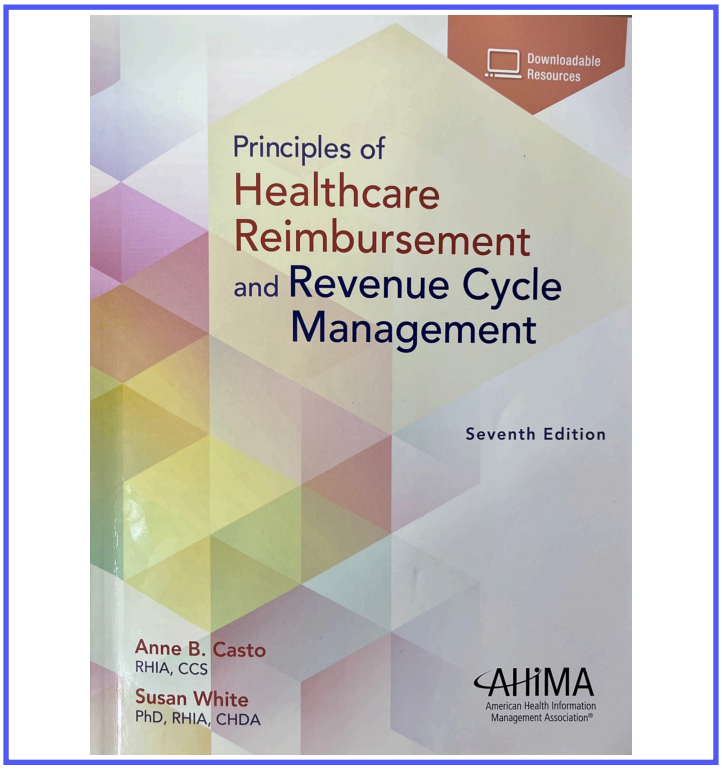


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Part I: Foundations of Healthcare Reimbursement

Chapter 1
Healthcare Reimbursement and Revenue Cycle Management

.earning Objectives

- Distinguish between the social insurance, national health service, and private health insurance healthcare delivery models
- Describe the US healthcare business model
- Define health insurance
- Explain the connection between US health insurar and employment
- Define revenue integrity
- Identify the three main components of the reven cycle

(ey Terms

Beneficiary
Guarantor
nsurance
ntegrated revenue cycle (IRC)
National health service (Beveridge) model
Policyholder
Premium
Private health insurance model
Reimbursement
Revenue cycle
Revenue cycle management (RCM)
Revenue integrity
Risk pool
Single-payer health system
Social insurance (Bismarck) model
Third-party payer
Universal healthcare coverage

Healthcare professionals who understand US healthcare reimbursement systems can assist their patients, organizations, and the public with navigating the business side of healthcare encounters. This book is a guide to healthcare reimbursement and revenue cycle management (RCM). **Reimbursement** is the amount paid to a healthcare provider for services provided to a patient. **Revenue cycle** is the regular set of tasks and activities that produces reimbursement (revenue). **Revenue cycle management (RCM)** is the supervision of all the administrative and clinical functions that contribute to the capture, management, and collection of patient service reimbursement. In this chapter and the chapters that follow, you will learn about healthcare delivery systems, health insurance, government-sponsored healthcare programs, healthcare reimbursement methodologies, revenue cycle process RCM, revenue compliance, and revenue cycle analys **Insurance**, in general, is a system of reducing a perso exposure to risk of loss by having another par an insurance company, assume the risk. Healthca professionals must understand health insurance and t revenue cycle in the US healthcare sector because their potential fiscal impact on people's lives.

A systematic approach makes the complexi of healthcare reimbursement and the revenue cyc manageable. Chapters 1 through 3 of this text discu the structure of healthcare delivery and health insuran in the US. Next, the text dives into the complex proce of healthcare reimbursement. The revenue cyc components are explained clearly and in detail. Step step, the procedures for obtaining correct and accur

eimbursement are discussed. Terms, abbreviations, nd acronyms are clearly defined. After reading this ext, healthcare professionals can feel confident in neir reimbursement and revenue cycle knowledge and vill be able to contribute to policies, procedures, and nalytics as members of the healthcare team.

National Models of Healthcare Delivery

hree national models for delivering healthcare ervices exist: social insurance, national health service, nd private health insurance (Kulesher and Forrestal 014, 127). These models can be seen in various ermutations in countries around the world. The models ary by sources of funding, number and types of payers volved, and levels of healthcare services. Here are escriptions of the three national models:

- **Social insurance model**, or the **Bismarck model**. Introduced in 1883 by German Chancellor Otto von Bismarck, this model is the oldest in the world. The foundation of this model is **universal healthcare coverage** for a set of benefits defined by the national government. Universal healthcare coverage is the minimum level of healthcare insurance defined by the government, which may include coverage for preventative and primary care, hospitalization, mental health benefits, and prescription drugs. In this model, every worker and employer must contribute to sickness funds, agencies that collect and redistribute money per government regulations; they are a form of social security. The amounts of the contributions are proportionate to workers' and employers' incomes. Workers can choose among competing sickness funds. With varying modifications, France, Japan, the Netherlands, and many other countries have adopted this German model. (Frogner et al. 2011, 72)
- **National health service model**, or the **Beveridge model**. In 1946, Sir William Beveridge created the national health service model for the United Kingdom (UK). In the UK, the government owns the clinics and hospitals and pays the doctors and healthcare professionals who work in these public facilities. This government-run model is a **single-pa health system**—the UK government is only payer. In this type of system, one en acts as an administrator of a single insura pool. The entity collects all health fees (taxe contributions) and pays all health costs for entire population. The single entity can be agency of the government or a government- organization. In the UK, the healthcare syst is financed by the country's general revent The general revenues come from taxes t increase in proportion to income (progress tax). With varying modifications, Spain a the Scandinavian countries have adopted t model. (Frogner et al. 2011, 72)
- **Private health insurance model**. In this moc many private health insurance companies ex The private health insurance companies coll premiums to create a pool of money. T pool of money is used to pay health clair Much as with the Bismarck model, work and employers contribute to the pool. Unl the Bismarck system, the insurance compa determines the contribution, and this contributi is not based on the employee's income. The l and Switzerland use the private health insurar model. In Switzerland, governmental regulati of health insurance is more extensive than in t US. (Frogner et al. 2011, 73)

No country's system is a pure version of the models (Kulesher and Forrestal 2014, 127). For examp a hybrid of the Bismarck and Beveridge models exis This hybrid is used in Canada, South Korea, and oth countries. Generally, however, one model dominat each country's system.

Each model has positive and negative attribut depending on the role of the observer: patient, provid or administrator. Cram et al. (2017) discuss the pr and cons of the Canadian healthcare system. T Canadian system is primarily a national health servi model. From the patient's perspective, the cons the Canadian system are higher taxes and longer w times for nonemergent procedures. Some of the pr include a more equitable healthcare system and l out-of-pocket treatment costs for patients (Cram 201 Although insured patients are generally able to acce nonemergent care more quickly in the US syste

ıigh out-of-pocket costs and lack of insurance are ɔarriers to care. In the Canadian system, there is little ıdministrative burden on the physician and hospital, ɔut the primary care physician must prioritize which patients receive high-cost tests and treatments. Chapter 4 in this text will present much of the detail around the administrative burden within the US healthcare system.

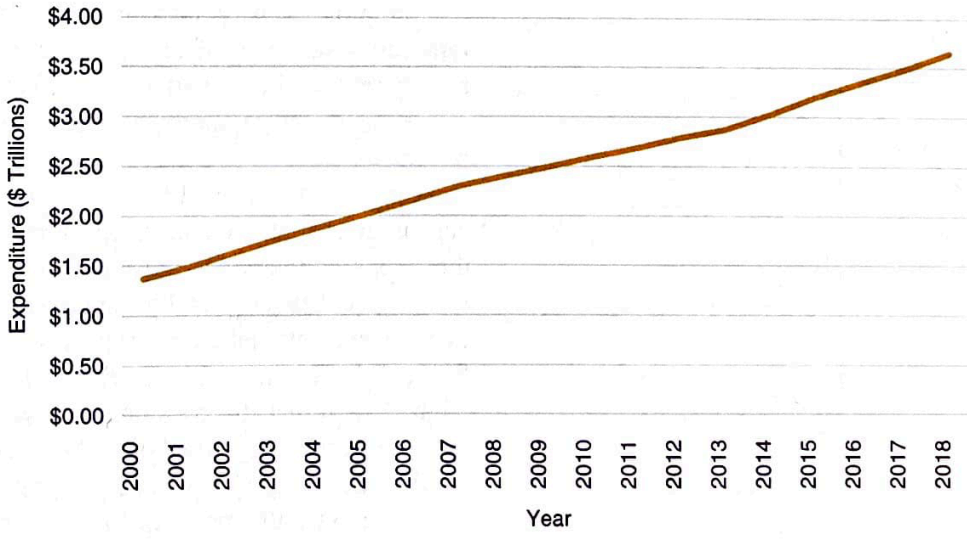
Healthcare Delivery in the US

The US healthcare sector represents a significant portion of the US economy. In 2018, the US healthcare sector accounted for $3.6 trillion, or 17.7 percent, of the nation's gross domestic product (GDP). The GDP is the value of all goods and services made within a country. National healthcare spending continues to grow each year and it grew at a rate of 4.6 percent from 2017 to 2018 (CMS 2019). The trend of increased spending on healthcare has been consistent for more than a decade. Although the actual expenditures continue to increase each year, as demonstrated in figure 1.1, figure 1.2 demonstrates that the percent increase is on a downward trend.

In addition to being large, the US healthcare system is complex. Facilities and physicians typically treat patients with various types of health insurance including commercial insurance and government-based insurance. Chapter 2, "Health Insurance," and chapter 3, "Government-Sponsored Healthcare Programs," discuss the structure of insurance in more detail. T contract between a health insurance company a facility can include a wide variety of plans, with ea plan designating which reimbursement methodologi will be employed for each service. The result is t facility or physician practice managing multiple pla within its revenue cycle. Moreover, the payment rat and terms of these contracts between providers a insurance plans can be revised, updated, or renew on different timetables, such as midyear, annually, after multiple years. The management of the numero insurance plans is required to ensure the financ viability of the provider and requires a significa amount of administrative burden.

Figure 1.3 depicts the relationships among t patient, the employer, the third-party payer, and t provider. The **third-party payer** is an insuran company or health agency that pays the physicia clinic, or other provider for the care or servic rendered to the patient. There are transactions a communication among all four parties. Relationship (represents transactions between the consumer or patie and the provider. Healthcare services are provided the patient. The patient contacts the provider to arran services and is responsible for payment if the patie does not have insurance coverage for the service. If t patient does have coverage, then the patient pays a cost sharing amount that may be required under t third-party payer coverage parameters. Relationsh (2) represents transactions between the provider a

Figure 1.1. Annual US national healthcare expenditures



Source: Adapted from CMS 2019, Table 1.