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Financial Analysis of New Medicare and Medicaid Guidelines, Reimbursement Rates, and Increased Enrollment on Four Nebraska Clinics

Jamilah J. Abdul-Hakim
University of Nebraska Medical Center

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Jamilah J. Abdul-Hakim

College of Public Health: Public Health Administration and Policy

Master of Health Administration (MHA) Candidate

Committee:

David W. Palm, Ph.D. (Chair)

Stephen M. Peters, M.A. (Committee Member)

Johnathan D. Rouse, DPM (Committee Member)

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Abbreviations

CMS	**Center for Medicare and Medicaid Services**
FFS	**Fee for Services**
DHHS	**Department of Health and Human Services**
ACA	**Affordable Care Act**
FPL	**Federal Poverty Level**
MACRA	**Medicare Access and CHIP Reauthorization Act**
CHIP	**Children's Health Insurance Program**
SGR	**Sustainable Growth Rate**
QPP	**Quality Payment Program**
MIPS	**Merit-based Incentive System**
AAPM	**Advanced Payment Model**
AMA	**American Medical Association**
AHA	**American Hospitals Association**
MLPC	**Midwest Limb Preservation Center**
EHR	**Electronic Health Records**

Abstract

Government health insurance plans such as Medicaid and Medicare were created with the intention of providing elderly, low-income, or disabled citizens with affordable and quality health insurance through government-contracted providers (Baicker et al., 2013). Medicare is a government health insurance program that provides healthcare to United States citizens who are 65 years and older, regardless of their income or past medical history. Medicaid was implemented as an assistance program to provide health insurance for low-income Americans and their families. Medicaid is administered by each state independently, which creates variation in reimbursement rates, services, and structure. (Grabowski, 2007).

Providers accepting Medicare and Medicaid payments agree to receive lower reimbursement rates in comparison to private insurance. Private insurance programs offer providers rates based on group contracts and affiliated capitation programs and typically reimburse higher than government payment models (Mark et al., 2020). Providers see a significant revenue difference between private pay and government reimbursement. For an established patient office visit, commercial insurers paid an average of 126 percent of Medicare rates (Mark et al., 2020). For many providers, especially if they have an overabundance or their patient base skews heavily on government patients, their revenues and financial well-being can be strained (Mark et al., 2020).

Lower reimbursement, coupled with higher expenses of caring for these patients, complex CMS guidelines, and increased Medicare and Medicaid enrollment, often can jeopardize providers financially. The purpose of this project is to complete a financial impact assessment of four clinics to determine the impact of Medicare and Medicaid guidelines,

reimbursement rates, and increased enrollment and apply that data to a financial decision tool that can assist in determining clinic decisions.

CHAPTER 1: Introduction

As part of a cost-containment strategy, coupled with value-based goals, the Centers for Medicare and Medicaid Services has introduced new guidelines for providers to follow, which has led to increased reporting and paperwork in addition to compliance training for providers. This has all occurred all the while reimbursement rates continue to be lower and lower than private insurance (Renshaw & Gould, 2018). These new guidelines have caused increased administrative burdens and staff increases to complete required Medicare and Medicaid paperwork for patients and ensure that all staff is compliant with CMS guidelines. Along with the increase in administrative burden and increasing costs, reimbursement rates set by CMS continue to decrease while having new formulas and reporting processes. A reduction in reimbursement rates by Medicare and Medicaid payment rates jeopardizes providers' financial viability, leading physicians to "opt-out" of the Medicare program, potentially leading to a shortage of physicians willing to treat Medicare beneficiaries and compromising patients' access to care (Holgash & Heberlein, 2019). In the last five years, the number of providers opting out of Medicare has nearly doubled, with over 10,000 physicians in the United States refusing Medicare patients (Holgash & Heberlein, 2019). This issue takes on even greater importance during the coronavirus pandemic, with COVID-19 deaths surpassing 200,000, including a disproportionate share of older adults (Ku & Brantley, 2021).

With both increased administrative costs to accept Medicare and Medicaid patients and a reduction in reimbursement rates, patients may find access to care more difficult as providers discontinue accepting these patients and focus on bringing in more patients with commercial insurance that have higher reimbursement (Holgash & Heberlein, 2019). Providers will be faced with making decisions regarding accepting government insurance patients, and if the trend

continues, fewer will do so. As more and more physicians consider dropping Medicare and Medicaid patients, reliable decision tools and or processes to evaluate and or assist with that financial decision are needed. Deciding to stop seeing Medicaid patients requires careful consideration of the financial and organizational impact, including patient impacts. The purpose of this project is to complete a financial impact assessment of four clinics to determine the financial effects of discontinuing care for Medicare and Medicaid patients. Along with the assessment aim, this work will examine the use of a criteria-based financial decision instrument that can be applied to assist in decisions on future Medicaid/Medicare acceptance.

CHAPTER 2: Background

a. Medicare

The 1950 census indicated that the aged population in the United States had grown from 3 million in 1900 to 12 million in 1950 (Blumenthal et al., 2015). During this time period, over 60 percent of older Americans earned less than $1,000 annually, and only 12.5 percent of older Americans had health insurance (Blumenthal et al., 2015). Between 1950 and 1963, this number grew exponentially as the older population grew from 12 million to 17.5 million. During this time period, the cost of healthcare was on the rise at a rate of about 7 percent a year, outpacing the growth in the incomes of older Americans (Blumenthal et al., 2015). During this time, private health insurance companies viewed elderly insurees as a risk as they were more prone to illnesses and injuries. Because of this assumption from insurance companies, rates from private insurance companies steadily increased to a point where retired older adults and those living in poverty could not afford private health insurance (Blumenthal et al., 2015). This disparity in access to health insurance and, subsequently, healthcare led to discussions among the Social Security Administration and the House of Representatives regarding potential proposals to mitigate the issue.

On July 30, 1965, President Lyndon B. Johnson signed into law the Social Security Amendments of 1965 (Berkowitz, 2005). The passage of the Social Security Amendments resulted in the implementation of Medicare and Medicaid, two health insurance programs that became America's most enduring social programs. Medicare is a federal health insurance program provided for people who are 65 or older, people with certain disabilities that received Social Security disability benefits for at least 24 months, people who are entitled to Railroad

Retirement benefits, and people with End-Stage Renal Disease (kidney failure) regardless of income or assets of the Medicare beneficiary (Berkowitz, 2005).

While Medicare helps with the cost of healthcare for the aforementioned demographic, it does not cover all medical expenses or the cost of most long-term care. Medicare plans also require beneficiaries to share some of the costs for deductibles and co-insurance. Medicare is comprised of different parts and policies that cover various treatments and services (Blumenthal et al., 2015). Those eligible for Medicare are enrolled in Medicare Part A, and Part B. Medicare Part A covers the insured's inpatient hospital stay, care in a skilled nursing facility, hospice care, and some home healthcare (Blumenthal et al., 2015). Medicare Part A is financed largely by federal payroll taxes paid into Social Security by employers and employees.

Medicare Part B covers certain doctor's services, outpatient care, medical supplies, durable medical equipment, and preventive services. Medicare Part B also covers the costs of what is deemed by the Center for Medicare and Medicaid Services (CMS) as medically necessary services, such as medical supplies, tests, or other services that are needed to diagnose and treat various medical conditions (Berkowitz, 2005). Medicare Part B is financed by monthly premiums paid by Medicare beneficiaries and by general revenues from the federal government. Medicare Part D helps cover the costs of prescription medications, including many recommended shots and vaccines (Berkowitz, 2005).

A few services not included in Medicare coverage are dental, vision, and hearing. There are optional managed care, Medicare Advantage, and supplemental plans that can be purchased that cover the additional healthcare costs not covered by Medicare. Medicare Part C is an optional Medicare Advantage plan sold through insurance firms that have contracted with the federal government (Blumenthal et al., 2015).

b. Medicaid

The implementation of Medicaid was also signed into law with the Social Security Amendments of 1965. However, Medicaid has changed and expanded significantly in the subsequent years. In 2010, the Affordable Care Act (ACA) expanded Medicaid coverage to nonelderly adults with income up to 138 percent of the Federal Poverty Level (FPL), a yearly income of about $18,000 in 2019 (Rudowitz, 2020). Prior to the implementation of the ACA, individuals had to meet certain income standards to qualify for Medicaid, leaving millions of low-income Americans ineligible for Medicaid services and without coverage options (Rudowitz, 2020). Before the ACA was introduced, federal law excluded adults without dependent children from the Medicaid program regardless of income or socioeconomic status. The ACA expansion of 2010 eliminated categorical eligibility and allowed a wider range of Americans to be eligible for Medicaid coverage (Rudowitz, 2020). However, as a result of a Supreme Court ruling in 2012, the ACA Medicaid expansion became optional for states to adhere to.

Medicaid provides healthcare coverage to eligible low-income adults, children, pregnant women, elderly adults, and people with disabilities. Unlike Medicare—a federally run and funded health insurance program—Medicaid is administered by states in compliance with federal regulations addressed in Title XIX of the Social Security Act (Berkowitz, 2005). These federal regulations govern the program, define federal Medicaid requirements and state options and authorities. The Centers for Medicare and Medicaid Services within the Department of Health and Human Services (DHHS) is responsible for implementing Medicaid (Rudowitz, 2020).

Medicaid is structured as a federal-state partnership and is jointly funded by individual states and the federal government. Subject to federal standards and regulations, states have the authority to determine covered demographics, covered services, healthcare delivery models, and methods for paying physicians and hospitals (Rudowitz, 2020). Because of this flexibility within individual states, there is a significant variation in Medicaid plans across states.

Medicaid coverage provides critical health care coverage for millions of Americans that may otherwise be unaffordable by most. Medicaid is the principal source of long-term care coverage for Americans. Medicaid plans cover the vast majority of health services and limit beneficiaries' out-of-pocket costs. All Americans who meet eligibility requirements for Medicaid are guaranteed coverage, and states are matched by the federal government for qualified services administered to eligible beneficiaries (Rudowitz, 2020).

The expansion of state Medicaid programs across 37 states has resulted in the steep decline of Americans without health insurance coverage. Medicaid covers many populations and plays a critical role in increased access to healthcare services. On average, state Medicaid plans cover over 50 percent of births, 83 percent of poor children, 48 percent of children with special health care needs, and 45 percent of nonelderly adults with physical and developmental disabilities such as autism, traumatic brain injuries, serious mental illness, and Alzheimer's disease (Corallo & Moreno, 2022). Medicaid plans with higher-income beneficiaries help cover gaps in private health insurance and limit out-of-pocket financial burden. Medicaid also assists over 20 percent of Medicare beneficiaries with Medicare premiums and cost-sharing and provides benefits not covered by Medicare plans (Corallo & Moreno, 2022).

State Medicaid plans cover a vast range of healthcare services that address the specific needs of the population in each individual state. There are ten "essential health benefits"

mandated by the ACA in which states are obligated to offer. These benefits include doctor's services, inpatient and outpatient hospital care, prescription drug coverage, pregnancy and childbirth, mental health services, dental care for children, emergency services, rehabilitative services and devices, laboratory services, preventative and wellness services, and pediatric services (Rudowitz, 2020). In addition to offering federal-mandated healthcare services, many states elect to offer additional services to their beneficiaries, such as prescription medications, physical and occupational therapy, dental, and vision. Medicaid also covers long-term care, including nursing home care, as well as community-based long-term services and supports (Rudowitz, 2020).

c. New Medicare and Medicaid Guidelines

Since the introduction of Medicare and Medicaid in 1965, the federally mandated insurance plans have expanded over the course of almost six decades. In 1965 Medicare and Medicaid were enacted as Title XVIII and XIX of the Social Security Act, providing hospital, post-hospital extended care, and home health coverage to 19 million Americans aged 65 or older, receiving Social Security disability assistance, and those considered as low-income individuals (Rudowitz, 2020). In the 1970s and 1980s, Medicare and Medicaid guidelines continued to expand to include different populations in need of government health insurance assistance. During the 1990s and early 2000s, more services were added and covered under Medicaid, and Medicare plans, including prescription drug coverage (Rudowitz, 2020). Between 2010 and 2015, the ACA expanded eligibility to a wider range of the American population.

Although new Medicaid and Medicare regulations, expansion, and guidelines have greatly benefited many Americans, these guidelines have also impacted healthcare providers in both negative and positive aspects. Between 2015 and 2021, there have been many new regulations and guidelines that have adverse effects on healthcare providers and organizations. One of the many impacts clinics and providers face is increased administrative burden. The administrative burdens created when physicians and insurers haggle over reimbursement payments result in substantial lost revenue for healthcare providers. The issue spans all forms of health insurance but is particularly acute with Medicaid, a key part of the social safety net. The administrative hoops result in what can be seen as a kind of additional tax that causes many doctors to choose not to see Medicaid patients, exacerbating disparities

in healthcare access (Duggan et al., 2016). Medicaid claims have payment denied for at least one service upon doctors' initial submission of a claim, a marked difference from other types of insurers. Denials are far less frequent for Medicare (7.3%) and commercial insurers (4.8%).

Following a denial, a physician can accept that the claim will not be paid, foregoing the potential revenue or commence a costly back-and-forth process to try to convince the insurer to pay. Even if insurers ultimately pay for some of the denied claims, in full or in part, this process is extremely costly for physicians – especially when submitting bills to Medicaid (Duggan et al., 2016).

One regulation that had an impact on healthcare providers and organizations was the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015. MACRA significantly changed the way Medicare paid physicians by replacing the Sustainable Growth Rate (SGR) methodology with the Quality Payment Program (QPP), a method that emphasizes value-based payment models (McWilliams, 2017). Under MACRA, Medicare and Medicaid are increasingly paying physicians based on the value rather than the volume of their services. Under the QPP, physicians choose to enroll between two Medicare payment tracks, the Merit-based Incentive System (MIPS) track or the Advanced Payment Model (AAPM) track.

MIPS adjusts Medicare part B payments based on performance in four performance categories—quality, cost, promoting interoperability, and improvement activities (McWilliams, 2017). Performance of health care organizations in the four categories is weighted and used to calculate a score and compared to a performance threshold set by CMS to determine payment adjustments. Final scores above the threshold will receive a positive payment adjustment. Performance in MIPS could affect salary and compensation contracts

and can result in positive or negative payment adjustments (McWilliams, 2017). A negative MIPS performance leads to fewer reimbursement amounts, lower salaries, and compensation for providers (McWilliams, 2017).

The AAPM offers physicians incentives to provide high-quality, cost-effective care. In order to qualify for AAPM, the organization must receive at least 50 percent of its Medicare Part B payments through the AAPM and see at least 35 percent of its Medicare patients through the AAPM (McWilliams, 2017). This model pressures physicians into seeing more Medicare patients as opposed to private commercial insurance beneficiaries in order to meet the minimum thresholds under the Medicare arrangement.

These new CMS guidelines pose many issues to providers and healthcare organizations. The MACRA metrics set by CMS make reporting requirements difficult to manage and require organizations to hire extra staff and implement new technologies to ensure CMS compliance (McWilliams, 2017). This guideline also forces organizations to work closely with other organizations to exchange data and track patients' overall progress. The lengthy reporting requirements require tracking metrics that providers have not historically monitored through the new set of measures. According to the American Medical Association (AMA), 90 percent of providers polled viewed the reporting requirements as burdensome. Fewer than 25 percent of providers believe that they are "well-prepared" to meet the requirements of the QPP. Fifty-one percent of providers believe that they are "somewhat" knowledgeable about the MACRA guidelines, and eight percent believe that they are "deeply knowledgeable" about the program (McWilliams, 2017). MACRA significantly affects small practices negatively. The CMS estimated that nearly nine out of ten solo practices were hit with negative adjustments totaling $300 million when the reimbursement regulations began in

2019 (Hacker, 2019). This financial impact will likely encourage the assimilation or purchase of smaller practices by larger organizations.

d. Increased Medicare and Medicaid Enrollment

Since the passing of the ACA in 2015, Medicare and Medicaid enrollment has increased exponentially due to expansion efforts, population needs, and federal regulations. One of the biggest increases in enrollment occurred during the COVID-19 pandemic in 2020. During the pandemic, over 10 million Americans enrolled in Medicaid for low-cost health coverage (Verma, 2020). The number of new enrollees in June of 2020 was 3.8 million (Verma, 2020). This number of new enrollees grew to 14.6 million by November 2021. With this increase, over 80 million people—a 14 percent increase over a 12-month period—were covered by Medicaid alone in 2021 (Corallo & Moreno, 2022).

The expansion and increased enrollment in 2020 and 2021 alone have outpaced overall Medicaid enrollment growth. This enormous increase in enrollment growth leads to potential federal and state obligations for spending and relative cost to Medicaid programs. This increased enrollment puts pressure on CMS and the federal government for additional funds allocated to Medicaid and Medicare services (Corallo & Moreno, 2022). Increased enrollment also affects physicians and healthcare organizations.

e. Reimbursement Rates

Although Medicaid and Medicare are both government healthcare programs aimed at helping individuals gain healthcare coverage, the reimbursement structures and fee schedules vary significantly by provider. Reimbursement refers to payments hospitals and physicians receive as a result of services provided to patients that are covered under Medicare and Medicaid.

Underpayment is the difference between the costs incurred and the reimbursement received for delivering care to patients (Scarcelli et al., 2007). Underpayment occurs when the payment received is less than the costs of providing care paid to organizations from Medicare or Medicaid for providing said care (Scarcelli et al., 2007). Costs for providing care include costs of hired personnel, technology, and other goods and services required to provide care to patients.

Many hospitals and healthcare organizations report underpayment by CMS for services rendered to individuals insured under Medicare or Medicaid. A study by the American Hospital Association (AHA) found that combined underpayments were $76.8 billion in 2017 (AHA, 2017). For Medicare and Medicaid, hospitals received payment of 87 cents for every dollar spent by hospitals caring for Medicare and Medicaid patients in 2017. In 2017, 66 percent of hospitals received Medicare payouts less than costs incurred by the hospital for treating Medicare patients (AHA, 2017).

Private insurance paid nearly double Medicare rates for provider services ranging from 189 percent to 264 percent of Medicare rates for the same services at the same locations (Scarcelli et al., 2007). Medicaid pays out an estimated 61 percent on average of what

Medicare does for outpatient physician services (Scarcelli et al., 2007). This underpayment by Medicare and Medicaid leads to limited provider participation and a lack of access to care for beneficiaries. However, most people who are now covered under Medicaid expansion were previously uninsured, and providers would have received no or very limited reimbursement previously.

f. The Midwest Limb Preservation Center: Defining the Issue

The subject of the financial analysis discussed in this report is the Midwest Limb Preservation Center in Nebraska. The Midwest Limb Preservation Center (MLPC) is comprised of four clinic entities, the Foot and Ankle Center of Nebraska (four specialty podiatry clinics), FAST Physical Therapy (two physical therapy clinics), FOOTSteps (a durable medical equipment department), and the Vein and Vascular Institute of Nebraska (a vein and vascular clinic/lab). The Midwest Limb Preservation Center is physician-led and is comprised of over 40 employees, with 13 of those employees being healthcare providers (podiatrists, physical therapists, pedorthists, and vascular surgeons).

The Midwest Limb Preservation has been established for over 30 years, and in recent years, the organization has been affected by Medicare and Medicaid guidelines, reimbursement rates, and increased Medicare and Medicaid enrollment. These factors have led to increased administrative burden, increased costs, and lower revenue. With Medicare and Medicaid enrollment at its peak between 2020 to current, without an increase in reimbursement rates, the clinics' biggest challenge and dilemma is deciding whether or not it is financially sound to continue to accept new Medicare and Medicaid patients.

The three factors mentioned previously have caused the clinics to increase costs without an increase in CMS reimbursement. Due to new Medicare and Medicaid guidelines—specifically the newly introduced MACRA metrics—MLPC has hired more staff to ensure adherence to CMS guidelines, process an excess of Medicare and Medicaid paperwork, and monitor and manage MACRA metrics set by CMS, resulting in an increase in funds allocated

to staffing salary budgets. These factors and administrative burdens have increased the costs by 3 to 5 percent on average per year for the clinics.

Because of increased Medicaid and Medicare enrollment, more patients covered by these insurance plans are becoming patients of MLPC, which decreases the amount of private commercial beneficiaries seen in MLPC's clinics leading to lower profits. The lower reimbursement rates paid out by Medicare and Medicaid as opposed to private insurance significantly affect MPLC, as will be discussed in Chapter 3. With lower reimbursement also comes a longer turnaround on payment to MLPC clinics, as CMS reimbursement can take up to 3 times as long to be paid to the clinics as private insurance.

Administrative burdens due to new CMS guidelines have increased the costs by 3 to 5 percent on average per year for the clinics. Lower reimbursement rates and increased enrollment has led to the decreased reimbursement of 6 to 12 percent per year for the clinics, for an overall contributing cost of 9 to 17 percent per year.

CHAPTER 3: Methods

a. Financial Data Analysis

Using data collected from the practice management and billing system of MLPC provided the content for a financial assessment to be completed and offered a detailed report. In order to generate the report, specific variables were assigned with report criteria, including financial class and dates of service. For the analysis, the financial class criteria included Medicare, Medicaid, and all commercial insurance companies. The Medicaid financial class includes all Nebraska Medicaid plans accepted by the clinics, including Healthy Blue, United Health Care Community Plan, and Nebraska Total Care. Because of the proximity of Nebraska to Iowa, the clinics also accept Iowa Medicaid patients. The summary report also includes Iowa Medicaid plans, including Amerigroup and Iowa Total Care. Commercial insurance includes all private insurance companies accepted by the clinics, including Blue Cross Blue Shield, United Healthcare, Aetna, Humana, and more. The Medicare financial class includes Medicare Part A and Part B. Medicare advantage, and replacement plans were not included in the generation of the report. The dates of services used for the report ranged from January 1, 2020, to December 31, 2021.

Once the variables of financial class and dates of service were entered as criteria for the financial report, an analysis of reimbursement rates was generated. This report shows a comprehensive list of all ICD-9 or diagnosis codes billed to insurance companies by the clinics and how much in reimbursement the clinic received from each financial class mentioned above. It includes the procedure code, units billed, the billed charge sent to insurance, the reimbursement payment from the respective financial classes, and the

adjustment. This report was then compared to the fee schedule to identify any irregularities in reimbursement.

b. Figures

Figure 1.

The figure below shows an example of a common diagnosis code used throughout the clinics. This figure shows the units billed to each financial class, commercial, Medicare, and Medicaid, and how much in payment was received from the respective insurance companies.

Reimbursement Analysis - Summary

By Financial Class, Date of Service, Date Ranges 1/1/2020 to 12/31/2021

FOOT AND ANKLE CENTER OF NE & IA

All Providers, All Charge Codes

All Provider Profiles, All Diagnosis Codes

All Carriers, All Financial Classes, All Facilities

Financial Class / Procedure	Units	Charge	Payment	Adjustment
Commercial				
10061 - DRAINAGE OF SKIN ABSCESS	66	$28,380.00	$21,617.01	
28002 - TREATMENT OF FOOT INFECTION	2	$1,814.00	$1,058.63	
11750 - REMOVAL OF NAIL BED	627	$297,650.00	$161,516.90	
17110 - DESTRUCT B9 LESION 1-14	214	$46,916.00	$36,981.47	
Medicare				
10061 - DRAINAGE OF SKIN ABSCESS	28	$7,568.00	$5,052.13	
28002 - TREATMENT OF FOOT INFECTION	3	$2,018.00	$867.33	
11750 - REMOVAL OF NAIL BED	92	$24,445.00	$12,611.45	
17110 - DESTRUCT B9 LESION 1-14	108	$15,308.00	$10,696.57	
Medicaid				
10061 - DRAINAGE OF SKIN ABSCESS	16	$6,740.00	$1,611.40	
28002 - TREATMENT OF FOOT INFECTION	1	$907.00	$214.33	
11750 - REMOVAL OF NAIL BED	132	$62,700.00	$18,818.20	
17110 - DESTRUCT B9 LESION 1-14	40	$8,788.00	$1,716.47	

Figure 2.

The figure below shows the total units billed, the charge from MLPC to the insurance company, and the payment received from the insurance company for each financial class, commercial, Medicare, and Medicaid, between January 1, 2020, to December 31, 2021.

	Units	Charge	Payment
CC - COMMERCIAL Total:	**45,975**	**$7,978,401.77**	**$4,400,444.25**
MC - MEDICARE Total:	**39,225**	**$3,380,599.83**	**$1,841,833.02**
MD - MEDICAID Total:	**8,232**	**$1,352,158.93**	**$406,346.34**

CHAPTER 4: Results

a. Financial Analysis

Through the analysis process, the results of the Reimbursement Analysis Summary, several inferences and assumptions came to light. First, across approximately 70 percent of diagnosis codes billed to insurance companies by MLPC of the three financial classes reviewed—commercial, Medicare, and Medicaid—it is shown that commercial insurances reimburse at a rate 130 to 154 percent higher than Medicare and Medicaid payers respectively. Not only do commercial insurances reimburse at a higher rate than Medicare and Medicaid, but they also release payment to the clinics at a much faster turnaround rate than Medicare and Medicaid.

According to the MLPC, new Medicare and Medicaid guidelines, and the new system for reimbursement, MACRA has also caused a financial burden on the clinics. In order to stay in compliance with MIPS, the clinics have hired multiple staff members to manage MACRA metrics and ensure the highest participation in the four qualities outlined in MIPS in order to effectively maximize reimbursement from CMS. In addition to hiring new staff, the clinics have added technologies within their EHR systems, such as reports generators that provide financial information and data analysis on the current standing in MIPS. With the everchanging Medicare and Medicaid guidelines, all staff also MUST be thoroughly trained in proper CMS practices and Medicare and Medicaid compliance. This requires time and money from the clinics, as well as the potential opportunity costs for training while the clinics are closed. Administrative burdens due to new CMS guidelines have increased the

costs by 3 to 5 percent on average per year for the clinics. Lower reimbursement rates and increased enrollment have led to the decreased reimbursement of 6 to 12 percent per year for the clinics, for an overall contributing cost of 9 to 17 percent per year.

b. Implications

With more and more healthcare organizations such as the MLPC deciding whether it is in the best interest of their organizations to accept Medicare and Medicaid, CMS could potentially run into issues with access to healthcare for its beneficiaries. As an increasing number of clinics decide to limit or eliminate the number of Medicare and Medicaid patients seen in their practice, options for healthcare may become more limited for CMS beneficiaries. Especially those beneficiaries that reside in rural or low-income areas where access to quality healthcare is already limited.

The CMS reimbursement fees vary greatly between hospitals and physician practices. Because clinics can charge various fees such as facility fees that clinics cannot, hospitals receive disproportionately higher reimbursement rates. If clinics decide it is not financially sound to accept Medicaid and Medicare patients, more beneficiaries may end up being treated in hospital systems in lieu of visiting provider practices due to a lack of acceptance for their insurance plan (Courtemanche et al., 2016).

Providers refusing to accept Medicare and Medicaid patients is likely to cause an influx of patients to community health centers and hospitals. As a result, patients may have longer wait times and less time with providers, which could negatively affect the quality of care given.

CHAPTER 5: Discussion

a. Financial Assessment Tool

In order to determine whether it is financially sound to accept Medicaid and Medicare at a healthcare organization, it is proposed in this work that healthcare organizations develop a criterion-based, financial assessment instrument tool that will aid in determining the financial impact of Medicare and Medicaid patients to the organization. The purpose of the financial assessment tool is to have an organization-specific decision-making tool determine whether it is financially sound to accept Medicare and Medicaid patients. First, an organization must develop criteria in which to apply to the tool. For MLPC, the criteria used were patient demographics, clinic location, reimbursement rates for services offered, and patient volume.

Patient volume is an important variable to consider when using the instrument. If an organization does not have an exceptionally high patient volume, it may consider accepting Medicaid and Medicare patients in order to obtain a profit. Patient insurance demographics are also a variable to include in the tool. If a high percentage of patients are covered by Medicaid and Medicare, it is probably wise to continue to accept these patients. However, if many patients in the demographics served by the clinic are privately insured, it may be more financially sound to limit the number of Medicare and Medicaid patients in order to optimize the reimbursement from private insurance.

Clinic location is a very important variable in a financial decision-making tool designed to aid in the decision to accept Medicare and Medicaid patients. If the clinic is in a rural area, areas where a majority of the population are generally enrolled in Medicare and Medicaid, or areas where there is not great access to healthcare, a clinic may find it financially sound to

accept CMS beneficiaries. However, if the clinic is in a location where healthcare is competitive, and there are many options available, or where most of the population is privately insured, it may be financially sound to limit the amount of Medicare and Medicaid patients seen. Clinics and organizations should also conduct reimbursement analysis summary reports to examine and compare reimbursement rates for the specific diagnosis codes billed by their practices.

After determining criteria or variables specific to the organization, the organization must determine a threshold for which they will evaluate whether the criteria show that it is financially sound to accept Medicare and Medicaid patients.

b. Financial Assessment Tool: MLPC Recommendations

With increased costs of 9 to 17 percent per year without increased reimbursement from CMS, it is recommended that MLPC utilize the financial assessment tool outlined in Chapter 5 to assist in implementing various policies across the four clinics in order to mitigate this issue. MLPC determined that their clinic locations in Council Bluffs, Iowa, and Fremont, Nebraska, primarily serve patient populations that are insured through Medicaid. Eighty-four percent of patients serviced at these two clinic locations are Medicaid patients. At the two remaining clinics in Omaha, Nebraska, and Papillion, Nebraska, 27 percent of the patients served are Medicaid patients. Therefore, when inputting the criteria of patient demographics and clinic location into the assessment tool, it is financially sound to only accept Medicaid patients at MLPC's Council Bluffs and Fremont clinics and to no longer accept Medicaid patients at the Omaha and Papillion clinic locations.

It was found in the analysis report that Iowa Medicaid had the lowest reimbursement for all services offered across the clinics of MLPC. Using the criteria in the decision tool of reimbursement rates for services offered, it can be determined that it is not financially sound for MLPC to accept Iowa Medicaid patients across its clinics.

CHAPTER 6: Summary and Conclusion

Medicare and Medicaid are some of the United States' most enduring social programs, and they have provided low-cost health insurance to millions of Americans. While these programs benefit many people, providers and healthcare organizations face a dilemma when determining whether to accept patients insured by Medicare or Medicaid. Through the financial analysis of MLPC's reimbursement from commercial, Medicare, and Medicaid insurances, and the use of the financial assessment tool, it seems that MLPC benefits greatly from Medicare patients, and the financial benefits of Medicare patients outweigh the costs from administrative burdens. It has also been determined that MLPC's patient demographic in its Iowa and Fremont, Nebraska clinics are primarily comprised of Medicaid patients, so it is financially sound to continue accepting Medicaid patients at these two clinics. However, in MLPC's Omaha and Papillion, Nebraska clinics, its patient population primarily consists of patients with commercial insurance with higher reimbursement, so it is more financially sound to continue to accept these patients and refuse Medicaid patients at these two clinics. This analysis has also found that Iowa Medicaid reimburses at the lowest rate among all financial classes and therefore it is not financially sound to continue to accept Iowa Medicaid patients across all clinics.

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