*Principles of Healthcare Reimbursement*

Instructor’s Manual

Chapter 1

Healthcare Reimbursement Methodologies



# Lesson Plan

# Background and Instructional Delivery

Chapter 1 introduces the reader to methods of healthcare reimbursement. An important aspect of the chapter is the initiation of the reader into the language of healthcare reimbursement. The chapter provides an overview of the major methods of payment for US healthcare. These methods are presented in terms of unit of payment, timeframe, and risk.

# Chapter Outline

### Objectives

**Key Terms**

**Introduction to Healthcare Reimbursement**

National Models of Healthcare Delivery

US Healthcare Sector

Dominance of Federal Healthcare Payment Methods

Health Insurance

Historical Perspectives

Health Insurance and Employment

Compensation for Healthcare

Third-Party Payment

Characteristics of Reimbursement Methods

**Types of Healthcare Reimbursement Methodologies**

Fee-for-Service Reimbursement

Self-Pay

Traditional Retrospective Payment

Fee Schedule

Discounted Fee-for-Service Payment

Uncertainty for Third-Party Payers

Criticism of Fee-for-Service Reimbursement

Managed Care

Features of Managed Care

Purposes of Managed Care

Forms of Managed Care

Criticisms of Managed Care

Episode-of-Care Reimbursement

Capitated Payment Method

Global Payment Method

Prospective Payment Method

Per Diem Payment

Case-Based Payment

Criticisms of Episode-of-Care Reimbursement

**Trends in Healthcare Reimbursement**

Constantly Increasing Healthcare Spending

Healthcare Reform

Background

Affordable Care Act

Purposes

Provisions

Implementation

Use of Health Information and Communication Technologies

Medical Tourism

Transparency

**Chapter Summary**

**References**

# Activities with Keys

### Theory into Practice

This chapter discusses concepts and definitions related to the types of healthcare reimbursement methodologies. Healthcare reimbursement methodologies are more than concepts and definitions. Instead, healthcare reimbursement methodologies are realities that affect people’s bank accounts and healthcare organizations’ financial positions every day.

In terms of individual people, healthcare reimbursement methodologies affect the amounts we pay for our prescriptions and clinic visits. Our healthcare insurance company pays a portion and we pay the remaining balance. These remaining balances are based on healthcare reimbursement methodologies. The human resources offices of employers get involved because employers want to provide their employees with the best possible menu of benefits. In terms of healthcare organizations, such as physician offices and hospitals, healthcare insurers negotiate discounted rates with these organizations. If a healthcare organization negotiates an unfavorable contract, it could be losing money with each patient. Of course, from the point of view of the healthcare insurance company, this negotiated contract is favorable because the insurance company is making money on each patient.

As a result, the general public, human resource administrators, healthcare providers, state agencies, and many other people try to anticipate their healthcare costs for the future. They ask themselves the following questions:

* How much should I budget for my prescription drugs and visits to my physician?
* What should our company include in future benefit packages for our employees?
* Will my practice be financially viable in the future?
* How much should we budget for our state’s Medicaid program and other healthcare programs?
* What’s in the future for us?

Have you or a relative ever asked one of these questions? Have you heard people talk about their employer’s healthcare benefits package? Were healthcare benefits a consideration in accepting a job offer? Consider these questions as you work through the book’s remaining chapters.

**Real-World Case**

States have insurance commissions or state insurance departments. See <http://www.naic.org/state_web_map.htm>. Generally, the missions of these commissions are to protect the public by regulating the insurance industry by overseeing its financial transactions and by providing assistance and information.

Many state insurance commissions provide information on selecting a health insurance company, avoiding scams, and reporting fraud. The websites of the state insurance companies have hotlinks to information sheets, other state agencies, and legislative updates.

As “hot topics” emerge, the state insurance departments respond with information and alerts. For the state health insurance departments, consumer knowledge is the best protection.

**Questions**

1. What is the name of your state’s insurance commission?

**Name depends upon the state of the student’s residence.**

2. What is the mission of your state’s insurance commission?

**Mission depends upon the insurance commission of the state of the student’s residence.**

3. List three consumer-related topics on the insurance commission’s website.

**Additional topics depend upon the insurance commission of the state of the student’s residence. However, common topics include fraud protection, long-term care coverage, supplemental Medicare insurance, rate comparisons, and children’s health insurance.**

### Lecture

Microsoft PowerPoint (.pptx) slides are available on ahimapress.org website. These slides may be used as lecture guides.

### Class Discussion

The Theory into Practice section, Real-World Case, Application Exercises, and questions in the Check Your Understanding sections located throughout the chapter can be used to stimulate class discussions or online chats.

# Application Exercises

1. Bring a healthcare insurance card to a class session or have a healthcare insurance card on hand for an online discussion.

**No answer necessary.**

2. List all the healthcare insurance companies represented by the cards of the members of the class.

**Type and number of healthcare insurance companies represented by the cards depends upon the composition of the class. If many members of the class or their parents or spouses all work for the same employer, fewer names will be listed than if there are many different employers.**

3. Is the language on the healthcare insurance cards standardized?

**No. Have the students compare and contrast the language on the cards, such as (a) plan vs. company, (b) enrollee vs. member vs. policyholder vs. subscriber vs. insured, (c) group number vs. member number v. subscriber number vs. identification number, (d) policy vs. group, (e) dependent vs. covered individual.**

4. Go to the websites of some of the healthcare insurance companies. What are some hot topics?

* **Free programs to help members to manage health conditions, such as asthma, diabetes, heart disease, pregnancy, obesity, and others.**
* **Health and wellness programs, such as smoking cessation, walking, exercise, seat belt use, and wellness incentives.**
* **Preventive care, such as immunizations and cancer screenings.**
* **Reports on issues, such as philanthropic activities (free flu shots), uninsured citizens, relief for victims of weather emergencies, and transparency and consumerism.**
* **Access to computer applications to create personal health records and health profiles.**

**Questions from Text with Keys**

**Check Your Understanding Questions**

**Check Your Understanding 1.1**

1. True or false? The national health service (Beveridge) model is different from the social insurance (Bismarck) model because the Beveridge model is financed by general revenue funds from fiscal taxes, whereas the Bismarck model is financed by workers’ and employers’ compulsory payroll contributions into sickness funds.

**True**

2. What are four characteristics of the US healthcare sector?

**Four characteristics of the United States are its large size, complexity, intricate payment methods and rules, and programs’ broad scopes.**

3. True or false? The federal role in the healthcare sector is limited to paying providers for the healthcare costs of senior citizens.

**False**

4. What do insurers receive in return for assuming the insureds’ exposure to risk or loss?

**Insurers receive premiums in return for assuming the insureds’ exposure to risk or loss.**

5. Insurers pool premium payments for all the insureds in a group, then use actuarial data to calculate the group’s premiums so that:

a. Premium payments are lowered for insurance plan payers

**b. The pool is large enough to pay losses of the entire group**

c. Accounting for the group’s plan is simplified

d. All of the above are reasons for using the data

**Check Your Understanding 1.2**

1. Where and when did health insurance become established in the United States?

**In Texas, in 1929, when Blue Cross first created a plan for school teachers**

2. What is the term for health insurance that only covers the employee?

**Individual or single coverage**

3. What is the term in healthcare that means compensation or repayment for rendering healthcare services?

**Reimbursement**

4. Who is the third party in healthcare situations?

a. Patient

b. Provider

**c. Payer**

d. Cannot be determined

5. All of the following are types of episode-of-care reimbursement except:

a. Global payment

b. Prospective payment

c. Capitation

**d. Self-insured plan**

6. What discounted fee schedule does Medicare use to reimburse physicians?

**Resource-based relative value scale (RBRVS)**

7. Name and describe some versions of the global payment method.

**Global surgical package, including the procedure, local/topical anesthesia, preoperative visit, and postoperative care/follow-up; bundling that combines the costs of dialysis services, injectable drugs, laboratory tests, and medical equipment and supplies; special-procedure package, including costs associated with a diagnostic or therapeutic procedure; ambulatory-visit package, including physicians’ charges, laboratory tests, and x-rays.**

# Review Quiz

1. Which one of the three models of healthcare delivery is used in the United States?

**The private health insurance model is used in the United States**

2. Why is the federal government a dominant player in the healthcare sector?

**The federal government is a dominant player in the healthcare sector because its Medicare program is the largest single payer for health services. The federal government also pays for health services for other populations including active duty and retired military personnel and their families, veterans, Native Americans, and injured and disabled workers.**

3. Who are the first, second, and third parties in healthcare situations?

**The first party is the patient, the second party is the healthcare entity providing care, and the third party is the insurance company or health agency that pays the second-party provider.**

4. Compare the UCR and CPR payment systems.

**UCR is usual, customary, and reasonable payment and was employed by private insurance companies. The CPR approach—customary, prevailing, and reasonable—was the system used by Medicare prior to the RBRVS schedule. Both were discounted fee-for-service payments that attempted to control healthcare costs before the era of prospective payment systems.**

5. Describe the two purposes of managed care.

**One purpose of managed care is to reduce healthcare costs that are reimbursed by third parties. This is accomplished by requiring prior approval for surgery and by requiring insureds to make partial payment for services. The other purpose of managed care is to ensure the continuing quality of care. Advocates of managed care argue that quality of care is enhanced under this system because unwarranted procedures are not performed or reimbursed.**

6. Why have many insurers replaced retrospective health insurance plans with group plans such as HMOs and PPOs?

**In retrospective payment methods, the insurer learns of the costs of health services after providers give patients care, and the third-party payer is at risk. To control financial risk, insurers have replaced retrospective and fee-for-service systems with hybrid plans and managed care plans such as HMOs, POSs, and PPOs.**

7. What are advantages of capitated payments for providers and payers?

**The advantage of capitated payment for providers is having a guaranteed customer base for a practice or facility. The advantage for third-party payers is knowing the cost of reimbursable services.**

8. How do third-party payers set per-diem payment rates?

**Third party-payers use historical data such as dividing total costs for all prior inpatients by their LOS.**

9. Describe the major benefits of episode-of-care reimbursement according to its advocates and the major concerns about episode-of-care reimbursement expressed by its critics.

**Advocates say that episode-of-care reimbursement rewards effective and efficient provision of healthcare services by enabling such providers to make money from their streamlined services. Critics say that the system creates incentives to substitute cheaper diagnostic and therapeutic tests and services and to delay or deny treatment.**

10. Why is the constant trend of increased national spending on healthcare a concern?

**This increased spending is a concern because money is a limited resource. As spending on healthcare increases, the money available for other sectors of the economy decreases.**

# Test Bank with Key

*Instructions:* For each item, complete the statement correctly or choose the most appropriate answer.

1. Why do health insurers pool premium payments for all the insureds in a group and use actuarial data to calculate the group’s premiums?

a. To increase premium payments for insurance plan payers

b. To simplify accounting for the group’s plan

**c. To assure that the pool is large enough to pay losses of the entire group**

d. A and B only

e. All of the above

2. Where and when did health insurance become established in the United States?

**a. Texas, 1929**

b. California, 1932

c. Washington, 1936

d. New York, 1941

3. There are 3 parties in healthcare reimbursement. Who is the first party?

**a. Patient or guarantor**

b. Provider of care or services

c. Payer

d. Society

4. There are 3 parties in healthcare reimbursement. Who is the second party?

a. Patient or guarantor

**b. Provider of care or services**

c. Payer

d. Society

5. There are 3 parties in healthcare reimbursement. Who is the third party?

a. Patient or guarantor

b. Provider of care or services

**c. Payer**

d. Society

6. In the healthcare insurance sector, what does UCR stand for?

a. Uniform Crime Report

**b. Usual Customary and Reasonable**

c. Universal and Common Rates

d. Usable Capital Receipts

7. What is the purpose of managed care?

a. To reduce the costs of healthcare services

b. To improve the quality of care for patients

c. To leverage negotiations with state and federal agencies

**d. A and B only**

e. All of the above

8. Which of the following phrases mean “per head”?

a. Per diem

**b. Per capita**

c. Per pedes

d. Per se

9. Which of the following payment methods are global?

a. Block grants

b. Surgical packages

c. Bundling

**d. All of the above**

10. All of the following methods are types of episode-of-care reimbursement **except**:

a. Global payment

b. Prospective payment

c. Capitation

**d. Self-insured plan**

11. True or False? Payers that use per-diem payment rates reimburse the provider a fixed rate for each day a covered member is hospitalized

**a. True**

b. False

12. The federal government funds significant portions of which groups’ healthcare?

a. Seniors, people with disabilities, and people with end-stage renal disease

b. Low-income persons on state Medicaid

c. Active-duty and retired military personnel and their families and veterans

d. Native Americans

e. A and C only

f. A, C, and D only

**g. All of the above**

13. True or False? The constant trend of increased national spending on healthcare is a concern because as spending on healthcare increases, the money available for other sectors of the economy decreases.

**a. True**

b. False

14. In the United States, what is healthcare insurance?

a. Federal program to provide medical care and services to indigent US citizens

b. State programs to provide medical care and services to deserving individuals

**c. Reduction of a person’s or a group’s exposure to risk for unknown healthcare costs by the assumption of that risk by an entity**

d. Set of negotiated guarantees that all healthcare expenses of a risk pool will be covered by employers

15. To which of the following factors is health insurance status most closely linked?

a. Access

**b. Employment**

c. Gender

d. Need

16. In the healthcare industry, what is the term for receiving compensation for healthcare services that were previously provided?

a. Fee schedule

b. Recompense

**c. Reimbursement**

d. Render

17. In which type of reimbursement methodology do healthcare insurance companies determine payment to providers before the services have been delivered?

a. Block grant

d. Global payment

**c. Prospective payment**

d. Retrospective payment

18. In which type of reimbursement methodology does the health insurance company have the greatest degree of risk?

a. Capitated payment

b. Global payment

c. Block grant

**d. Retrospective**

19. Which type of reimbursement methodology is associated with the abbreviation “PMPM”?

**a. Capitated payment**

b. Global payment

c. Block grant

d. Retrospective

20. In the healthcare industry, what is another term for “fee”?

a. Capitated rate

**b. Charge**

c. Discount

d. Reimbursement

21. In the accounting system of the physician office, the account is categorized as “self-pay.” How should the insurance analyst interpret this category?

a. The employer’s self-insured healthcare insurance plan will cover the account.

b. The physician, himself or herself, will pick up the balance of the bill.

**c. The guarantor will pay the entire bill.**

d. The patient will pay deductibles and non-covered charges.

22. The bill that the pathologist’s office submitted for a laboratory test was $54.00. In its payment notice (remittance advice), the healthcare plan lists its payment for the laboratory test as $28.00. What does the amount of $54.00 represent?

a. Allowable fee

**b. Charge**

c. Discounted rate

d. Premium

23. Which discounted fee-for-service healthcare payment method does Medicare use to reimburse physicians?

a. ACO

b. CPR

**c. RBRVS**

d. UCR

24. Which statement describes the per diem payment method?

a. Consolidation of all types of services, such as speech, physical, and occupational therapy, into a single lump sum payment

b. Monthly payment of $4,500 representing $15 for each of 300 enrollees

**c. Fixed rate for each day a covered member is hospitalized**

d. Payment for each service that a physician renders

25. Which national model for the delivery of healthcare services is financed by general revenue funds from taxes?

a. Social insurance (Bismarck) model

**b. National health service (Beveridge) model**

c. Private health insurance model

d. A and B only

e. All of the above