PUTTING MEDICARE CONSUMERS IN CHARGE pdf

1: things to know about Medicare reimbursement

Putting Medicare consumers in charge: lessons from the FEHBP / Walton Francis. p. ; cm. Includes bibliographical references and index. ISBN ISBN X 1.

Comments Off on Insurers put out lures as Medicare recipients face big changes Free rides to the doctor. Health insurers are dangling extra benefits in front of roughly 1 million Minnesotans on Medicare who have the chance in the coming weeks to pick a health plan for next year. Paul, a retired health policy professor at the University of Minnesota who has been advising friends on the transition. Federal law is forcing health insurers next year to eliminate Medicare Cost plans across 66 counties in the state, resulting in more than , people switching coverage all at once. Those consumers face a choice between enrolling in a Medicare Advantage health plan sold by an insurance company, or coverage through the original Medicare program run by the federal government. Many who opt for original Medicare also purchase a Medigap supplement policy plus a Part D prescription drug plan, both of which are sold by private insurers. The Cost plans will be lost across most of the state, however, including much of the Twin Cities metro. People who are losing the coverage have a one-time right to buy a Medigap supplement without answering health questions that could block their enrollment later. So, consumer advocates say it makes sense for people to look closely at their Medigap options now. Medigap policies tend to have higher premiums than Medicare Advantage MA plans, but they also provide broad and easy access to doctors and hospitals. Across the country, MA plans have been growing in popularity for several years, with health insurers touting extra benefits the plans offer beyond original Medicare. Earlier this year, the federal government expanded the chance for extra benefits, which insurers say is part of how MA plans coordinate care to help enrollees. Kentucky-based Humana is introducing a transportation benefit for in Minnesota, where subscribers are entitled to 12 one-way trips per year of up to 25 miles each. Minneapolis-based UCare is offering a program that provides discounts on healthy foods at the grocery store. Beyond the network limits, Advantage plans have out-of-pocket spending requirements when people use care. People who buy the coverage and want Part D benefits must buy them from the Advantage plan, whereas Medigap plans can be paired with drug coverage from any of more than two dozen companies. And the benefits with Advantage plans can change from year to year, said Jerry Maher, a volunteer insurance counselor with the Metropolitan Area Agency on Aging. What do you have to give up in terms of coverage in order to get these extras? One way to level the playing field, Lipschutz said, is to make sure the extra benefits with Advantage plans are also available in original Medicare. The focus instead has been health care provider networks, prescription drug coverage, pharmacy participation and monthly premiums, Greiner said. Foote, the retired health policy expert from the U, said she has mixed feelings about the extra benefits. On the one hand, they could be important in helping some people maintain their health by making it easier to visit doctors, exercise and eat healthy foods. On the other hand, the extras might simply be frills that attract subscribers without adding much value. We want to know we can get things taken care of. Sign up now for local coverage you wonut find anywhere else, special sections and your favorite columnists. StarTribune puts Minnesota and the world right at your fingertips.

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2: Putting Medicare Consumers in Charge: Lesson from the Fehbp by Walton Francis

In an unplanned natural experiment between two fundamentally different program designs, the federal government has operated two major health insurance programs side by side for nearly fifty years: Medicare and the Federal Employees Health Benefits Program (FEHBP). Until a recent government decision.

For hospitals, health systems and other providers, it has been the most influential healthcare program for the industry in recent decades. Medicare continues to play a prominent part in various reform movements, such as the shift from fee-for-service to value-based payments and the push for greater price transparency. The following list sheds some light on the many facets of and issues surrounding Medicare reimbursement in the form of things to know, covering everything from the latest update to the Inpatient Prospective Payment System to the Bundled Payments for Care Improvement Initiative. Inpatient hospital reimbursement 1. About 3, acute-care hospitals and long-term care hospitals receive payments under the IPPS. Hospitals generally receive IPPS payment on a per-discharge or per-case basis for Medicare beneficiary inpatient stays. Discharges are assigned to diagnosis-related groups, which sorts them by similar clinical conditions and procedures administered by the hospital during the stay. The IPPS per-discharge payment is based on two national base payment rates for operating expenses and capital expenses. The fiscal year IPPS final rule was released in early August and increases hospital inpatient payment rates by 1. That overall payment increase reflects a 2. Hospitals must publicize a list of their standard charges or provide their policies for allowing the public to view a list of those charges in response to an inquiry. Despite protests from hospitals about the two-midnight rule â€" under which inpatient admissions must span at least two midnights to qualify for Medicare Part A payments â€" the FY IPPS final rule leaves the controversial policy intact. CMS has initially focused on readmissions for heart attack, heart failure and pneumonia; the agency plans to add chronic obstructive pulmonary disorder and total hip and knee replacement to the program for fiscal year Additionally, the IPPS final rule promotes quality care by enacting a 1 percent reimbursement cut for hospitals with the poorest performance in the lowest quartile in reducing hospital-acquired conditions. The program has three measures, including the patient safety indicators PSI 90 composite measure, the central line-associated bloodstream infections measure and the catheter-associated urinary tract infections measures. In fiscal year , CMS took back 1. In fiscal year , hospitals lost more than 0. For , the final rule increases the applicable percent reduction to fund the program to 1. The IPPS final rule reflects that in a 1. DSH payments are distributed to hospitals that treat a significantly disproportionate amount of low-income patients. Outpatient hospital reimbursement OPPS rates vary depending on ambulatory payment classification groups for procedures and services. That overall increase reflects a projected hospital market basket increase of 2. Additionally, the OPPS proposed rule includes additional comprehensive-ambulatory payment classifications. Comprehensive-APCs were created to pay for high-cost device-dependent services using a single payment for a hospital stay in 29 device-dependent APCs. A comprehensive-APC policy meant to expand the items and services packaged into a single payment for a comprehensive primary care service was included in a final rule for calendar year ; CMS delayed implementation by a year to give the agency and hospitals more time to evaluate and comment on the policy. Under the rule, CMS would also maintain the community mental health center outlier payments threshold at 3. CMS has also proposed that for hospitals to receive outlier payments under the PPS, the cost of the service administered must be more than the multiple threshold of 1. Earlier this summer, in the same rule that included proposed payment and policy changes for hospital outpatient departments, CMS released proposed payment and policy updates for ASCs for ASC reimbursement rates are updated annually to reflect inflation by the percentage increase in the Consumer Price Index for all urban consumers. The ASC annual update also takes a multi-factor productivity adjustment into account. The Consumer Price Index update is projected to be 1. The debate over site-neutral payments The Medicare program currently pays significantly different rates for the same services provided in different settings. For instance, according to the Medicare Payment Advisory Commission, Medicare paid hospital outpatient departments 78 percent more on average than ambulatory surgery centers for the same procedure in MedPAC

and CMS have been considering options to eliminate the gap between payment rates for different settings for certain care services, a proposal that has been met with backlash from hospital advocates. The controversy surrounding site-neutral payments has been inflamed partly by the recent shift of services from physician offices to HOPDs, according to Health Affairs. MedPAC and others have expressed concerns about this development, with MedPAC in particular pointing out the share of physician visits evaluation and management services and certain diagnostic cardiology procedures administered in a HOPD setting increased by 8 percent between and and by 9 percent between and MedPAC has recommended limiting payments to hospital outpatient departments. In , the Commission advised Congress to set payment rates for evaluation and management services provided in HOPDs that are equivalent to rates paid under the physician fee schedule. Hospital leaders and organizations such as the American Hospital Association have criticized these site-neutral payment proposals, arguing that hospitals need the higher payments because all of them â€" even those not designated as safety-net hospitals â€" play a unique role in their communities, compared with ASCs and other outpatient care providers. The Protecting Access to Medicare Act, which President Barack Obama signed into law April 1, could give CMS an additional opportunity and authority to revisit the site-neutral payment issue through its provisions expanding the types of information CMS can use to determine costs under the physician fee schedule. The law also encourages the agency to address potentially misvalued codes, according to the issue brief. The three-day hospital stay requirement The three-day requirement has led to problems for Medicare beneficiaries who were in the hospital under observation care rather than as inpatients, according to the report. The payment experiments that waive the three-day rule include the Medicare Pioneer Accountable Care Organization program. The Pioneer ACO project involves approximately , senior patients at more than hospitals, according to the report. Under this initiative, which currently involves more than 6, provider participants, Medicare provides a set fee for any of 48 procedures selected by a participating hospital. Medicare Advantage plans, an alternative to traditional Medicare administered by private health insurers, are already allowed to disregard the three-day requirement. This year, 95 percent of Medicare Advantage plans waived the rule, according to an analysis conducted by health research firm Avalere Health for Kaiser. Some have argued the Medicare program should get rid of the three-day requirement for nursing home coverage before the various payment experiments show results. For instance, Diane Paulson, a senior attorney at Greater Boston Legal Services who handles observation care appeals, told Kaiser nursing home care and other benefits should be covered if they are medically necessary. However, others have advocated for caution. The two-midnight rule As mentioned in the inpatient hospital reimbursement section, the two-midnight rule mandates inpatient admissions must span at least two midnights to qualify for Medicare Part A payments. Inpatient stays shorter than two midnights should be treated and billed as outpatient services. CMS included the two-midnight rule in its Medicare IPPS rule to better monitor Medicare reimbursement for short inpatient stays and ensure inpatient admissions are medically necessary. The rule was originally due to take effect earlier this year. Medicare administrative contractors and recovery auditors will not conduct two-midnight post-payment reviews of claims with admissions dates between Oct. However, MACs and RAC will carry out prepayment reviews or "probe and educate" audits of hospital admissions that occur between March 31, , and Sept. Depending on the hospital, auditors will review 10 to 25 claims per facility. Physician documentation will be crucial to two-midnight rule compliance. CMS has stated a reasonable inpatient stay that lasts more than two midnights must show "sufficient documentationâ€¦rooted in good medical practice. CMS has also instructed Medicare contractors to use the general two-midnight benchmark instruction when reviewing claims that involve canceled surgical procedures. That means that if the physician expects a patient going in for surgery to require a hospital stay that spans two or more midnights at the time of admission and documents that expectation in the medical record, the inpatient admission will be considered appropriate for payment under Medicare Part A, according to CMS. Hospital leaders, physicians and healthcare groups have criticized the two-midnight rule, saying it is unclear and undermines the medical judgment of physicians. Congressional lawmakers have also opposed the new policy. The two-midnight rule is expected to speed up the decline in inpatient volumes as care shifts to an outpatient setting. The rule adds to other pressures driving the rise in outpatient admissions, including Medicare reviews of medical necessities and changes in care delivery models.

These hospitals with low average lengths of stay are generally smaller, lower-rated and are therefore less capable of handling reduced revenue than other hospitals. The drop in revenue will also affect all hospitals that rely on inpatient care for most of their operating profit, regardless of their size. For this reason, tertiary hospitals and academic medical centers that focus on inpatient care will see negative financial effects. The two-midnight rule could have one upside for hospitals: RACs have reviewed the medical necessity of many short-stay admission claims, contributing to the shift from inpatient care to outpatient settings and reducing hospital revenue. By clearing up any ambiguity regarding short-stay admissions, the two-midnight rule could make the RAC situation less stressful for providers. The PFS assigns relative values to more than 7, services meant to account for the amount of work, malpractice expenses, and direct and indirect practice expenses associated with providing the service. The relative value components are also multiplied by a geographic adjustment factor to account for cost variations across localities. The final figures will be announced in the final rule issued in November. In order to emphasize primary care, CMS has proposed making separate payments for chronic care management services, starting in Additionally, CMS has not proposed establishing separate standards providers furnishing these services would have to meet. As part of an ongoing effort to identify and review misvalued codes, CMS has proposed adding 80 codes to the list of those that could potentially be misvalued. The agency identified most of these codes by reviewing high-expenditure services by specialty, although others were selected through methods such as public nomination. Additionally, the proposed rule would refine how CMS accounts for infrastructure costs related to radiation therapy equipment. This would result in a reduction in radiation therapy service payments, which the agency would redistribute to other services. Also under the misvalued code initiative, CMS has proposed converting all and day global codes to 0-day global codes beginning in calendar year For , the agency conducted its third comprehensive review and update of the RVUs and has proposed new malpractice RVUs for all services, based on updated professional liability insurance premiums. As required by law, the proposed rule would also update geographic price indices for the PFS. Under the proposed rule, CMS would begin collecting data on services furnished in off-campus provider-based departments by requiring physicians to report a modifier for services administered in these settings. Furthermore, the proposed PFS rule would waive the deductible and coinsurance associated with anesthesia related to screening colonoscopies, since anesthesia provided separately by an anesthesia professional is "becoming the prevalent practice in connection with screening colonoscopies, replacing the previous standard of moderate sedation provided intravenously by the endoscopist, which was bundled into the payment for the screening colonoscopy codes," according to CMS. The proposed rule also includes several measures meant to increase transparency. For instance, it includes a provision that would ensure all revisions to payment inputs underpinning final PFS payment rates would be subject to public comment before being used for payment. Additionally, CMS has proposed eliminating the continuing medical education exclusion under the Sunshine Act, which would require pharmaceutical and medical device companies to report payments to physicians for CME. The sustainable growth rate Rather, if the actual expenditures are greater than the SGR target, the Physician Fee Schedule update is supposed to be reduced. Under the law, the update for the year is determined by comparing cumulative actual spending to cumulative target spending from April 1, through the end of the year preceding the year the update will apply to. Consequently, the commission has recommended that Congress repeal the SGR. Every year since , Congress has enacted a short-term legislative patch to delay the SGR cuts, a practice MedPAC said has provoked uncertainty and anger among providers and anxiety among beneficiaries. In addition to the House bill approved last summer, the Senate Finance and House Ways and Means committees issued a proposal earlier this year that would repeal and replace the physician pay formula. Both measures would replace the flawed Medicare physician payment formula with a value-based payment system beginning in

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In Putting Medicare Consumers in Charge: Lessons from the FEHBP, Walton Francis analyzes the successes and failures of both programs and proposes reforms that will revive the FEHBP and improve Medicare.

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