pdf (Accessed on 8/9/2012), p. 3.

Independent Diagnostic Testing Facilities (IDTF) Reimbursement

- Medicare Part B reimburses IDTFs according to the MPFS
- The Deficit Reduction Act of 2005 (DRA) capped the technical component for certain imaging services provided in physician offices and IDTFs, which could also be provided in a hospital outpatient setting, at the OPPS rate for identical services
  - Applies to imaging services provided on or after January 1, 2007, including:
    - X-ray
    - Ultrasound
    - Nuclear medicine
    - Magnetic resonance imaging (MRI)
    - Computed tomography (CT)
    - Fluoroscopy

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"Deficit Reduction Act of 2005" Pub. L. 109-171, 120 STAT 39-40 (February 8, 2006).

Independent Diagnostic Testing Facilities (IDTF) Reimbursement

- Possibly more vulnerable to a higher level of abuse than other services
  - 2012 Office of the Inspector General (OIG) Study
    - In 2009, the 20 highest Core Based Statistical Areas (CBSA) accounted for 10.5% of Medicare Part B payments to IDTF, 4 times the average amount received by the remaining CBSAs
  - The 20 highest CBSAs allegedly submitted twice as many claims to Medicare that were noted as having at least two questionable characteristics

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"Questionable Billing for Medicare Independent Diagnostic Testing Facility Services" By Timothy S. Brady, et al., Office of the Inspector General, OEI-09-09-00380, March 2012, p. 9-11.

ESRD Reimbursement

- Based on a *predetermined prospective payment* for each dialysis treatment conducted, known as a *composite rate* (CR)
  - Covers the costs associated with a single dialysis treatment, including:
    - Nursing
    - Diet counseling
    - Other clinical services
    - Social services
    - Supplies
    - Equipment
    - Certain laboratory tests & drugs
- Adjusted to account for geographic differences in prices and case-mix

"Outpatient Dialysis Services" Medicare Payment Advisory Commission, Report to the Congress: Medicare Payment Policy, 2006 Washington, D.C., March 2006, p. 121. "Outpatient Dialysis Services" Medicare Payment Advisory Commission, Report to the Congress: Medicare Payment Policy, 2006 Washington, D.C., March 2006, p. 105-129. "Outpatient Dialysis Services Payment System" Medicare Payment Advisory Commission, Payment Basics, October 2009, p. 2.

ESRD Reimbursement

- Section 153(b) of the Medicare Improvements for Patients and Providers Act (MIPPA) replaced the basic composite payment system with a bundled ESRD prospective payment system (ESRD PPS) for Medicare outpatient ESRD facilities
  - Bundled payment system includes:
    - Services included in the CR as of 2010
    - Other injectable medications furnished to ESRD beneficiaries and separately paid for under Medicare Part B
    - Laboratory tests and other items and services provided to beneficiaries for ESRD treatment

"Outpatient Dialysis Services Payment System" Medicare Payment Advisory Commission, Payment Basics, October 2009, p. 3.
"Medicare: ESRD Payment" Centers for Medicare and Medicaid Services, March 23, 2012, http://www.cms.gov/ESRDPayment (Accessed 2/18/2010).

Factors Used to Adjust ESRD PPS Base Rate Payments

Adjustment Factor	Description
Patient-Level Adjustments for Case-Mix	Based on demographics that play a role in the cost of providing care, including: patient age; body surface area; low body mass index; onset of dialysis; and the following six specified co-morbidities: (1) Hereditary Hemolytic and Sickle Cell Anemia; (2) Monoclonal Gammopathy (in the absence of multiple Myeloma); (3) Myelodysplastic Syndrome; (4) Bacterial Pneumonia; (5) Gastrointestinal Bleeding; and, (6) Pericarditis
Facility-Level Adjustments	Facilities that are certified to furnish home or self-care dialysis training services will receive a training add-on payment. This adjustment applies to both peritoneal dialysis and hemodialysis training treatments
Adjustments for Pediatric Patients	Treatments provided to pediatric patients (i.e., individuals under the age of 18) are subject to a payment adjustment to reflect the higher total payments for pediatric composite rate and separately billable services, compared to adult patients
Outlier Adjustments	An additional outlier payment is applied when a beneficiary's payment per treatment for outlier services exceeds the predicted payment amount per treatment for the outlier services plus a fixed dollar amount. Outlier services include drugs, laboratory testing, and other items that facilities separately billed under the old payment system, such as ESRD-related medical and surgical supplies

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"Medicare Program; End-Stage Renal Disease Prospective Payment System and Quality Incentive Program; Ambulance Fee Schedule; Durable Medical Equipment; and Competitive Acquisition of Certain Durable Medical Equipment, Prosthetics, Orthotics and Supplies; Final Rule," Centers for Medicare and Medicaid Services, Federal Register, Vol. 76, No. 218, (November 10, 2011), p. 70230.

Durable Medical Equipment (DME) Reimbursement

- Medicare is responsible for approximately 20% of expenditures on medically necessary and physician prescribed *DME, prosthetics, orthotics, and other medical supplies* (DMEPOS)
- The categories with largest scope of Medicare reimbursement are DME and *prosthetics and orthotics* (PO)
  - **DME**: Any equipment that: *"(1) can withstand repeated use, (2) is used to serve a medical purpose, (3) generally is not useful in the absence of an illness or injury and, (4) is appropriate for use in the home"*
  - **PO**: Those devices that replace all or part of an internal body organ or body part, e.g., colostomy bags, artificial parts, and leg braces

"National Health Expenditure Projections 2013-2023" Center for Medicare & Medicaid Services, September 17, 2014, http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html (Accessed 11/19/2014), Table 15.

The National Association of Medical Equipment Services' Six-Point Plan

- Designed to stabilize Medicare reimbursements to DMEPOS and to increase the *rent/purchase cap* from $120 to $150
- Classified DMEPOS into 6 categories:
  - Inexpensive or Other Routinely purchased DME (Rent or Purchase)
  - Items Requiring Frequent and Substantial Servicing (Rental Only)
  - General Prosthetic and Orthotic Devices and Supplies, Miscellaneous Supplies and Other Items (Purchase Only)
  - Capped Rental Items (Rent or Purchase)
  - Oxygen (Rental Only) and Oxygen Equipment
  - Customized Equipment (Including Customized Prosthetic and Orthotic Devices) (Purchase Only)

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"The Home Care Evolution" Home Care Magazine, January 1, 2003, http://homecaremag.com/mag/medical_home_care_evolution/ (Accessed 5/29/2007); "Reimbursement Challenges Hit Home" By David Gourley, RT for Decision Makers in Respiratory Care, (2006), p. 1-4. "Region C DMERC: DMEPOS Supplier Manual" Palmetto GBA and Centers for Medicare and Medicaid Services, Spring 2007, p. 8.2-8.7.

Deficit Reduction Act (DRA) of 2005

- Terms of beneficiary ownership of certain DMEPOS were altered
  - Rentals – Payments must be made monthly, but not for longer than 13 months of continuous use
  - If rental item is used for more than 13 continuous months, the supplier will transfer the title of the item to the individual
    - Exception: The power-driven wheelchair, which is required to be offered for purchase at a lump sum price at the time the supplier furnishes the item
- Maintenance and servicing responsibility changed
  - Maintenance and servicing for capped rental items and certain oxygen-generating equipment is supplier's responsibility

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"Deficit Reduction Act of 2005" Pub. Law 109-171, 120 Stat. 4 (February 8, 2006), p. 37-38.

Competitive Bidding

- Unique to certain DMEPOS
  - Patient safety items, ambulatory aids, wheelchairs, and hospital beds
- DMEPOS manufacturers submit competing bids to Medicare based on the *charge per unit*, the lowest of which is granted a government DMEPOS contract to be a Medicare provider of DMEPOS in 1 of 10 different metropolitan areas
- Designed to reduce out-of-pocket costs to patients, as well as costs incurred by Medicare, by combatting provider fraud

"Apria Healthcare Group, Inc. 10K Form," United States Securities and Exchange Commission, December 31, 2006. "Medicare DME Bidding Program Set to Relaunch in 2010," By Chris Silva, American Medical News, May 4, 2009, http://www.ama-assn.org/amednews/2009/05/04/gvsd0504 (Accessed 11/10/09). "Medicare Announces Competitive Acquisition Program for Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies" Centers for Medicare and Medicaid Services, April 2, 2007, http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=2097&intNumPerPage=10&checkDate=&checkKey=&srchType=&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=1%2C+2%2C+3%2C+4%2C+5&intPage=&showAll=&pYear=&year=&desc=&cboOrder=date (Accessed 08/16/2012).

Physician Services Reimbursement Resource Based Relative Value Scale (RBRVS)

- Determines payments based on the relative value of the resources necessary to provide a particular service
- Developed by Harvard economist, William C. Hsiao, PhD, in 1986 and endorsed by the Physician Payment Review Commission (PPRC), currently known as MedPAC
  - Composed a common scale of relative values across physician specialties and services
- Replaced the Customary, Prevailing, and Reasonable (CPR) system

"Overview of the RBRVS," American Medical Association, http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/medicare/the-resource-based-relative-value-scale/overview-of-rbrvs.shtml (Accessed 10/5/09).
"A National Study of Resource-Based Relative Value Scales for Physician Services" By William C. Hsiao et al., Cambridge, MA, 1988, p.1-25.

Resource Based Relative Value Scale (RBRVS)

Three Relative Value Unit (RVU) Components:

- ***Physician Work (wRVU)*** - *"The relative levels of time, effort, skill, and stress associated with providing each service"*; approximately 55% of RVU value
- ***Practice Expense (PE RVU)*** - *"The expenses physicians incur when they rent office space, buy supplies and equipment, and hire nonphysician clinical and administrative staff"*; approximately 42% of RVU value
- ***Malpractice Expense (MP RVU)*** - The *"premiums physicians pay for professional liability insurance, also known as medical malpractice insurance"*; approximately 3% of RVU value

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"Physician and Other Health Professionals Payment System" Medicare Payment Advisory Committee, Payment Basics (October 2011, http://medpac.gov/documents/MedPAC_Payment_Basics_11_Physician.pdf (Accessed 8/14/12), p. 1-2.; "Gauging Emergency Physician Productivity: Are RVUs the Answer?" By John Proctor, ACEP Reimbursement Committee, Posted on American College of Emergency Physicians, www.acep.org/practres.aspx?id=30306 (Accessed 08/14/12).

RBRVS Modifiers

- Adjust each RVU component, as well as the total number of RVUs for a given service based on factors such as:
  - Multiple procedures performed during one encounter
  - Procedure performed by more than one physician
  - Procedure was exclusively for a professional service
  - Procedure was discontinued due to threats to the patient's health

"Physician and Other Health Professionals Payment System" Medicare Payment Advisory Committee, Payment Basics (October 2011, http://medpac.gov/documents/MedPAC_Payment_Basics_11_Physician.pdf (Accessed 8/14/12), p. 2.

Geographic Practice Cost Index (GPCI)

- Accounts for geographic differences in the costs of providing healthcare services across the country
- Every Medicare payment locality has a distinct GPCI for each RVU component
- A locality's GPCI is determined by taking into consideration the median cost of:
  - Hourly earnings of workers in the area
  - Office rents
  - Medical equipment and supply costs
  - Other miscellaneous expenses

"Physician Fee Schedule Look-Up, Overview," CMS, HHS.gov, January 7, 2009, http://www.cms.hhs.gov/PFSLookup/, (Accessed on July 30, 2009); "Physician Reimbursement Under Medicare," By Alan M. Scarrow, MD., Neurosurgical Focus, Vol. 12, No. 4, April, 2002, p. 2. "Physician Reimbursement Under Medicare," By Alan M. Scarrow, MD., Neurosurgical Focus, Vol. # 12, no. (4): Article 8, (April, 2002), p. 2.

Conversion Factor

- A monetary amount multiplied by the composite RVU from a specific locality to determine the amount to reimburse for a given service
- Originally three conversion factors
  - Surgical
  - Specialty
  - Primary care services
- Today, all physician services, except anesthesia services, use a single CF
- Updated as part of the CMS annual MPFS update

"Physician Reimbursement Under Medicare," By Alan M. Scarrow, MD., Neurosurgical Focus, Vol. # 12, no. (4): Article 8, (April, 2002), p. 2. "2009 Master Medicare Guide" By Pam Carron and Nicole T. Stone, Chicago, IL: CCH, 2009, p. 901; "Payment for Physicians' Services" Social Security Act § 1848(d)(3), 42 U.S.C. § 1395w-4.

RVU Payment Calculation

Key

RVU = Relative Value Unit
w = Work
PE = Practice Expense
MP = Malpractice
GPCI = Geographic Price Index
CF = Conversion Factor

Facility Payment Amount:

Payment = [(wRVU * wGPCI) + (*Facility* PE RVU * PE GPCI) + (MP RVU * MP GPCI)] * [*CF adjusted for budget neutrality*]

Non-Facility Payment Amount:

Payment = [(wRVU * wGPCI) + (*Non-Facility* PE RVU * PE GPCI) + (MP RVU * MP GPCI)] * [*CF adjusted for budget neutrality*]

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"Introduction to Relative Value Units (RVUs) and how Medicare Reimbursement is Calculated," American College of Radiation Oncology, 2009, (Accessed 4/1/09).

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The Sustainable Growth Rate (SGR)

- Determines the *update adjustment factor*
  - Used to calculate the conversion factor, which is used to calculate physician fee schedule update
- Represents a spending target for the total annual expenditures on Medicare Part B services
- Annual adjustments are made to the MPFS based on whether actual spending was above or below the set target
  - If actual spending is above target, payment rates are adjusted down
  - If actual spending is below target, payment rates are adjusted up

"The Sustainable Growth Rate Formula for Setting Medicares Physician Payment Rates," Congressional Budget Office, Economic and Budget Issue Brief, Sept. 6, 2006, http://www.cbo.gov/ftpdocs/75xx/doc7542/09-07-SGR-brief.pdf (Accessed 10/9/09), p. 2, 4-5.

The Sustainable Growth Rate (SGR)

SGR calculation relies upon 4 factors:

- *"The estimated percentage change in fees for physicians' services;*
- *The estimated percentage change in the average number of Medicare fee-for-service beneficiaries;*
- *The estimated 10-year average annual percentage change in real GDP per capita; and,*
- *The estimated percentage change in expenditures due to changes in law or regulations"*

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"Estimated Sustainable Growth Rate and Conversion Factor, for Medicare Payments to Physicians in 2013" Centers for Medicare & Medicaid Services, 2012, p. 1.

The Sustainable Growth Rate (SGR)

- Purpose of SGR formula:
  - To ensure patient access to physician services
  - To predictably control federal spending on Medicare Part B
- SGR formula has indicated downward adjustments to the MPFS every year since 2002
  - Since 2003, Congress has consistently intervened and stepped in at the last moment to override the mandated decreases to the MPFS, typically replacing scheduled cuts with increases in payment
  - Repealed on April 16, 2015

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"Medicare's Physician Payment Rates and the Sustainable Growth Rate" Statement of Donald B. Marron before the Subcommittee on Health, Committee on Energy and Commerce, and U.S. House of Representatives, Congressional Budget Office, July 25, 2006, p. 3-4. "CMS Proposes Payment, Policy Changes for Physicians Services to Medicare Beneficiaries in 2010," Centers for Medicare and Medicaid Services, Press Release (July 1, 2009) http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=3469 (Accessed 10/9/09); "Senate Votes 69-30 to Approve Legislation That Would Halt Medicare Physician Payment Cut" Kaiser Daily Health Report, July 10, 2008, http://www.kaisernetwork.org/daily_reports/rep_index.cfm?hint=3&DR_ID=53221 (Accessed 10/16/08); "D.C. Week: Senate Passes SGR Repeal Bill, FDA OKs Heart Failure Drug" By Shannon Firth, Medpage Today, April 18, 2015, http://www.medpagetoday.com/Washington-Watch/Washington-Watch/51072 (Accessed 4/21/2015).

Annual Updates to the MPFS CF (CMS Final Rule v Congressional Action), 2002-2015

	A	B	C
	Year	Physician Fee Schedule Update Under CMS Final Rule	Physician Fee Schedule Update After Congressional Actions
1	2002	-4.8%	N/A
2	2003	-4.4%	1.6%*
3	2004	-4.5%	1.5%
4	2005	1.5%	1.5%
5	2006	-4.4%	0.0%
6	2007	-5.0%	0.0%
7	2008	-10.1%	0.5%
8	2009	1.1%	1.1%
9	2010 (Jan - May)	-21.2%	0.0%
10	2010 (June-Dec)		2.2%
11	2011	-24.9%	0.0%
12	2012	-27.4%	0.0%
13	2013	-26.5%	0.0%
14	2014	-20.1%	0.5%
15	2015 (Jan-March)	-21.2%	0.0%

"Medicare Program; Revisions to Payment Policies and Five-Year Review of and Adjustments to the Relative Value Units Under the Physician Fee Schedule for Calendar Year 2002: Final Rule with Comment Period" Federal Register Vol. 66, No. 212 (November 1, 2001), p. 55312; "Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2003 and Inclusion of Registered Nurses in the Personnel Provision of the Critical Access Hospital Emergency Services Requirement for Frontier Areas and Remote Locations" Federal Register, Vol. 67, No. 251 (December 31, 2002), p. 80018; "Medicare Program; Physician Fee Schedule Update for Calendar Year 2003: Final Rule" Federal Register Vol. 68, No. 40 (February 28, 2003), p. 9567; [The revision of the SGR calculation is permitted due to the passage of the Consolidated Appropriations Resolution of 2003, section 402] "Consolidated Appropriations Resolution, 2003" Pub. L. No. 108-7, § 402, 117 Stat. 548 (February 20, 2003); "Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule for Calendar Year 2004" Federal Register Vol. 68, No. 216 (November 7, 2003), p. 63196; "Medicare Program; Changes to Medicare Payment for Drugs and Physician Fee Schedule Payments for Calendar Year 2004: Interim Final Rule with Comment Period" Federal Register Vol. 69, No. 4 (January 7, 2004), p. 1095; "Medicare Prescription Drug, Improvement, and Modernization Act of 2003" Pub. L. No. 108-173, § 601, 117 Stat. 2300 (December 8, 2003); "Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule for Calendar Year 2005" Federal Register Vol. 69, No. 219 (November 15, 2004), p. 66236; "Medicare Prescription Drug, Improvement, and Modernization Act of 2003" Pub. L. No. 108-173, § 601, 117 Stat. 2300 (December 8, 2003); "Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2006 and Certain Provisions Related to the Competitive Acquisition Program of Outpatient Drugs and Biologicals Under Part B" Federal Register Vol. 70, No. 223 (November 21, 2005), p. 70116; "Deficit Reduction Act of 2005" Pub. L. No. 109-171, § 5104, 120 Stat. 40-41 (February 8, 2006); "Medicare Program; Revisions to Payment Policies, Five-Year Review of Work Relative Value Units, Changes to the Practice Expense Methodology Under the Physician Fee Schedule, and Other Changes to Payment Under Part B; Revisions to the Payment Policies of Ambulance Services Under the Fee Schedule for Ambulance Services; and Ambulance Inflation Factor Update for CY 2007" Federal Register Vol. 71, No. 231 (December 1, 2006), p. 69624; "Tax Relief and Health Care Act of 2006" Pub. L. No. 109-432, § 101, 120 Stat. 2975 (December 20, 2006); "Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, and Other Part B Payment Policies for CY 2008; Revisions to the Payment Policies of Ambulance Services Under the Ambulance Fee Schedule for CY 2008; and the Amendment of the E-Prescribing Exemption for Computer Generated Facsimile Transmissions" Federal Register Vol. 72, No. 227 (November 27, 2007), p. 66222; "Medicare, Medicaid, and SCHIP Extension Act of 2007" Pub. L. No. 110-173, § 101, 121 Stat. 2493 (December 29, 2007); "Medicare Program; Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2009" Centers for Medicare and Medicaid Services, Federal Register Vol. 73, No. 224 (November 19, 2008), p. 69726; "Medicare Improvements for Patients and Providers Act of 2008" Pub. L. No. 110-275, § 131, 122 Stat. 2520 (July 15, 2008); "Medicare Program; Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2010" Federal Register Vol. 74, No. 226 (November 25, 2009), p. 61738; "Department of Defense Appropriations Act, 2010" Pub. L. No. 111-118, § 1011, 123 Stat. 3473-3474; "Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010" Pub. L. No. 111-192, § 101, 124 Stat. 1280 (June 25, 2010); "Medicare Program; Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2011; Final Rule" Federal Register Vol. 75, No. 228 (November 29, 2010), p. 73283; "Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2011; Corrections: Correction on Final Rule with Comment Period" Federal Register Vol. 76, No. 7 (January 11, 2011), p. 1670; "Medicare and Medicaid Extenders Act of 2010" Pub. L. No. 111-309, § 101, 124 Stat. 3285-3286; "Medicare Program; Payment Policies Under the Physician Fee Schedule, Five-Year Review of Work Relative Value Units, Clinical Laboratory Fee Schedule: Signature on Requisition, and Other Revisions to Part B for CY 2012; Final Rule" Federal Register Vol. 76, No. 228 (November 28, 2011), p. 73277; "Temporary Payroll Tax Cut Continuation Act of 2011" Pub. L. No. 112-78, § 301, 125 Stat. 1283-1284 (December 23, 2011); extended by "Middle Class Tax Relief and Job Creation Act" Pub. L. No. 112-96, § 3003, 126 Stat. 186-187 (February 22, 2012); "Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, DME Face-to-Face Encounters, Elimination of the Requirement for Termination of Non-Random Prepayment Complex Medical Review and Other Revisions to Part B for CY 2013; Final Rule" Federal Register Vol. 77, No. 222 (November 16, 2012), p. 69138; "American Taxpayer Relief Act of 2012" Pub. L. No. 112-240, § 601, 126 Stat. 2345 (January 2, 2013); "Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, Clinical Laboratory Fee Schedule & Other Revisions to Part B for CY 2014; Final Rule" Federal Register Vol. 78, No. 237 (December 10, 2013), p. 74398; "Protecting Access to Medicare Act of 2014" Pub. L. No. 113-93, § 101, 128 Stat. 1041 (April 1, 2014); "Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, Clinical Laboratory Fee Schedule, Access to Identifiable Data for the Center for Medicare and Medicaid Innovation Models & Other Revisions to Part B for CY 2015; Final Rule" Federal Register Vol. 79, No. 219 (November 13, 2014), p. 67742; "Protecting Access to Medicare Act of 2014" Pub. L. No. 113-93, § 101, 128 Stat. 1041 (April 1, 2014).

Medicare Access and CHIP Reauthorization Act of 2015

- Repealed the SGR and replaced it with a series of pre-determined updates
  - Vary based on payment model used by provider
- Annual conversion factor updates:
  - July 2015 to December 2019 – 0.5%
  - 2020 to 2025 – 0.0%
  - 2026 forward – 0.25%
    - 0.75% for *alternative payment model* (APM) participants

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"Medicare Access and CHIP Reauthorization Act of 2015" H.R. 2, January 6, 2015, p. 3-4.

AMA/Specialty Society Relative Value Scale Update Committee

- CMS and the AMA often rely on the analysis of the *AMA/Specialty Society Relative Value Scale Update Committee (RUC)* when updating RVUs
- A somewhat controversial panel of 29 physicians from different specialties recommend updates to various RVU's to CMS
- Historically, CMS has followed 90% of RUC recommendations regarding physician reimbursements
  - Has based at least 20% of physician payments on RUC recommendations

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"Gauging Emergency Physician Productivity: Are RVUs the Answer?" By John Proctor, ACEP Reimbursement Committee, Posted on American College of Emergency Physicians, www.acep.org/practres.aspx?id=30306 (Accessed 08/14/12).
"AMA/Specialty Society RVU Update Committee: The RUC is The RUC is Not" American Medical Association: Chicago, IL, June 16, 2007. "AMA/Specialty Society RVS Update Committee (RUC)" By Barbara S. Levy, AMA/Specialty Society RVS Committee Chair, American Medical Association, March 5, 2010, p.4.
"A Small Group of Physicians has a Big Say in What you Get Paid: What Every Physician Should Know about the RUC" By Kent J, Moore, et al., Family Practice Management, February 2008; "AMA/Specialty Society RVU Update Committee: The RUC is The RUC is Not" American Medical Association: Chicago, IL, June 16, 2007.

Quality Limitations on Medicare Reimbursement

- Medicare will not reimburse for treatments that contribute to unnecessary cost and waste, i.e.,
  - Never Events
  - Sentinel Events
- The Joint Commission's definition of a sentinel event
  - An unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof
    - ***"Or the risk thereof":*** Any process variation for which an occurrence would result in a significant chance of a serious adverse outcome

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"Never Event Fact Sheet" By The Leapfrog Group, March 2008, http://www.leapfroggroup.org/media/file/Leapfrog-Never_Events_Fact_Sheet.pdf (Accessed 2/8/2011).

Quality Limitations on Medicare Reimbursement

- The National Quality Forum (NQF) has identified 28 events that should *"never"* happen in a hospital and can be prevented
  - Includes:
    - Surgical events
      - Performing the wrong surgical procedure
    - Product or device events
      - Contaminated drugs or devices
    - Criminal events
      - Abduction of a patient

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"Healthcare Valuation: The Financial Appraisal of Enterprises, Assets, and Services" By Robert James Cimasi, MHA, ASA, FRICS, MCBA, AVA, CM&AA, John Wiley & Sons Inc., 2014, p. 166.

Quality Limitations on Medicare Reimbursement

- Healthcare Associated Infections (HAIs)
  - Estimated that 1 in every 20 hospital inpatients will develop a HAI
  - Accounts for $28 to $33 billion in preventable healthcare expenditures
  - New CMS Policy - Adjusts reimbursement amounts so as to not include payment for services linked to HAIs that were not present on a patient's admission
- CMS publishes statistics regarding never and sentinel events for every hospital that provides services to Medicare beneficiaries

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"National Action Plan to Prevent Healthcare-Associated Infections: Roadmap to Elimination" Steering Committee for the Prevention of Healthcare-Associated Infections, April 2012, Draft Available at http://www.hhs.gov/ash/initiatives/hai/index.html (Accessed 9/7/2012), p. 8.

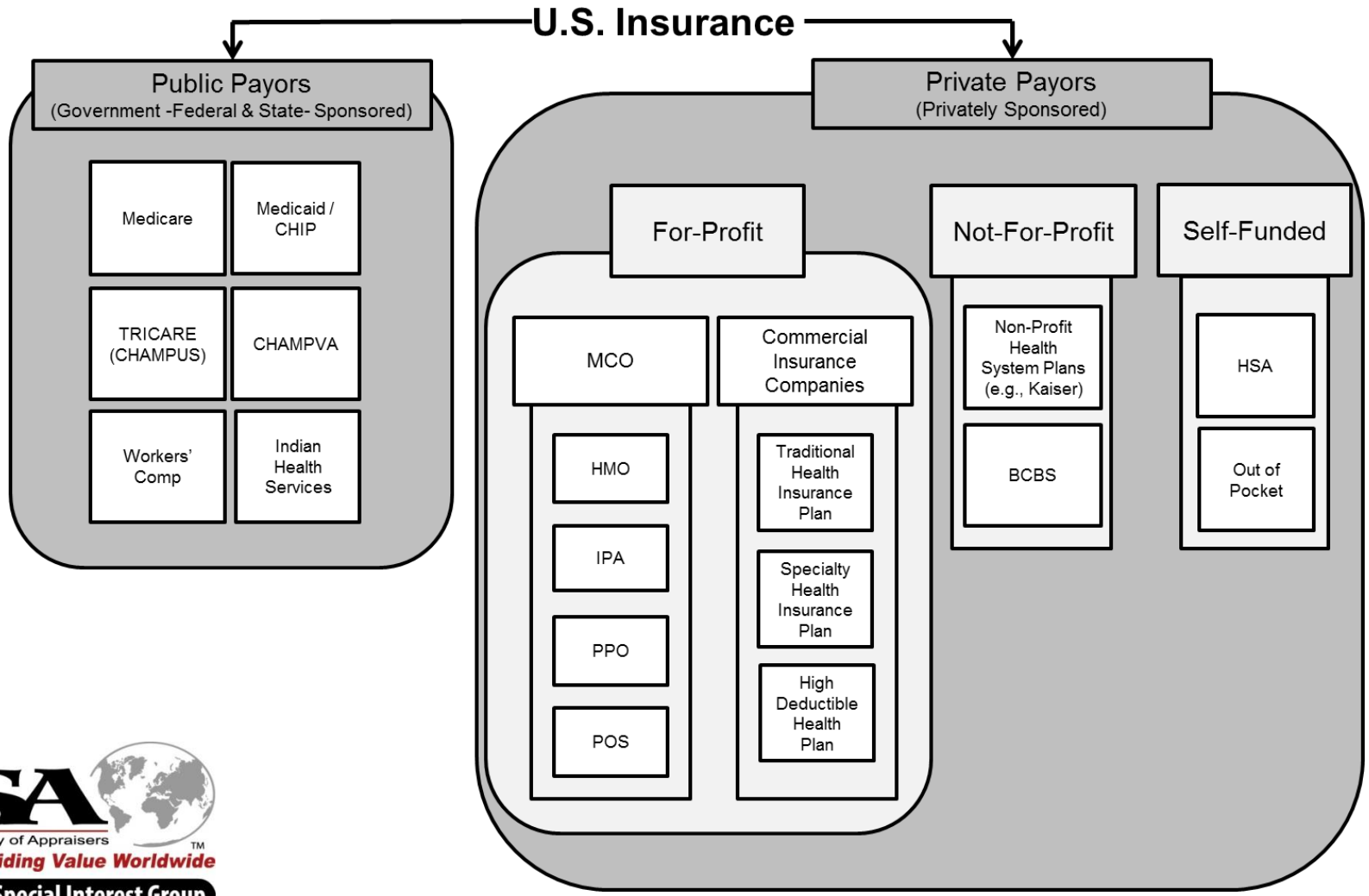
Quality Limitations on Medicare Reimbursement

- ACA Section 3025
  - Penalty for excessive hospital readmissions under the Hospital Readmissions Reduction Program
- Anti-Markup Rule
  - Provider cannot bill Medicare more than actual cost for technical component of diagnostic test performed by a subcontractor

"Changes in Medicare Reimbursement for Hospital-Acquired Conditions Including Infections" By Patricia W. Stone, American Journal of Infection Control, Vol. 37, 2009, p. 17A.
"Patient Protection and Affordable Care Act" Pub. L. 111-148, 128 STAT 408, §3025 (March 23, 2010).

Types of Payors

U.S. Health Insurance Providers and Plans



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Public Payors

Overview

- Medical spending by federal or state governments
  - Most significant programs are Medicare and Medicaid
- Often funded by a mixture of specific designated taxes, as well as general fund support
- In 2013, Medicare and Medicaid accounted for an estimated $591 billion and $450 billion of total national health expenditures, respectively
- Private reimbursement rates often reflect Medicare's reimbursement rates due to its significant presence in the healthcare reimbursement arena

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"National Health Expenditure Projections 2013-2023" Center for Medicare & Medicaid Services, September 17, 2014, http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html (Accessed 11/19/2014), Table 3.

Medicare

Overview

- Created in 1965 as Title XVIII of the Social Security Act
- An entitlement program that provides health insurance benefits to:
  - Individuals age 65 and over
  - Individuals with permanent disabilities
  - Individuals with end stage renal disease (ESRD)

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"Key Milestones in CMS Programs" Centers for Medicare and Medicaid Programs, Accessed at http://www.cms.gov/About-CMS/Agency-Information/History/downloads/CMSProgramKeyMilestones.pdf (Accessed 11/02/09).

The Four Parts of Medicare

Part	Description of Benefits
Part A	Covers inpatient hospital care
Part B	Covers outpatient visits
Part C	Allows beneficiaries to choose a managed care replacement for Parts A and B, known as *Medicare Advantage*
Part D	Created under the Medicare Modernization Act (MMA) and implemented in 2006, covering prescription drug benefits

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"CCH Medicare Explained: §100" Editor Pamela K. Carron and Nicole T. Stone, Chicago, IL: CCH, 2012, p. 17.

Medicare

- Individuals who are not *automatically eligible* may enroll in coverage for Medicare Part A and Part B, for which they would either:
  - Pay a *premium* for Medicare Part B
  - Elect to enroll in a Medicare Advantage (MA) managed care plan (also known as Medicare Part C)
- Individuals may or may not decide to enroll in Medicare Part D

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"CCH Medicare Explained: §100" Editor Pamela K. Carron and Nicole T. Stone, Chicago, IL: CCH, 2012, p. 17. "Title XVIII, Social Security Act," Sections 1811, 1831, 1851, 1860D, 2009, http://www.ssa.gov/OP_Home/ssact/title18/1800.htm (Accessed 6/19/09); "Medicare Electronic Booklet," By the Social Security Administration, ssa.gov (Accessed 11/02/09). "

Medicare Reimbursement

Medicare uses a combination of:

- Fee-for-service (FFS) payments
- Managed care arrangements
- Payments from health savings accounts (HSA) to reimburse providers
- Medicare contracts with private companies (i.e., fiscal intermediaries and carriers) to process and pay claims

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Enrolling in Medicare

- To enroll, providers must be assigned a specific National Provider Identifier (NPI), provided by the National Plan and Provider Enumeration System (NPPES)
  - Physicians enter into Medicare participating provider (PAR) agreements with CMS under their NPI through a CMS-855 provider enrollment application that is sent to their region's Medicare Administrative Contractor's (MAC) enrollment department
  - Once accepted as a Medicare provider, the MAC enrollment department issues the provider a Provider Transaction Access Number (PTAN) and the National Unique Provider Identification Number Registry issues the provider a UPIN

"Difference between the Medicare Provider Numbers" WPS Medicare J5 MAC Part B, August 16, 2012, http://www.wpsmedicare.com/j5macpartb/resources/new_providers/providernumber.shtml (Accessed 9/18/2013).

Medicare Allowable Charge: Participation vs. Non-participation

- Non-participation does not *bar* reimbursement payments from Medicare, but the amount reimbursed is significantly limited
- Three scenarios under which providers may submit claims to CMS for reimbursement under the Medicare program:
  - Participation
  - Non-participation
  - Private contracting

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Medicare Allowable Charge: Participation vs. Non-participation

Participation

- In 2011, approximately 96% of all physicians billing Medicare were participating providers (PAR)
- PAR physicians enter into an assumed contractual agreement with CMS to accept the Medicare allowable fee for a given procedure and cannot charge above that amount (guaranteed 80% of the allowable charge)

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"Table VI.6: Medicare Participating Physician Program" In "Centers for Medicare and Medicaid Services Data Compendium" CMS/OFM, December 2011, http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/DataCompendium/2011_Data_Compendium.html (Accessed 8/6/2012).
"CCH Medicare Explained: §870" Editor Pamela K. Carron and Nicole T. Stone, Chicago, IL: CCH, 2012, p. 426.

Medicare Allowable Charge: Participation vs. Non-participation

Non-Participating Providers (*non*PARs)

- May still see Medicare patients, but they must choose:
  - To agree to accept the Medicare reimbursement amount on a claim-by-claim basis
  - To fully reject the Medicare program
- Subject to a *limiting charge*
  - Dictates what they may charge Medicare beneficiaries for covered services
    - 5% less than the allowable fee that PARs are paid for similar services

"Understanding Health Insurance: A Guide to Billing and Reimbursement" By Michelle A. Green and JoAnn C. Rowell, Ninth Edition, Clifton Park, NY: Cengage Learning, 2008, p. 437.
"CCH Medicare Explained" By Pamela K. Carron and Nicole T. Stone, Chicago, IL: CCH, 2012, p. 413.

Medicare Allowable Charge: Participation vs. Non-participation

NonPARs that choose to accept Medicare assignment on a claim-by-claim basis must agree to 6 criteria:

- File all Medicare claims
- Restrict fees for non-assigned claims in accordance with the limiting charge
- Forgo balance billing patients
- Collect only the patient deductible and coinsurance amounts at the time of service when accepting assignment on a claim
- Require patients to sign a *"Surgical Disclosure Notice"* when charges for non-assigned surgical fees exceed $500
- Accept assignment on clinical laboratory charges

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Medicare Allowable Charge: Participation vs. Non-participation

Private Contracting

- Balanced Budget Act of 1997 - Providers and patients may opt to privately contract for the payment of services outside Medicare guidelines
- Providers must fully opt out of Medicare for at least two years and are not allowed to submit any claims to Medicare
- To opt out, providers must file an affidavit with their specific CMS carrier

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Medicare Advantage

- Medicare Part C (Medicare Advantage) is administered through managed plans offered by private insurance companies
  - Medicare Advantage organizations must pay 95% of clean claims submitted by non-participating providers within 30 days
  - Must include a prompt payment provision in their contracts with participating providers, but may negotiate as to the contract's terms

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"Prompt Payment by MA Organization." 42 C.F.R. § 422.520.

Medicare Advantage

- Medicare Advantage subsidies are calculated by taking the difference between:
  - The private insurance plan predicted cost of care, demonstrated through a bid submitted to CMS
  - The maximum Medicare Part A and Part B payment for traditional Medicare benefits in a geographic area, referred to as the benchmark
- If bid is below the benchmark (generally the case), the private plan receives a rebate (savings) equal to 75% of the difference
- If bid is above the benchmark, Medicare beneficiaries are charged a premium to cover the overage

"Payment Reform will Impact Medicare Advantage" By Patrick J. Dunks, et al., Milliman Healthcare Reform Briefing Paper, February 2011, p. 1. "Medicare Provisions in PPACA (P.L. 111-148)" By Patricia A. Davis, et al., Congressional Research Service, April 21, 2010, p. 10.

Medicare Advantage & the Affordable Care Act (ACA)

Several ACA provisions are designed to lower the additional costs Medicare Advantage plans add to the federal budget by:

- Freezing benchmark amounts
- Reducing benchmarks over a two to six year phase-in period, beginning in 2010, to be determined by CMS rankings of FFS costs in each county

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"Patient Protection and Affordable Care Act" Pub. L. 111-148, Section 3201 (March 23, 2010), p. 442.

Medigap Coverage

- Designed to cover "*gaps"* in Medicare coverage created from the percentage of the allowable charge remaining after Medicare reimburses a provider
- Offered by private insurance companies but regulated by federal and state agencies
- Insurance companies seeking to offer Medigap coverage must conform to the National Association of Insurance Commissioners' (NAIC) standards
- Beneficiaries are responsible for premiums under Medigap
- Beneficiaries enrolled in Medicare Advantage plans already operated by private insurance companies are not eligible for Medigap

"CCH Medicare Explained: §740" Editor Pamela K. Carron and Nicole T. Stone, Chicago, IL: CCH, 2012, p. 360-61.

Medicaid

Overview

- A state-administered health insurance program for low-income individuals and certain federally recognized eligible groups
  - Funded by both federal and state governments
- Medicaid is "*optional*," but every state and the District of Columbia has an established Medicaid program
- To receive federal matching funds, states must operate their Medicaid programs within the federal government's established parameters

"Brief Summaries of Medicare & Medicaid: Title XVIII and Title XIX of The Social Security Act as of November 1, 2007" By Earl Dirk Hoffman, Jr., Barbara S. Klees, and Catherine A. Curtis, Centers for Medicare and Medicaid Services, http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/downloads/MedicareMedicaidSummaries2007.pdf (Accessed 8/23/12). "Medicaid: An Overview of Spending on Mandatory vs. Optional Populations and Services" Kaiser Commission on Medicaid and the Uninsured, June 2005, Accessed at http://www.kff.org/medicaid/upload/Medicaid-An-Overview-of-Spending-on.pdf (Accessed 10/6/09), p. 1.

Medicaid Mandatory Eligibility Groups

- Elderly and disabled social security income beneficiaries
- Children under age 6 in families earning below 133% of the federal poverty guidelines
- Children age 6 and older in families earning below 100% of the federal poverty guidelines
- Parents in families earning below a state's welfare eligibility cutoff for 1996 (roughly 50% of the federal poverty guidelines)
- Pregnant women in families earning at, or below, 133% of the federal poverty guidelines
- Elderly and disabled individuals in families earning at, or below, 74% of the federal poverty guidelines who are receiving Supplemental Security Income
- Certain working disabled individuals
- Medicare buy-in groups

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"State Plans for Medical Assistance" 42 U.S.C. §1396a(a)(10)(A) (2010).

Medicaid Mandatory Services

- Physician services
- Inpatient and outpatient hospital care
- Nursing facility care
- Laboratory and x-ray services
- Early and periodic screening, diagnostic, and treatment services for individuals under 21
- Family planning and supplies
- Federally qualified health center services
- Rural health clinic services
- Nurse midwife services
- Certified pediatric and family nurse practitioner services
- Nursing facility services for individuals 21 and older
- Home health care services for individuals entitled to nursing facility care

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"Medicaid: An Overview of Spending on Mandatory vs. Optional Populations and Services" Kaiser Commission on Medicaid and the Uninsured, June 2005, http://www.kff.org/medicaid/upload/Medicaid-An-Overview-of-Spending-on.pdf (Accessed 10/6/09), p. 5.

Medicaid

- States may receive federal matching funds for covering other optional services and optional groups, including:
  - Prescription drugs
  - Dental services
  - Medical care provided by allied health professionals and other non-physician providers
- If a state chooses to offer an optional service to an optional group, it generally must offer that service to the mandatory edibility group
- Eligibility determined based on federal poverty guidelines

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"Medicaid: An Overview of Spending on Mandatory vs. Optional Populations and Services" Kaiser Commission on Medicaid and the Uninsured, June 2005, Accessed at http://www.kff.org/medicaid/upload/Medicaid-An-Overview-of-Spending-on.pdf (Accessed 10/6/09), p. 1, 5.

2015 Federal Poverty Level (FPL)

	A	B
	Persons in family/household	**Poverty Guideline**
1	1	$11,770
2	2	$15,930
3	3	$20,090
4	4	$24,250
5	5	$28,410
6	6	$32,570
7	7	$36,730
8	8	$40,890
9	For each additional person over 8, add $4,160	

"Annual Update of the HHS Poverty Guidelines" Federal Register Vol. 80, No. 14 (January 22, 2015), p. 3237. Note that the Poverty Guidelines in Alaska and Hawaii deviate from those of the 48 contiguous states.

Medicaid

- 57 million individuals enrolled in Medicaid in September 2014
- 2010 ACA legislation required Medicaid expansion
  - Modified by the U.S. Supreme Court decision
- States given the option to expand Medicaid coverage to 133% of the FPL in exchange for federal funding for all newly eligible individuals
  - 27 states, including D.C., expanding Medicaid in 2014
  - 5 states debating Medicaid expansion
  - 19 states not moving forward with expansion at this time

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"April-September 2014 Medicaid MBES Enrollment Report" Centers for Medicare & Medicaid Services, April 10, 2015, http://www.medicaid.gov/medicaid-chip-program-information/program-information/downloads/mbes-enrollment-report-april-september-2014.pdf (Accessed 4/21/2015); "Status of State Action on the Medicaid Expansion Decision, 2014," The Henry J. Kaiser Family Foundation, http://kff.org/medicaid/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/#note-1 (Accessed 4/11/2014); "Natl. Federation of Independent Business v. Sebelius" Nos. 11-393, 11-398 and, 11-400, 2012 BL 160004, 53 EBC 1513 (U.S. June 28, 2012); "Medicaid Enrollment: June 2013 Data Snapshot," The Kaiser Commission on Medicaid and the Uninsured, January 2014, http://kaiserfamilyfoundation.files.wordpress.com/2014/01/8050-07-medicaid-enrollment-june-2013-data-snapshot1.pdf (Accessed 4/11/2014).

Medicaid

Billing and Reimbursement

- Paid by states on a FFS basis or under a pre-paid managed care arrangement
- Medicaid reimburses on a lump-sum basis, i.e., providers receive one payment for several submitted claims
- Often considered the *"payor of last resort"*

"The Medicaid Resource Book" By Andy Schneider, et al., Menlo Park, CA: Henry J. Kaiser Family Foundation, July 2002, p. 100.
"From Patient to Payment: Insurance Procedures for the Medical Office" By Cynthia Newby, Third Edition, Columbus, OH: Glencoe/McGraw-Hill, 2002, p. 135.
"Timely Claims Payment" 42 C.F.R. § 447.45(d) (January 16, 1990).
"Understanding Health Insurance: A Guide to Billing and Reimbursement" By Michelle A. Green and JoAnn C. Rowell, Ninth Edition, Clifton Park, NY: Cengage Learning, 2008, p. 479.

Medicaid

Billing and Reimbursement

- Each state can develop its own reimbursement process and payment rates, with 3 exceptions:
  - *Institutional Services* - Payment may not exceed amounts that would be paid under Medicare payment rates
  - *Disproportionate Share Hospitals (DSH)* - Hospitals that treat a disproportionate number of Medicaid patients, different limits apply
  - *Hospice Care Services* - Payment may not surpass amounts that would be paid under Medicare payment rates

"The Medicaid Resource Book" By Andy Schneider, et al., Menlo Park, CA: Henry J. Kaiser Family Foundation, July 2002, p. 141.

Disproportionate Share Hospital (DSH) Payments

- A form of *additional* reimbursement under Medicaid for hospitals that care for a large number of Medicaid and uninsured patients
- States are required to supplement reimbursements to DSHs in order to receive augmented funding allotments from the federal government
  - In order to receive their DSH allotment, a state must submit an annual report and certified audit documenting payments made to DSH
  - Each state has discretion over which hospitals will receive DSH distributions
- DSH payments are calculated differently for each state according to a statutory formula

"The Basics: Medicaid Disproportionate Share Hospital (DSH) Payments" By Christie Provost Peters, National Health Policy Forum, The George Washington University, June 15, 2009, Accessed at http://www.nhpf.org/library/the-basics/Basics_DSH_06-15-09.pdf (Accessed 10/5/09), p. 1.

Long-Term Care Reimbursement

- Medicaid is the *primary payor* for long-term care services
- To qualify for Medicaid services, beneficiaries requiring long-term care must have monthly incomes equal to or below the Supplemental Security Income (SSI)
  - 2012 eligibility level - $698 per month
- Most states reimburse under a FFS model
  - As of 2011, 11 states have contracted with capitated managed care plans to administer Medicaid reimbursement for these services

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"Medicaid and Long-Term Care Services" Kaiser Family Foundation, Kaiser Commission on Medicaid and the Uninsured, Medicaid Facts, June 2012, http://www.kff.org/medicaid/upload/2186-09.pdf (Accessed 10/2/2012).

Dual Eligibles

- Beneficiaries that are eligible for both Medicare & Medicaid
  - Over 9 million dual eligibles in 2015
- This population is generally more costly than other populations
- Medicare operates as the primary payor
- Covers acute care services for dual eligible beneficiaries
- Medicaid operates as a secondary payor
- Provides coverage for*:*
  - Premiums
  - Cost sharing
  - Long-term care services

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"Report to Congress: Medicare and the Health Care Delivery System" Medicare Payment Advisory, June 2012, p. 61.
"Report to Congress: New Approaches in Medicare" Medicare Payment Advisory, June 2004, p. 82-83.
"State Demonstration Proposals to Integrate Care and Align Financing and/or Administration for Dual Eligible Beneficiaries" The Henry J. Kaiser Family Foundation, February 6, 2015, http://kff.org/medicaid/fact-sheet/state-demonstration-proposals-to-integrate-care-and-align-financing-for-dual-eligible-beneficiaries/ (Accessed 2/24/15).

Levels of Dual Eligibility

Eligibility Level	Medicare Coverage	Medicaid Coverage	Requirements of Eligibility
Full Dual Eligibles	Full	Full	Incomes ≤ 73 percent of poverty guidelines and assets < $2,000 for individuals and $3,000 for couples
Medicare savings programs (QMB)	Full	Premiums and Cost Sharing	Incomes ≤ 100 percent of poverty guidelines and assets < $4,000 for individuals and $6,000 for couples
Medicare savings programs (SLMB)	Full	Medicare Part B Premiums	Incomes btw 100-120 percent of poverty guidelines and assets < $4,000 for individuals and $6,000 for couples
Medicare savings programs (QI)	Full	Medicare Part B Premiums	Incomes btw 120-135 percent of poverty guidelines and assets < $4,000 for individuals and $6,000 for couples

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"Medicaid's Role for Dual Eligible Beneficiaries" Kaiser Family Foundation, Kaiser Commission on Medicaid and the Uninsured, April 2012, p. 3.

Children's Health Insurance Program (CHIP, f/k/a SCHIP)

- State-federal partnership that provides assistance to children and pregnant women in families whose income is above the Medicaid threshold
- Implemented by every state, territory, & the District of Columbia
- CHIP covered approximately 5.7 million children in 2013, in addition to the 28 million children enrolled in Medicaid
- States determine (within federal parameters) who may be eligible for CHIP funds, as well as other details
- State funds are *matched* by the federal government up to a certain *capped* amount

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"Overview: The Childrens Health Insurance Program (CHIP)" Centers for Medicare and Medicaid Services, http://www.cms.hhs.gov/LowCostHealthInsFamChild/ (Accessed 10/6/09).
"Health Coverage of Children: The Role of Medicaid and SCHIP: Key Facts," By the Kaiser Commission on Medicaid and the Uninsured, November 2008, http://www.kff.org/uninsured/upload/7698_02.pdf (Accessed 10/6/09).
"Children's Health Coverage: Medicaid, CHIP and the ACA" by Robin Rudowitz et al, The Henry J. Kaiser Family Foundation, March 2014, p. 1, https://kaiserfamilyfoundation.files.wordpress.com/2014/03/8570-children_s-health-coverage-medicaid-chip-and-the-aca1.pdf (Accessed 2/5/15).

TRICARE (CHAMPUS)

Overview

- U.S. Department of Defense's healthcare program for:
  - Active duty military personnel
  - Members of the National Guard and Reserves
  - Retirees
  - Their dependents; survivors; and, certain former spouses
- Uses military healthcare providers as the main provider of services, supplemented by civilian healthcare providers, facilities, pharmacies, and suppliers
- Covered about 9.5 million beneficiaries as of 2014

"What is TRICARE?" TRICARE Management Activity, June 12, 2012, http://tricare.mil/mybenefit/ProfileFilter.do;jsessionid=QTLTRCBSJ6PhsQNnzh9hf0XfnDKh2bcDKgMZPF3xH4M66twQF0TX!875501913?puri=%2Fhome%2Foverview%2FWhatIsTRICARE (Accessed 9/14/2012).
"Licensed Mental Health Counselors and the Military Health System" By Lt. Rick Schobitz, TRICARE Management Activity, Institute of Medicine, http://www.iom.edu/~/media/Files/Activity%20Files/MentalHealth/TRICAREMentalHealth/SchobitzLicensedmentalhealthcounselorsandtheMHS.pdf, (Accessed 8/23/12). "TRICARE Facts and Figures" TRICARE Management Activity, 2012, http://www.tricare.mil/pressroom/press_facts.aspx (Accessed 9/14/2012).
"Evaluation of the TRICARE Program: Fiscal Year 2014 Report to Congress" U.S. Department of Defense, February 25, 2014, p. 5.

TRICARE (CHAMPUS)

Billing and Reimbursement

- Providers reimbursed under FFS and managed care arrangements
- Payment rate determined using Medicare's RBRVS system
- Only pays for services provided by authorized providers
- Participating providers must accept the *allowable fee* as *payment in full* for covered services
- Primary payor if a beneficiary qualifies for Medicaid coverage
  - Assumes secondary payor status if patient is covered by another primary health plan

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"From Patient to Payment: Insurance Procedures for the Medical Office" By Cynthia Newby, Third Edition, Columbus, OH: Glencoe/McGraw-Hill, 2002, p. 152-153, 155.
"Understanding Health Insurance: A Guide to Billing and Reimbursement" By Michelle A. Green and JoAnn C. Rowell, Ninth Edition, Clifton Park, NY: Cengage Learning, 2008, p. 514.
"Completing and Processing Form CMS-1500 Data Set: Health Insurance Claim Form CMS-1500" Centers for Medicare and Medicaid Services, Medicare Claims Processing Manual, Chapter 26, Section 10, March 21, 2011; "From Patient to Payment: Insurance Procedures for the Medical Office" By Cynthia Newby, Third Edition, Columbus, OH: Glencoe/McGraw-Hill, 2002, p. 155, 157.

Civilian Health and Medical Program of the Department of Veteran Affairs (CHAMPVA)

Overview

- To be eligible, a beneficiary must be:
  - The spouse/child of a veteran who has a permanent service-connected disability
  - The surviving spouse/child of a veteran who died as a result of their service-related disability
  - The surviving spouse/child of a veteran who, at the time of their death, was permanently or totally disabled due to their service-connected disability
  - In certain instances, the surviving spouse or child of a service member that died in the line of duty

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"CHAMPVA" By Department of Veterans Affairs Health Administration Center, December 31, 2008, http://www.va.gov/hac/forbeneficiaries/champva/champva.asp (Accessed September 30, 2013).

Civilian Health and Medical Program of the Department of Veteran Affairs (CHAMPVA)

Billing and Reimbursement

- Reimburses providers for services rendered on a FFS basis up to the CHAMPVA allowable fee
  - Equal to Medicare's and TRICARE's allowable fees
- Providers may elect to participate in the program by either submitting a claim or agreeing to treat a CHAMPVA beneficiary
  - Must accept CHAMPVA allowable fee as payment in full
- Both a primary and secondary payor

"Fact Sheet 01-11: Payment Methodology" Department of Veterans Affairs Health Administration Center, CHAMPVA, July 2008, http://www.va.gov/hac/factsheets/factsheets.asp, (Accessed on 08/18/09).
"Fact Sheet 01-15: Participating Providers VA Health Administration Center" Department of Veterans Affairs Health Administration Center, July 2008, http://www.va.gov/hac/factsheets/factsheets.asp, (Accessed 08/18/09).
"From Patient to Payment: Insurance Procedures for the Medical Office" By Cynthia Newby, Third Edition, Columbus, OH: Glencoe/McGraw-Hill, 2002, p. 157.

Workers' Compensation

Overview

- Provides coverage and payments to employees injured at their place of employment or suffering from an occupational disease
- The U.S. Department of Labor's Office of Workers' Compensation Programs (OWCP) oversees 4 workers' compensation programs covering federal employees:
  - The Energy Employees' Occupational Illness Compensation Program
  - The Federal Employees' Compensation Program
  - The Longshore and Harbor Workers' Compensation Program
  - The Black Lung Benefits Program

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"Workers' Compensation: Benefits, Coverage, and Costs, 2010" By Ishita Sengupta, et al., Washington, D.C.: National Academy of Social Insurance, August 2012, p. 1-2.
"Workers' Compensation" By United States Department of Labor, DOL.gov, http://www.dol.gov/dol/topic/workcomp/index.htm (Accessed September 30, 2013).
Healthcare Valuation: The Financial Appraisal of Enterprises, Assets, and Services" By Robert James Cimasi, MHA, ASA, FRICS, MCBA, AVA, CM&AA, John Wiley & Sons Inc., 2014, p. 191-192

Workers' Compensation

Billing and Reimbursement

- Providers treating ill or injured employees covered under one of the federal workers' compensation acts are reimbursed according to OWCP's fee schedule
  - Federal Black Lung Benefits Act uses a modified version of the fee schedule
  - Partly based on the MPFS, with some program-specific adjustments
- State workers' compensation programs reimburse providers using either a FFS model established by the state compensation board or commission, or a managed care plan

"Office of Workers Compensation Program Medical Fee Schedule 2009" By Hilda Solis, United States Department of Labor, May 12, 2009, Accessed at http://www.dol.gov/esa/owcp/regs/feeschedule/fee/fee09/fs09instructions.htm, (Accessed 08/19/09), p. 2-3.
"Understanding Health Insurance: A Guide to Billing and Reimbursement" By Michelle A. Green and JoAnn C. Rowell, Ninth Edition, Clifton Park, NY: Cengage Learning, 2008, p. 544.

Indian Health Services (IHS)

Overview

- Located within HHS
- Provides healthcare services to approximately 2 million American Indians and Alaskan Natives
  - Directly, through tribal healthcare programs
  - Indirectly, using contract health services

"Indian Health Service: A Quick Look" Indian Health Service, August 2009, http://info.ihs.gov/QuickLook09.asp, (Accessed on August 26, 2009).
"Indian Health Service Introduction" By Indian Health Services, IHS.gov, June 2009, , (Accessed on August 10, 2009); "Indian Health Service: A Quick Look" Indian Health Service, January 2012 http://www.ihs.gov/PublicAffairs/IHSBrochure/QuickLook.asp (Accessed 8/29/2012).

Indian Health Services (IHS)

Billing and Reimbursement

- Contracts with non-IHS facilities and providers to deliver healthcare services when the following criteria are met:
  - No IHS facility exists
  - The direct care entity is incapable of providing the required emergency and/or specialty care
  - The direct care entity has an overflow of medical care workload
  - To supplement alternate resources
- Considered a payor of last resort

"Indian Health Service: A Quick Look" By Indian Health Services, IHS.gov, August 2009, http://info.ihs.gov/QuickLook09.asp, (Accessed on August 26, 2009);"CHS 101" By Contract Health Services Data Quality Work Group, HIS.gov, http://www.ihs.gov/NonMedicalPrograms/dqwg/dqwg-section1-home.asp, (Accessed on August 27, 2009); "Indian Health Services Fact Sheet: Contract Health Services" By Indian Health Services, IHS.gov, June 2009, http://info.ihs.gov/CHS.asp, (Accessed on August 26, 2009).
Healthcare Valuation: The Financial Appraisal of Enterprises, Assets, and Services" By Robert James Cimasi, MHA, ASA, FRICS, MCBA, AVA, CM&AA, John Wiley & Sons Inc., 2014, p. 194-195.

Private Payors

- Consist of:
  - For-profit commercial insurers
  - Not-for-profit commercial insurers
  - Self-funded plans
- Private health insurance accounted for an estimated $948 billion, or 33.8% of the total national expenditures in 2013

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"National Health Expenditure Projections 2013-2023" Center for Medicare & Medicaid Services, September 17, 2014, http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html (Accessed 11/19/2014), Table 3. Healthcare Valuation: The Financial Appraisal of Enterprises, Assets, and Services" By Robert James Cimasi, MHA, ASA, FRICS, MCBA, AVA, CM&AA, John Wiley & Sons Inc., 2014, p. 195-196.

For-Profit Commercial Insurers

Overview

- ***Commercial Health Insurance*:** Healthcare plans offered by life insurance companies, casualty insurance companies, and companies formed for the sole purpose of offering health insurance
  - Organized as mutual or stock insurers
    - *Mutual*: Owned by their policyholders
    - *Stock*: Owned by their stockholders

"Healthcare Finance: An Introduction to Accounting and Financial Management, Third Edition" By Louis C. Gapenski, Third Edition, Chicago, IL: Health Administration Press, 2005, p. 35.
"Introduction to Health Services" By Alma Koch, Clifton Park, NY: Thomson Delmar Learning, 2008, pg. 114.

For-Profit Commercial Insurers

Billing and Reimbursement

- Variety of plan options
  - Different co-pays and deductibles
  - Reimbursement methods
  - Claim form requirements
  - Claims submission deadlines
  - Remittance schedules
  - Policies
- Offer insurance plans across the risk spectrum

Managed Care

Overview

- Integrates the financing and provision of health services under the administration of a managed care organization (MCO)
- Costs contained by holding providers accountable for quality of services and care to a population at predetermined reimbursement levels
- Utilizes several means of monitoring, including:
  - Clinical practice standardization
  - Selective contracting
  - Low-cost settings
  - Reduced discretionary hospital admissions
  - Effective staff use

"Healthcare Finance: An Introduction to Accounting and Financial Management, Third Edition" By Louis C. Gapenski, Third Edition, Chicago, IL: Health Administration Press, 2005, p. 4; "A Guide to Consulting Services for Emerging Healthcare Organizations," By Robert James Cimasi, New York, NY: John Wiley & Sons, Inc., 1999, p. 12.
Healthcare Valuation: The Financial Appraisal of Enterprises, Assets, and Services" By Robert James Cimasi, MHA, ASA, FRICS, MCBA, AVA, CM&AA, John Wiley & Sons Inc., 2014, p. 198-199.

Managed Care

- Typically established by a payor that:
  - Controls its own provider network
  - Creates a network via contracts with independent providers
- Three popular models of managed care plans are:
  - Health maintenance organizations (HMOs)
  - Preferred provider organizations (PPOs)
  - Point of service plans (POS)

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"Healthcare Finance: An Introduction to Accounting and Financial Management, Third Edition" By Louis C. Gapenski, Third Edition, Chicago, IL: Health Administration Press, 2005, p. 37.
Healthcare Valuation: The Financial Appraisal of Enterprises, Assets, and Services" By Robert James Cimasi, MHA, ASA, FRICS, MCBA, AVA, CM&AA, John Wiley & Sons Inc., 2014, p. 199-200

Health Maintenance Organizations (HMO)

Overview

- Responsible for either *providing* or *arranging* for provision of healthcare services, including *preventive care*, for plan enrollees via contractual arrangements with providers
- Plans are able to limit *financial risk* by contracting with providers to care for a specified enrolled population for a *fixed payment amount per member per month* (PMPM)
- Under some models, enrollees must select a *primary care physician* to operate as a *gatekeeper*, to oversee and coordinate their healthcare with specialists

"Fundamentals of Health Law, Fourth Edition" By Daniel J. Schwartz, Fourth Edition, Washington, D.C.: American Health Lawyers Association, 2008, p. 247.
"Healthcare Finance: An Introduction to Accounting and Financial Management, Third Edition" By Louis C. Gapenski, Third Edition, Chicago, IL: Health Administration Press, 2005, p. 38.

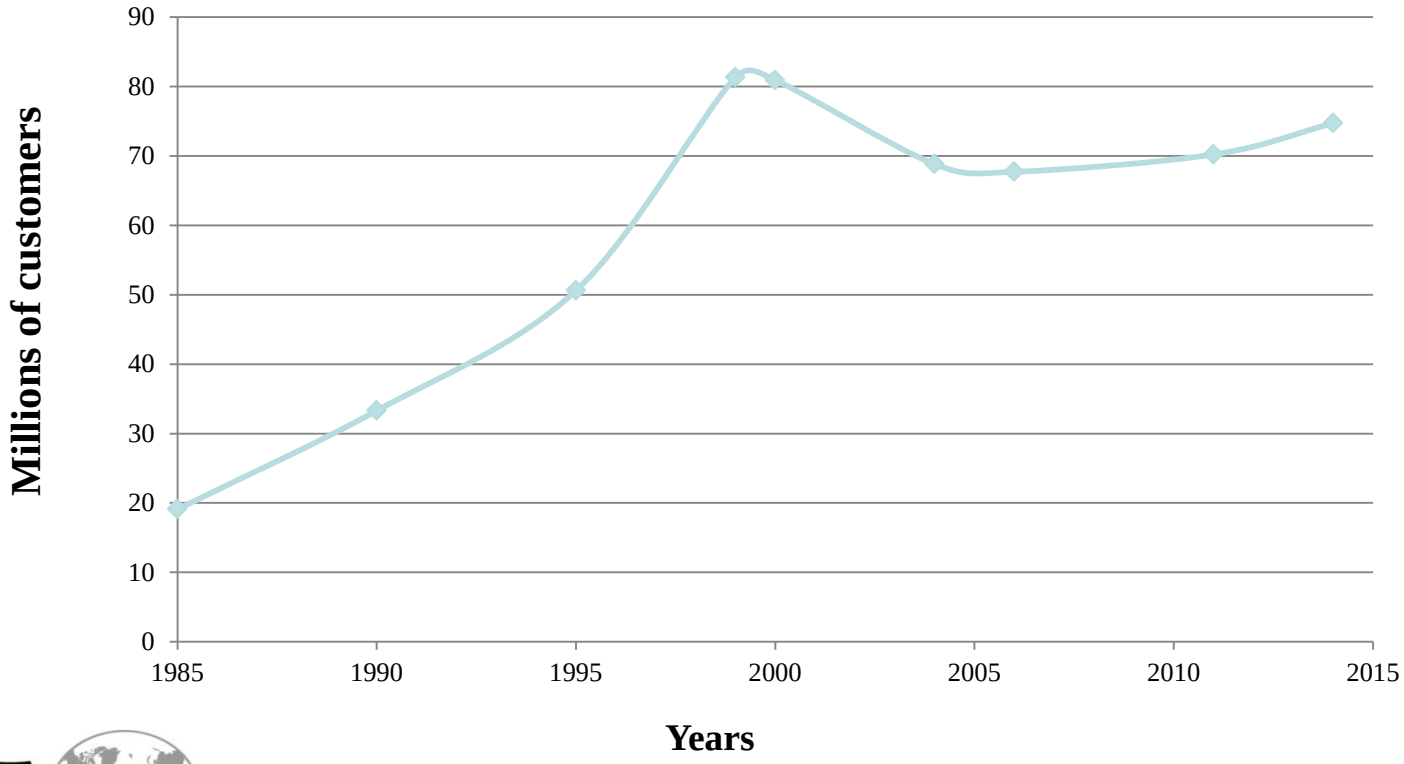
HMO Options

HMO Model	Description
Staff Model HMO	Directly employ all the physicians that provide healthcare services to plan enrollees
Group Model HMO	Contract with one physician practice to provide care to plan enrollees
Network Model HMO	Contract with many independent physician practices who may also treat other patients who are not enrolled in the plan
Independent Physician Model (IPA) HMO	Contract with an association of independent physicians who maintain their own private practices, but who have jointly entered into an agreement to treat the plan's enrollees

"Essentials of Managed Health Care" By Peter R. Kongstvedt, 6th Edition, Burlington, MA: Jones and Bartlett Learning, LLC, 2013, p. 25.

National HMO Enrollment: 1985-2015

HMO Total Enrollment



"Managed Care Museum Timeline: The History of Managed Care and More" Managed Care Museum: Modesto, CA, February 2011, http://www.managedcaremuseum.com/timeline.htm (Accessed 4/10/2012).

Healthcare Valuation: The Financial Appraisal of Enterprises, Assets, and Services" By Robert James Cimasi, MHA, ASA, FRICS, MCBA, AVA, CM&AA, John Wiley & Sons Inc., 2014, p. 203.

Health Maintenance Organizations (HMO)

Billing and Reimbursement

- HMO patients generally pay a monthly fixed premium to be enrolled in a plan and co-payments at the time of treatment
  - Co-payments sometimes waived due to a coinsurance payment requirement

Healthcare Valuation: The Financial Appraisal of Enterprises, Assets, and Services" By Robert James Cimasi, MHA, ASA, FRICS, MCBA, AVA, CM&AA, John Wiley & Sons Inc., 2014, p. 203.

Preferred Provider Organizations (PPO)

- Managed care plan that allows members to choose from an array of participating healthcare providers that have contracted with the health plan to provide services at a discount
  - Hybrid of an HMO and a traditional health insurance plan
  - Currently the most popular model of managed care
- Manage costs by incentivizing enrollees to receive services from *"in-network providers"*
- Members benefit from lower coinsurance and deductibles when they see in-network providers
  - Not required to have a gatekeeper physician authorize care
  - Not required to use the preferred providers on their plan's list

"Healthcare Finance: An Introduction to Accounting and Financial Management, Third Edition" By Louis C. Gapenski, Third Edition, Chicago, IL: Health Administration Press, 2005, p. 38; "Introduction to Health Services" By Alma Koch, Clifton Park, NY: Thomson Delmar Learning, 2008, pg. 124-125.
"Essentials of Managed Health Care" By Peter R. Kongstvedt, 6th Edition, Burlington, MA: Jones and Bartlett Learning, LLC, 2013, p. 28.
Healthcare Valuation: The Financial Appraisal of Enterprises, Assets, and Services" By Robert James Cimasi, MHA, ASA, FRICS, MCBA, AVA, CM&AA, John Wiley & Sons Inc., 2014, p. 204-205

Preferred Provider Organizations (PPO)

- The collection of increasing deductibles & coinsurance is a significant issue for providers
  - Out-of-pocket costs for patients increasing at faster rate than payor spending
  - Results in larger burden of cost sharing between patients and their health insurance provider

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"The Slowdown In Health Care Spending In 2009–11 Reflected Factors Other Than The Weak Economy And Thus May Persist," By Alexander J. Ryu et al.,, Health Affairs Vol. 32 No. 5 (2013), p. 837-38. "2012 Health Care Cost and Utilization Report," Health Care Cost Institute, 2013, p. iii.

Exclusive Provider Organizations (EPO)

Overview

- Sub-model of a PPO
- Uses the preferred provider network established for an existing PPO
- Eliminates out-of-network option, except for emergency services
- Becoming popular as an option for self-funded employer plans

"Essentials of Managed Health Care" By Peter R. Kongstvedt, 6th Edition, Burlington, MA: Jones and Bartlett Learning, LLC, 2013, p. 29.
"From Patient to Payment: Insurance Procedures for the Medical Office" By Cynthia Newby, Third Edition, Columbus, OH: Glencoe/McGraw-Hill, 2002, p. 113.
"Evaluation of a Preferred Provider Organization" By James A. Hester, Annemarie Wouters and Norman Wright, The Milbank Quarterly, Vol. 65, No. 4 (1987).

Point-of-Service (POS) Plans

Overview

- Combine many of elements of HMOs and PPOs
- Generally an addition to an HMO product that allows enrollees the benefit of seeking care from *non-participating* providers
- Enrollees typically pay no deductible or coinsurance for in-network providers
- Enrollees may receive services out-of-network, subject to higher cost-sharing
- One of the least restrictive forms of managed care

"Fundamentals of Health Law, Fourth Edition" By Daniel J. Schwartz, Fourth Edition, Washington, D.C.: American Health Lawyers Association, 2008, p. 258.
"The Health Insurance Picture in 1990" By Cynthia B. Sullivan and Thomas Rice, Health Affairs, Vol. 10, No. 2, May 1991, p. 107-108.

Point-of-Service (POS) Plans

Billing and Reimbursement

- Providers generally reimbursed according to the terms of their contract with the managing health plan
  - Specialty services traditionally paid on a FFS basis
  - Primary care gatekeeper typically receives a capitated per person fee
- Enrollees generally pay only a small co-payment, with no coinsurance and no deductibles for care received from in-network providers and out-of-network providers to whom they have obtained a referral from their primary care provider

"From Patient to Payment: Insurance Procedures for the Medical Office" By Cynthia Newby, Third Edition, Columbus, OH: Glencoe/McGraw-Hill, 2002, p. 112-113.
"Point-of-Service Plans" International Foundation of Employee Benefit Plans, Inc., 2003, http://www.ifebp.org/pdf/harker/POS_Plans.pdf (Accessed 9/14/2012).
"Understanding Health Insurance: A Guide to Billing and Reimbursement" By Michelle A. Green and JoAnn C. Rowell, Ninth Edition, Clifton Park, NY: Cengage Learning, 2008, p. 39.

Health System Plans

Overview

- Controlled by the health system that also manages the delivery of medical services
- The size and scope of the health system is generally determined by the size and scope of the health plan

Billing and Reimbursement

- The plans are the primary payor at their own healthcare facilities
  - They can streamline billing and reimbursement and limit the cost and complexity of their payment systems
- Offers various benefits for care coordination efforts, i.e., accountable care organizations (ACOs)

Blue Cross Blue Shield (BCBS)

Overview

- **Blue Cross** - Provided private health insurance for hospital expenses
- **Blue Shield** - Provided insurance for physician services
- Blue Cross and Blue Shield merged to form a single not-for-profit, Blue Cross Blue Shield Association (BCBSA) in 1977
- Today, BCBSA consists of 37 independent BCBS companies
- Not all BCBS plans are not-for-profit
- The largest managed care network in the US

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"Introduction to Health Services" By Alma Koch, Clifton Park, NY: Thomson Delmar Learning, 2008, p. 114; "The Blues: A History of the Blue Cross and Blue Shield System" By Robert Cunningham III and Robert M. Cunningham, Jr., DeKalb, IL: Northern Illinois University Press, 1997, p. vii, 196-199.;"About the Blue Cross and Blue Shield Association" Blue Cross Blue Shield Association, http://www.bcbs.com/about-the-association (Accessed 8/15/12); "BlueCross BlueShield" BlueCross BlueShield Association, 2015, http://www.bcbs.com/ (Accessed 2/16/15), p. 2.

Blue Cross Blue Shield (BCBS)

Billing and Reimbursement

- Reimburses providers using a FFS reimbursement model and various managed care arrangements
- Requires participating providers to accept the allowable fee as payment in full
- Non-participating providers may collect the full allowable fee from the patient
  - The patient will in turn receive payment directly from the BCBS plan in which they are enrolled

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"Understanding Health Insurance: A Guide to Billing and Reimbursement" By Michelle A. Green and JoAnn C. Rowell, Ninth Edition, Clifton Park, NY: Cengage Learning, 2008, p. 402-408.

Consumer Driven Health Plans

- Many employers have begun to implement defined contribution health insurance plans instead of the traditional defined benefit plans
  - Modeled after defined contribution pension programs, e.g., 401(k)
- Allows the employer to contribute a designated amount of funding
- Gives the employee the freedom to choose how to spend it

"Defined Contribution Health Insurance" By Greg Scandlen, National Center for Policy Analysis, October 26, 2000, http://www.ncpa.org/pdfs/bg154.pdf (Accessed 9/10/09), p. 7.
"Defined Contribution: From Managed Care to Patient-Managed Care," By E. Haavi Morreim, Cato Journal, Vol. 22, No 1 (Spring/Summer 2002), p. 110-112.

Health Savings Accounts (HSA)

Overview

- Where employers and employees both contribute to a special account from which the employee can draw funds to pay for health services
- Usually coupled with enrollment in a high deductible health plan (HDHP)
- Employer's contributions are not taxable to the employee
- Employee's contributions count as *above-the-line* deductions
  - Subtracted from an individual's total income, lowering the amount of income tax owed

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"All About HSAs," U.S. Treasury Department, July 22, 2007, http://www.treas.gov/offices/public-affairs/hsa/pdf/all-about-HSAs_072208.pdf (Accessed 7/1/09), p. 14.
"Frequently Asked Questions" Department of Treasury, Office of Public Affairs, May 15, 2007, http://www.ustreas.gov/offices/public-affairs/hsa/faq_eligibility.shtml, (Accessed 5/21/10).
"Healthcare Valuation: The Financial Appraisal of Enterprises, Assets, and Services" By Robert James Cimasi, MHA, ASA, FRICS, MCBA, AVA, CM&AA, John Wiley & Sons Inc., 2014, p. 212-213.

Employer Self-Insurance

Overview

- One of the leading trends in health insurance since the late 1970s
- Plans vary by amount of risk the employer is willing to assume
  - Fully Self-Funded Plan
  - Partially Self-Funded Plan
  - Minimum Self-Funded Plan
  - Self-Funding with Stop-Loss Insurance

Billing and Reimbursement

- Typically contract directly with providers and reimburse them according to their specific contract terms, or contract with managed care plans to rent (gain access to) their credentialed provider panel

"Self-Insured Group Health Plans" By Self-Insurance Institute of America, Inc., siaa.org, 2012, http://www.siia.org/i4a/pages/Index.cfm?pageID=4546, (Accessed on 8/20/12); "Introduction to Health Services" By Alma Koch, Clifton Park, NY: Thomson Delmar Learning, 2008, pg. 113.
"Healthcare Valuation: The Financial Appraisal of Enterprises, Assets, and Services" By Robert James Cimasi, MHA, ASA, FRICS, MCBA, AVA, CM&AA, John Wiley & Sons Inc., 2014, p. 215-217.

Self-Pay

Overview

- Individuals paying out-of-pocket

Billing and Reimbursement

- Paid in a variety of ways, primarily determined by the provider
- Most self-pay patients lack the knowledge, ability, or market leverage to negotiate lower charges in establishing their payment amount
- Self-payors may be charged up to 2 ½ times higher than what public or commercial payors would pay for the same procedure

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"From Soak The Rich To Soak The Poor: Recent Trends In Hospital Pricing" By Gerard F. Anderson, Health Affairs, Vol. 26, No. 3, May/June 2007, p. 780.
"Healthcare Valuation: The Financial Appraisal of Enterprises, Assets, and Services" By Robert James Cimasi, MHA, ASA, FRICS, MCBA, AVA, CM&AA, John Wiley & Sons Inc., 2014, p. 217-218.

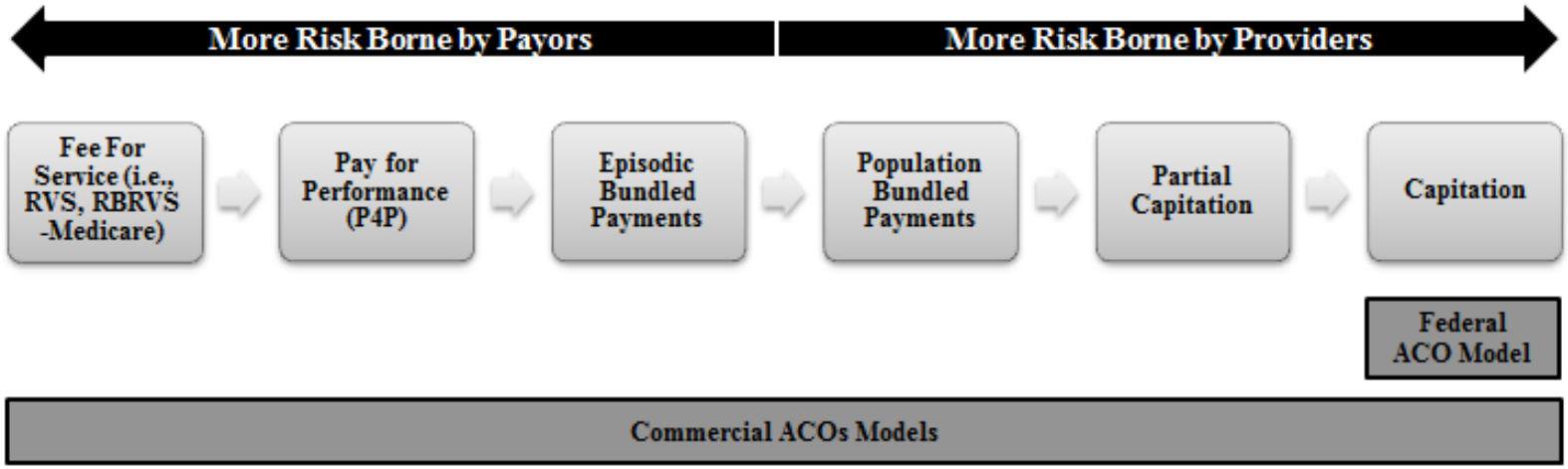
Payor Mix & the Effect on the Revenue Cycle

- *Payor Mix*: The percentage mix of different payors representing the patient population served
- An appropriate payor mix may ensure financial viability
  - Too many or too few of one type of method may *negatively* impact practice revenue
  - Complementary reimbursement models incentivize and reward providers for various activities

Methods of Reimbursement

Methods of Reimbursement

U.S. Health Insurance Reimbursement Options



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Methods of Reimbursement

Fee for Service (FFS)

- When health care providers receive separate compensation for each service they provide, such as an office visit or procedure
- The most common form of reimbursement utilized in the current healthcare environment
- Previously used as an incentive for healthcare providers to join a managed care organization (MCO) in markets where managed care penetration was low

"Insurance Programs: Glossary," By U.S. Office of Personnel Management, p. 16.
"The Managed Health Care Handbook" By Peter R. Kongstvedt, Gaithersburg, MD: Aspen Publishers, Inc., 1996, p. 139.

Methods of Reimbursement

Pay for Performance (P4P)

- Remuneration system in which part of the payment is dependent on performance
  - Measured against a defined set of criteria
- The common elements to all systems include:
  - A set of targets or objectives that define what will be evaluated
  - Measures & performance standards for establishing target criteria
  - Rewards (typically financial incentives) that are at risk, including the amount and method for allocating the payments among those who meet or exceed the reward threshold

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"Pay-for-Performance in Health Care" By Jim Hahn, Congressional Research Service, November 2, 2006, p. 2, 4.

Bundled Payments

- Occurs when payments for multiple *related procedures or diagnoses* are combined, or *bundled*, to reimburse for the entirety of one *episode of care*
- Medicare has established DRG bundling for certain services, e.g., end stage renal disease (ESRD)
  - If two procedures are inextricably linked, then reimbursement cannot be claimed for each procedure separately, but only for one episode of care

"End Stage Renal Disease Drugs: Facility Acquisition Costs and Future Medicare Payment Concerns", Statement by the HHS Office of Inspector General Daniel R. Levinson, September 2010, p. i-iv.

Bundled Payments for Care Improvement Initiative (Bundled Payments Initiative)

- Aims to improve patient care through a patient-centered approach, emphasizing care coordination and quality
- Four approaches to bundled payments
- Each designed to incentivize coordination of care and lower costs by allowing providers to share in any cost savings achieved based on a historic fee for service payment rate and a discounted target price per episode of care

"Affordable Care Act Initiative to Lower Costs, Help Doctors and Hospitals Coordinate Care," US Department of Health and Human Services, August 23, 2011, http://www.hhs.gov/news/press/2011pres/08/20110823a.html (Accessed 10/24/2011); "Bundled Payments for Care Improvement Initiative," Centers for Medicare and Medicaid Services, August 23, 2011, http://www.innovations.cms.gov/areas-of-focus/patient-care-models/bundled-payments-for-care-improvement.html (Accessed 10/24/2011).
"Bundled Payments for Care Improvement Initiative," Center for Medicare and Medicaid Innovation, http://www.innovations.cms.gov/areas-of-focus/patient-care-models/bundled-payments-for-care-improvement.html (Accessed 10/24/2011), p. 3.
"Healthcare Valuation: The Financial Appraisal of Enterprises, Assets, and Services" By Robert James Cimasi, MHA, ASA, FRICS, MCBA, AVA, CM&AA, John Wiley & Sons Inc., 2014, p. 239.

Methods of Reimbursement

Capitation

- Reimburses providers a set price for providing medical services to a defined population for a defined set of services, regardless of service utilization
- Determined on a per member per month (PMPM) basis
- *Full Risk Capitation (Global Capitation)*
  - When a health plan, facility, or provider accepts the entire financial risk for a plan's members
- *Blended Capitation*
  - Combines PMPM rates and FFS remuneration, based on service being provided

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"Dictionary of Health Insurance and Managed Care" By David Edward Marcinko and Hope Rachel Hetico, New York, NY: Springer Publishing Company, 2006, p. 126.

Current & Emerging Reimbursement Trends

Emerging Reimbursement Trends

- ACA provisions aim to utilize financial incentives and policies to:
  - Address the rising cost of services
  - Improve health outcomes
  - Improve access to healthcare services
- Shift from FFS
  - The pendulum has swung back and forth between FFS and capitation throughout the years
  - Currently, capitation and other reimbursement models that shift risk to providers have been gaining acceptance throughout the healthcare delivery market

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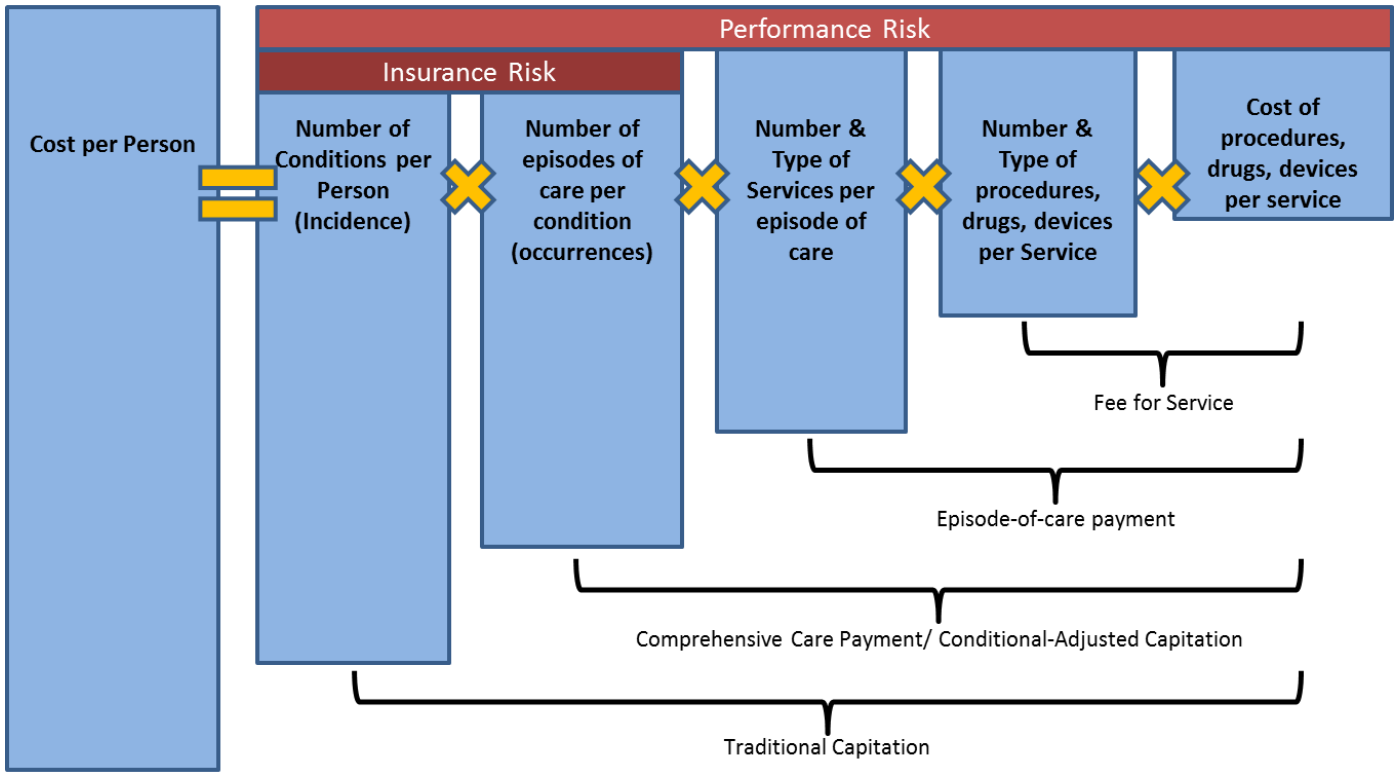
Variable Provider Risk Under Alternative Payment Systems



"From Volume to Value: Better Ways to Pay For Health Care," By Harold D. Miller, Health Affairs, Vol. 28, No. 5, 2009, p. 1418-1428.

Episode of Care Payments

- *"…[b]undles all costs of care across a clinical condition for a defined period of time and for all settings involved in direct and indirect care to the patient"*
- Designed to lower the occurrence of fraud and abuse and to incentivize the value of care provided
- Can be modeled in two ways:
  - **Episode-Based Payments**: Defined by a *series* of services
  - **Value-Based Purchasing**: Defined by a *population*, either patients or providers

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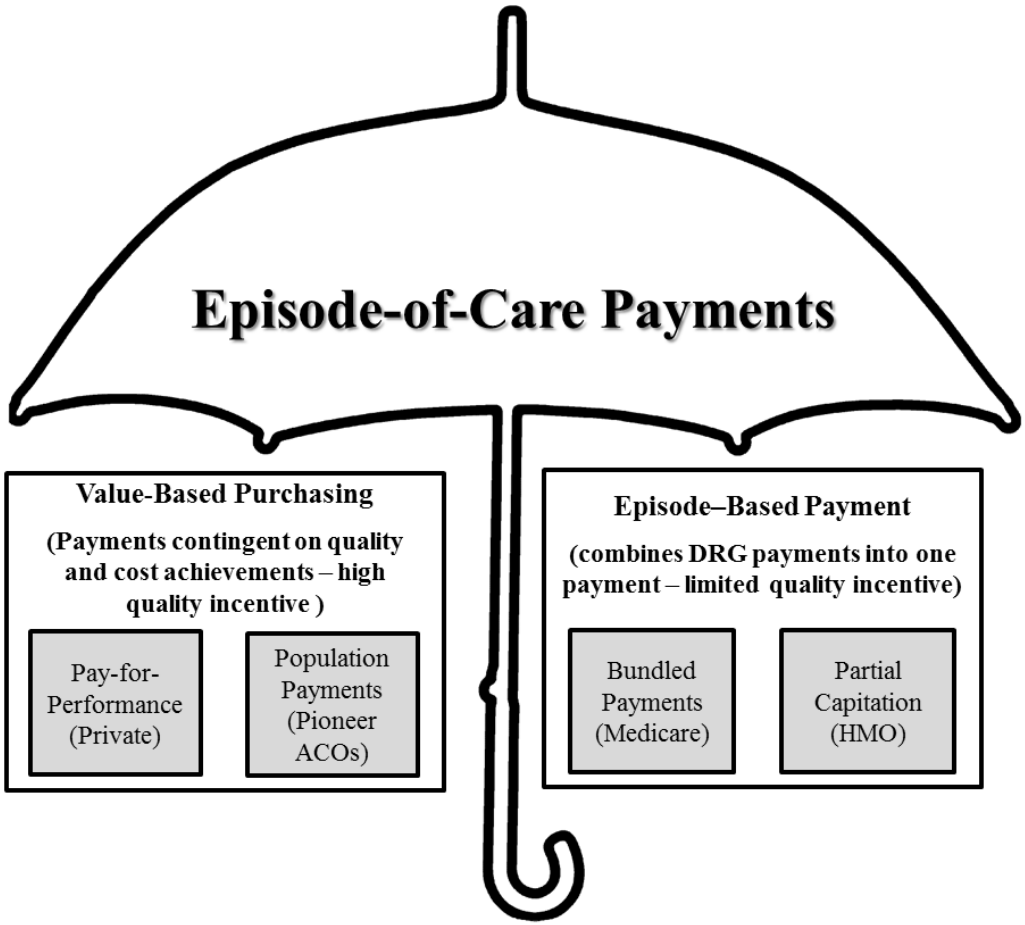
"Acute Care Episode Demonstration," Centers for Medicare and Medicaid Services, March 20, 2009, http://www.cms.hhs.gov/DemoProjectsEvalRpts/downloads/ACEFactSheet.pdf (Accessed 6/1/2009). "Healthcare Valuation: The Financial Appraisal of Enterprises, Assets, and Services" By Robert James Cimasi, MHA, ASA, FRICS, MCBA, AVA, CM&AA, John Wiley & Sons Inc., 2014, p. 233-234.

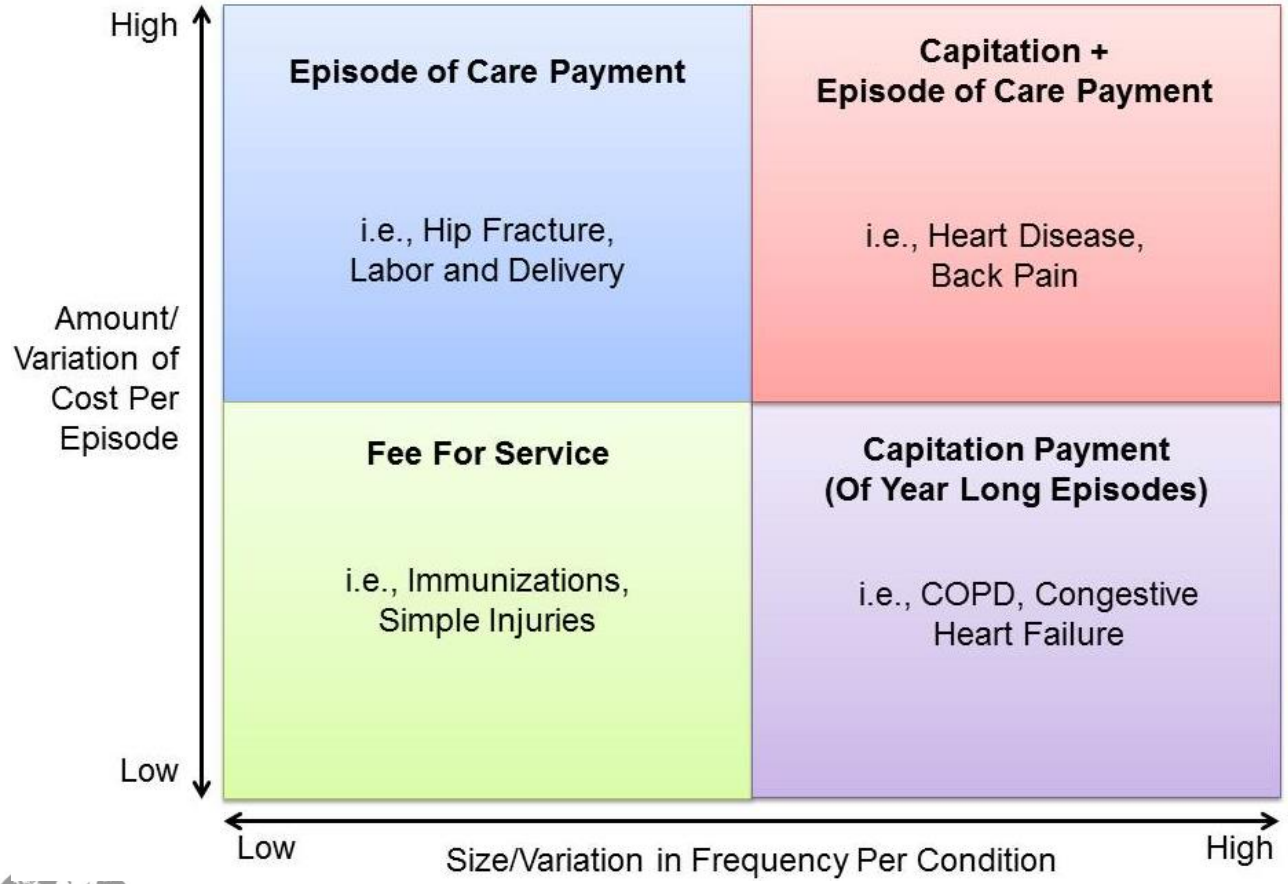
Episode of Care Payment Models



"Opportunities and Challenges for Episode-Based Payment" By Robert E. Mechanic, The New England Journal of Medicine, Vol. 365, No. 9, September 1, 2011, p. 777.

"Healthcare Valuation: The Financial Appraisal of Enterprises, Assets, and Services" By Robert James Cimasi, MHA, ASA, FRICS, MCBA, AVA, CM&AA, John Wiley & Sons Inc., 2014, p. 234.

Episode of Care v. Capitation



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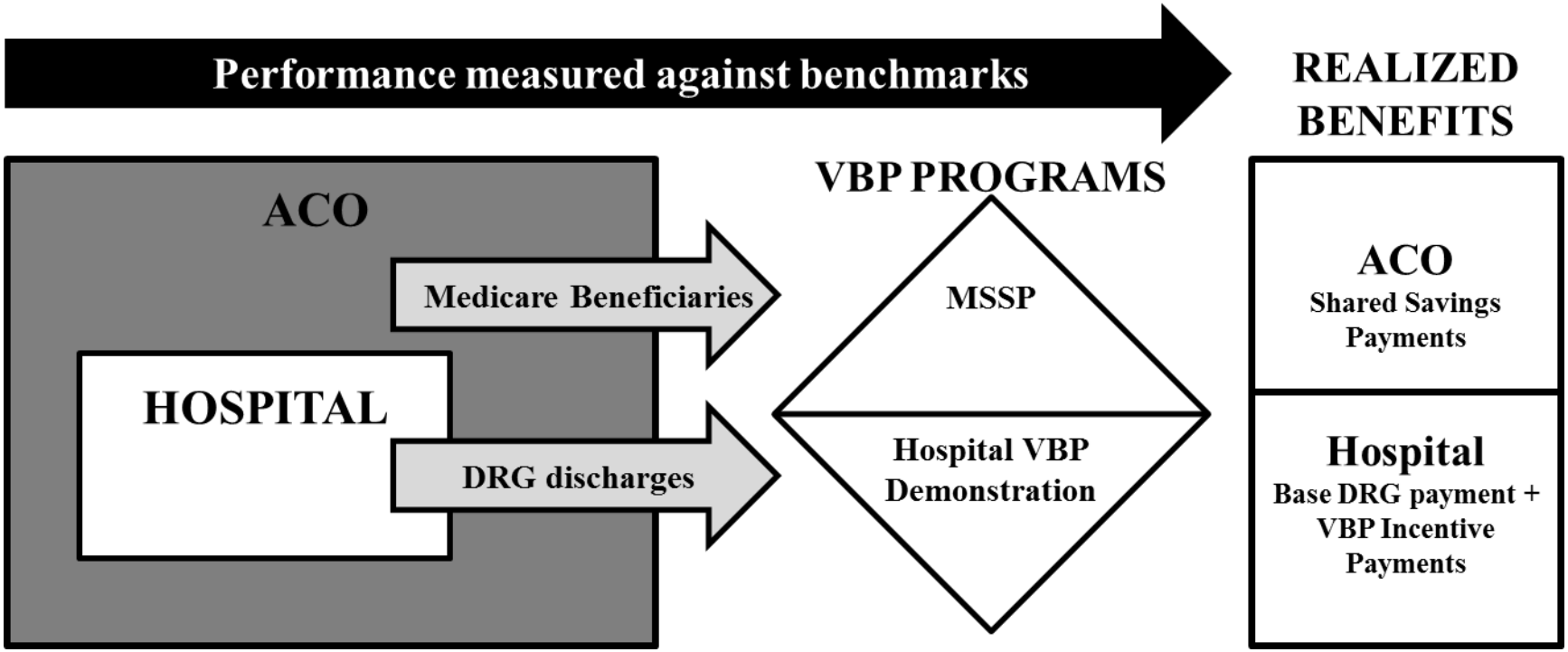
"Politics of Episode of Care Financing" By Robert James Cimasi, Healthcare Financial Management Association, HFMA Greater St. Louis Chapter.

Value-Based Purchasing (VBP)

- Any model of provider payments that links reimbursement or incentive bonus payments to the quality and the cost of care which a provider can achieve for a defined patient population
- Rewards are offered to providers who meet:
  - Established standards for patient health outcomes; and,
  - Set percentage reductions in actual patient expenditures
- Example: Medicare Shared Savings Program (MSSP)
  - Links shared savings incentive payments to ACO participants that achieve established quality metrics and expenditure reductions for Medicare beneficiaries

"Lessons from Medicare's Demonstration Projects on Disease Management, Care Coordination and Value-based Payment", By Lyle Nelson, Congressional Budget Office, January 2012, p. 1.
"Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations," Federal Register Vol. 76 No. 212, (November 2, 2011).
"Healthcare Valuation: The Financial Appraisal of Enterprises, Assets, and Services" By Robert James Cimasi, MHA, ASA, FRICS, MCBA, AVA, CM&AA, John Wiley & Sons Inc., 2014, p. 242.

Illustration of Value-Based Purchasing Models



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"Accountable Care Organizations: A Roadmap for Success: Guidance on First Steps" By Bruce Flareau and Joe Bohn, 1st ed., Virginia Beach, VA: Convergent Publishing, LLC, 2911, p. 22.

Accountable Care Organizations

- Organizations in which a set of providers, usually physicians and hospitals, are held accountable under an ACO contract with a payor for the cost and quality of care delivered to a specific local population
- Included under § 3002 of the ACA
  - Expanded by the subsequent CMS Final Rule published on November 2, 2011
- May experience financial incentives through 2 VBP models:
  - Shared savings (bonus) payments
  - Commercial value-based reimbursement arrangements

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"Can Accountable Care Organizations Improve the Value of Health Care by Solving the Cost and Quality Quandaries?" By Kelly Devers and Robert Berenson, Robert Wood Johnson Foundation, Urban Institute, October 2009, http://www.rwjf.org/files/research/acosummaryfinal.pdf (Accessed 1/19/12), p. 1.

Background & the Path to Accountable Care

- Latest version in an evolving dialogue as to how to manage the rising cost of healthcare in a manner that addresses both cost & quality
  - Began as early as 1932 with the Committee on the Costs of Medical Care (CCMC)
- Health Maintenance Organization Act of 1973
  - Funded the development and spread of HMOs
  - Promised some of the same major fundamental objectives of accountable care (lower costs & higher quality outcomes)
- ACOs have certain tenants similar to managed care, but are more akin to the theory of managed competition

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"Accountable Care Organizations: Value Metrics and Capital Formation" By Robert James Cimasi, MHA, ASA, FRICS, MCBA, AVA, CM&AA, Boca Raton, FL: Taylor & Francis Group, LLC, 2013, p. 2, 4, 5.

Types of ACOs within the 4 Pillars

4 Pillars	Federal ACOs	Commercial ACOs
Regulatory	Regulated by the MSSP	Must be compliant with same rules as non-ACO providers
	Waivers for Stark Law, Anti-kickback, and CMP	Not yet eligible for CMS, DOJ, FTC waivers
	Guidelines and policies available for antitrust	
	Accredited by NCQA Standards	Accredited by NCQA Standards
Reimbursement	Reimbursed through FFS	Reimbursements range from FFS to single capitation
	Shared Savings under three disbursement options.	Any number of value-based purchasing agreements (negotiated between ACO & payor)
	Shared risk based on whether benchmarks are met (only for two sided option) leading to possible shared losses	Shared risk located within overall reimbursement (i.e., capitated payment) or as shared losses (less common for commercial)
	Shared savings only for Medicare population	Shared savings for negotiated population
Competition	Medicare beneficiaries not required to stay within the ACO, leading to competition	Population may or may not go outside of ACO depending on payor contract
Technology	Doesn't require EHR, but requires sophisticated data gathering	Doesn't require EHR, but requires sophisticated data gathering
		Some payors help implement telecommunications within the ACO

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"Accountable Care Organizations: Value Metrics and Capital Formation" By Robert James Cimasi, MHA, ASA, FRICS, MCBA, AVA, CM&AA, Boca Raton, FL: Taylor & Francis Group, LLC, 2013, p. 78, 103.

Background & the Path to Accountable Care

- The current federal ACO model is based on perceived success of a demonstration project
  - Medicare Physician Group Practice (PGP) Demonstration Project
    - Medicare's first physician pay-for-performance initiative
- *"Accountable care"* was termed in 2006 by Elliott Fisher, a physician and professor of medicine at Dartmouth Medical School

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"Physician Group Practice Demonstration First Evaluation Report" By Michael O. Leavitt, Report to Congress (2006) p. 11.
"Creating Accountable Care Organizations: The Extended Hospital Medical Staff" By Elliott S. Fisher, et al., Health Affairs, Vol. 26, no. 1 (2007), p. 56, note 7.

Federal ACOs

- Governed by the MSSP
  - Implements the **Value-Based Purchasing Theory**
    - The notion that purchasers hold healthcare providers accountable for both the quality and cost of care
- Experience risk through their *shared savings payments*, which may be *managed* under either:
  - A one-sided distribution model
  - A two-sided distribution model

"Accountable Care Organizations: Value Metrics and Capital Formation" By Robert James Cimasi, MHA, ASA, FRICS, MCBA, AVA, CM&AA, Boca Raton, FL: Taylor & Francis Group, LLC, 2013, p. 25-26.
Glossary of Terms Commonly used in Health Care, AcademyHealth, 2004 Edition.
"Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations" Federal Register Vol. 76, No. 212 (November 2, 2011), p. 67985-67987.

Federal ACO Development Timeline

June 2009
MedPAC "Report to Congress: Improving Incentives in the Medicare Program"
Report included an entire chapter regarding ACOs based on the PGP Demonstration Project. This report was influential in the ACA's drafting.

March 23, 2010
Patient Protection and Affordable Care Act (ACA) Signed into Law
Section 3200 created the Medicare Shared Savings Program (MSSP) and authorized CMS to create standards and regulations for provider participation

April 7, 2011
MSSP Proposed Rule Published
This rule led to over 1,200 comments from concerned providers – Some commenters believed Federal ACOs were *dead in the water*.

December 19, 2011
32 Pioneer ACOs Announced
CMS selected organizations already experienced with providing services across the continuum of care, with the program to begin on January 1, 2012, for a minimum of 5 years.

January 1, 2012
CMS ACO Rules Must be Implemented
Under the ACA, CMS was required to begin implementation of an ACO program by January 1, 2012. CMS created rolling applications deadlines within the Final Rule to begin at this date.

April 10, 2012
27 ACO Applications Accepted
These ACOs were approved to serve an estimated 375,000 beneficiaries in 18 states.

April and July 1, 2012
First Federal ACO Submission Due Date
In the Final Rule, CMS announced that the first ACO agreements would begin on April and July 1, 2012 with subsequent rolling admission to the program

July 9, 2012
89 ACO Applications Accepted
These ACOs were approved to serve an estimated 1.2 million beneficiaries in 40 states.

November 2, 2011
MSSP Final Rule Published
The Final Rule changed many of the most controversial provisions of the Proposed Rule in response to provider concerns

January 10, 2013
106 ACO Applications Accepted

December 8, 2014
CMS Proposes Track 3 ACOs
As proposed, Track 3 ACOs would operate in a manner similar to Track 2 ACOs, but with greater risks and rewards

March 2015
CMS Announces Next Generation ACOs

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Distribution Models for Federal ACOs

	A	B	C	D
	Issue	**Track 1: One-sided**	**Track 2: Two-sided**	**Proposed Track 3: Two-sided**
1	Minimum Savings Rate	2.0-3.9%, depending on number of beneficiaries	Fixed at 2.0%	Fixed at 2.0%
2	Minimum Loss Rate	N/A	Fixed at 2.0%	Fixed at 2.0%
3	Amount of Shared Savings Given to ACO	50%	60%	75%
4	Amount of Shared Savings Kept by CMS	50%	40%	25%
5	Performance Payment Limit	10%	15%	20%
6	Loss Sharing Limit	N/A	5-10%, depending on years of participation	15%

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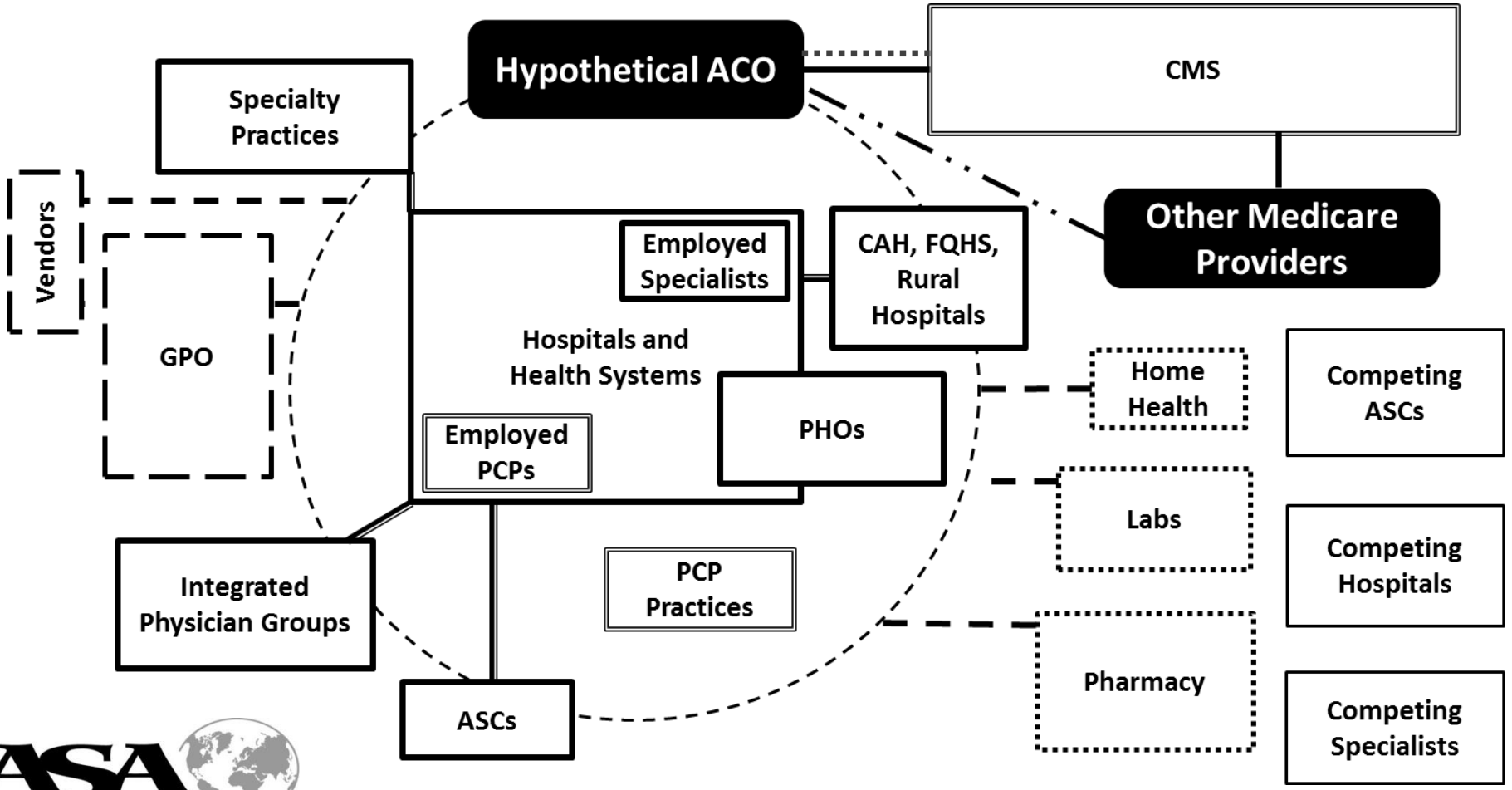
"Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations; Proposed Rule" Federal Register Vol. 79, No. 235 (December 8, 2014), p. 72845.

Federal ACOs

- An ACO must contract with the secretary of HHS to participate in the MSSP for at least a 3 year period
- Medicare beneficiaries are assigned to the ACO based on their location and other characteristics
- The ACO must collect expenditure information and quality data and submit to CMS
- As of January 2014, total of 368 Medicare ACOs

"Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations" Federal Register Vol. 76 No. 212, (November 2, 2011), p. 67807; "Accountable Care Organizations: Value Metrics and Capital Formation" By Robert James Cimasi, MHA, ASA, FRICS, MCBA, AVA, CM&AA, Boca Raton, FL: Taylor & Francis Group, LLC, 2013, p. 47; "Accountable Care Organizations Now Serve Up To 17% Of Americans", Oliver Wyman, April 23, 2014.

Potential Federal ACO Structure



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"Accountable Care Organizations: Value Metrics and Capital Formation" By Robert James Cimasi, MHA, ASA, FRICS, MCBA, AVA, CM&AA, Boca Raton, FL: Taylor & Francis Group, LLC, 2013, p. 101.

Pioneer ACO Program

- Created by Center for Medicare & Medicaid Innovation (CMI)
- Separate and distinct from the MSSP model, but they are designed to work cooperatively and be complementary
- Intended for *"mature ACO"* organizations that have already begun coordinating care efforts
- Offers higher rewards than traditional federal ACOs can achieve in exchange for higher risks
- After the first two years of its contract term with CMS, the ACO will be given the option to transition from a volume-based FFS reimbursement model to a population-based payment model for their Medicare beneficiaries

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"The Pioneer ACO Model" Healthcare Financial Management Association, 2011, http://www.hfma.org/PioneerACOModel/ (Accessed 7/15/11). "Accountable Care Organizations: Value Metrics and Capital Formation" By Robert James Cimasi, MHA, ASA, FRICS, MCBA, AVA, CM&AA, Boca Raton, FL: Taylor & Francis Group, LLC, 2013, p. 57

Next Generation ACOs

- Announced by CMS in March 2015
- Next generation ACOs (NGACOs) can opt for either 80% shared savings/losses rate, or *"full performance risk"* option, i.e., ACO receives 100% of shared savings/losses
- Introduces *"benefit enhancement tools"* to improve ACO's ability to engage with patients
- In addition to traditional FFS payments, NGACOs have access to *alternate payment mechanisms*, including:
  - *Per-beneficiary-per month* (PBPM) infrastructure payments that must be repaid to CMS
  - Full capitation (available in 2017)

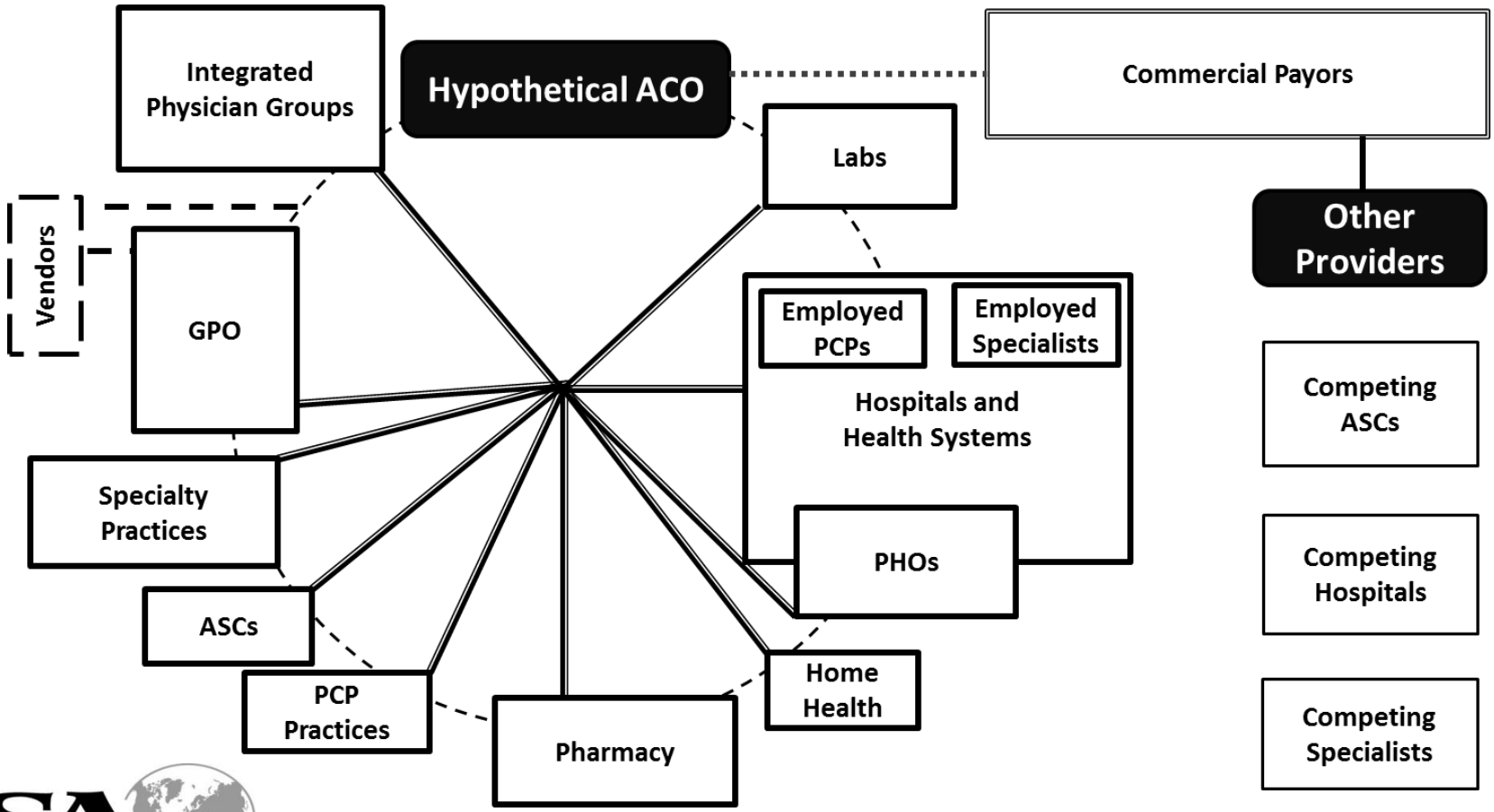
"Next Generation ACO Model" Centers for Medicare & Medicaid Services, http://innovation.cms.gov/initiatives/Next-Generation-ACO-Model/ (Accessed 3/18/2015); "Next Generation ACO Model: Model Overview Presentation" Centers for Medicare & Medicaid Services, March 17, 2015, http://innovation.cms.gov/Files/slides/nextgenaco-odf1slides.pdf (Accessed 3/20/2015); "Next Generation ACO Model: Request for Applications" Centers for Medicare & Medicaid Services, http://innovation.cms.gov/Files/x/nextgenacorfa.pdf (Accessed 3/20/2015); "CMS preps 'next generation' ACO model" By Melanie Evans, Modern Healthcare, March 10, 2015, http://www.modernhealthcare.com/article/20150310/NEWS/150319994?template=print (Accessed 3/18/2015).

Commercial ACOs

- Contract with private payors and utilize a variety of VBP arrangements
- Some may choose to emulate the federal MSSP, opting for a basic *FFS* reimbursement model, accompanied by a shared savings arrangement
- Others may utilize any number of reimbursement models, ranging from *pay-for-performance* to *capitation*
- As of January 2014, there were approximately 150 commercial ACOs

"Global Cap Dominates Some Private-Sector Payment Models; Others Seek Partial Cap" ACO Business News, Vol. 1, No. 1, November 2010, p. 1; "Accountable Care Organizations: Value Metrics and Capital Formation" By Robert James Cimasi, MHA, ASA, FRICS, MCBA, AVA, CM&AA, Boca Raton, FL: Taylor & Francis Group, LLC, 2013, p. 88; "Are You Ready for an ACO?" By Margaret Dick Tocknell, HealthLeaders Magazine, May 2012, p. 1; "Accountable Care Organizations Now Serve Up To 17% Of Americans", Oliver Wyman, April 23, 2014.

Potential Commercial ACO Structure



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"Accountable Care Organizations: Value Metrics and Capital Formation" By Robert James Cimasi, MHA, ASA, FRICS, MCBA, AVA, CM&AA, Boca Raton, FL: Taylor & Francis Group, LLC, 2013, p. 104.

ACOs by Participating Provider Type

Provider Type	Description	Percent of ACO Market
Insurer ACO	An insurance company that accepts responsibility and accountability for the care provided to a patient population	8%
Insurer-Provider ACO	An insurance company and a provider organization are equally responsible and accountable for the care provided to a patient population	6%
Single Provider ACO	Typically an integrated delivery system that accepts responsibility and accountability for the care provided to a patient population, while the payors involvement is limited to providing reimbursement under a risk-based reimbursement model	67%
Multiple Provider ACOs	Two, or more, providers, e.g., a hospital and a physician group, partner to be responsible and accountable for the care provided to a patient population, while the payors involvement is limited to providing reimbursement under a risk-based reimbursement model	19%

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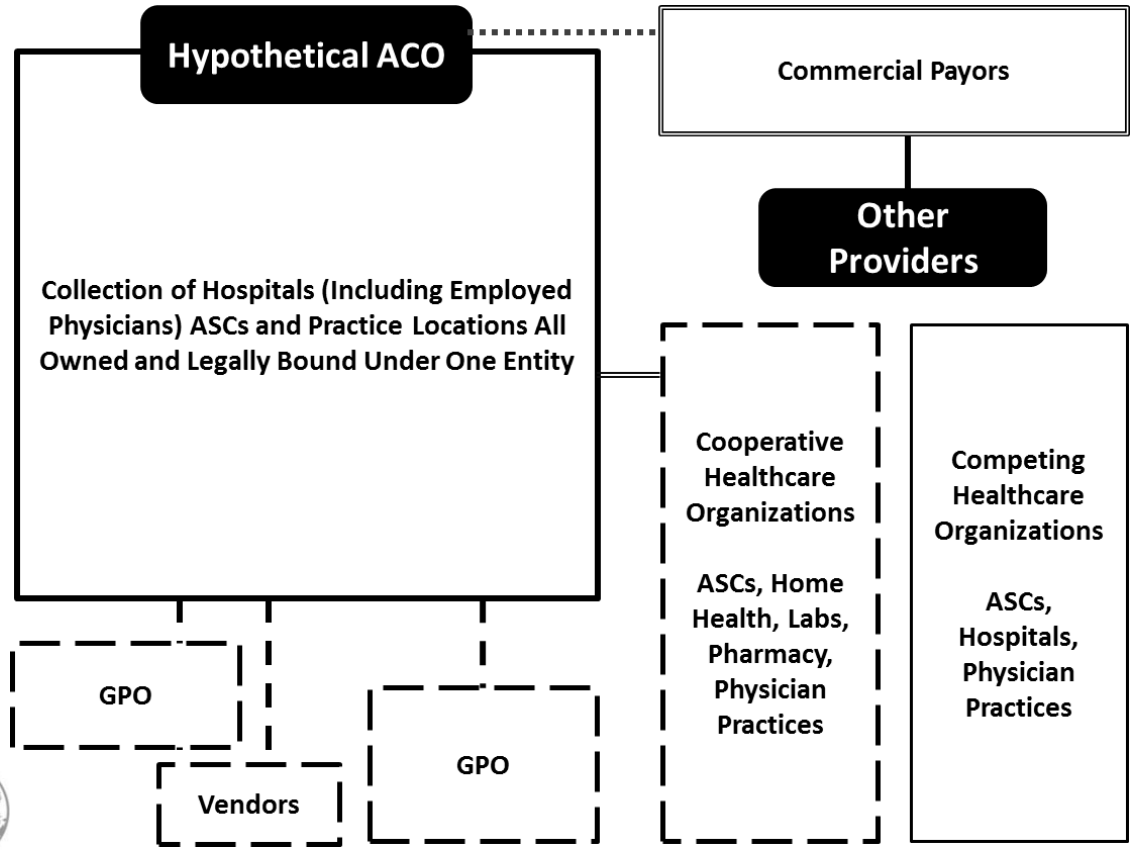
Potential Commercial Health System ACO: External Payor Structure



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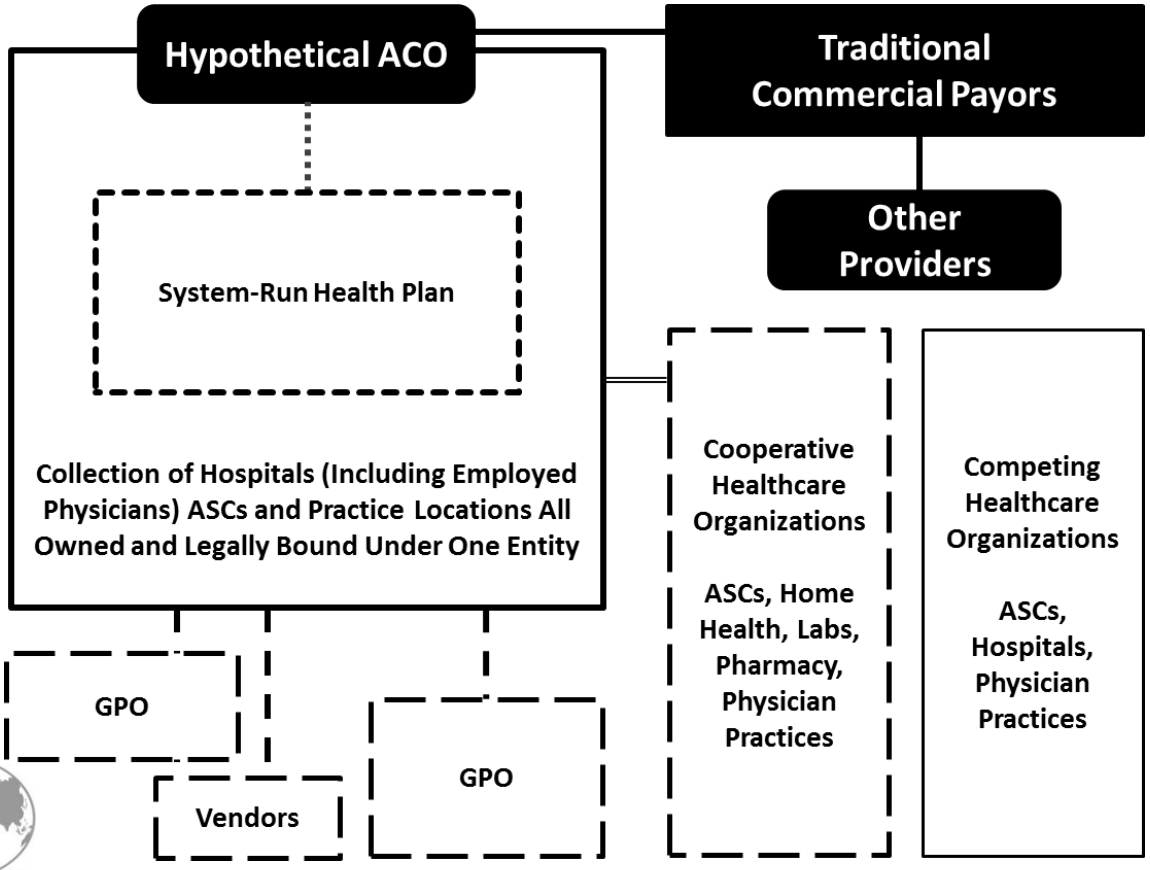
"Accountable Care Organizations: Value Metrics and Capital Formation" By Robert James Cimasi, MHA, ASA, FRICS, MCBA, AVA, CM&AA, Boca Raton, FL: Taylor & Francis Group, LLC, 2013, p. 105.

Potential Commercial Health System ACO: Internal Payor Structure



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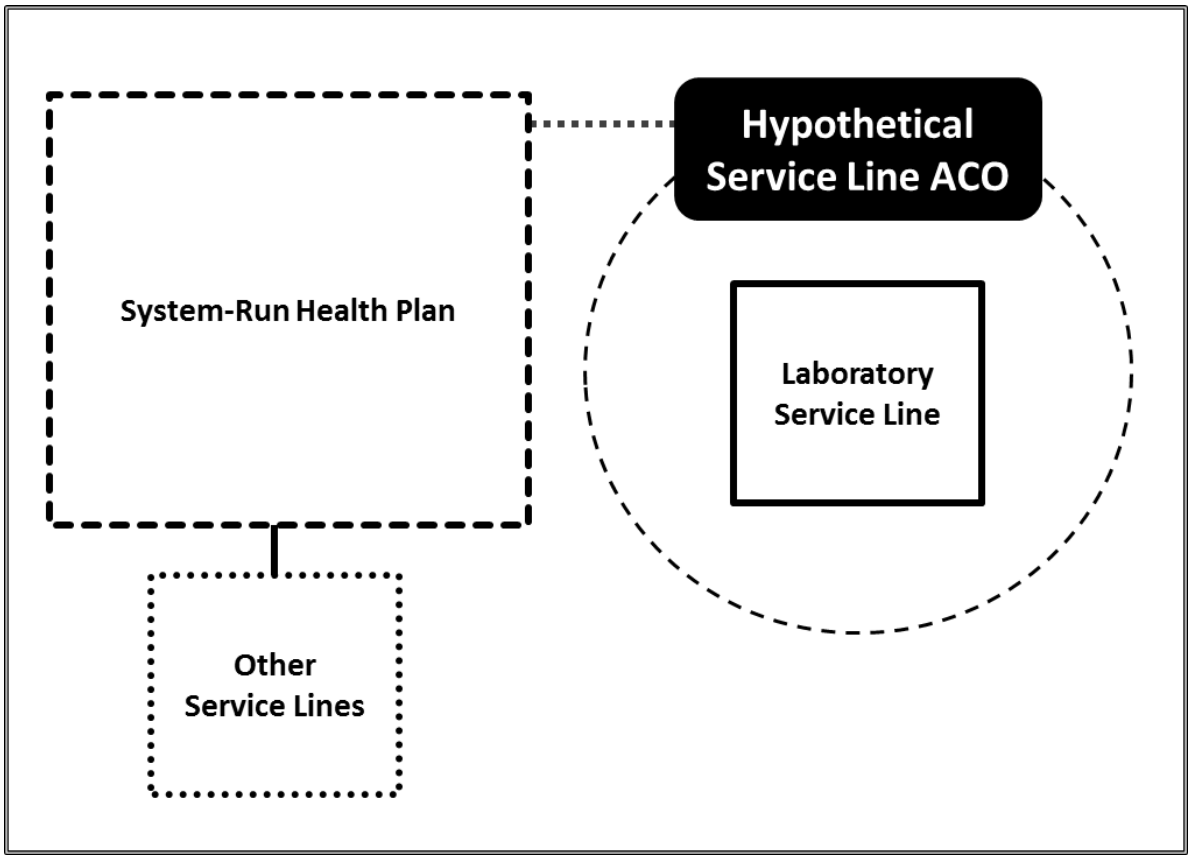
"Accountable Care Organizations: Value Metrics and Capital Formation" By Robert James Cimasi, MHA, ASA, FRICS, MCBA, AVA, CM&AA, Boca Raton, FL: Taylor & Francis Group, LLC, 2013, p. 106.

Potential Commercial Service Line ACO Structure



"Accountable Care Organizations: Value Metrics and Capital Formation" By Robert James Cimasi, MHA, ASA, FRICS, MCBA, AVA, CM&AA, Boca Raton, FL: Taylor & Francis Group, LLC, 2013, p. 107.

Other Reimbursement Trends: Electronic Prescribing (eRx) Incentive Program

- Reporting system
- Used ***incentive payments*** (0.5% in 2013) to promote electronic prescribing by EPs who successfully e-prescribe for covered Physician Fee Schedule Services furnished to Medicare Part B FFS beneficiaries
- Imposed ***payment adjustments*** (1.5% in 2013) on EPs who do not successfully e-prescribe Medicare Part B services
- In 2013, to be considered a successful e-prescriber, an EP must report the e-prescribe measure for 25 or more unique electronic prescribing events

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"Electronic Prescribing (eRx) Incentive Program" Centers for Medicare and Medicaid Services, July 17, 2013, http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/ERxIncentive/index.html (Accessed 10/7/13).

Other Reimbursement Trends: Physician Quality Reporting System (PQRS)

- Uses ***incentive payments*** and ***payment adjustments*** to encourage eligible professionals (EPs) to report quality information
  - ACA's authorized incentive payments through 2014:
    - 2011 PQRS – 1.0%
    - 2012 PQRS – 0.5%
    - 2013 PQRS – 0.5%
    - 2014 PQRS – 0.5%
- Starting in 2015 – ***Payment adjustment*** of 1.5% applied to EPs who do not adequately report data on quality measures

"Physician Quality Reporting System: Physician Quality Reporting System (Physician Quality Reporting or PQRS) formerly known as the Physician Quality Reporting Initiative (PQRS)" Centers for Medicare & Medicaid Services, September 27, 2013, http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html (Accessed 10/5/13).
"Analysis and Payment" Centers for Medicare & Medicaid Services, September 27, 2013, http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/AnalysisAndPayment.html (Accessed 10/5/13).
"Physician Quality Reporting System (PQRS): Updates for 2013" Centers for Medicare & Medicaid Services, June 2013, http://http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2013_PQRS_Updates_Whats_New_060313.pdf (Accessed 10/5/13).

Other Reimbursement Trends: Implementation of Electronic Health Records (EHR)

- **Health Information Technology for Economic Clinical Health (HITECH) Act -** Incentivizes providers to implement health information technology (HIT) and certified EHR systems through increased reimbursement rates
- **The American Recovery and Reinvestment Act of 2009 (ARRA)** provides $1.5 billion in federal grants to assist providers with the capital requirements for either:
  - Implementing an EHR system
  - Upgrading an existing EHR system to meet "*meaningful use*" standards

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"Health Information Technology for Economic and Clinical Health Act" found in "American Recovery and Reinvestment Act of 2009" Pub. Law 111-5, 123 STAT 226 (February 17, 2009).
"Summary of HHS Recovery Operational Plan, May 2009" HIMSS, http://www.himss.org/content/output/A99BCB56C33E4E41B76896C29F350300.pdf (Accessed 6/3/09), p.4.

EHR and Meaningful Use

- Health Information Technology for Economic Clinical Health (HITECH) Act
  - Incentivizes providers to implement health information technology (HIT) and certified EHR systems that function within established *meaningful use* standards through increased reimbursement rates
  - In 2013 and subsequent years, the state government must grant *"$1 [toward state planning* and *implementation grants] for each $3 of Federal funds provided under the grant."*

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"Health Information Technology for Economic and Clinical Health Act" found in "American Recovery and Reinvestment Act of 2009" Pub. Law 111-5, 123 STAT 226 (February 17, 2009), p. 252.
Healthcare Valuation: The Financial Appraisal of Enterprises, Assets, and Services" By Robert James Cimasi, MHA, ASA, FRICS, MCBA, AVA, CM&AA, John Wiley & Sons Inc., 2014, p. 244.

EHR and Meaningful Use

Meaningful Use: For both Medicare and Medicaid healthcare providers to qualify for HITECH incentives, they must demonstrate fulfillment of 3 requirements for "*meaningful use*" of EHRs:

- *"(1) Use of certified EHR technology in a meaningful manner (for example, electronic prescribing);*
- *(2) that the certified EHR technology is connected in a manner that provides for the electronic exchange of health information to improve the quality of care; and,*
- *(3) that, in using certified EHR technology, the provider submits…information on clinical quality measures and such other measures selected by the Secretary."*

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"Medicare and Medicaid Programs; Electronic Health Record Incentive Program; Final Rule", Federal Register, Vol. 75, No. 144 (July 28, 2010), p. 44326-66327.
"Healthcare Valuation: The Financial Appraisal of Enterprises, Assets, and Services" By Robert James Cimasi, MHA, ASA, FRICS, MCBA, AVA, CM&AA, John Wiley & Sons Inc., 2014, p. 552.

EHR and Meaningful Use

- American Recovery and Reinvestment Act of 2009 (ARRA)
  - Provides $1.5 billion in federal grants to assist providers with the capital requirements for either:
    - *Implementing* an EHR system
    - *Upgrading* an existing EHR system to meet meaningful use standards

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"Summary of HHS Recovery Operational Plan, May 2009" HIMSS, http://www.himss.org/content/output/A99BCB56C33E4E41B76896C29F350300.pdf (Accessed 6/3/09), p.4.

Impact of Healthcare Reform

Impact of ACOs: Addressing Industry Concern

Regulatory Concerns

- Anti-kickback Statute
- Stark Law
  - Not applicable in commercial ACO market
- Civil Monetary Penalty Laws (CMPL)
- Antitrust Laws
  - Do not directly apply to commercial ACOs
- Corporate Practice of Medicine (CPOM) Laws

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"Accountable Care Organizations: Value Metrics and Capital Formation" By Robert James Cimasi, MHA, ASA, FRICS, MCBA, AVA, CM&AA, Boca Raton, FL: Taylor & Francis Group, LLC, 2013, p. 117.
Medicare Program; Final Waivers in Connection with the Shared Savings Program, Vol. 76 Fed. Reg. p. 68001 (November 2, 2011).

Impact of ACOs: Addressing Industry Concern

Reimbursement Concerns

- Differing reimbursement structures may have varying levels of impact on the furtherance of ACOs' overall goals
- Concerns typically relate to the cost containment abilities of ACOS and the potential market power of ACOs

Competition Concerns

- Competition that providers and payors to an ACO contract will likely face from other ACOs and non-ACO providers
  - Want to keep patients within the ACO to ensure quality standards and maintain established value metrics

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Impact of ACOs: Addressing Industry Concern

Technology Concerns

- Successful ACOs require health information technology (HIT) and a *"…sophisticated technology infrastructure to facilitate [their] objectives of improving quality and reducing cost"*
- EHR interoperability will likely have a significant impact on an ACO's success

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"Technology Fundamentals for Realizing ACO Success" Medicity, September 2010, http://www.himss.org/content/files/Medicity_ACO_Whitepaper.pdf, (Accessed June 30, 2011), p. 3.
"The Next Phase of Cost Control: Buzz Survey" By Philip Betbeze, Healthleaders Media Impact Analysis, January 2012, p. 4, 7.
"Accountable Care Organizations: Value Metrics and Capital Formation" By Robert James Cimasi, MHA, ASA, FRICS, MCBA, AVA, CM&AA, Boca Raton, FL: Taylor & Francis Group, LLC, 2013, p. 144.

Capital Finance Considerations for the Development and Operation of an ACO

Development of an ACO will initially require significant levels of capital investment to establish the necessary infrastructure for ACO success:

- Network development and management
- Care coordination, quality improvement, and utilization management
- Clinical information systems
- Data analytics

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"Accountable Care Organizations: Value Metrics and Capital Formation" By Robert James Cimasi, MHA, ASA, FRICS, MCBA, AVA, CM&AA, Boca Raton, FL: Taylor & Francis Group, LLC, 2013, p. 167.

Capital Finance Considerations for the Development and Operation of an ACO

Operating costs for ACOs include:

- Network development and management
- Quality improvements
- Utilization management
- Clinical information systems
- Data analytics

Financial Feasibility Analysis for ACO Investments

Several metrics exist to assist the management of a healthcare enterprise in determining the financial feasibility of an ACO investment:

- Payback and Discounted Payback Methods
- Average Accounting Rate of Return
- Net Present Value (NPV) Method
- Internal Rate of Return (IRR) Method

"Accountable Care Organizations: Value Metrics and Capital Formation" By Robert James Cimasi, MHA, ASA, FRICS, MCBA, AVA, CM&AA, Boca Raton, FL: Taylor & Francis Group, LLC, 2013, p. 208.
"Essentials of Managerial Finance, Ninth Edition" By J. Fred Weston and Eugene F. Brigham, 1990, Chicago, IL: The Dryden Press, p. 564.

Patient-Centered Medical Homes (PCMH)

- Approaches the delivery of healthcare services through coordinated patient care
  - Centered on a primary care physician who accepts responsibility for managing across the continuum of care for a beneficiary and the spectrum of services they may require
- Designed to improve the quality of patient care through the incorporation of a value-based payment model
- Limited to a single physician practice setting, with one primary care physician coordinating the patient's care

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"Joint Principles of the Patient-Centered Medical Home" American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, and American Osteopathic Association, February 2007, http://www.aafp.org/online/etc/medialib/aafp_org/documents/policy/fed/jointprinciplespcmh0207.Par.0001.File.dat/022107medicalhome.pdf (Accessed 12/14/11).

Patient-Centered Medical Homes (PCMH)

Several ACA provisions support the further development of PCMHs:

- *§ 3502 - Establishing Community Health Teams to Support the Patient-Centered Medical Home*
  - CMS will establish a program to spur national use of the PCMH model through grants and/or contracts
- *§2703 - State Option to Provide Health Homes for Enrollees with Chronic Conditions*
  - Focused on implementing medical home models for state Medicaid populations
- *§5405 - Primary Care Extension Program*
  - Provides funding for state organized programs to educate primary care physicians on preventative care and health literacy

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"Patient Protection and Affordable Care Act" Public Law 111-148 (March 23, 2010), p. 156, 513, 649.

Vermont's Single Payor Insurance System

- First state-financed single-payor health insurance system in the U.S.
- Lays out a framework to provide *"a universal and unified health system"* to each Vermont resident by 2017 and aims to control rapidly growing healthcare costs within the state
  - Establishes an initial insurance exchange
  - Plans to subsequently transfer insured and uninsured individuals into a single, statewide insurance payor funded by Vermont tax dollars rather than private insurance copayments or premiums

"VT Governor Signs Single-Payer Bill" By Margaret Dick Tocknell, Health Leaders Media, May 27, 2011, http://www.healthleadersmedia.com/print/TEC-266668/VTGovernor- Signs-SinglePayer-Bill (Accessed 5/31/2011).
"An Act Relating to a Universal and Unified Health System" VT LEG 264981.2 [H.202] (May 26, 2011), § 1829, pg. 1, 138; "Vermont Moving Toward Single-Payer Health Care" By Zach Howard, Reuters, May 26, 2011, http://www.reuters.com/article/2011/05/26/us-vermont-healthidUSTRE74P89420110526 (Accessed 5/31/2011).
"An Act Relating to a Universal and Unified Health System" VT LEG 264981.2 [H.202] (May 26, 2011), § 1829, pg. 139; "Vermont Has a Plan for Single-Payer Health Care" By Steven Findlay, Consumer Reports, May 26, 2011, http://news.consumerreports.org/health/2011/05/vermontestablishes-road-map-for-single-payer-health-care.html (Accessed 5/26/11).

Concluding Remarks

Concluding Remarks

Pursuing Interdisciplinary Collaboration

Healthcare Industry Specific Appraisal Assignments

Real Estate Appraisal • Machinery & Technical Specialties

Personal Property • Business Valuation • Intangible Assets/IP

Separate and Distinct Disciplines in the Same Profession

- Similar Tools to Solve Similar Problems
- Shared Clients
- Interdisciplinary Approach Yields Significant Benefit to Both ***Clients*** and ***Appraisers***

We CAN Work Together!

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Concluding Remarks

We Can (and should) All Work Together!

- To obtain the requisite background for forecasting the future performance of healthcare enterprises, assets, and services in the current dynamic era of healthcare reform, valuation professionals should develop and maintain an in-depth understanding of the history and the development of healthcare delivery, as well as, the unique dynamics of those often complex business arrangements that comprise newly emerging healthcare organizations and the various elements of property value involved in each.
- A multidisciplinary project team of appraisers has the potential to provide an enhanced scope and diversity of knowledge and breadth of experience to the benefit of both the ***appraisers*** and the ***client***.

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Concluding Remarks

We Can (and should) All Work Together!

- When developing an understanding of the forces and stakeholders that have the potential to drive healthcare markets, valuation professionals must examine the subject enterprises, assets, and services as they relate to and within the context of:
- ***"The Four Pillars of the Healthcare Industry"***
  - Reimbursement
  - Regulatory
  - Competition
  - Technology
- These four elements serve as a conceptual framework for analyzing the viability, efficiency, efficacy, and productivity of the subject property interest(s)

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Concluding Remarks

We Can All Work Together!

- More informed and uniform valuation practice would benefit the users of healthcare valuations and *improve public confidence in appraisers*
- To enhance competency, significant specialized education and training is an important benefit for healthcare appraisers and clients
- Given these issues, a multidisciplinary approach toward advanced education related to healthcare industry valuation is an important initiative of the ASA, as the premier multidisciplinary valuation society of professional appraisers

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Multidisciplinary Advanced Education in Healthcare Valuation Program

		A	B	C	D	E	F	G	H	I	J	K	
			Session Details				Time				Speakers		
		Program Events	Course Title	Session #	Presentation Day	Time of Day	Date	Start	End	Duration	Presenter	Co-Presenter	
1	DAY 1	Registration and Breakfast			Friday	Morning	10/16/2015	7:30 AM	8:15 AM	45 Minutes			1
2		Session 1	*Overview of Healthcare Industry*	1	Friday	Morning	10/16/2015	8:15 AM	9:15 AM	1 Hour	Todd Zigrang, ASA		2
3		Session 1	*Regulatory Environment of the Healthcare Industry*	1	Friday	Morning	10/16/2015	9:15 AM	10:30 AM	1 Hour 15 Minutes	John Kirnser, Esq.	Todd Zigrang, ASA	3
4		Break			Friday	Morning	10/16/2015	10:30 AM	10:45 AM	15 Minutes			4
5		Session 1	*Regulatory Environment of the Healthcare Industry*	1	Friday	Morning	10/16/2015	10:45 AM	12:30 PM	1 Hour 45 Minutes	John Kirnser, Esq.	Todd Zigrang, ASA	5
6		Lunch			Friday	Afternoon	10/16/2015	12:30 PM	1:30 PM	1 Hour			6
7		Session 1	*Regulatory Environment of the Healthcare Industry*	2	Friday	Afternoon	10/16/2015	1:30 PM	2:15 PM	45 Minutes	John Kirnser, Esq.	Todd Zigrang, ASA	7
8		Session 2	*Healthcare Reimbursement Environment in an Era of Reform*	2	Friday	Afternoon	10/16/2015	2:15 PM	3:00 PM	45 Minutes	Lisa Han, Esq.	Todd Zigrang, ASA	8
9		Break			Friday	Afternoon	10/16/2015	3:00 PM	3:15 PM	15 Minutes			9
10		Session 2	*Healthcare Reimbursement Environment in an Era of Reform*	2	Friday	Afternoon	10/16/2015	3:15 PM	5:30 PM	2 Hour 15 Minutes	Lisa Han, Esq.	Todd Zigrang, ASA	10
11	DAY 2	Breakfast			Saturday	Morning	10/17/2015	7:30 AM	8:00 AM	30 Minutes			11
12		Session 3	*Impact of Competitive Forces*	3	Saturday	Morning	10/17/2015	8:00 AM	10:15 AM	2 Hours 15 Minutes	Jack Beal, Esq.	Todd Zigrang, ASA	12
13		Break			Saturday	Morning	10/17/2015	10:15 AM	10:30 AM	15 Minutes			13
14		Session 4	*Technology Development*	3	Saturday	Morning	10/17/2015	10:30 AM	12:45 PM	2 Hours 15 Minutes	Hal Katz, Esq.	Todd Zigrang, ASA	14
15		Lunch			Saturday	Afternoon	10/17/2015	12:45 PM	2:00 PM	1 Hour 15 Minutes			15
16		Session 4	*Q & A - Discussion Conclusion and Course Review*	4	Saturday	Afternoon	10/17/2015	2:00 PM	3:15PM	1 Hour 15 Minutes	Todd Zigrang, ASA		16
17		Break			Saturday	Afternoon	10/17/2015	3:15 PM	3:30 PM	15 Minutes			17
18		Session 4	*Examination*	4	Saturday	Afternoon	10/17/2015	3:30 PM	4:30 PM	1 Hour			18