A KNOWLEDGE NOTE[1]…

A MEDICARE MYSTERY – SOLVED!?

WHY MEDICARE PAID ONLY $1,300 ON A $14,300 BILL…

KNOWLEDGE IS POWER!

A LITTLE BIT OF SUNSHINE IS A GREAT DISINFECTANT…

IF YOU HAVE AN APPETITE FOR GREATER COMPREHENSIVE UNDERSTANDING AND THINGS YOU COULD DO TO IMPROVE YOUR MEDICARE RIGHTS…

AND HEALTH RELATED COSTS…

THEN …READ ON…

- *Depending on a reader's interest, you may refer to the following sections as desired:*

[1] Author: Larry D Killion, retired licensed attorney and registered professional engineer in Texas. Not a Medicare expert, just a curiously minded Medicare patient, seeking knowledge to better manage health costs. This topic is admittedly complex. My intent was to present facts and information in a format that is reasonably understandable by other non-expert Medicare interested readers. Apologies in advance as I have presented some of the information in a repetitive format with examples, which causes the Note length to increase. I've tried to honor the KISS process: Keep It Simple Stupid; and err on elegant simplicity instead of intellectual complexity. I'm sure I have failed in this mission in some areas Contact: 11235ldk@comcast.net.

SUMMARY OF FINDINGS

This Knowledge Note[2] was researched and prepared, after the author failed[3] to obtain in plain English from Medicare resources and experts, answers to a Medicare ***Mystery***.

What is the Mystery?

- Why a health provider (your doctor or the hospital),
- Who submits a medical bill for a patient's medical expenses to Medicare,
- Because the health provider has contracted with and accepts payment from Medicare,
- Regularly accepts from Medicare as full payment, only a small portion of the medical bill?
- Why is there often a large difference between what Medicare paid and reimbursed a health provider compared to the health provider's original (larger) medical bill amount?

The author set out to answer these questions:

- Is the health provider over charging for its services?
- Has Medicare accurately valued the medical services of the health provider and is paying too low an amount?
- Why doesn't the health provider just bill what Medicare will pay (the allowable payment)?
- Is there some advantage to the health provider charging a high price but only being paid from Medicare a fraction of the bill?
    - Such as…
        - Taking the unpaid portion as a financial loss and deducting that from the health provider income tax filings, thus reducing its tax bill; or
        - Reporting the higher charge as an 'account receivable' in its financial reports, which has positive effects on the financial value (greater current asset value) of the health provider.
- If the medical bill is not paid by Medicare (a patient not eligible for Medicare) nor reimbursed from any other health insurance plan, does the health provider expect full payment for its bill from its uninsured patient – or is there an allowed discount?

As an illustrative but real example, of a Medicare Summary Notice (MSN) sent to a Medicare patient:

• Health provider billing:		$14,341.50
• Medicare 'approved' claim and charge:	$14,341.50	
• Medicare Allowed Payment:	$1,306.80	
• Applied to Patient Deductible	-$63.41	
• Net Allowed Payment:	$1,243.39	
• Amount Medicare Paid (80%):		$994.71
• Patient Medicare Co-Insurance (20%):	$248.68	

[2] This Knowledge Note primarily assesses 'original or Traditional Medicare' plans (Plans A, B, D) and not Medicare Advantage Plans (Plan C). A comparison of Original Medicare and Advantage Plans is presented in a summary table at the end of this note along with a comment of things to consider as to which to choose and why.

[3] The Author consulted with: Medicare (Center for Medicare and Medicaid Services - CMS); relevant medical provider billing department; Medicare Supplemental Insurance plan carrier; internet research…

- Maximum Amount Patient May Be Billed ($63.41+$248.68): $312.09
- Paid by Patient's Medigap/Medicare Supplemental insurance: $312.09
- Amount owed by the patient: $0.00[4]
- Total amount paid to health provider: $1,306.80
- Balance ('forgiven' or 'discounted' or other, 91%): $13,034.70

So, what happened to the $13,034.70 (91%!) balance? THE MYSTERY!!!…

Summary Explanation Of the Mystery
Answers to the Questions
Based on Findings in this Knowledge Note[5]

- Is the health provider over charging for its services?
  - The Standard Pricing from a hospital charge-master (or similar pricing sheet used by non-hospital health providers), used to establish the charge for a health provider service or good, is not transparent to the public and influenced by many objective and subjective factors, including the extent of potential insurance reimbursement contract discounts and varies among health providers.
  - Standard Prices may or may not reflect a fair market value price for health care.
  - The actual and/or apparent cost of providing a health provider service or good is not transparent, is complicated to determine, and influenced by many objective and subjective factors. Knowing the actual cost of service or good assists with establishing a fair profit margin. The typical use of a Cost-To-Charge ratio, while less complicated than a detail cost accounting process, may or may not represent a realistic basis to determine cost of a service or good.
  - Answer: It is possible for a health provider to overcharge for its services. But only the shadow knows.
- Has Medicare accurately valued the medical services of the health provider?
  - Because Medicare is a regulated price fixing government mandated process, any time a competitive fair market economy does not determine prices, a substituted government regulated price environment results in complications, a mix of fair and unfair results, participants gaming the system to optimize their own selfish objectives, and interference from unintended circumstances (such as needed Medicare issue approval votes affected by political ransom demands to achieve non-Medicare political objectives).
  - Medicare price fixing process is complicated and not based on fair market competitive mandates and can be adjusted by factors that have nothing to do with health care.

[4] *Most patients will end their knowledge curiosity at this point – they owe nothing!, and not pursue why there is an apparent 91% discount of the original bill…*

[5] The author of this Knowledge Note does not claim to be an expert in Medicare or medical insurance. The author does claim to be a curious Medicare Beneficiary and desiring to better understand how Medicare and medical insurance works to be better informed to make better decisions and better understand the nation's political leaders health related debates as they struggle with how to address the Nation's rising health costs and how consumers and patients can have access to good and timely medical care at fair and reasonable costs.

- Since most health providers accept Medicare (assignment) they must do so most likely because it is in their economic best interest…consequently Medicare fixed pricing must have some aspect of fairly compensating health providers.
- Answer: It is possible for Medicare to establish fair health care prices, assuming the non-health related influencing factors are better managed if not eliminated.

- Why doesn't the health provider just bill what Medicare will pay (the allowable payment)?
  - The health provider deals with both Medicare and commercial insurance companies as well as dealing with uninsured patients.
  - As a matter of practice the health provider will bill the same Standard Pricing for any of its services, leaving the ultimate payment amount to be adjusted, if applicable, by the terms and conditions of the relevant applicable insurance plan or in the case of uninsured patients, the health provider payment policy for such patients (which typically entails a discount) or any applicable governing law.
  - The billing amount (Standard Pricing) is presumptively what the health provider believes to be a fair and reasonable price for its services.
  - In addition, there could be contractual legal disputes if a health provider billed different costs to different insurance plans for the same service.
- Is there some advantage to the health provider charging a high price but only being paid from Medicare a fraction of the bill?
  - Such as…
    - Taking the unpaid portion as a financial loss and deducting that from the health provider income tax filings, thus reducing its tax bill; or
    - Reporting the higher charge as an 'account receivable' in its financial reports (greater current asset value), which has positive effects on the financial value of the health provider.
  - Health providers reporting their billed charges (Standard Pricing) in their financial statements on an accrual basis suggests such reporting would show strength in their financial status because of favorable higher potential revenues in income statements, attractive account receivables in balance sheet and higher current asset values.
  - Health providers will charge the same Standard Price to all patients no matter what type of medical insurance reimbursement plan they have.
  - Health provider strong financial statements are beneficial for the following reasons…
    - Financial strength is important to report such to stockholders if a pubic entity or government bodies if a non-profit,
    - Complies with debt servicing financial strength tests,
      - depending on the debt of a health provider, if its financial position becomes too weak, it may be required to put up more security or pay down debt or other risk reduction requirements,
    - Strong financial condition usually improves key performance indicators (KPIs) used to establish bonus and other incentive benefits to employees and executives,

        - Reporting shortfalls[6] in reimbursement allowed payments from Medicare (difference between what the health provider billed and what Medicare paid – allowed payment) as typically described as a Community Benefit, buttressing community service goodwill and non-profit income tax reporting[7]. Part of the argument is that the community benefit provided by the health provider relieves the government from stepping in and having to shoulder the same burden.
        - Thus there is a three headed argument:
            - (1) on one hand the shortfall could be viewed as a 'loss' to the health provider – being paid less than what was billed and the difference a 'loss'; or,
            - (2) the shortfall difference of what was billed and what was paid - is viewed as a Community Benefit, and a positive thing, the higher Standard Pricing amount billed could be consciously or subconsciously accepted as an appropriate charge or
            - (3) the health provider has over-charged and Medicare has underpaid, and the more honest argument is somewhere in between.
        - Answer: Yes there is a benefit.
- If the medical bill is not paid by Medicare (a patient not eligible for Medicare) or any other commercial medical insurance, does the health provider expect full payment for its bill from its uninsured patient – or is there an allowed discount?
    - Payment obligations for health related services and goods are influenced by the health provider being a public or private or profit or not-for-profit entity. Each will have its own policies and procedures for uninsured patients affected by the financial status of the patient.
    - Many will allow an automatic discount depending on the patient and circumstance.
    - Some patients may have access to financial assistance from the health provider or third party.
    - Answer: Generally for uninsured patients there is some form of discount by most health providers. This is a rational decision because paying the cost of an unpaid medical bill

[6] Medicare Surplus and Shortfall: In 2016, one reported study showed 71 percent of participating hospitals in a survey reported having Medicare shortfalls. Medicare reimbursement shortfalls occur when the Federal government reimburses the hospitals less than their costs for treating Medicare patients. Most hospitals described why their Medicare shortfall should be treated as community benefit: • They explained on their Schedule H forms that non-negotiable Medicare rates are sometimes out-of-line with the true costs of treating Medicare patients. • By continuing to treat patients eligible for Medicare, hospitals alleviate the Federal government's burden for directly providing medical services. The IRS has acknowledged that lessening the government burden associated with providing Medicare benefits is a charitable purpose. • Additionally, many hospitals pointed to IRS Rev. Rul. 69-545 in their explanation of Medicare shortfall as a community benefit. IRS Rev. Rul. 69-545 states that if a hospital serves patients with government health benefits, including Medicare, then this is an indication that the hospital operates to promote the health of the community. .

[7] A not-for-profit health provider files annually Internal Revenue Service Form 990 Return of Organization Exempt From Income Tax. That publicly available form contains extensive financial performance information and various election confirmations (such as accrual accounting; costs determined by cost-to-charge ratio) as well as community service discussion regarding shortfall between billed revenues and Medicare payments.

collection lawsuit may result in no recovery. Its better to try and obtain partial payment and write the balance off as a bad debit and take a tax write-off advantage. Its all economics.

Part 1

Important Things To Know About Health Providers and Medicare Billings To Help Solve the Mystery

Health Provider Types

- Health provider types include: doctors, hospitals, medical equipment vendors and other similar health related entities.
- Health provider types can be for profit, non-profit, private or non-private (public) entities.
    - Not-for-profit health care providers don't assess the patient's intent and ability to pay for their responsibility (deductible or coinsurance) prior to providing services.
    - If any health provider contracts with and accepts Medicare as a form of payment, then the health provider whether or not publicly or privately owned, or profit or not-for-profit is:
        - (i) contractually obligated to accept Medicare's 'fixed' reimbursement allowable amounts for a bill as full payment, and also
        - (ii) obligated to disclose and report to the public, certain information,

WHY IS THIS IMPORTANT?

HEALTH PROVIDERS ARE ALL DIFFERENT. COMPARING HOSPITALS OR DOCTORS IS DIFFICULT AND COMPLEX, SINCE EACH HAVE DIFFERENT CHARACTERISTICS THAT AFFECT THE SERVICES THEY PROVIDE, THEIR PRICING AND THE COST OF THOSE SERVICES.

Health Provider Accounting and Financial Reporting Practice and How They Affect the Mystery

Accrual / Cash Accounting

- Health providers report their financial status on either an (i) **accrual** or (ii) **cash**, accounting basis (see Figure 1).

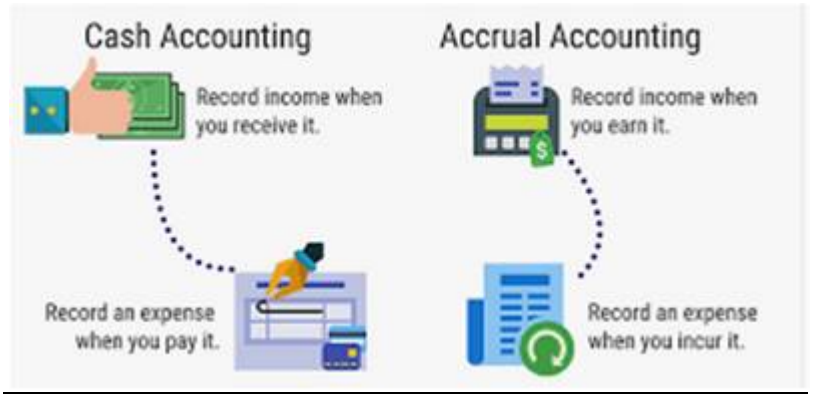

Figure 1

- **Accrual** accounting is **an accounting method where revenue or expenses are recorded when a transaction occurs rather than** when payment is actually received or made. In other words, accrual accounting records *anticipated* financial results before cash is actually received or paid. For example

- Expected revenue (such as a bill sent to a patient) is recorded as **accrued** revenue, when the bill is sent (but before it is actually paid).
- Expected expenses, such as monthly salaries of employees, are reported as **accrued** expenses, before the salary is actually paid.
- Accrual accounting theory cites that **accrual** accounting more accurately and smoothly reflects the financial status of the health provider.

- **Cash** accounting is **an accounting method where payment receipts are recorded during the period in which they are received**, and expenses are recorded in the period in which they are actually paid. In other words, cash accounting records financial results when cash is actually received or paid. For example
  - When a medical bill is actually paid, the payment is recorded as revenue.
  - When an expense is actually paid (such as paying the electric bill), the payment is recorded as an expense.
- Most health providers use the **accrual** method of accounting.

WHY IS THIS IMPORTANT?

UNDERSTANDING HEALTH PROVIDER ACCRUAL ACCOUNTING BASIS HELPS TO EXPLAIN HOW HEALTH PROVIDERS PREPARE THEIR FINANCIAL STATEMENTS TO REFLECT AS OPTIMISTIC STRONG FINANCIAL CONDITION AS POSSIBLE.

Health Provider Standard Pricing or Charges[8]

- Following is a discussion of hospital[9] billed charges (pricing), contractual adjustments, allowed amount, payments by insurers, payments by patients and health care costs:

Allowed Amount = Hospital Billed Charges - Contractual Adjustments

[8] Standard Prices or charges are rarely discussed with patients before treatment because of patients' lack of time, ability, and knowledge; physicians' professional norms against discussing fees; the complexity of hospital accounting; and the lack of price transparency. Consider the patient wanting to compare hospital prices before an elective surgery. That person would need to know differences in quality and patient satisfaction across the potential hospitals for the specific procedure. The patient would also want to compare prices across the potential hospitals using the hospital's chargemaster file and the Medicare cost report. Both documents are extremely complex, and a comparison is impossible unless the patient knows exactly which services will be ordered and how the services will be coded. Some hospitals might unbundle services (creating more categories of billable services to maximize revenue), which makes it more challenging for patients to precisely estimate a price for the total service. Furthermore, the price and quality of physicians and other clinicians caring for the patient would need to be compared as well. Knowing all of the relevant information about the hospital without knowing the price and quality of physician services is like purchasing a suit and only knowing the price of the pants. The patient, however, usually does not know all of the physicians who will provide care, because some physicians are in network and others are out of network, a factor that could significantly affect the actual amount the patient would pay. A patient wanting to compare hospital prices faces a substantial information asymmetry for an elective procedure, and the time necessary to conduct price and quality comparisons is not available in most medical emergencies.

[9] Non-hospital health providers will have similar billing and pricing systems.

Allowed Amount	**=**	**Paid Amount by Insurer + Patient Share[10]**
Hospital Cost	**=**	**Hospital Expenses for Providing Care**

- How health providers determine their billed charges or price for its services, identified by many names such as **gross price/charge** or **billed charge** or **Standard Pricing (SP)**, is complex and varies among providers providing the same service.
- In the United States, hospitals use a **chargemaster**, a list of procedure codes with corresponding **Standard Prices** for thousands of billable items, to record services provided, determine the charges for each service, and generate hospital bills. **Standard Price** setting is not transparent and varies with each health provider. **Standard Pricing** may or may not reflect a rational fair market valued price of a particular health service. Physicians use comparable charging methodology.
    - **Chargemaster** (**Standard Price**) rates are established by individual hospitals and are not subject to any limit in most states. The rates are often several times the Medicare-allowable cost of providing care. Each hospital or health system builds their chargemaster to meet their unique needs. There is no consistency between different hospitals unless they are part of a group of hospitals using common practices.
    - Except in a few situations, hospital markups (ratios of charges over Medicare-allowable costs) do not have an effect on the amounts publicly insured patients pay because Medicare and Medicaid determine their own rules for paying hospitals.
    - Non-Medicare patients who are not protected by Medicare's fixed price reimbursement rules, can be negatively affected by high hospital markups. Uninsured patients in particular lack bargaining power and are commonly subject to the full hospital charges.
    - The **Standard Price (SP)** from the chargemaster are generally much higher than what is actually paid (the *allowed amount*) by Medicare and commercial medical insurance policies. Every insurance contract has terms that generally require a health provider to accept as full payment, a lesser amount (the *allowed amount*) than what was actually billed.
        - If a price tag was attached to each medical service as in the retail industry, everything is on sale without people knowing what the sales price is. No other industry has comparable ratios or standard discounts. In most industries, you pay the price on the tag, perhaps with a discount for the sale or closeout pricing.
    - There generally are not any restrictions or definitions of what is a reasonable assumption to be used in building a charge-master or setting individual Standard Prices on the charge-master.
- **Gross prices** (or charge) or **Standard Prices** are regularly reviewed and updated by health provider board of directors or executive management, typically on an annual basis.
    - The **gross charge or Standard Price** is the amount a hospital charges when billing for services rendered.

[10] Patient's payment share is affected by: Copayments (e.g., patient pays $20 per physician visit) or Coinsurance (e.g., patient pays 35% of the Emergency Department Amounts) or a Deductible (e.g., enrollee pays the first $1,000 of care in a given year before insurance coverage kicks in); or if uninsured, personal liability of the patient for the entire charge.

- The actual (allowed) amount paid to the health provider is based upon (i) the negotiated reimbursement rate the health provider has with a patient's insurance (and different insurance policies will have different reimbursement terms), (ii) the benefit plan the patient has or (iii) the agreed payment if self-pay (no insurance).
- **Standard Pricing** can be influenced by many factors, some objective and some subjective, such as: Percent of charge basis; Per day rate; Diagnosis-related group (DRGs) or All patient refined diagnosis-related group (APR-DRG) basis; Ambulatory Payment Classifications (APC) or Enhanced Ambulatory Patient Groups (EAPG) basis; Fee Schedule basis (Medicare); insurance policy reimbursement discounts; uninsured discount; financial assistance.

- A health provider who accepts Medicare is obligated to provide to its patients a 'transparent' process for assessing some of the health providers Standard Pricing. While such processes are in place, they are complicated to access and interpret and often times the prices are burdened with so many restrictions or caveats that the pricing disclosure is somewhat useless. See footnote 7 for a more detail discussion of the complexity of price disclosure information.

WHY IS THIS IMPORTANT?

UNDERSTANDING HOW HEALTH PROVIDERS DETERMINE THEIR NON-TRANSPARENT STANDARD PRICES FOR THEIR GOODS AND SERVICES WILL ASSIST THE PATIENT TO BETTER UNDERSTAND THE BASIS OF PRICING OF THEIR MEDICAL BILL AND HOW IT IS PAID…

AS WELL AS BEING BETTER INFORMED WHEN OUR ELECTED OFFICIALS DEBATE THE BEST LOWER COST MEDICAL CARE SYSTEM FOR THE NATION.

Health Provider Cost Assessment

- There generally are two methods for determining the cost of health services by a health provider: (1) **cost accounting system** and (2) **cost-to-charge ratio**. Each varies with each health provider.
  - **Cost accounting system, the more accurate system of the two,** is very complicated and time consuming to determine. It involves assessing every service and identifying all activities, personnel time (service time studies), equipment used, overhead costs, variables that can swing the cost (such as variations affected by unforeseen complications that develop, additional tests or procedures, or additional interventions ordered by a physician based on the patients medical needs in order to provide the patient with the best possible care, different cost control procedures by health providers, etc.). Because of its complexity, few health providers use **cost accounting**.
  - **Cost-to-charge ratio** is much less complicated and used by most health providers. The cost-to-charge ratio is calculated as a hospital's total Medicare-allowable cost (say over a years period) divided by its total gross charges (over the same year). Periodically (say on a yearly basis) the health provider will…
    - Add up all of its **Medicare-allowable costs** (the ***aggregate* costs**);
      - **Medicare-allowable cost** refers to the cost determined by the Centers for Medicare and Medicaid Services (CMS – the federal government's

agency that administers Medicare and Medicaid) to be associated with care for all patients, not just Medicare patients (both inpatient and outpatient). **Medicare-allowable cost** includes both direct patient cost (for example, emergency department, operating room, and intensive care) and indirect general service cost (for example, administration, laundry, and pharmacy) but excludes items not related to the patient care provided by the hospital, such as services of the gift shop and private physicians' offices.

        - Add up all of its **gross charges** (**Special Prices**) billed to patients (the ***aggregate* charge** or aggregate of all billed Standard Prices).
        - The **aggregate cost** is divided by the **aggregate charge** to determine a **Cost-to-charge ratio**.
            - For example, assume the **aggregate Medicare-allowable cost** is 100 and the **aggregate charge** is 400, then the cost-to-charge ratio is 100/400 or 0.25 or 25%. The inverse of this number, being 4 (400/100) is called the **charge-to-cost ratio**, and in this example indicates a charge is 4 times greater than the underlying cost.
- To determine the cost of a service when using the **Cost-to-charge ratio** method, the health provider will take its **Standard Price (for hospitals, from the chargemaster)**, then multiply it by the Cost-to-charge ratio, to determine its *apparent* cost for that billed service. This calculation methodology is a little dubious since the Standard Price is not necessarily a transparent, objective, realistic price.
    - For example, assume the Standard Price from the chargemaster is 400, the composite Cost-to-charge ratio is 0.25, then 400 x 0.25 = 100 as the *apparent* cost of that service associated with that charge. Such an *apparent* cost may or may not reflect a more accurate *real* cost that could be obtained from a **cost accounting method**.
    - Health providers typically compare this cost of service against Medicare fixed price reimbursement allowable payments to assess whether or not Medicare has over paid or underpaid for the service.
        - For example, assume for a particular service, Medicare allowed payment (Medicare allowable cost) is 50. The health provider Special Pricing billing was for 400 and using its 0.25 cost-to-charge ratio, determines its costs for that service is 100. The health provider would assess the Medicare allowed payment (50, being only 12.5% of its Special Pricing billing) to be less than its cost (100) by a factor of 2 (100 cost/50 payment = 2).
            - This analysis is subject to testing (i) how accurate the Special Pricing amount is; (ii) is Medicare allowed payment and associated Medicare allowed cost determinations accurate; (iii) how realistic is the cost-to-charge ratio index.
            - The answer is somewhere in the middle…just like a carpenter's level, having the bubble in the middle is normally a good thing.
    - While the **Cost-to-charge** ratio process is less complicated, the process to determine the cost of the service using this method is somewhat speculative and may or may not be a fair representation of the true cost of a service.

- The inverse of the Cost-to-charge ratio is the Charge-to-cost ratio. Typical Charge-to-cost ratios range from 1.4 to 4, but in the extreme can be as high as 10, which means a charge that is 1000% above the Medicare allowable-costs.

WHY THIS IS IMPORTANT?

UNDERSTANDING HOW HEALTH PROVIDER COSTS ARE DETERMINED ARE ESSENTIAL TO

- ***UNDERSTAND TO WHAT EXTENT A CHARGE IS REASONABLE COMPARED TO ITS TRUE VS APPARENT VALUE;***
- ***BETTER UNDERSTAND WHETHER A 'DISCOUNTED' OR CONTRACT ADJUSTED INSURANCE PAYMENT THAT IS LESS THAN THE BILLED CHARGE IS REASONABLE;***
- ***BETTER UNDERSTAND WHETHER OR NOT A HEALTH PROVIDER HAS BEEN OVER PAID, UNDERPAID OR PAID JUST RIGHT…***
- ***BETTER UNDERSTANDING OF OUR ELECTED OFFICIAL DEBATE OVER WHAT IS THE BEST LOW COST HEALTH CARE PLAN FOR THE NATION***

Account Receivables

- Health providers prepare an income statement which is **a financial statement that shows the provider's income (revenues) and expenditures**. It also shows whether a provider is making profit or loss for a given period. The income statement, along with balance sheet and cash flow statement, helps the provider and interested parties to understand the financial health of the practice.
- Health providers report their **accrued** actual billings-**Gross Charges or Standard Pricing** (not yet paid for) as an **account receivable** in their financial statements.
- **Accounts receivable (AR**) is **the balance of money due or owed** to a health provider for goods or services delivered or used but not yet paid for by the patient. (See Figure 2 example) **Accounts receivables** are listed on the financial statement balance sheet of the health provider as a **current asset (and not a liability) since it is money owed to the health provider**. Equally, Account payables, are expenses owed by the health provider but not yet paid, are listed on the financial statement balance sheet of the health provider as a current liability.
- **Account receivables** is an important measure of outstanding revenue to be collected and also measures delinquency in payments if the **AR** continues to increase and not otherwise adjusted (such as reducing the AR when payments are made in the future or writing off as a loss some of the **AR** as a bad debt).

Figure 2

A Simple Balance Sheet

Assets		Liabilities and Owners' Equity		
Cash	13,200	Liabilities		
Accounts Receivable	12,400	Notes Payable	10,000	
Tools & Equipment	50,000	Accounts Payable	50,000	
		Total Liabilities		60,000
		Owners' Equity		
		Capital Stock	14,000	
		Retained Earnings	1,600	
		Total Owners' Equity		15,600
Total	75,600	Total		75,600

WHY THIS IS IMPORTANT?

UNDERSTANDING HOW HEALTH PROVIDERS REPORT THEIR ACCOUNT RECEIABLES IN THEIR FINANCIAL STATEMENTS IS IMPORTANT SINCE ACCOUNT RECEIVABLES IS A MEASURE OF THE FINANCIAL HEALTH OF THE HEALTH PROVIDER –
A LARGE AR INDICATES LOTS OF SERVICES HAVE BEEN RENDERED AND EITHER (i) PAYMENT IS EXPECTED IN THE FUTURE OR (ii) DELINQUENT PAYMENTS ARE PILING UP.
ACCOUNT RECEIVALBES ARE BASED ON STANDARD PRICING CHARGES (WHAT THE HEALTH PROVIDER BILLED ITS PATIENT, NOT WHAT IT EXPECTS TO RECEIVE FROM MEDICARE OR ANY OTHER INSURANCE PLAN)

Contractual Adjustment (*explicit price concession*)

- **Contract Adjustments** are adjustments (normally a reduction) shown in financial statements associated with a health provider charge or gross (Standard Price) billing that is affected by the reimbursement terms and conditions of any applicable: (i) commercial insurance policy – such as an employer medical plan, personal medical insurance; (ii) Medicare regulated fixed prices (Fee For Services) for medical services; or (iii) uninsured patients who are personally responsible for a health provider charge or billing (or at least part of the bill depending on the health provider policy and discounts).
    - A **Contractual Adjustment** is a part of a patient's bill that a doctor or hospital must write-off (not charge for) because of billing agreements with the insurance company (including Medicare). Adjustments, or write-offs, are the dollars that are adjusted off a patient account for any reason. The Contractual Adjustment is the most common type of adjustment.
    - The term Adjustment in Contractual Adjustment indicates: denied, zero payment, partial payment, reduced payment, penalty applied, additional payment, supplemental payment
    - In simple language, it is an amount which is reduced from the medical bill just because the patient has a contract with the insurance company whose terms reimburse less than what was billed.
    - Providers typically charge more for services than what the insurance company agrees to pay and the amount that is paid by the insurance is known as an allowable amount. The extra amount which provider charges is reduced from the final amount when paid. This happened because the patient has a contract or billing agreement with the insurance company which has reduced the extra amount charged by provider. So if a provider charges $80 for a service and the insurance company's allowance for that particular service is only $70, then a patients has a contract with the insurance company, then the $10 will be written-off (not charged for) from the final payment. For example, if Medicare agrees to pay 65% of a normal charge for a particular service, the Contractual Adjustment would be 35% **of the invoice amount** of the Account related to such service.
    - In regard to financial accounting, when a gross billing is entered as a receivable or accounts receivable, then when the bill is actually paid at a lower amount, a Contractual Adjustment can then be entered to show the actual lower amount of cash received. This accounting process allows prior to the Contractual Adjustment, reporting in financial

records a high receivable revenue, which would temporarily indicate stronger financial position than what will ultimately be paid.

- Medicare fixed price *allowed payments* are typically less than the health provider **Standard Price** bill.
    - When Medicare eventually and actually pays (***Allowed Payment***) a lower amount for a health provider's bill after receipt of the health provider billing and the billing analyzed for completeness and accuracy, because of Medicare and health provider mutual contract commitment such allowed payment is considered full payment for that bill, the health provider's previous recorded billed revenue based on its original higher billing in (i) the income statement and (ii) the **accounts receivable** on the balance sheet, are adjusted (downward) and the reduction or adjustment described as a **Contract Adjustment (or explicit price concession and not a bad debt)**[11]. (See Figure 3 example)

Figure 3 ((i) Balance Sheet/(ii) Income Statement, reflecting Contractual Adjustment accounting)

Hospital accounts receivable	$3,254,936
Nursing home accounts receivable	$66,293
Clinic accounts receivable	$742,714
	$4,063,943
Less:	
Allowance for contractual adjustments	$937,000
Allowance for uncollectible accounts	$510,000
Accounts receivable – Net	$2,616,943

(i)

[11] Health care providers (whether or not they accept Medicare) under Financial Accounting Standard Board (FASB) rules must use FASB Topic 606 when applying General Accepted Accounting Practices (GAAP) for preparing its financial statements. Under FASB Topic 606, health care providers must differentiate between an **explicit price concession**, an **implicit price concession** and a **bad debt** under U.S. GAAP. An **explicit price concession** occurs when a provider accepts a discount or concession to standard pricing that's explicitly stated, e.g., a contractually negotiated rate or self-pay policy discount (such as with Medicare). An **implicit price concession** occurs when the provider 'voluntarily' makes a determination that it will or is likely to accept a discount or concession to standard pricing for an individual patient or portfolio of patients before a credit risk assessment can be made, e.g., collection write-off. **Bad debts** write-off results when patients or payors who have been determined to have the financial capacity to pay for health care services (through a formal credit assessment prior to services being rendered) are later unwilling or unable to settle the claim. Under FASB Topic 606 guidance, most previous **bad debts** will be classified as **implicit price concessions** in a traditional health care environment. As example of reporting Account Standard Update – ASU - of a bad debt, explicit and implicit price concession…

Revenue Recognized Under Existing Guidance		
Gross Charges	$	10,000
Contractual		(5,000)
NPSR Before Bad Debt		5,000
Bad Debt		(4,000)
Net Patient Service Revenue	$	1,000

Revenue Recognized Under ASU 2014-09		
Gross Charges	$	10,000
Explicit Price Concession		(5,000)
Implicit Price Concession		(4,000)
Net Patient Service Revenue	$	1,000
Bad Debt		-

Gross patient service revenue:	
Inpatient services	$5,530,734
Outpatient services	$9,791,310
Nursing home	$1,816,428
Clinic	$5,785,209
Total	$22,923,681
Less – Contractual adjustments and other deductions	$7,204,311
	$15,719,370

(ii)

WHY THIS IS IMPORTANT?

UNDERSTANDING CONTRACTUAL ADJUSTMENT IS IMPORTANT FOR THE MEDICARE PATIENT TO BETTER UNDERSTAND WHY A BILLING STATEMENT SHOWS A HIGH BILLING AMOUNT BUT A [MUCH] LOWER ACTUAL ALLOWED PAYMENT AND THE REASON IN PART IS DUE TO THE APPLICABLE INSURANCE REIMBURSEMENT TERMS AND CONDITIONS;
HOW THE HEALTH PROVIDER RECORDS BILLING AND PAYMENT IN ITS FINANCIAL STATEMENTS; AND
HOW THE HEALTH PROVIDER DETERMINES ITS BILLED PRICE

Part 2

Medicare Basics

Understanding the basics of Medicare will help in solving the Mystery.

(If you are reasonably knowledgeable about Medicare, you may wish to skip or scan through Part 2)

MAGIC WORDS

Medicare, like any law, has many special defined terms. Understanding the meaning when using the defined terms is important. Important defined terms described as *magic words* in this Knowledge Note, will help immensely with understanding and securing your Medicare rights. Highlighted in this Knowledge Note are many of the *magic words* the reader should become familiar. When *magic words* are first used in this Knowledge Note, a footnote is used to emphasize the word(s) is a *magic word*.

Medicare History

In 1965, President Johnson administration progressed the Medicare Law as part of the Social Security Act Amendments (Public Law 89-97). Section 1871 of the Law prescribes regulations to be passed to implement the Medicare Law.

Medicare[12] is a U.S. federal government health insurance program for:

- People aged 65 or older[13].
- People under age 65 with certain disabilities.
- People of all ages with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).
- Medicare is a federal program run by a federal agency, the Centers for Medicare & Medicaid Services or *CMS*[14], which is part of the Department of Health and Human Services (HHS).
- CMS contracts with private contractors known as *MACs*[15] - ***Medicare Administrative Contractor***[16], which are private health care insurers that have been awarded a geographic jurisdiction in the

[12] Medicare is a form of *socialized medicine*, a government sponsored progamme similar to the National Health Service in the United Kingdom, a regulated fixed price medical system, though unlike the UK, health providers (doctors, hospitals, etc.) in the U.S. are not government employees.

[13] For people younger than 65, they are obligated because of the Affordable Care Act (ACA) also known as Obamacare, if they do not have medical insurance from their employer or other source, to obtain their own medical insurance from the open market. The ACA law has 3 primary goals: (1) Make affordable health insurance available to more people. The law provides consumers with subsidies ("premium tax credits") that lower costs for households with incomes between 100% and 400% of the federal poverty level (FPL). **Note:** If your income is above 400% FPL, you may still qualify for the premium tax credit in 2021.(2) Expand the Medicaid program to cover all adults with income below 138% of the FPL. (Not all states have expanded their Medicaid programs.)and (3) Support innovative medical care delivery methods designed to lower the costs of health care generally.

[14] *Magic Word*

[15] *Magic Word*

[16] See https://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/Who-are-the-MACs, for list of MACs and their geographic area of activity. Don't confuse MACs with a big hamburger although at times when you complain to them about a medical bill, you may think MACs treat you like hamburger.

U.S. to process (i) Medicare Part A and Part B (A/B) medical claims or (ii) *Durable Medical Equipment (DME)*[17] claims for *Medicare Fee-For-Service (FFS)*[18] Medicare qualified patients.

- CMS fixes the prices to be paid for medical services and goods and a health provider who accepts Medicare as a form of payment, contracts with Medicare that they will accept the fixed prices as full payment for their goods and services. Prices are updated regularly to take into account local conditions, inflation and technology. Part 3 of this Knowledge Note will go into detail how prices and costs are determined.
- Medicare Fee-For-Service (FFS) program pays physicians, hospitals, and other health care facilities based on statutorily established payment systems, most of which are updated annually through regulations.

Medicare has different parts that help cover the medical costs of specific services

- **Medicare Part A (Hospital Insurance) -** helps cover the *Medicare Allowable Cost* of inpatient care in hospitals, including critical access hospitals, and skilled nursing facilities (not custodial or long-term care). It also helps cover the cost of hospice care and some home health care. Beneficiaries[19] (a patient who qualifies to be covered by Medicare) must meet certain conditions to get these benefits as described above. Most people don't pay an insurance premium for Part A insurance because they or a spouse already paid for it through their payroll taxes while working.
- **Medicare Part B (Medical Insurance) -** helps cover the *Medicare Allowable Costs* of doctors' services and outpatient care. It also covers the cost of some other medical services that Part A doesn't cover, such as some of the services of physical and occupational therapists, and some home health care. Part B helps pay for these covered services and supplies when they are medically necessary[20]. Most people pay a monthly premium for Part B insurance (which is typically deducted from a Beneficiary's social security check).
- **Medicare Part D (Prescription Drug Coverage) -** is available to everyone with Traditional Medicare (but not Medicare Advantage Plans – Plan C). To get Medicare prescription drug coverage, Beneficiaries must join a private insurance plan approved by Medicare that offers Medicare drug coverage[21]. Most people pay a monthly premium for Part D insurance (which is typically deducted from a Beneficiary's social security check).

Insurance Basics

Medicare insurance (structured like most insurance policies) is essentially a contract – among the (i) US federal government, (ii) you the patient (Beneficiary) and (iii) the health provider (doctor or hospital or medical goods provider), represented by a 'policy' (or contract), in which you the patient (Beneficiary) receive financial protection or reimbursement (80%) for medical expenses from Medicare. Beneficiaries pay part of their medical costs through deductibles and Co-insurance (20% after deducting the deductible amount). Many Beneficiaries also pay an additional out-of-pocket monthly premium for a Supplemental A Medicare patient has the option to participate (and pay its premiums) in a Medicare (or Medigap)

[17] *Magic Word*
[18] *Magic Word*
[19] *Magic Word*
[20] *Magic Word*
[21] If a Beneficiary obtains Medicare Advantage Plan, such plan includes a prescription drug plan and the Beneficiary is then precluded from also signing up with a Medicare Part D Prescription Drug Plan.

insurance policy with a private insurance company, which policy generally will pay for approved Medicare claims and costs not otherwise paid for by Medicare (such as paying for deductibles and copay).

Important Schedule

The *Annual Enrollment Period (AEP)*[22], also called the *Annual Election Period*, is the Medicare open enrollment period. ... AEP **runs from October 15th to December 7th every year**, and it allows Medicare Beneficiaries to make changes to their plans (Part D Prescription or Supplemental Medicare Plans, switch to a Medicare Advantage Plan), switch plans, or disenroll from a plan. If no action is taken, the current year plans are automatically renewed for the following year and after December 7th if no changes are made, the Beneficiary must wait until the following October 15 to make any changes. Many Beneficiaries also subscribe to private dental, hearing and vision insurance, not affected by Medicare or the Annual Enrollment Period schedule, which plans can be changed at any time.

Insurance Risk Management

The expectation in any insurance or risk management program, is that there are many participants participating in the insurance program and paying premiums[23]. The health costs of all the participants will vary from those that are very healthy and do not incur much medical expenses (and the hope that the vast majority fall in this category), to the very sick, that require major health care and large expenditures. So, by pooling all participants premium funds into a common insurance policy account, it is expected that there are sufficient funds in the account to pay for the broad spectrum of possible medical cost claims of all participants. As the population ages and older folk enter the Medicare programme, it is probable health costs will rise, meaning Medicare insurance premiums may have to be increased or other adjustments made to Medicare to offset higher costs (such as higher deductibles-copays-coinsurance, some procedures no longer covered by Medicare, etc.).

Medicare Funding

The US Treasury holds two trust fund accounts to pay for Medicare costs: the **Hospital Insurance Trust Fund (HI)** and the **Supplemental Medical Insurance Trust Fund (SMI)**.

The Hospital Insurance Trust Fund (HI) is funded by

(i) our payroll taxes (from you the employee and your employer),
(ii) income taxes paid on Social Security benefits,
(iii) investment interest earned on the trust fund's investments, and

[22] *Magic Word*

[23] The Affordable Care Act or Obamacare, anticipated that private medical insurance companies would issue Obamacare medical insurance policies because it made good economic sense to do so. The concern was that enough participants would sign up for such policies thereby creating a pool of funds from enough premium payments to cover the medical costs of the participants in the open market plans. It appears such plans are working as sufficient number of participants have signed up. The inception of the Act included penalties for those who did not have qualified coverage, known as the individual mandate. This controversial portion of the ACA was repealed beginning January 1, 2019, removing the federal tax penalty if you failed to enroll in an ACA-compliant healthcare plan. While the penalty rules still apply, the penalty amounts were changed to $0, eliminating the financial consequences of not carrying qualified coverage. While the fine at the federal level has been repealed, you may still face a fine by your state government, depending on where you live. States encourage Obamacare participation so that the State does not have to fund for the care of uninsured patients.

(iv) Medicare Part A insurance premiums from people who aren't eligible for premium-free Part A.

This Hospital Trust funds and pays for Medicare Part A benefits and Medicare Program administration.

The Supplemental Medical Insurance Trust Fund (SMI) is paid for by

(i) funds authorized by Congress (that are funded from tax revenues),
(ii) insurance premiums from people enrolled in Medicare Part B[24] and Medicare Part D[25], and
(iii) interest earned on its investments.

This Supplemental Trust funds and pays for Part B benefits, Part D, and Medicare Program administration.

Medicare Statistics (2020)

- Medicare covered 62.6 million people
  - 54.1 million aged 65 and older

[24] When a person is enrolled in Medicare (i.e., no longer receiving employer medical insurance and over 65 (or otherwise qualifies as a Medicare Beneficiary) or does not have their own open market coverage – 'Obamacare'), Medicare Part B insurance premiums are typically deducted from the Beneficiary's Social Security check. The basic monthly premium for 2021 is $148.50, but can be higher depending on one's income, and can be as high as $504.90 per month because of the addition of an extra Income Related Monthly Adjustment Amount (IRMAA). In other words, Part B insurance premium amounts are subject to a 'means test', higher one's income, higher the Part B insurance premium. A retired person's income will include Required Minimum Distribution (RMD) income, which are mandatory minimum withdrawals from a retiree's tax deferred IRA or other similar accounts once they reach a certain age (such as 72). RMDs are included as income for determining if IRMAA premiums are to be paid. The income used to determine IRMAA is a form of Modified Adjusted Gross Income (MAGI), but it's specific to Medicare. The Modified Adjusted Gross Income [(line 7 of IRS Form 1040) plus tax-exempt interest income (line 2a of IRS Form 1040)] is different from your Adjusted Gross Income, because some people have additional income sources that have to be added to their AGI in order to determine their IRMAA-specific MAGI.

If your 2019 MAGI was:			You pay each month (in 2021)
File individual tax return	File joint tax return	File married & separate tax return	
$88,000 or less	$176,000 or less	$88,000 or less	$148.50
Above $88,000 up to $111,000	Above $176,000 up to $222,000	Not applicable	$207.90
Above $111,000 up to $138,000	Above $222,000 up to $276,000	Not applicable	$297.00
Above $138,000 up to $165,000	Above $276,000 up to $330,000	Not applicable	$386.10
Above $165,000 and less than $500,000	Above $330,000 and less than $750,000	Above $88,000 and less than $412,000	$475.20
$500,000 or above	$750,000 and above	$412,000 and above	$504.90

Source: https://www.medicare.gov/your-medicare-costs/part-b-costs

See https://turbotax.intuit.com/tax-tips/irs-tax-return/what-is-the-difference-between-agi-and-magi-on-your-taxes/L7kHckNS3 for a more comprehensive discussion of how MAGI is calculated (income and allowed adjustments.)

[25] When a person is enrolled in Medicare (i.e., no longer receiving employer medical insurance and over 65 (or otherwise qualifies as a Medicare Beneficiary) or does not have their own open market coverage – 'Obamacare'), and is enrolled in Part D prescription insurance plan, Part D prescription Insurance plan premiums are typically deducted from one's Social Security check. The basic monthly premium for 2021 depends on the plan one selects – typically ~ $25 per month (2020). In addition to the basic Part D plan insurance premium, Medicare also charges an extra monthly premium that can range in 2021 from $12.30 to $77.10, depending on one's income (Income Related Monthly Adjustment Amount (IRMAA), another 'means test' – higher one's income, higher the Part D prescription insurance plan premium.

- 8.5 million disabled.

- 40 percent chose to enroll in Part C private health plans
  - Medicare Part C (also called Medicare Advantage Plan) operates more like traditional health insurance that Original Medicare. Multiple private insurers offer different Part C plans. If you choose to enroll in Medicare Part C, it will replace your Part A and B coverage (and Part D prescription coverage).
- Total Medicare expenditures were $925.8 billion
  - HI (Trust Fund): $402.2 billion
  - SMI (Trust Fund): $523.6 billion
- Total Medicare income was $899.9 billion
  - HI: $341.7 billion
  - SMI: $558.2 billion
- Assets decreased by $26.0 billion to $277.3 billion
  - HI: 134.1 billion
  - SMI: 143.2 billion

Health Provider Medicare Participation

- Health providers (your doctor or hospital or medical equipment supplier, for example) must elect (contract with and take *ASSIGNMENT*[26]) to participate in the Medicare programme and be paid by Medicare at Medicare fixed prices, for a patient's (Beneficiary) medical expenses.
- If you're enrolled in the original (not a Medicare Advantage Plan) Medicare program, it's important to ask any doctor you see whether he or she accepts "*MEDICARE ASSIGNMENT*" — before you receive care — because this can have an impact on what you pay as your out-of-pocket expenses.
- There are three types of Medicare participants or providers, meaning three different relationships a provider can have with Medicare. A provider's type determines how much you will pay for Part B-covered services.
  - **Participating providers** accept Medicare and always take *Assignment*. Taking Assignment means that the provider accepts Medicare's approved amount (fixed price) for health care services (*Medicare Allowed Costs*) as full payment. These providers are required to submit a bill (file a claim) to Medicare for care you receive. Medicare will process the bill and pay (Medicare fixed price or *allowed payment* which is typically lower than the actual bill amount based on the health providers **Standard Prices**) your provider directly for your care. If your provider does not file a claim for your care, there are troubleshooting steps to help resolve the problem.
    - If a patient sees a participating provider, the patient is responsible (after paying any applicable deductible or copay) for paying a 20% coinsurance for Medicare-covered services. [Note Medicare Advantage Plans, while on their face indicate lower premiums than traditional Medicare plan, Medicare Advantage Plans include a high deductible paid by patients before Advantage Plan payment terms kick in. See the discussion at the end of this Knowledge Note as to a

[26] *Magic Word*

comparison between traditional Medicare and Advantage Plans and which to choose and why].

- Certain providers, such as clinical social workers and physician assistants, must always take Assignment if they accept Medicare.

- **Non-participating providers** accept Medicare but do not agree to take Assignment in all cases (they may on a case-by-case basis). This means that while non-participating providers have signed up to accept Medicare insurance, they do not accept Medicare's approved amount for health care services as full payment.
  - Non-participating providers can be paid up to 15% more than Medicare's fixed price approved amount for the cost of services you receive (known as the *limiting charge*[27]). This means you are responsible for up to 35% (20% coinsurance + 15% limiting charge) of Medicare's approved amount for covered services.
  - Some states may restrict the limiting charge when you see non-participating providers. For example, New York State's limiting charge is set at 5%, instead of 15%, for most services. For more information, contact your State Health Insurance Assistance Program (SHIP)[28].
  - If you pay the full cost of your care up front (Medicare fixed price plus 15%), your provider should still submit a bill to Medicare. Afterward, you should receive from Medicare a Medicare Summary Notice (MSN) and reimbursement for 80% of the Medicare-approved amount (not including the limiting charge). An example calculation is in the footnote.[29]
  - The limiting charge rules do not apply to durable medical equipment (DME) suppliers.
- **Opt-out providers** do not accept Medicare at all and have signed an agreement to be excluded from the Medicare program. This means they can charge whatever they want for services but must follow certain rules to do so.
  - Medicare will not pay for care you receive from an opt-out provider (except in emergencies). You are responsible for the entire cost of your care.
  - The provider must give you a private contract describing their charges and confirming that you understand you are responsible for the full cost of your care and that Medicare will not reimburse you.
  - Opt-out providers do not bill Medicare for services you receive.
  - Many psychiatrists opt out of Medicare.
- Providers who take Assignment submit a bill to a Medicare Administrative Contractor (MAC) within one calendar year of the date you received care. If your provider misses the filing deadline, they cannot bill Medicare for the care they

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[27] *Magic Word*

[28] *Magic Word*

[29] Assume your medical bill is based on $100 and is an approved Medicare fixed price cost and an allowed payment amount. The Non-participating provider charges another 15% or $15 – a limiting charge. You pay the provider $115. The provider submits a paid invoice to Medicare, and you receive back from Medicare reimbursement of 80% of the $100 or $80. Your out-of-pocket cost is then $20 + $15 or $35. If you also had a Medicare Supplemental insurance plan, that plan may pay for both the coinsurance and limiting charge resulting in you owing no out-of-pocket expense.

provided to you. However, they can still charge you a 20% coinsurance and any applicable deductible amount based on Medicare's fixed priced allowed payment amount (and not based on what the health provider billed – its Standard Price).

  - If a Medicare eligible patient has Medigap (Medicare Supplement) insurance, all such policies cover Part B's 20 percent patient or Beneficiary copays in full or in part, thus in most cases, the patient (Beneficiary) will not pay any part of the bill. Other Supplemental Policies (such as Plans F and G, typically has higher premium costs) also cover excess charges from doctors who don't accept *ASSIGNMENT*.

- The above rules apply only to the original Medicare program. If you're enrolled in a **Medicare Advantage plan,** such as an HMO or PPO, you pay the specific copays for doctors' services that your plan requires. ***This Knowledge Note focuses on original Medicare programs and not Medicare Advantage plans. At the end of this Note is a comparison between original Medicare and Advantage Plans.***

Part 3
Advanced Medicare Detail Insights
Understanding the details of Medicare will help in solving the Mystery.

What Does Medicare Cover?

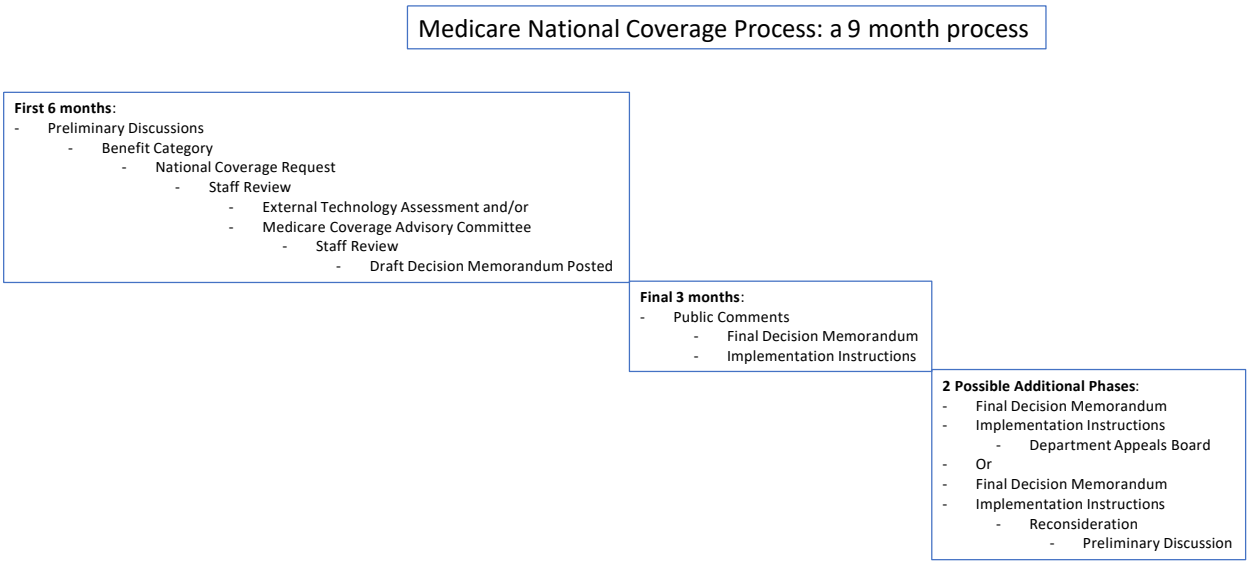
Medicare (CMS) regularly evaluates what approved health provider services and medical goods claims will be eligible for Medicare coverage and also what fixed prices will apply toward any costs:

- The provided service or good must first be an **approved Medicare service or good**
  - Medicare coverage is limited to items and services that are ***reasonable and necessary for the diagnosis or treatment of an illness or injury (and within the scope of a Medicare benefit category)***[30], so called *National Coverage Determinations*[31].
  - **National Coverage Determinations (NCDs)** are made through an evidence-based (fact finding) process, with opportunities for public participation. In some cases, CMS' own research is supplemented by an outside technology assessment and/or consultation with the Medicare Evidence Development & Coverage Advisory Committee (MEDCAC).
  - In the absence of a national coverage policy, an item or service may be covered at the discretion of the Medicare contractors, MACs[32] based on a *Local Coverage Determination*[33] *(LCD)*. LCD are goods and services that are unique to a particular geographic area and any local special conditions taken into account when determining if a good or service is an approved Medicare good or service.
  - On Wednesday, August 7, 2013, CMS published a Federal Register notice, (78 FR 48164-69), updating the process used for opening, deciding or reconsidering national coverage determinations (NCDs) under the Social Security Act (the Act).
  - The following entities can submit a request that medical equipment or services be covered by Medicare:
    - an individual, (including a Beneficiary – the Medicare patient),
    - a manufacturer,
    - a physician or a physician professional association or
    - an entity (including a medical professional society, hospital or business interest).

    A National Coverage Determination to determine what goods and services are covered by Medicare, typically requires a 9-month review process as outlined in Figure 4, below.

[30] *Magic Word*
[31] *Magic Words*
[32] Medicare uses many non-government contractors operating in certain geographic areas in the U.S., to administer Medicare activities, **MACs - Medicare Administrative Contractor**. A patient or Beneficiary in regard to a Medicare claim will normally interface with a MAC and not directly with Medicare (CMS) personnel.
[33] *Magic Words*

Figure 4.



Healthcare Common Procedure Coding System (HCPCS) [34]

- **HCPCS** is a collection of standardized identification codes (numbers or letters and numbers) that represent medical procedures, supplies, products and services. **HCPCS** is prepared and published by CMS.

- HCPCS is used by physicians and other health care professionals and insurance programs when identifying their services and when a bill is submitted to Medicare for payment. HCPCS is updated annually. IF AN INCORRECT HCPCS CODE IS ENTERED BY THE SERVICE PROVIDER WHEN SUBMITTING A MEDICARE CLAIM, THEN MEDICARE (THE MACs ON BEHALF OF CMS) WILL REJECT THE CHARGE FOR PAYMENT…SO IT IS VERY VERY IMPORTANT THAT THE CORRECT MEDICAL SERVICE AND GOOD HCPCS CODES ARE USED WHEN A CLAIM IS SUBMITTED TO MEDICARE. IT WILL BE A TIME-CONSUMING HEADACHE FOR THE PATIENT TO CORRECT AN ERRONEOUSLY SUBMITTED CODE AND OBTAIN MEDICARE PAYMENT (AUTHOR'S EXPERIENCES – plural!).

HCPCS vs. CPT

- ***Current Procedural Terminology (or CPT)***[35] is a code set (technically not the same as HCPCS codes, but very similar) maintained by the American Medical Association (AMA) through the CPT Editorial Panel. It was designed to describe medical, surgical, and diagnostic services accurately. It is also used as a form of uniform communication among physicians, coders, patients, accreditation organizations, and those who pay for administrative, financial, and analytical purposes about medical procedures and services.

[34] *Magic Word*
[35] *Magic Word*

- CPT operates in three categories: Standard CPT Codes, CPT Codes specific for performance measurement, and CPT Codes that are specific for emerging technology.
- In terms of public knowledge, the CPT Codes are not particularly private; however, because the AMA holds the sole copyright to the codes, they have mandated that anyone interested in finding out the codes must pay a license fee –for those who want to compare Relative Value Unit (RVU)[36] [*VERY IMPORTANT WORDS EXPLAINED LATER REGARDING HOW MEDICARE DETERMINES THEIR FIXED PRICES FOR GOODS AND SERVICES*] values to the CPT codes. As such, the AMA receives upwards of $70 million per annum from these fees. As far as the HCPCS is concerned, the practices are public record and can be accessed freely by those who use Medicare, Medicaid, or any other private insurer to ensure that practices are being followed accurately. Though the use of codes was voluntary at its inception, beginning in 1996 the Health Insurance Portability and Accountability Act made it mandatory for this information to be easily accessible by physicians, technicians, and patients alike.

- **Healthcare Common Procedure Coding System (or HCPCS)** is a set of health care procedure codes based on CPT. It was designed to provide a standardized coding system in order to describe specific items and services that are provided when health care is delivered. It is a necessary form of coding for anyone who accepts Medicare, Medicaid, and other health insurance programs in order to ensure that insurance claims are processed efficiently.
  - HCPCS operates on three separate levels:
    - **Level I** is the numeric CPT coding maintained by American Medical Association are made up of 5-digit numbers classified into six major groups:
      1. Evaluation and Management (E/M) Codes starts from CPT 99201 to CPT 99499
      2. Anesthesiology Codes starts from CPT 00100 to CPT 01999
      3. Surgery Codes starts from CPT 10000 to CPT 69990
      4. Radiology Codes starts from CPT 70010 to CPT 79999
      5. Pathology and Laboratory Codes starts from CPT 80002 to CPT 89399
      6. Medicine Codes starts from CPT 90281 to CPT 99607
    - **Level II** consists of alphanumeric codes made up of one alphabetical letter followed by four numbers, which include non-physician services (for instance, ambulance services and prosthetic devices).
    - **Level III** codes (also known as local codes) were developed by the state Medicaid agencies, Medicare contractors (MACs), and private insurers to be used in specific jurisdictions for specific programs.
- Providers can also append ***modifiers***[37] to HCPCS codes to indicate that a procedure or service has been altered by some circumstance, but the definition of the procedure or the procedure code itself is unchanged. This policy is relevant to modifiers identified as affecting payment. The Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA) and public-domain specialty societies determine payment modifiers that are appropriate for billing with certain procedure codes. The AMA publishes the Current Procedural Terminology (CPT) HCPCS Level I modifiers and CMS publishes the valid list of HCPCS Level II modifiers.

[36] *Magic Word*
[37] *Magic Word*

- What is a CPT® modifier? A modifier consists of two numbers, two letters, or a number and a letter. Many situations require a coder to append modifiers to a CPT code to further describe the service or procedure provided. For example, some modifiers show that a procedure was performed on the right side of the body, versus the left side or both sides. Other modifiers indicate that a physician took extra time and effort to perform a service or procedure. Maybe you wonder why a CPT code doesn't include the additional information provided by a modifier. Quite simply, CPT code books would be too large and cumbersome if they contained a code for every scenario a coder might encounter. A short list of modifiers goes a long way in expanding the unique circumstances of services and procedures performed. List of modifiers are available at: https://www.aapc.com/codes/cpt-codes-range/

- Sometimes services are always grouped together, in which case their codes may also be grouped. These are called "bundled" codes.
- **Where Patients May Find HCPCS / CPT Codes**.
    - Patients can find HCPCS / CPT Codes in a number of places. As you leave the healthcare provider's office, you are handed a review of your appointment which may have a long list of possible services your practitioner provided, with some of them circled. The associated numbers, usually five digits, are the codes. If your appointment requires a follow-up billing by your healthcare provider for copays or co-insurance, then the codes may be on those bills. A wise patient and smart healthcare consumer will use these codes to review medical billings from healthcare provider, testing centers, hospitals or other facilities. It's a good way to be sure your insurance (and your co-pays and co-insurance) are paying only for those services you received. If you receive statements from either the healthcare provider or your health insurance and the HCPCS / CPT codes do not appear, then contact the party who sent them and request a new statement that does include the codes.
    - Some useful internet sites where to find HCPCS/CPT codes and Modifiers are: https://www.codingahead.com/hcpcs-level-i-codes-html/; https://www.findacode.com/index.html; https://www.hcpro.com/HIM-284009-8160/Note-similarities-and-differences-between-HCPCS-CPT-codes.html; https://episodealert.com/HCPCS-codes.aspx; http://www.medicalbillingandcodingu.org/introduction-to-hcpcs-level-i-coding/ ; https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/how_to_mpfs_booklet_icn901344.pdf https://www.medicalbillingcptmodifiers.com/list-of-cpt-hcpcs-modifiers

- Next Medicare will make a determination of the 'approved' (fixed) price (allowable payment) for an approved service or good. ***Warning***, be aware of the difference of the two approvals: that being (1) an 'approved' claim has a different meaning from (2) what Medicare will 'approve' as the allowed payment amount (fixed price or allowed payment) for the claim – thus there is a two-step approval process: (1) claim approval and then (2) (fixed) price (allowed payment) approval.
    - Typical Medicare Summary Notices[38] sent to the patient (Beneficiary) will show a health providers service and its bill, what claims are approved Medicare services or goods, the amount of the bill that is 'approved' and a different (usually lower) amount actually approved (the Medicare fixed price or allowed payment) to pay for such claim. The lower

[38] *Magic Word*

amount is used to determine the 80% paid by Medicare and the 20% coinsurance for the patient (Beneficiary) after deducting any deductible or copayment amounts (see Footnote 7 for a detail discussion of copayment, deductible and coinsurance).

- **Medicare Payment To Physicians**
- Payments under the *Physician Fee Schedule (PFS)*[39] – fixes the prices (allowed payment) to be paid by Medicare for such services.
- Each service is assigned the unique identification code - based on national uniform relative value units (RVUs) or the resource-based relative value scale (**RBRVS**) that account for the relative resources used in furnishing a service. RVUs are a measure of the amount of effort, time or resources used to provide a particular service. They are used in a formula (See Figure 5) determining the fixed price (allowable payment) to be paid for the service. RVUs for physicians are established for three categories of resources used to provide the service:
  - (1) **Work RVUs (W)**[40]; plus
  - (2) **practice expense RVUs (PE)**[41]; and plus
  - (3) **malpractice RVUs (MP) expense**[42].
- All three are periodically adjusted for geographic practice cost indexes (GPCI)[43]. By regulation, each year's payment amounts for all physicians' services paid under the PFS, incorporates geographic adjustments to reflect the variations in the costs of furnishing services in different geographic areas. Ultimately these units are multiplied by a **Conversion Factor (CF)**[44] to convert the relative value units (RVUs) into (fixed price) allowable payment rates. A single Conversion Factor - $/RVU (updated annually) is used to determine fixed prices, so variances in the cost of services or goods is affected by the RVUs used since the same Conversion Factor is used to determine fixed prices for all Medicare service and good costs.

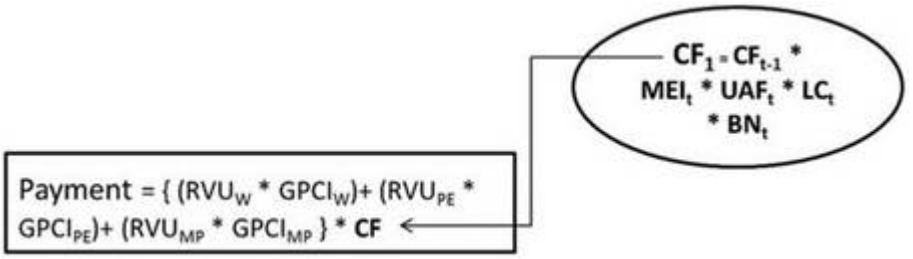


Figure 5 Role of the conversion factor in the Medicare physician fee schedule.

- **It is complicated to understand how Medicare fixed prices – allowable payments are determined (but not any more complicated when trying to understand how health provider Standard Pricing is determined).** There are specialists that make a career of how to properly submit billing codes to Medicare and assessing what fixed prices-allowable payments will apply.

[39] *Magic Word*
[40] *Magic Word*
[41] *Magic Word*
[42] *Magic Word*
[43] *Magic Word*
[44] *Magic Word*

- Not uncommon, any time government regulated prices are determined other than by a competitive free marketplace process, the regulated price fixing formula and components that affect the formula are naturally complex and requires much effort in an attempt to balance the objectives of all interested parties. This complexity is aggravated when such regulated price fixing is also influenced by political motivated objectives, which somewhat masks over the original principle purpose of Medicare: to provide a fair and reasonable health insurance programme for older Americans.

- To understand the Medicare compensation system for **physician services**, it is necessary to understand how the relative values of medical services are translated into fee schedule payment amounts (See Figure 5). Basically, the Relative Value Unit (RVU) of a procedure multiplied by the number of dollars per Relative Value Unit ($/RVU) is the fee paid by Medicare for the procedure.
    - First, (RVU_W = physician work, RVU_{PE} = practice expense, RVU_{MP} = malpractice), the value units for the three components, are all adjusted for their respective geographic practice cost indices (GPCIs).
    - The GPCIs reflect the relative costs of Work, PE, and MP in a specific geographic area (Montana costs will be different than say New York costs) compared to the national average costs for each component.
    - The Conversion Factor (CF: $/RVU – its statutory formula further discussed below) is the number of dollars assigned per RVU. It is calculated by use of a **complex formula** (See Figure 5) that takes into account…
        - the overall state of the economy of the United States,
        - the number of Medicare Beneficiaries,
        - the amount of money spent in prior years, and
        - changes in the regulations governing covered services**.**

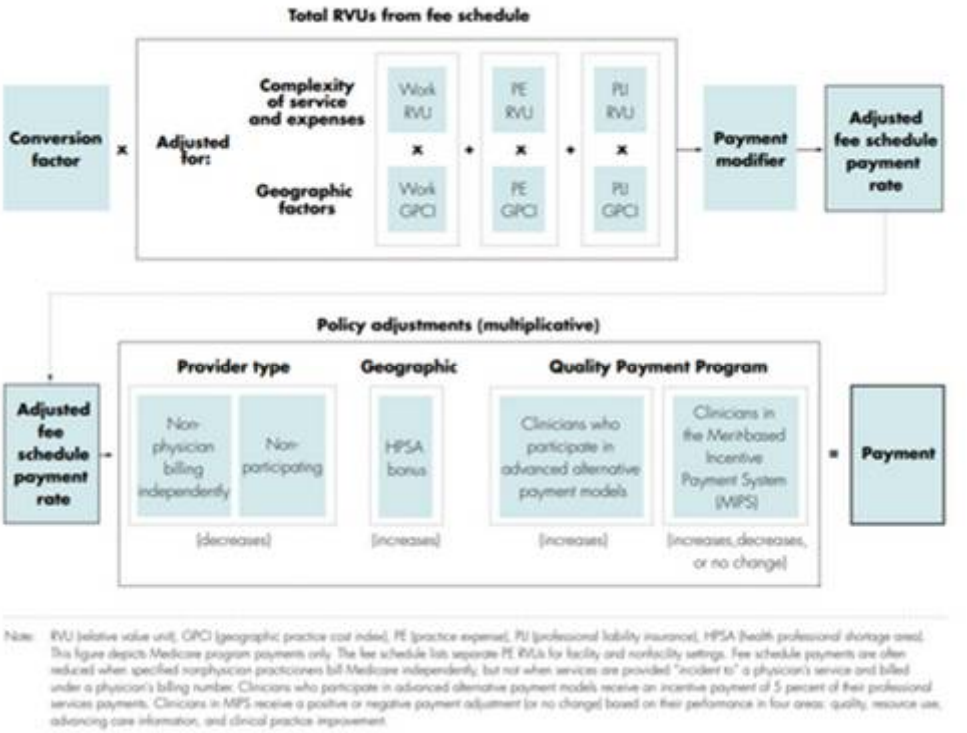
- **Medicare fees are set according to a relative value scale rather than a free market**, payments are made by third parties rather than consumers, and the labor market for physicians is illiquid, so the pricing mechanisms that regulate markets in other parts of the economy are not effective in rationalizing prices. The factors that influence the CF calculation are similar to those that are used in calculating global health care budgets; therefore, the principles are durable, even if the precise formula might be altered in the future.
- In addition to Physician Service Fees, Medicare also pays for **clinical diagnostic laboratory tests** (CDLTs) on the Clinical Laboratory Fee Schedule (CLFS). There has been added a new subcategory of CDLTs called Advanced Diagnostic Laboratory Tests (ADLTs) with separate reporting and payment requirements. CDLTs furnished on or after January 1, 2017, be equal to the weighted median of private payor rates determined for the test, based on certain data reported by laboratories during a specified data collection period. Different reporting and payment requirements will apply to a subset of CDLTs that are determined to be ADLTs. Use G codes, which are part of the Healthcare Common Procedure Coding System (HCPCS) are used for programmatic purposes, to temporarily identify new ADLTs and new laboratory tests that are cleared or approved by the Food and Drug Administration (FDA). The temporary codes would be in effect for up to 2 years until a permanent HCPCS code is established. (**Confused yet?** – I am trying to make some sense out of all this for you and me…)
- Details of the RVUs and CF follow:

- **Work RVUs** (W) are developed with extensive input from the physician community. A research team at the Harvard School of Public Health developed the original Work RVUs for most services, where each service is assigned a unique standardized identification code, under a cooperative agreement with the Department of Health and Human Services (HHS). In constructing the code-specific vignettes used in determining the original physician work RVUs, Harvard worked with panels of experts, both inside and outside the federal government, and obtained input from numerous physician specialty groups. The Work component of physicians' services means the portion of the resources used in furnishing the service that reflects physician time and intensity.
    - **Diagnostic services** are generally comprised of two components: A **professional component (PC)** or the time spent by a physician; and a **technical component (TC)** such as specialty medical equipment to provide a service. The PC and TC may be furnished independently or by different providers, or they may be furnished together as a global service. When services have separately billable PC and TC components, the payment for the global service equals the sum of the payment for the TC and PC.
    - The **RVU Work** component accounts for an average of 51% of the total relative value for each service. The factors used to determine physician work include the time it takes to perform the service, the technical skill and physical effort, the required mental effort and judgment and stress due to the potential risk to the patient. The physician work relative values are updated each year to account for changes in medical practice.

- **Practice Expense RVUs (PE)** are determined based on the Clinical Practice Expert Panel (CPEP) data; and the AMA's Socioeconomic Monitoring System (SMS) data. Separate PE RVUs are established for services furnished in facility settings, such as a hospital outpatient department (HOPD) or an ambulatory surgical center (ASC), and in nonfacility settings, such as a physician's office.
    - The nonfacility RVUs reflect all of the direct and indirect PEs involved in furnishing a service described by a particular HCPCS code. PEs are generally direct and indirect overhead costs associated with a medical service (such as office and utility costs, maintenance, administration costs such as billing and document management, etc.).
    - The practice expense component accounts for an average of 45% of the total relative value for each service. The values were based on a formula using average Medicare-approved charges from 1991 (the year before the RBRVS was implemented) and the proportion of each specialty's revenues attributable to practice expenses. In January 1999, CMS began a transition to resource-based practice expense relative values for each CPT code, which differ based on the site of service.

- **The Malpractice (MP) RVUs** are based on commercial and physician-owned insurers' MP insurance premium data from all the states, the District of Columbia, and Puerto Rico.
    - The MP component of the RBRVS accounts for an average of 4% of the total relative value for each service.
- CMS publishes the below (Figure 6) illustration of the formula used to determine physician fee allowable payments. (And yes it is complicated, regulated prices by definition are complicated)…

Figure 6 Physician and other health professional payments system



Note: RVU (relative value unit), GPCI (geographic practice cost index), PE (practice expense), PLI (professional liability insurance), HPSA (health professional shortage area). This figure depicts Medicare program payments only. The fee schedule lists separate PE RVUs for facility and nonfacility settings. Fee schedule payments are often reduced when specified nonphysician practitioners bill Medicare independently, but not when services are provided "incident to" a physician's service and billed under a physician's billing number. Clinicians who participate in advanced alternative payment models receive an incentive payment of 5 percent of their professional services payments. Clinicians in MIPS receive a positive or negative payment adjustment (or no change) based on their performance in four areas: quality, resource use, advancing care information, and clinical practice improvement.

- **The monetary Conversion Factor, CF** is one of three key elements that determine physician payment under the Medicare Physician Fee Schedule. The three components of the allowed payment equating being the CF, the RVUs and the GPCIs.

    - The CF, a national dollar multiplier, is used to "convert" the geographically adjusted RVU to determine the Medicare-allowed payment amount for a particular physician service.

    - The CF is updated annually according to a complex formula set by statute. Every year, by use of the formula, the Centers for Medicare and Medicaid Services (CMS) must publish an estimated Sustainable Growth Rate (SGR) and estimated CF applicable to Medicare payments for physician services

for the following year, as well as the data underlying these estimates. CMS cannot change its overall budget by more than $20 million. The use of this SGR target is intended to control growth of aggregate Medicare spending. The targets are not expenditure limits, but an update to the Physician Fee Schedule to reflect a comparison of actual to target expenditures. If RVU adjustment causes a differential greater than that $20 million or exceeds the target, CMS uses the Budget Neutrality factor (explained below – a 'fudge' factor (author's description) to insert into the Conversion Factor formula to achieve a predefined result) to bring overall payments down to an acceptable level.

- The CF is used separately to price facility and nonfacility payment amounts. **Facility pricing** typically covers services provided to inpatients or in a hospital outpatient clinic setting or other off-site hospital facilities. **Nonfacility pricing** covers services generally provided in a physician office or other freestanding setting such as an Independent Diagnostic Testing Facility.

- There is only one CF value for each year and for 2021 it is $34.89.[45]

- Annually, the updated CF_1 is based on the previous year's CF_{t-1}, adjusted by the Medical Economic Index (MEI_t), the Update Adjustment Factor (UAF_t), Legislative Change (LC_t), and Budget Neutrality (BN_t).

- **$CF_1 = CF_{t-1} * (MEI_t) * (UAF_t) * (LC_t) * (BN_t)$.**

    - Next year Conversion Factor is CF_1.

    - Current year Conversion Factor is CF_{t-1} .

    - The Medical Economic Index (MEI_t) is a calculation of the inflation rate for medical services, which is generally higher than inflation in consumer prices overall.

    - The Update Adjustment Factor (UAF_t) encompasses the Sustainable Growth Rate (SGR) that takes into account growth or decline in the Gross Domestic Product, changes in the number of Beneficiaries, and certain regulatory adjustments that may affect the demand for and costs of providing Medicare services.

    - Legislative Change (LC_t) is the mechanism through which the relative proportion of Part B Medicare spending is maintained at an acceptable level with respect to overall government spending and the size of the economy as a whole. The process of setting the CF each year balances increases in demand for medical services and the finite productive capacity of the economy. In effect this is a 'fudge factor' (author's description), a highly

[45] To the author, a common CF factor that affects all health related costs is a bit like determining the physicist's Theory of Everything, and summing up all of the science of physics in one neat little equation, or summing up all the cost principles of health care into one neat little factor. Did I say it was complicated?

subjective adjustment factor that can be manipulated to result in a predetermined outcome of the formula.

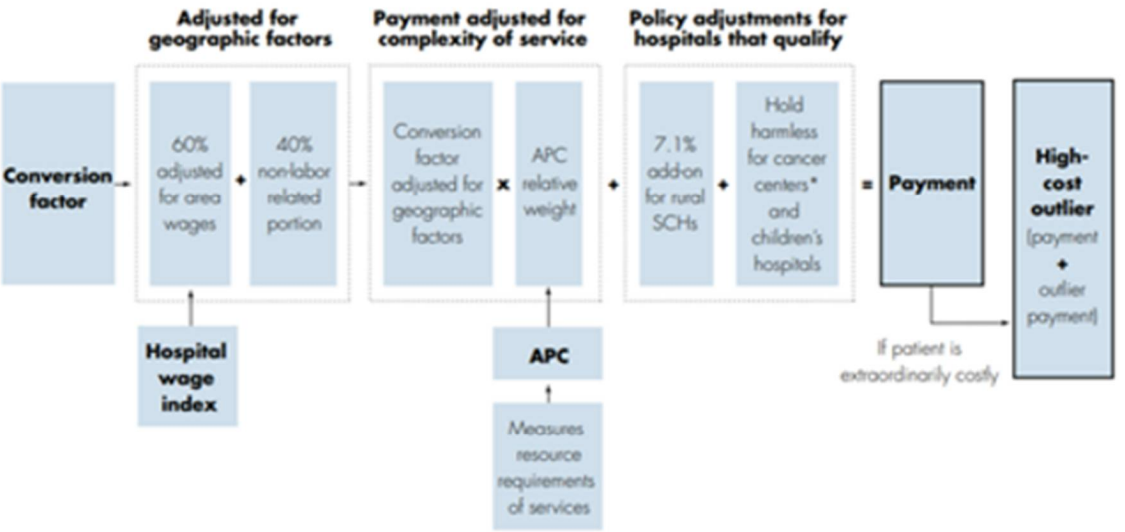
- The calculation is then subject to Budget Neutrality (BN_t), - for all practical purposes another 'fudge' factor (author's description), requiring any increase in the relative expenditures in one area of the Medicare program to be offset by cuts in other areas. The calculation must result in a budget for Medicare that is within $20 million of the target.
    - **BY PRESETTING A MEDICARE BUDGET, BY DEFAULT RESULTS IN CAUSING PHYSICIAN FEES AND ALLOWABLE PAYMENTS TO BE SUBJECT TO AN ARBITRARY STANDARD THAT MAY OR MAY NOT BE REFLECTIVE OF THE REAL COSTS OF MEDICAL CARE. CONSEQUENTLY, THERE IS A VALID CONCERN AS TO WHETHER MEDICARE PRICES ARE REALISTIC OR NOT. (CONFUSED MORE?)**
- ***The Conversion Factor formula is somewhat of an opaque, black box calculating machine, since the components that go into its calculation are somewhat subjective, sourced from different areas and influenced by factors not associated with health related cost proof. And in the conspiracy theory perspective, it is possible that instead of a go-forward calculation, where objective information is inserted into the formula to determine a new Conversion Factor, the system could be gamed and run backwards to first define next year's Conversion Factor and insert subjective components to fabricate that pre-defined result.***

- Under statute, the update for each year is determined by comparing cumulative actual expenditures with cumulative target expenditures since April 1, 1996, through the end of the year before the year in question. As an example, the update for 2013 compares the cumulative actual with cumulative target expenditures from April 1, 1996, through December 31, 2021.
- Annually, the Sustainable Growth Rate–mandated cuts in the CF have been overridden by Congress, usually through last-minute negotiations that cover numerous contentious polticial issues (many of those issues are unrelated to health care).
- Many interested in health policy recognize the need for a reform of this process to improve clarity and remove uncertainty from the annual determination of the

CF (now there's an understatement!). Because of the large and growing discrepancy between the statutory CF and the established CF, the budgetary need for a more permanent solution is also considered important, going forward. The magnitude of the adjustment required in the CF to maintain Budget Neutrality has been revised downward. It is likely that this is a temporary consequence of the disparate timing of effects on the various components of the Sustainable Growth Rate formula related to recent economic conditions. As the economy returns to more normal levels of growth, we can expect these short-term trends to revert to their prior patterns and continue to increase (maybe).

- Some of the proposals on the table to improve health care pricing (and refined CF factor) include cuts in the overall level of Medicare fees weighted heavily toward cuts in specialist services such as imaging and relatively sparing primary care. Others reduce costs by changing the calculation of Medicare premiums and/or means testing them. Another approach is to adjust the relationship between the CF and the rate of inflation and the rate of economic growth. Other proposals seek a more fundamental overhaul of the program, through premium support models similar to those already being used in Medicare Part D. Others seek to preserve the status quo. Regardless of the fate of the current CF formula and the precise relationships among the components, the ingredients of the CF are combined in recipes for global health care budgets under discussion in health care policy circles.
- In contrast to physician fee payment system, Figure 7 illustrates the comparable Medicare allowable payment system formula for hospital outpatient services, which illustrates a comparable complex calculation formula process.

Figure 7, Hospital outpatient services prospective payment system.



Note: APC (ambulatory payment classification), SCH (sole community hospital). The APC is the service classification system for the outpatient prospective payment system. *Medicare adjusts outpatient prospective payment system payment rates for 11 cancer centers so that the payment-to-cost ratio (PCR) for each cancer center is equal to the average PCR for all hospitals minus 1 percentage point.

- The historical values of the Conversion Factors for physician services over a 21-year period indicate the year-on-year change is essentially flat and the trend over the 1998 thru 2021 time period for the Conversion Factor has generally decreased. (See Figure 8) Also shown is the change in US Inflation which indicates a similar 'flat' profile over the same time period.

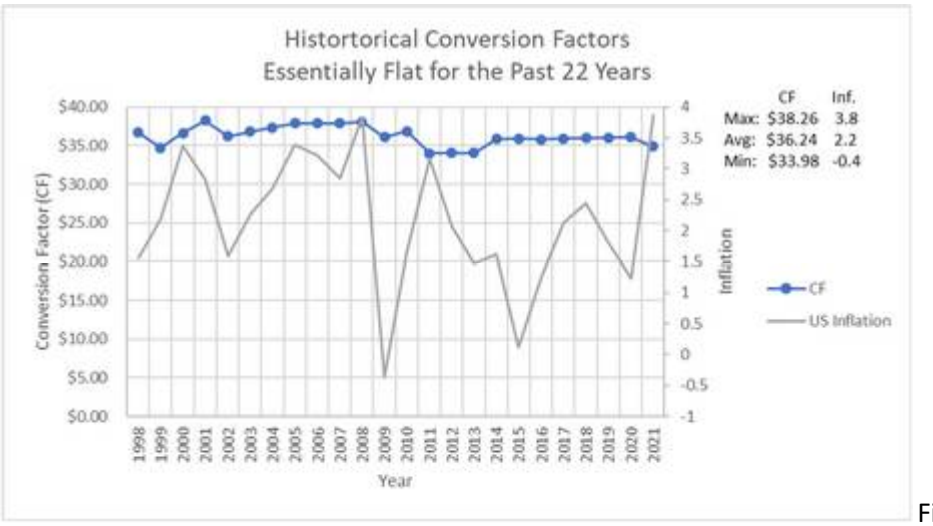


Figure 8

- Shown in Figure 9 are the US Consumer Price Indices (CPIs) for US in general, medical care, hospital services, physician services and prescription drugs. All of these indices over the past 10 years show increasing CPIs (increasing costs).

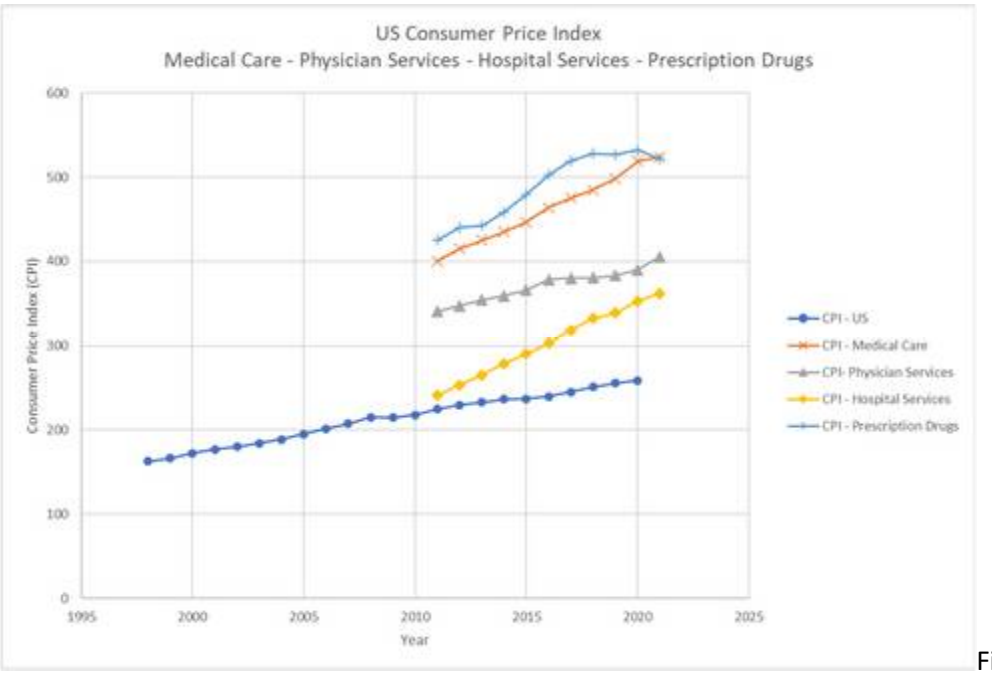


Figure 9

- Shown in Figure 10 is a *normalized (values converted to reflect a common range from 0 to 1 by dividing each value by its maximum value in each category[46])* chart comparing the Conversion Factor for physician services, inflation, and CPIs for US, medical, hospital, physician and prescriptions. As shown, inflation and CPIs tend to show an increase over the past 20 years compared to the Conversion Factor's flat trend. This indicates the use of Medicare Conversion Factor is not keeping up with cost increases in health care.

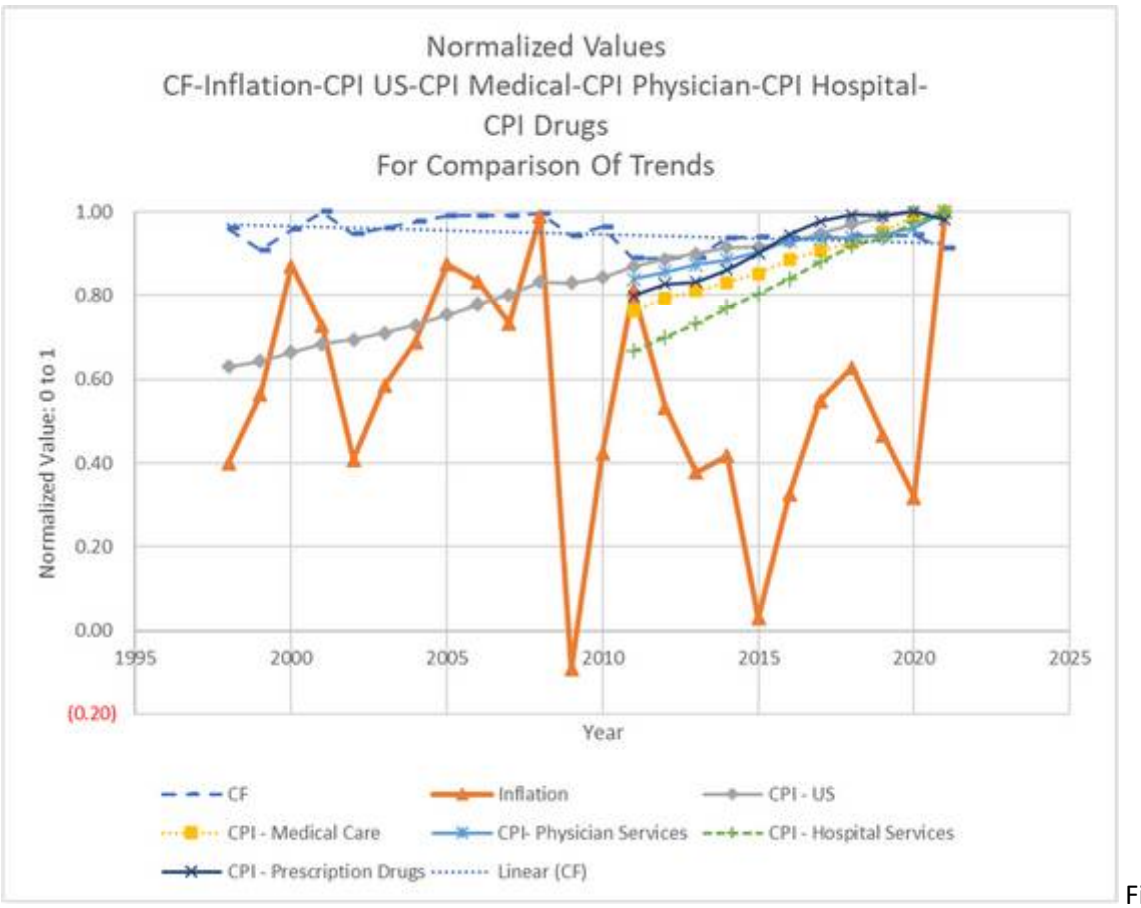
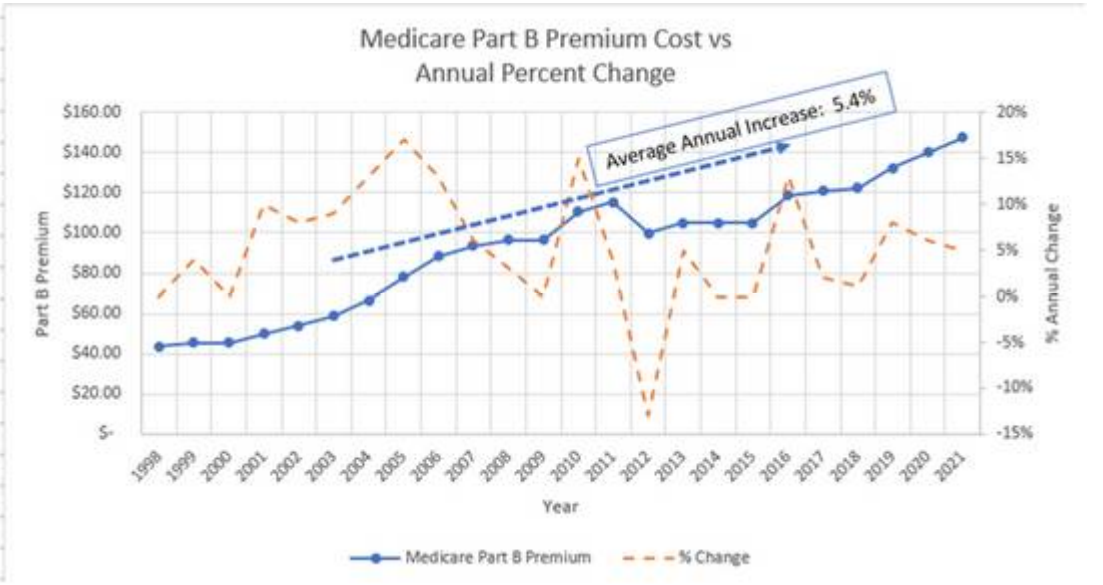


Figure 10

- Shown in Figure 11 are historical Medicare Plan B Premium costs and its annual % change. As shown, from 1998 to 2021, Plan B Premiums have been increasing on average 5.4% per year.

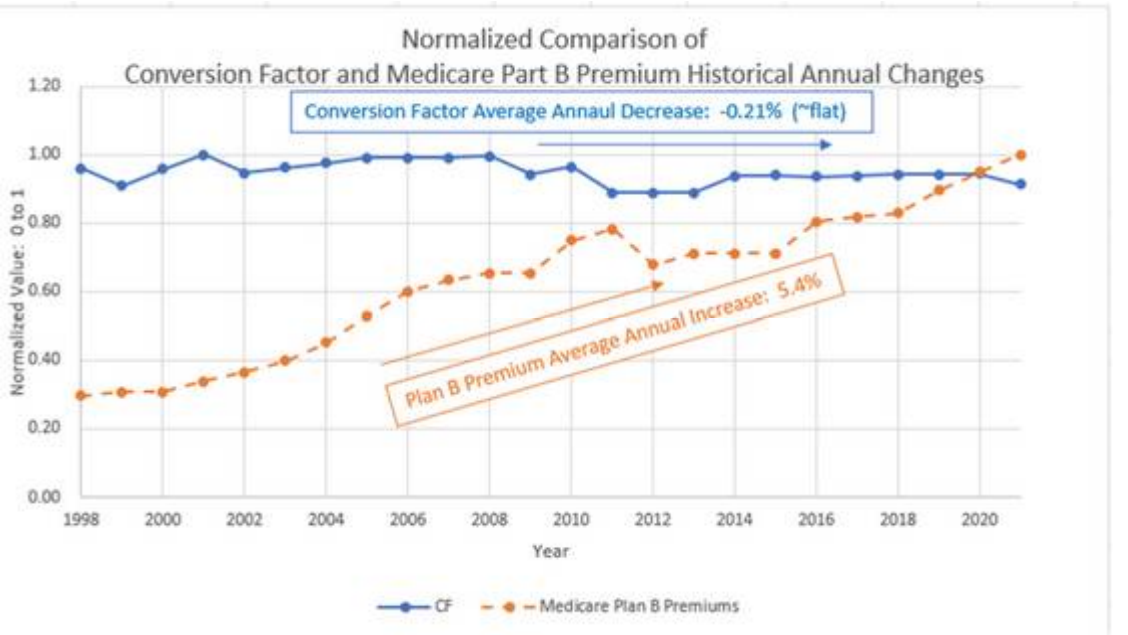
[46] Normalization example: assume a list of number 2, 5, 9 and 10. Dividing each by the highest number (10), converts each number to a number ranging from 0 to 1, or in this example, 0.2 (=2/10), 0.5, 0.9 and 1. Plotting normalized numbers against other normalized list of numbers is a convenient way to illustrate their comparison and how the relate to one another.

Figure 11



- Shown in Figure 12 is a comparison between the normalized annual changes of the Conversion Factor for physician services and Medicare Plan B Premium costs. Plan B Premium costs from 1998 to 2021 have been increasing on average 5.4% per year. Over the same time period, the Conversion Factor change has been essentially 0 or flat. This again illustrates the Conversion Factor is not keeping up with real health care costs which would indicate the determination of Medicare allowable payments are below real costs.

Figure 12



- Consequently, the following observations are made from Figures 8-12:
    - Health related costs are increasing year-on-year from 1.6% to 2.5%, depending on the category of care (hospital, physician, drugs, care).
    - Medicare Plan B Premiums are increasing on average 5.4% per year
    - Conversion Factor (for physicians) used to determine Medicare fixed prices (allowable payments) have been flat (slight decrease of -0.21%).
    - If health related costs and Medicare Plan B Premiums are increasing yet Medicare (fixed price-allowable payment) Conversion Factor (for physician services) reimbursement payments are remaining flat…
        - Is the health industry losing money by taking Medicare patients?[47]
        - Should the health industry trend toward not taking Medicare patients, will this put at risk Medicare eligible participants ignoring some of their health care needs because of too high cost or unavailable health care providers?[48] Or will the health care burden shift to the government?
        - Since there is continued publication of concerns that future Medicare funds may be insufficient to pay all claims and health costs continue to increase… is this problem exacerbated by:
            - An aging population and number of participants in the Medicare programme increasing faster than the increase in Medicare Plan B Premium rates?
- Medicare will make a determination how much you, the patient (Beneficiary) is personally responsible for paying (in many cases, such patient cost responsibility is paid for by a patient's Medigap or Medicare Supplemental insurance policy – or Medicare Advantage Plan).
    - Careful…your Medigap insurance policy (commonly called Medicare Supplement) will only reimburse the health provider for those costs not paid by Medicare and also are approved Medicare service or goods AND Medicare approved billing (allowable payment)…which is not uncommonly less than what the health provider has billed. In other words, if a service or good is not an approved Medicare expense, then the cost of the service or good is more than likely the responsibility of the patient, even if they have Medicare Supplemental insurance.
- Administration of Medicare activities (process and pay claims) is conducted through Medicare Administrative Contractors (MACs) on behalf of Centers for Medicaid and Medicare Services (CMS[49]). So if you have a complaint or question you deal with the MACs.

[47] Since health providers accept Medicare, it must be in their economic best interest to do so.
[48] ditto
[49] The Centers for Medicare & Medicaid Services (CMS) provides direction and technical guidance for the administration of the Federal effort to plan, develop, manage and evaluate health care financing programs and policies.

Part 4

Comparison of Original Medicare Plans With Medicare Advantage Plans

- The table below includes information that compares *Original Medicare* with *Medicare Advantage Plans*.
    - *Original Medicare* is where a Medicare Beneficiary subscribes to Medicare Part A and Part B plans with the U.S. government (and Medicare funds the costs of health care), which Plans may also be supplemented by Medicare Plan D Prescription Plan and private Medicare Supplemental Insurance Plans.
    - *Medicare Advantage Plans (Plan C)* are in effect health insurance with a private insurance company (who funds the payment of health costs), that rolls equivalent Medicare Part A, B and D Plans into one plan, and unlike *Original Medicare, Advantage Plan*s can also cover dental, hearing and vision.
    - *Medicare Advantage Plans* generally require use of in-network health providers whereas *Original Medicare* does not have that restriction. If a participant anticipates large ongoing medical and drug costs, the Advantage plan may be more prudent provided the in-network health provider is acceptable.
    - Generally the monthly plan costs for *Original Medicare (higher premiums but lower deductibles)* and *Medicare Advantage Plans* (lower premiums but higher deductibles) are similar, and the higher premiums offset some by higher deductible. (Technically Original Medicare out of pocket expense does not have a cap, whereas Advantage Plans do).
- Medicare pays a fixed amount for your care every month to the companies offering *Medicare Advantage Plans*. These companies must follow rules set by Medicare. Those rules are set out in Medicare Managed Care Manual, Chapter 11, Medicare Advantage Application Procedures and Contract Requirements [https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019326]. However, each *Medicare Advantage Plan* can charge different out-of-pocket costs and have different rules for how you get services (like whether you need a referral to see a specialist or if you have to go to only doctors, facilities, or suppliers that belong to the plan – in network - for non-emergency or non-urgent care). These rules can change each year.
- There is considerable variation in the negotiated prices that private health insurers pay to medical providers for treating commercially insured patients in the United States. Unlike commercial payers, *Original Medicare* reimburses physicians and other clinicians according to an administratively set fee schedule (fixed price – allowable payment and use of the **Conversion Factor**).
- Nearly 40% of Medicare beneficiaries are covered by private insurers through the Medicare Advantage (MA) program, Plan C, and less is known about how these private MA plans reimburse clinicians. (Lack of transparency in the health system seems to be present everywhere).
- In a 2017 study[50] of 144 million claims for common services from 2007 to 2012, ***physician reimbursement in Medicare Advantage was more strongly tied to Original Medicare rates than to negotiated private commercial prices – not governed by Medicare rules***, although Medicare Advantage plans tended to pay physicians less than Original Medicare. However, Medicare Advantage plans take advantage of the commercial market's favorable pricing for services for

[50] *Physician Reimbursement in Medicare Advantage Compared With Traditional Medicare and Commercial Health Insurance,* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5710575/

which original Medicare tends to overpay, including laboratory tests and durable medical equipment. Recall insurance policies are contracts between the patient, insurer and medical providers…thus providers have agreed to reimbursement and compensation terms for their services. Insurers who have many policyholders have some commercial advantage when they negotiate with a medical service provider due to the quantity of potential patients the insurer can direct to the provider.

- The most annoying aspect of the public discourse on physician payment is the tone of victimization.
    - Physicians complain that insurers have consolidated and are underpaying them relative to the value they generate.
    - Insurers complain that clinicians and health care institutions have consolidated and are demanding unaffordable rates.
    - Who is right? The Shadow knows…

Original Medicare:	Medicare Advantage:
Doctor & hospital choice	
You can go to **any doctor or hospital that takes Medicare, anywhere in the U.S.**	In many cases, you'll need to only use **doctors and other providers who are in the plan's network** (for non-emergency care). Some plans offer non-emergency coverage out of network, but typically at a higher cost.
In most cases you **don't need** a referral to see a specialist.	You **may need** to get a referral to see a specialist.
Cost	
For Part B-covered services, **you usually pay 20% of the Medicare-approved amount** after you meet your (small) deductible . This is called your coinsurance.	**Out-of-pocket costs vary** – plans may have different out-of-pocket costs for certain services.
You pay a **premium (monthly payment) for Part B**. If you choose to join a Medicare drug plan, you'll pay a separate premium for your Medicare drug coverage (Part D)	You pay the monthly **Part B premium** and may also have to **pay the plan's premium**. Plans may have a $0 premium and may help pay all or part of your Part B premium. Most plans include Medicare drug coverage (Part D).
There's **no yearly limit** on what you pay out-of-pocket, unless you have supplemental coverage – like Medicare Supplement Insurance (Medigap)	Plans have a **yearly limit** on what you pay out of pocket for services Medicare Part A and Part B covers. Once you reach your plan's limit, you'll pay nothing for services Part A and Part B covers for the rest of the year.
You **can get** Medigap to help pay your remaining out-of-pocket costs (like your 20% coinsurance). Or, you can use coverage from a former employer or union, or Medicaid.	You **can't buy and don't need** Medigap.
Coverage	

Original Medicare:	Medicare Advantage:
Original Medicare covers most medically necessary services and supplies in hospitals, doctors' offices, and other health care facilities. Original Medicare doesn't cover some benefits like eye exams, most dental care, and routine exams.	Plans must cover all of the medically necessary services that Original Medicare covers. Most plans offer **extra benefits that Original Medicare doesn't cover** – like some routine exams and vision, hearing, and dental services.
You can join a **separate Medicare drug plan** to get Medicare drug coverage (Part D).	**Medicare drug coverage (Part D) is included in most plans.** In most types of Medicare Advantage Plans, you can't join a separate Medicare drug plan.
In most cases, you don't have to get a service or supply approved ahead of time for Original Medicare to cover it.	In some cases, you have to get a service or supply approved ahead of time for the plan to cover it.
Foreign Travel	
Original Medicare generally **doesn't cover care outside the U.S.** You may be able to buy a Medicare Supplement Insurance (Medigap) policy that covers emergency care outside the U.S.	Plans generally **don't cover care outside the U.S.** Some plans may offer a supplemental benefit that covers emergency and urgently needed services when traveling outside the U.S.
Insurance Premium Cost (2021)	
• Pay Medicare Part B Premium $148/mo (2020) plus an IRMAA (up to $500/mo),[MANDATORY] • Pay Part D Drug Premium ~ $25/mo plus IRMAA (up to $71.50/mo) [OPTIONAL] • Pay Supplement Medicare Plan, $230/m. Plan F [OPTIONAL]	• Pay Medicare Part B Premium $148/mo (2020) plus an IRMAA (up to $500/mo),[MANDATORY] • Pay deductible before plan pays (generally at least ~300/mo) • Some pay extra for Drug coverage (usually deductible applies)

- Consequently, which plan to choose, Original vs Advantage, is influenced by many factors.
- A patient would tend to favor Original Medicare Plans if:
    - They prefer to use certain health providers (whether in or out of network)
    - They prefer to make their own decision to see specialists whether or not their General Practitioner doctor makes a referral
    - They prefer to contract for their own Prescription drug plan (Part D)
    - They plan to have a Medicare Supplemental Policy to put a cap on their yearly out of pocket limit
    - They will cover dental, hearing and vision insurance with separate plans.
    - They are ok with typical medical necessary coverage and don't have any unique medical needs.
    - They are ok with Medicare and Medicare Supplement premium, coinsurance, deductible and copayment costs.
- A patient would tends to favor Medicare Advantage Plan C if:

    - They are ok using in network health providers (and willing to pay a higher cost if out of network health providers are used)
    - They are ok to have specialists covered only if their GP makes a referral.
    - They are ok to have their prescription drug coverage bundled or automatically included in the Advantage Plan
    - Yhey don't require a Medicare Supplement Plan (and can't have one anyway if you join an Advantage Plan)
    - They are ok also bundling in an Advantage Plan, dental, vision or hearing insurance coverage.
    - They are ok with Advantage Plan premium, coinsurance, deductible (typically much higher than Original Medicare) and copayment
- Be aware both Original Medicare and Advantage Plan participant remain liable for any Social Security check deductions for Medicare Part B and IRMAA premium payments (for both Medicare Part B and prescription plans)!