The Healthcare System

• Organizations that provide health services
  – Hospitals, physicians, nursing homes, home healthcare

• Organizations that pay for the care
  – Government plans
  – Non-government plans

Impact of Community Hospitals on U.S. Economy (in $ billions)

Percent of Total Regional Employment by Hospitals
The Healthcare System

- Organizations that provide health services
  - Hospitals, physicians, nursing homes, home healthcare
- Organizations that pay for the care
  - Government plans
  - Non-government plans

Government Plans

- Origin of Medicare and Medicaid
  - In 1965, the Social Security Act established both Medicare and Medicaid
  - Medicare was a responsibility of the Social Security Administration (SSA)
  - Federal assistance to the State Medicaid programs was administered by the Social and Rehabilitation Service (SRS)
  - SSA and SRS were agencies in the Department of Health, Education, and Welfare (HEW)

Government Plans

- Origin of Medicare and Medicaid
  - In 1977, the Health Care Financing Administration (HCFA) was created under HEW to effectively coordinate Medicare and Medicaid
  - In 1980 HEW was divided into the Department of Education and the Department of Health and Human Services (HHS)
  - In 2001, HCFA was renamed the Centers for Medicare & Medicaid Services (CMS) (www.cms.hhs.gov/)

- Medicare
  - Depending on the hospital, represents 40-60% of revenue
  - Currently provides healthcare benefits to approximately 44 million enrollees
  - Largest single purchaser of hospital and physician services in the U.S.
Government Plans

• Medicare
  – Two parts
    • Part A - Hospital insurance that pays for inpatient hospital stays, care in a skilled nursing facility, hospice care and some home health care
    • Part B - Medicare medical insurance that helps pay for doctors’ services, outpatient hospital care, durable medical equipment, and some medical services that are not covered by Part A
Government Plans

• Medicare
  – DRGs work by grouping the 10,000+ ICD-CM codes into a more manageable number of meaningful patient categories (490+)
  – Patients within each category are similar clinically and in terms of resource use
  – The top ten most common DRGs account for approximately 30% of total Medicare patients

<table>
<thead>
<tr>
<th>DRG</th>
<th>DRG Description</th>
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<tbody>
<tr>
<td>1</td>
<td>127 Heart Failure &amp; Shock</td>
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<tr>
<td>2</td>
<td>089 Simple Pneumonia &amp; Pleurisy Age&gt;17 w/CC</td>
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<tr>
<td>3</td>
<td>014 Specific Cerebrovascular Disorders except TIA</td>
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<tr>
<td>4</td>
<td>430 Psychoses</td>
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<tr>
<td>5</td>
<td>088 Chronic Obstructive Pulmonary Disease</td>
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<tr>
<td>6</td>
<td>209 Major Joint &amp; Limb Reattachment Procedures, Lower Extremity</td>
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<tr>
<td>7</td>
<td>140 Angina Pectoris</td>
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<tr>
<td>8</td>
<td>182 Esophagitis, Gastroenteral &amp; Misc Digestive Disorders Age&gt;17 w/CC</td>
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<tr>
<td>9</td>
<td>174 G.I. Hemorrhage w/CC</td>
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<tr>
<td>10</td>
<td>296 Nutritional &amp; Misc Metabolic Disorders Age&gt;17 w/CC</td>
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Government Plans

• Medicare - determining IPPS payments
  – Section 1886(d) of the Social Security Act sets forth a system of payment for the operating costs of acute care hospital inpatient stays under Medicare Part A (Hospital Insurance) based on prospectively set rates

Government Plans

• Medicare - determining IPPS payments
  – This payment system is referred to as the inpatient prospective payment system (IPPS). Under the IPPS, each case is categorized into a diagnosis-related group (DRG)
  – Each DRG has a payment weight assigned to it, based on the average resources used to treat Medicare patients in that DRG

Government Plans

• Medicare - determining IPPS payments
  – The base payment rate is divided into a labor-related and nonlabor share
  – The labor-related share is adjusted by the wage index applicable to the area where the hospital is located, and if the hospital is located in Alaska or Hawaii, the nonlabor share is adjusted by a cost of living adjustment factor
  – This base payment rate is multiplied by the DRG relative weight

Government Plans

• Medicare - determining IPPS payments
  – If the hospital treats a high-percentage of low-income patients, it receives a percentage add-on payment applied to the DRG-adjusted base payment rate
  – This add-on, known as the disproportionate share hospital (DSH) adjustment, provides for a percentage increase in Medicare payment for hospitals that qualify under either of two statutory formulas designed to identify hospitals that serve a disproportionate share of low-income patients
  – For qualifying hospitals, the amount of this adjustment may vary based on the outcome of the statutory calculation
Government Plans

- Medicare - determining IPPS payments
  - Also, if the hospital is an approved teaching hospital it receives a percentage add-on payment for each case paid through IPPS
  - This add-on known as the indirect medical education (IME) adjustment, varies depending on the ratio of residents-to-beds under the IPPS for operating costs, and according to the ratio of residents-to-average daily census under the IPPS for capital costs

- Medicare - determining IPPS payments
  - Finally, for particular cases that are unusually costly, known as outlier cases, the IPPS payment is increased
  - This additional payment is designed to protect the hospital from large financial losses due to unusually expensive cases
  - Any outlier payment due is added to the DRG-adjusted base payment rate, plus any DSH or IME adjustments

- Medicaid
  - Many groups of people are covered by Medicaid
  - Even within these groups, though, certain requirements must be met - these may include age, whether the individual is pregnant, disabled, blind, or aged; income and resources (like bank accounts, real property, or other items that can be sold for cash); and whether the individual is a U.S. citizen or a lawfully admitted immigrant

- Medicaid
  - A child may be eligible for coverage if he or she is a U.S. citizen or a lawfully admitted immigrant, even if the parents are not (however, there is a 5-year limit that applies to lawful permanent residents)
  - Eligibility for children is based on the child's status, not the parent's
  - Also, if someone else's child lives with you, the child may be eligible even if you are not because your income and resources will not count for the child

- DRGs are a “fixed” rate of reimbursement
  - If a hospital or other healthcare organization can provide the necessary treatment for less, it can pocket the excess
  - If not, it must make up the difference
  - So the hospital's focus is on cost containment, minimizing the patient's length of stay and reducing unwarranted admissions
Medicaid Enrollees, 1990-2007

- Medicaid Beneficiaries and Payments by Eligibility Group

- Births Financed by Medicaid as a Percent of Total Births
  - Medicaid Pays for about 1 in 3 of the nation’s births

- Total Medicaid Expenditures by Type of Service

- Total State Spending

- Federal Funds Provided to States
Government Plans

- State Children’s Health Insurance Plan (SCHIP)
  - The Balanced Budget Act of 1997 created a new children’s health insurance program called the State Children’s Health Insurance Program (SCHIP)
  - This program gave each state permission to offer health insurance for children, up to age 19, who are not already insured
  - SCHIP is a state administered program and each state sets its own guidelines regarding eligibility and services

Government Plans

- State Children’s Health Insurance Plan (SCHIP)
  - Families who earn too much to qualify for Medicaid may be able to qualify for SCHIP
  - Families that do not currently have health insurance are likely to be eligible, even if you are working
  - The states have different eligibility rules, but in most states, uninsured children under the age of 19, whose families earn up to $36,200 a year (for a family of four) are eligible
  - For little or no cost, this insurance pays for: doctor visits, immunizations, hospitalization and emergency room visits

Non-government Plans

- Types of insurance plans
  - Fee for service health care (indemnity insurance)
  - Managed care
    - Health maintenance organizations (HMO)
    - Preferred provider organizations (PPO)
    - Point of service plans (POS)
    - Medical savings account (MSA)

Non-government Plans

- Fee for service health care (indemnity insurance)
  - The traditional health insurance - has gradually become less prevalent as managed care becomes the norm
  - Offers unlimited choice - the member controls the choice of physician and facility, from primary caregiver to specialist, surgeon and hospital; flexible coverage also means immediate treatment for medical emergencies or unexpected illness
### Non-government Plans

**Fee for service health care (indemnity insurance)**
- These plans do have care restrictions - they do not traditionally cover preventative medicine, so check-ups, office visits and shots (among a few other services) are the member’s responsibility
- This can make indemnity insurance impractical for a large family that requires a lot of routine visits and preventative care

**Health maintenance organization (HMO)**
- HMO members pay a fixed monthly fee, called a premium - in return, the health insurance company and its health care network provide a variety of medical benefits
- The range of health care services covered by an HMO varies and some health care services, such as outpatient mental health care, are only covered on a limited basis
- HMOs consist of a network of physicians - from this list, the member must choose a primary care physician, who is then responsible for the member’s health care as well as for making referrals to specialists and approving further medical treatment

**Preferred provider organizations (PPO)**
- Lie between HMOs and pure fee-for-service plans - health care is managed (and restricted), but there is a degree of choice in providers
- PPOs operate like HMOs in that the member pays a fixed monthly premium, and, in return, the insurance company and its network provide basic medical benefits
- PPOs differ from the original HMO blueprint in that a primary care physician or “gatekeeper” physician is not required; as a result, seeing a specialist does not require a referral

**Point of service plans (POS)**
- POS plans are based on the basic managed care foundation: lower medical costs in exchange for more limited choice - but POS health insurance does differ from other managed care plans
- Enrollees in a POS plan are required to choose a primary care physician to monitor their health care - this primary care physician must be chosen from within the health care network, and becomes the “point of service”
## Non-government Plans

### Point of service plans (POS)
- The primary POS physician may then make referrals outside the network, but then only some compensation will be offered by the health insurance company.
- For medical visits within the health care network, paperwork is completed for the members, if members choose to go outside the network, it is their responsibility to fill out the forms, send bills in for payment, and keep an accurate account of health care receipts.

### Medical Savings Accounts (MSA)
- MSAs are not an insurance plans - they are actually a means of making coverage more affordable for people who traditionally have high health insurance costs.
- Rather than pay a high monthly premium for a policy with a low deductible and low co-pays, the individual opts for a high deductible health plan (HDHP/SO) to help in the event of an emergency or major expense and makes regular deposits into a medical savings account to cover health-related expenses.

### Deposits made toward the medical savings plan are 100% tax-deductible, and can be used towards any out-of-pocket medical expense, like satisfying your deductible, covering office visits, etc.
- Any medical savings account funds not used will remain in the account, drawing interest on a tax-favored basis, until needed for future medical expenses or retirement.

### Medical savings accounts (MSA)
- The benefits of a medical savings account can be substantial, but their availability is limited - only those employed by a business of 50 persons or fewer (including the self-employed) qualify.
- Both the insurance policy and the medical savings account must conform to government guidelines.

### To qualify, one
- must be covered under a HDHP
- can have no other health coverage (some exceptions exist)
- cannot be enrolled in Medicare
- cannot be claimed as a dependent on someone else's tax return

### Medical Saving Accounts (MSA)
- There are financial requirements as well
- the insurance policies that qualify are limited to those with an individual deductible of between $1,650 and $2,500, or a family deductible of between $3,300 and $4,950.
- the maximum allowable out-of-pocket expense is $3,300 for individuals and $6,050 for families.