The Payment and Reimbursement Process under the ACA

by Shanna Hanson, FHFMA

Summary

One of our industry’s health care reform knowledge leaders overviews how, under the provisions of the Affordable Care Act, payments and reimbursement to health care providers will be impacted. Among the topics covered in this paper are Disproportionate Share Hospital funding (Medicare and Medicaid), DSH reductions, premium lapses (with examples), Medicaid cost-sharing, insurance verification and “churn.”
In one way, hospitals are like any organizations, whether for profit or not for profit; they rely on an income that is greater than expenses. “Not for profit” does not mean no profit; it simply means that there are no shareholders and the organization does not pay income taxes on its profits because it has to provide a community benefit.

Payment and reimbursement are not “nice things to have,” but rather necessities to operate the facility and fulfill a mission. No margin, no mission. Unlike other organizations, payment does not equal charges, and recipients of services pay for them after they are delivered. These are not new challenges for hospitals, but they are challenges. In this document, several payment and reimbursement issues are reviewed along with their potential to impact the bottom line.

**DSH Reductions**

The Affordable Care Act (ACA) adds new challenges, one of which is Disproportionate Share Hospital (DSH) payment cuts, both in Medicare and in Medicaid. Collectively, hospitals agreed to a decrease in their DSH payments with the understanding that there would be fewer uninsured. These newly insured now would have their accounts paid by Medicaid instead of being charity write-offs.

In 2012, the Supreme Court decision made Medicaid expansion optional for states. This put hospitals in non-expansion states at risk of a reduction in their DSH payments and the insured status of patients, a real “double whammy.”

**Medicare DSH**

In the IPPS final rule for 2014, published on August 19, 2013, the Centers for Medicare and Medicaid Services (CMS) finalized its methodology to implement the Medicare 25% DSH payment provision as well as provide a defined framework for the implementation of the uncompensated care payment (the 75% lost in the DSH reduction).

**Medicaid DSH**

In a “pre-publication – Inspection” posting of the “Disproportionate Share Hospital Payment Reductions (CMS-2367-F)” final rule released September 13, 2013, CMS finalized its methodology for implementing reductions in the Medicaid DSH program. This final rule achieves the specified savings contained in the ACA – $500 million in 2014 and $600 million in 2015. At the national level, that reduction is about 4.3% which will vary by state. How CMS will distribute those cuts has been a major concern for the hospital industry.

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Medicaid DSH dollars will be reduced based at least partly on a state’s percentage of uninsured residents (states with the lowest percentage of uninsured patients receive larger reductions). States that do not target their Medicaid DSH allotments to hospitals with high levels of uncompensated care will see larger reductions than States that do. The DSH funding method outlined in the final rule is only for the first two years of the reduction, as data will be available in 2016 that take into account Medicaid expansion. CMS intends to issue a separate rule for DSH allotment reductions for FY 2016 and thereafter.

President Barack Obama asked Congress to delay the cuts until 2015 in his budget proposal early this year. The final rule specifies that will not happen without Congressional action and, in the absence of a legislative change, the aggregate reductions in federal DSH funding will begin with FY 2014 as required by current law.

**Premium Lapses**

Individuals who are ineligible for Medicaid or CHIP and have income over 100% of the Federal Poverty Level (FPL) may enroll in a Qualified Health Plan (QHP) through the Marketplace. And if their income is between 100% and 400% of the FPL, they will be eligible for Advanced Payment of Tax Credits (APTCs) to supplement their premium cost.

This allows for two groups to be enrolled in a Qualified Health Plan – those who are subsidized, and those who are not. Hospitals are not likely to know into which group a consumer falls, but the rules are different for each and the subsidized group may put providers at greater risk of non-payment due to a premium lapse.

HHS issued rules concerning rescissions of health insurance coverage. Under these, issuers are permitted to cancel coverage retroactively due to a failure to pay premiums in a timely fashion (PHS Act section 2712; 45 CFR 147.128). However, the final standards for QHP issuers add more consumer protections than the generally applicable PHS Act’s counterparts. ²

The Affordable Care Act allows individuals receiving Advance Premium Tax Credits a three-month grace period for non-payment of premiums if they have paid at least one month of the premium during the coverage year. This is the subsidized group. The impact of non-payment of premiums varies by consumer, Qualified Health Plan, provider, and month of the grace period as summarized in the table below.

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The grace period may be reset only if a consumer has paid all outstanding premiums. Once a grace period has been initiated by a QHP, the consumer has three months to settle all outstanding premium payments, at which time the grace period is either resolved and claims awaiting judgments are paid or the individual’s coverage is terminated retroactive to the end of the first month of the grace period. A QHP must provide the enrollee with a notice of termination of coverage at least 30 days prior to effecting termination. According to the *Sacramento Bee*, “Families whose policies are canceled for missing payments are not barred from simply buying another one during the next annual enrollment period. They would face a tax penalty, but no repayment requirement, no fine, no increase in cost of premium, and no ban on receiving a new subsidy.”

Claims awaiting decisions or judgments increase uncertainty for providers and increase the burden of uncompensated care. For this reason, Health and Human Services added to the final Exchange rule that QHP issuers must notify providers who submit claims for services rendered during the second and third months of the grace period that any such claims will await decisions/judgments, and potentially not reimbursed by the QHP if the consumer does not settle

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outstanding premium payments. They go on to suggest there are technology-based approaches to provide this notification.

Clearly hospitals and other providers are at risk for consumers receiving APTCs who do not pay their premiums. Providers need to plan for this and make decisions as to how they will pursue collections and what bad debt they will allow. Understanding the policies of the QHPs in their state will be helpful in making those decisions. How and when will the QHP notify the provider of a premium lapse? Will the QHP pay or await judgments/decisions on claims?

Below are three examples that pull together the rules around the grace period and its impacts. 4

**Assumptions for a monthly premium for all three examples:**

- Premium: $500.
- Advance premium tax credit share of premium: $450.
- Enrollee share of premium: $50.
- First month of grace period: March.
- Individual pays enrollee share of premium for January and February coverage.

**Example 1:**
An individual misses the $50 payment that is due on February 28 for March coverage. He realizes his mistake and pays $100 on March 31st for both March and April coverage, satisfying all obligations for premium payments through the end of March.

- Issuer adjudicates claims for March consistent with normal practices (for non-grace periods).
- Individual will have full coverage for March and April.
- Individual is eligible for premium tax credit for March and April.

**Example 2:**
An individual misses the $50 payment that is due on February 28 for March coverage and misses the $50 payment that is due on March 31st for April coverage. He pays $150 on April 30 for March, April and May coverage.

- Issuer adjudicates claims for March.
- Coverage continues for April and May (2nd and 3rd months of the grace period), but...
- Providers are notified of the potential for a denied claim.
- Issuer awaits judgment or decision on claims for services performed in April and May until individual pays outstanding premiums.
- Individual has paid full premium for March, April and May and, therefore, is eligible for premium tax credit for March, April and May.

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4 Ob. cit., “Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers, A Rule by the Health and Human Services Department on 03/27/2012”
Example 3:
Same facts as Example 2 except now the individual does not pay his share of premiums for March, April or May.

- Coverage is terminated retroactively to March 31.
- Issuer can deny claims for services rendered during April and May. Providers may then seek payment directly from the individual for any services provided during that time.
- Individual may have additional tax liability attributable to the $450 for the advance payment of the premium tax credit paid on his or her behalf for March coverage. The exact amount of additional tax liability will be determined in accordance with the rules for tax credit reconciliation under section 36B of the code.

Proposed Medicaid Cost-sharing

When Massachusetts implemented its state health care reform, Boston medical centers saw an increase, not a decrease, in emergency room usage. A final rule issued July 2013 assists states by allowing Medicaid cost-sharing flexibilities to promote the most effective use of services. Specifically, CMS is permitting states to 1) update their maximum allowable cost-sharing levels, 2) establish higher cost-sharing for non-preferred drugs, and 3) impose higher cost-sharing for non-emergency use of the emergency department. Cost-sharing encompasses deductibles, copayments, coinsurance and other similar charges. Below is a sample of the maximum cost-sharing allowed per the regulations CMS issued in its July 2013 rule.5

<table>
<thead>
<tr>
<th>Inpatient</th>
<th>Outpatient</th>
<th>Non-Emergency use of the ED</th>
<th>Preferred Drugs</th>
<th>Non-Preferred Drugs</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;100% FPL</td>
<td>$75.00</td>
<td>$8.00</td>
<td>$4.00</td>
<td>$8.00</td>
</tr>
<tr>
<td>&gt;100% - &lt;150% FPL</td>
<td>50% of cost the state pays for the first day of care or 10% of total cost the state pays for the entire stay.</td>
<td>Up to 10% of the cost paid by the state for such services.</td>
<td>$8.00</td>
<td>$4.00</td>
</tr>
<tr>
<td>&gt;150% FPL</td>
<td>50% of cost the state pays for the first day of care or 20% of total cost the state pays for the entire stay.</td>
<td>Up to 20% of the cost paid by the state for such services.</td>
<td>No limit</td>
<td>&lt;20% of the cost the agency pays for the drug.</td>
</tr>
</tbody>
</table>

How the modified cost-sharing will impact hospitals remains to be seen. Will it cut down on non-emergency use of the emergency department (ED) or will it leave hospitals with uncollectible cost-sharing amounts? Hospitals need to be alert to the final rule, their state’s response, and the financial impact to their institutions.

Insurance Verification and Churn

Insurance verification will become more important than ever with more insured consumers, qualified health plans, and varying degrees of deductibles and co-pays (Medicaid, Bronze, Silver, Gold, and Platinum). Financial counseling may be needed to help the newly insured to understand their policies. Terminology and concepts such as deductibles and co-pays may be foreign to them. They may mistake “applied” with “approved.” It will be up to the providers from whom they seek services to be prepared to counsel them. Individuals will struggle.

Hospitals today miss 10-15% of active insurance coverage held by the patients they assist. With more patients insured beginning January 1, 2014, particularly ones that don’t understand what they need to do and how, that number is at risk of increasing. Hospitals need to evaluate their processes and identify ways to uncover insurance while the patient is still in the facility. It may be as simple as reworking processes with eligibility vendors or using a new choice of words with the patients.

Churn will play into this too. What Medicaid/CHIP and QHPs have in common may be the same consumer, caught in a revolving door of health care coverage referred to as “churning.” That is, participants with job, marital, family or other life changes whose eligibility for health care coverage transitions them in and out of various coverage categories and health plans. Medicaid/CHIP and the QHP may be the two most common, but there are others including, but not limited to, employer coverage, private health insurance, COBRA and the Basic Health Plan (BHP).

Churning is not a new concept; however, with increased insurability beginning January 1, 2014, under the ACA, the ramifications are multiplied. According to a 2011 Health Affairs report:

“Using national survey data, we estimate that within six months, more than 35 percent of all adults with family incomes below 200 percent of the federal poverty level will experience a shift in eligibility from Medicaid to an insurance Exchange, or the reverse; within a year, 50 percent, or 28 million, will.”

This transitioning is confusing for the patient and expensive for the health plan. Providers can get caught in the middle. Verifying coverage with each and every visit will be imperative.

Financial Assistance

Bad debt and charity care will not go away, but it will look different. The opportunity for providers to revise and update charity applications, policies and procedures is here.

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Optimizing Reimbursement

Unique situations exist that require knowledge beyond the basics. A critical patient presents on January 25, 2014. Application is made for a QHP on February 15 and is approved. Coverage starts March 1. The patient is still in the hospital March 15 and is disabled. Knowing what steps to take to maximize coverage and reimbursement is a service to both the patient and the facility.

Application of coverage through the Marketplace does not preclude application for a MAGI-excepted Medicaid program. In fact, both applications can be processed simultaneously, albeit by two different agencies. Medicaid, in most states, is retroactive, so it is possible an individual can be dually eligible for both MAGI-excepted Medicaid and a QHP for a short period of time. During such a period of retroactive coverage, customary rules regarding third-party liability apply and Medicaid would serve as a secondary payer.

Using the example above, application can be made for a MAGI-excepted Medicaid program (disability program) while simultaneously applying for the QHP. If approved, Medicaid will be the primary coverage for January and February and secondary to the QHP in March. Beyond that, Medicaid most likely will be primary and the QHP eligibility will cease.

Viewing the patient holistically and maintaining an awareness of all eligibility and coverage options are important factors in optimizing payment and reimbursement.

About the Author

Shanna Hanson, FHFMA, is Manager of Business Knowledge for Human Arc (Cleveland, OH), an innovation leader in reimbursement and revenue enhancement services for hospitals and health plans nationwide. She has responsibility for research and reporting on all legislative and environmental changes and trends impacting the company’s health care markets, services and product development initiatives. This includes strategic knowledge leadership for the company on national health care reform and the Affordable Care Act which she has researched for many years. Prior to her present role, Ms. Hanson served 14 years as Human Arc Midwest Operations Leader for its Medicaid eligibility enrollment services. She has been a driving force behind her region’s Healthcare Financial Management Association for many years. Ms. Hanson has served as its President and earned the designation of Fellow of the Healthcare Financial Management Association (FHFMA). She holds the organization’s Certificate of Advanced Technical Study in Mastering Patient Financial Services as well as the Founders Medal of Honor Award. She is a recognized industry writer and speaker on health care and related topics, conducts webinars on health care reform, and is a frequent health care reform blog contributor.