Principles of Health Care Payment Programs: What Trustees Should Know

2013 Wisconsin Rural Health Conference

Wisconsin Hospital Association

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Today’s Discussion Outline

- Complexity of Healthcare Business
- Key Healthcare Terms
- Types of Reimbursement Methodologies
- Overview of Medicare Programs
- Overview of Medicaid Programs
- The Future of Reimbursement: ACOs
- Questions
Complexity of Healthcare

- Healthcare organizations are unique in that they receive payment for services provided based on a variety of different methodologies often defined/determined by the payer (customer).

- The revenue (and reimbursement) component of the health care puzzle is complex, but understanding this piece is critical to the success of any health care organization.

Management’s challenge is to create and maintain a spread between revenue and cost (i.e. profit) to generate resources to sustain the organization

- Does it matter if your organization is a for-profit entity or not-for-profit entity?
- How can the health care mission be realized without a (profit) margin?
- Differences in cost functions may not be all that significant between urban and rural, for-profit and not-for-profit, large and small entities . . . but the revenue can be very different.

- Revenue in health care organizations can vary for primarily four reasons.
Why is health care revenue different?

1. Most of the payments are not paid by the patients – they are paid by third-party payers on behalf of the patient.

2. The amount of the payment for an identical service can vary dramatically by payer.

3. The actual determination of the payment by the 3rd-party payer is complex, based on pre-established or negotiated rates that are driven off of codes based on procedures and diagnosis.

4. The government (i.e., Medicare and Medicaid) is generally the largest single payer and does not negotiate payment but simply defines the rules for payment.
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**Key Healthcare Terms**

- **Health Insurance**
  - Like any other insurance, health insurance is a means to reduce a person’s risk of loss by having insurance company assume the risk
  - The risk is the unknown cost of healthcare for a person or group of people
  - Risk is reduced by insurance companies distributing risk among large groups of people or populations (aka, “Risk Pools”)
  - Premiums are paid in return for an insurance company assuming risk

- **Reimbursement**
  - Refers to compensation or payment for healthcare services
  - Generally pay for services already performed (retrospective) using predetermined methods (prospective)

- **Third-party Payment**
  - First party is the patient
  - Second party is the provider (hospital, physician, nursing home, clinic, etc.)
  - Third party is the insurance company (e.g., 3rd-Party Payer)

- **Covered Service**
  - A service provided that is covered under insurance companies payment policy
  - Differs dramatically between payers

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**Types of Reimbursement Methodologies**

- **Fee-for-Service**

- **Population Health**

- **Episode-of-Care**

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Types of Reimbursement Methodologies

Fee-for-Service Reimbursement Method
- Fee-for-Service (FFS) Reimbursement
  - Payment for each service provided
  - Fee is a set amount or price charged for each type of service (in this case may also be referred as a charge)
  - Health insurance company pays each fee for a “covered” service
  - Services are generally included on a claim form (like a detailed bill) that list each service provided
  - FFS plans often have high deductibles or copayments associated with each visit
  - Most physician services are paid under a FFS methodology
- Self Pay
  - A type of FFS because the patient pays a specific amount for the service provided
  - Patients that typically don’t have access to healthcare
  - Pay the providers directly – there is no 3rd-Party Payer
  - Patients with high-deductible plans, may be considered self pay in some cases, or after insurance has paid, internal billing system may categorize them as self pay
  - Self-insured plan is not the same – it is a related concept where the employer has eliminated the “middle-man.”

Fee-for-Service Reimbursement Method (Continued)
- Fee Schedules
  - Established by 3rd-party payers that is a predetermined list of fees that insurance companies will allow for payment
  - Allowable fee represents the average or maximum amount a 3rd party payer will reimburse a provider
- Discounted FFS Payments
  - A cost control method where 3rd-party payers negotiate reduced fees for their insured members
  - Discounts are generally applied to UCR charges (Usual, customary, or reasonable charges)
    - **Usual** for the provider’s practice or charges
    - **Customary** for the community
    - **Reasonable** for the type of service provided
Types of Reimbursement Methodologies

Fee-for-Service Reimbursement Method (Continued)
- Discounted FFS Payments (continued)
  - Resource-based Relative Value Scale (RBRVS) is a common discounted FFS method
    - First introduced by Medicare in 1992, remains the primary method of reimbursing for physician services by Medicare
    - Commonly used by other 3rd-party payers (some variation of RBRVS)
    - Payment method takes into consideration
      - Value of the physicians effort, time, complexity, etc.
      - Practice expense (i.e., Overhead)
      - Professional liability

Types of Reimbursement Methodologies

Episode-of-Care Reimbursement
- Payment method where providers receive one lump sum payment for all services provided related to a condition or disease (e.g., inpatient stay, a global period of time)
- Eliminates the FFS reimbursement method because the payment represents the episode, not the individual services provided
- Capitated Payments
  - Capitation is a method of payment (generally a characteristic of HMOs) that 3rd-party payers reimburse providers a fixed amount per person that is a member of a HMO
    - Also known as PMPM (per member per month)
    - Volume or intensity of services has no relation to payment
    - There is no adjustment for complexity or extent of services
    - Amount of services provided and utilization of the patient impacts provider “profit”
    - If member is not seen, still receive payment
Types of Reimbursement Methodologies

Episode-of-Care Reimbursement (cont.)

- Global Payment Method
  - 3rd-party payer makes one combined payment to cover the services of multiple providers who are treating a single episode of care
  - Similar to capitation, there is no additional payment for higher volumes of service or more expensive or complex services
  - Varying spectrums of comprehensiveness of global payments
  - Home Health Agency services are a good example as services are consolidated into a single payment that include:
    - Speech therapy
    - Physical therapy
    - Occupational therapy
    - Skilled nursing visits, supplies, etc.
  - Most comprehensive example of a global payment model would be the new Healthcare Reform payment model—Accountable Care Organizations (ACOs) that might include
    - Facility costs (hospital, nursing home, rehab center)
    - Lab, radiology, and pathology services
    - Physician services
    - Home care

- Prospective Payment Methods
  - Least comprehensive example of a global payment model would be a surgery episode where there is a “global” period that would encompass:
    - The operation
    - Anesthesia
    - Preoperative clinic visit
    - Immediate postoperative visit (inpatient round)
    - Postoperative clinic visit
    - One payment would be made for all the above services (i.e., a Hip replacement)

- Predetermined rates are generally based on averages
- On individual patients, providers can make money or lose money over time or break even.
**Types of Reimbursement Methodologies**

**Episode-of-Care Reimbursement (cont.)**

- **Prospective Payment Methods (or Systems, i.e., PPS)**
  - Per-diem Payments
    - Generally related to hospitalization
    - Reimbursement is based on a daily rate established by 3rd-parties
  - Case-based Payments
    - Patients' health services are reimbursed based on a condition or disease
    - Example of case-based payments are DRGs (diagnosis related groups)
    - Each DRG categorizes patients into clinical profiles that have similar diagnosis and treatments, consume the same resources and have similar lengths of stay
      - Each DRG has a payment “weight” or relative value that takes into consideration the intensity of the services due to severity of the illness
      - Each hospital has a payment rate that is multiplied by the DRG weight to arrive at the reimbursement to the hospital
      - Higher weights are associated with patients requiring more resources
      - Higher weights translate into higher payments
      - Case Mix Index is a term associated with DRGs used to measure severity of I/Ps of a hospital

- **Outpatient Prospective Payment System (OPPS)**
  - Another case-based payment system that more resembles the physician fee schedule payment system
  - Payment for hospitals outpatient services is based on APCs (Ambulatory Payment Classification)
    - Each APC has a payment relative value that takes into consideration the intensity of the services and cost of providing the care
    - Each hospital has a payment rate that is multiplied by the APC conversion factor to arrive at the reimbursement to the hospital
    - Higher weights are associated with patients requiring more resources
    - Higher weights translate into higher payments
    - Not all O/P hospital services are reimbursed by APCs (e.g., lab is paid on a fee schedule)
    - However, most all hospitals that are PPS hospitals receive some pre-established rate, or prospective payment method.
Types of Reimbursement Methodologies

Population Health
- Managed Care Model
  - Method of managing the cost of healthcare and outcomes of care provided over a given population
  - Features
    - Comprehensive care
    - Coordination and planning
    - Education to providers and patients
    - Quality
    - Controlling costs
- Purpose of Managed Care
  - Reduce cost, ensure quality, improve outcomes
- Many forms of managed care
  - HMO (Health Maintenance Organizations)
  - PPO (Preferred Provider Organizations)
  - ACO (Accountable Care Organizations)
- Managed care is often criticized due to limiting patient access and freedom to choose their healthcare provider
- Managed care can also impact the ability of providers to treat patients (e.g., ordering of tests, or procedures)

Complexity of Healthcare

Typical Managed Care Contract

- Physician (paid on Fee Schedule, discounted charges, or cost per visit)
- Outpatient (paid based on DRO or a per diem)
- Inpatient (paid based on APC, or cost per day)
**Medicare Overview**

**What is Medicare?**
- Title XVIII of the Social Security Act (known as Medicare)
- The nation’s largest health insurance program
- Run by The Centers for Medicare and Medicaid Services (“CMS”)

**Who is eligible for Medicare services?**
- Individuals 65 years and older
- Disabled individuals
- Individuals with permanent kidney failure
- Over 50 million individuals covered by Medicare nationally
- Nearly 900,000 individuals covered in Wisconsin (about 15% of total population)
- 2013 projected Medicare benefits of $590B nationally
**Medicare Overview (Continued)**

*What services does Medicare Part A pay for?*
- Inpatient hospital services
- Nursing home services
- Home health care
- Hospice care

*What services does Medicare Part B pay for?*
- Outpatient hospital services
- Medical equipment
- Medical supplies
- Physician and non-physician practitioner professional services
- Other health services and supplies

**Medicare Overview (Continued)**

*Medicare Advantage Plans (Part C)*

A Medicare Advantage Plan (like an HMO or PPO) is another Medicare health plan choice beneficiaries have as part of Medicare. Medicare Advantage Plans, sometimes called “Part C” or “MA Plans,” are offered by private companies approved by Medicare (A managed care type plan)

- You must have Part A and Part B to join a Medicare Advantage Plan
- **What services does it pay for?** Same as Part A and Part B
  - Inpatient hospital services
  - Nursing home services
  - Home health care
  - Hospice care
  - Outpatient hospital services
  - Medical equipment
  - Medical supplies
  - Physician and non-physician practitioner professional services
  - Other health services and supplies
Medicare Overview (Continued)

**Medicare Prescription Drug Coverage (Part D)**

- Medicare offers prescription drug coverage to everyone with Medicare.
- Beneficiaries need to decide to join a Medicare drug plan when they are first eligible.
- To get Medicare prescription drug coverage, you must join a plan run by an insurance company or other private company approved by Medicare.
- Each plan can vary in cost and drugs covered.
- 2 ways to get Medicare drug coverage:
  - **Medicare Prescription Drug Plans** - These plans (sometimes called “PDPs”) add drug coverage to Original Medicare, some Medicare Cost Plans, some Medicare Private Fee-for-Service (PFFS) Plans, and Medicare Medical Savings Account (MSA) Plans.
  - **Medicare Advantage Plans** (like an HMO or PPO) or other Medicare health plans that offer Medicare prescription drug coverage. You get all of your Part A and Part B coverage, and prescription drug coverage (Part D), through these plans.
    Medicare Advantage Plans with prescription drug coverage are sometimes called “MA-PDs.”

Prospective Payment System (PPS) Hospital

Medicare reimbursement depends on the services provided:

**Inpatient services:**
- Fixed amount per discharge – depending on service provided based on Diagnosis-Related Group – DRG
  - Base rate for each hospital is calculated based upon:
    - National labor rate adjusted by the hospital’s area wage index
    - Nonlabor add-on
    - Capital add-on
    - Rate excludes disproportionate share (DSH) and indirect medical education (IME)

**Swing bed services:**
- Fixed amount per day – depending on service provided based on Resource Utilization Group – RUG

**Outpatient services:**
- Fixed amount per visit – depending on service provided based on Ambulatory Patient Classification – APC
- Minimal services are paid based upon the provider’s cost:
  - CRNA for facilities providing less than 800 procedures per year
  - FL vaccines and administration
Medicare Overview (Continued)

Critical Access Hospital (CAH)

Medicare reimbursement depends on the services provided:

**Inpatient and swing bed services:**
- Based on 101% of average cost per day for inpatient services (as computed in the Medicare cost report)
  - Paid on an interim basis using a per diem rate for routine and ancillary costs.
  - Final settlement for each fiscal year is based upon the filed Medicare cost report after the intermediary completes their audit (i.e., retrospective payment)

**Outpatient services:**
- Based on 101% of cost to provide services to Medicare patients (as computed in the Medicare cost report)
  - Paid on an interim basis using a percentage of Medicare charges. (The percentage is calculated by dividing the overall allowable Medicare costs by the overall Medicare charges. This is the Medicare cost-to-charge ratio).
  - Final settlement for each fiscal year is based upon the filed Medicare cost report after the intermediary completes their audit (i.e., retrospective payment)

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Services often tied to a CAH that are not cost-based reimbursed?

- Free-standing clinics
- Professional component
- Hospital-based home health agencies
- Hospital-based skilled nursing facility
- Ambulance services (if not the only local provider)
- Distinct part psych and rehab units
- Reference lab
Medicare Overview (Continued)

Medicare Cost Reports - Both PPS and CAHs are required to submit annual cost reports
- The cost report is a systematic method of cost accounting determining allowable cost
- Requires a settlement process at the end of each entity’s fiscal year that reconciles cost of providing Medicare services to interim payments made throughout the year
- Cost reports are due 5 months after an organization’s fiscal year end
- Medicare cost report is important to PPS services but has minimal impact on settlement accounts (primarily impacts wage index calculations in setting PPS rates)
- CAH settlement can have a very dynamic impact on financial statements if not closely monitored

Medicaid Overview

What is Medicaid?
- Title IX of the Social Security Act (known as Medicaid)
- Medical Assistance (MA) is the largest of Wisconsin’s publicly funded health care programs
- Provides coverage for more than 1,000,000 low-income people per month
- Run by the Wisconsin Department of Health Services and Overseen by The Centers for Medicare and Medicaid Services (“CMS”)
- Funded by a combination of state and federal sources

Who is eligible for Medicaid services?
- Must meet program rules about income, assets, and other insurance coverage
- Primarily low-income people defined as a % of the federal poverty guidelines (differs by category, but generally 200% in Wisconsin):
  - Pregnant women
  - Families and children
  - Adults with disabilities
  - Children with disabilities
  - Adults without children (expanded coverage under the federal Accountable Care Act)
  - People over 65 years of age
  - People who need nursing home care
- Visit [www.dhs.wisconsin.gov/forwardhealth](http://www.dhs.wisconsin.gov/forwardhealth) for detailed list of requirements
Medicaid Overview (Continued)

April 2013 Members

- 202,857 BadgerCare Plus
- 205,040 Elderly & Disabled Coverage
- 758,291 Other Coverage

Medicaid Overview (Continued)

What services does Medicaid pay for?
- Inpatient hospital services
- Outpatient hospital services
- Medical equipment
- Medical supplies
- Nursing home services
- Home health care
- Hospice care
- Physician services
- Dental services
- Preventive care
- Other health services and supplies
Medicaid Overview (Continued)

Medicaid Expansion in Wisconsin

The Accountable Care Act included a provision to expand the Medicaid program in an effort to reduce the number of uninsured individuals in the United States. The expansion would be funded 100% by federal sources rather than the normal state/federal blend. Full federal funding would occur in 2014 through 2016, after which time States would be required to contribute no more than 10% to the continued cost of the expanded coverage.

Currently 25 states (plus Washington D.C.) have approved Medicaid expansion; Wisconsin is one of 14 states to reject the expansion. The remaining 11 states have not officially declared their intention, although this can and does change daily.

The Future of Reimbursement: Accountable Care Organizations

Projected Growth of the U.S. Economy and Federal Spending for Major Mandatory Programs

Effect of Excess Cost Growth

Effect of Aging

In the Absence of Aging and Excess Cost Growth
The Future of Reimbursement: ACOs

- The Affordable Care Act presents providers with many challenges and opportunities.
  - Emphasis on primary care driven care continuum across all delivery modalities
  - Fee-for-service moving to “bundling” and “outcomes based” payment
  - Reduction in payments, movement toward a lower cost of care models
  - Pilot programs and demonstration project funding for development of “new care delivery models”.
  - Targeted, consistent and transparent quality and outcome measures across the care continuum.
  - Patient centered, alternate models of care will grow in all provider areas.
  - Alignment, collaboration and consolidation of all constituents across the traditional care continuum and related clinical providers.
  - Moving to a Global Payment Methodology for all services. Will they get to capitation reimbursement?

ACO Payment Structures
- The primary differentiator in ACO definition is payment. Payment structures range from current FFS with shared savings to full capitation.
- Ability to manage risk increases across this continuum.
- Reform starts with FFS with shared savings but allows for adoption of partial comprehensive payment.
- Comprehensive payment may provide greater cost and quality incentives but would require more ACO management skills and investment.
- Note that most definitions of ACOs do not envision these organizations accepting insurance risk (unless they are prepared to do so). Fully functioning ACOs should be able to accept performance risk.

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<th>Low ACO Risk</th>
<th>Highest ACO Risk</th>
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<td>Fee-for-Service (FFS) plus shared savings</td>
<td>Comprehensive Payment (Global Payment)</td>
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<td>Episodic Payment</td>
<td>Partial Comprehensive Payment Plus P4P (Pay for performance)</td>
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Questions and Discussion

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