HIM 252 Healthcare Payment Systems

Credit Hours:
3 hours

Instructor:
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Description:
Overview of the management of healthcare payment systems including insurance, billing/collection processes, case mix analysis, corporate compliance, HIPAA, and other current reimbursement issues.

Textbooks:
Casto and Forrestal. Principles of Healthcare Reimbursement, 5th ed. ISBN: 978-1-58426-434-7

Please note: You must have a new paper textbook to get access to the electronic student workbook. The unique student code for the student workbook is revealed once s/he scratches off the sticker provided in the paper textbook.

Evaluation:
The final course grade will be derived from percentage of achieved points accumulated from quizzes, tests, and assignments (exercises) in relation to total points possible.

The following Grade System will be used:

100% - 90%	A
89% - 80%	B
79% - 70%	C
69% - 60%	D
59% - 0%	F

To calculate your ongoing grade in the class, divide the points you receive by total possible points for what you have completed.

Example: If you have received 71 points out of a possible 80 points, calculate 71 divided by 80 (71/80= .8875) and multiply by 100. In the example, the grade would be rounded to 89% or a high "B".

Course Access:

Course can be accessed on Blackboard through the http://www.wku.edu website or https://blackboard.wku.edu/.

You must download a free copy of Respondus Lockdown Browser, which is available from the Blackboard Software tab at the top of your screen. For help with this process contact the IT Helpdesk at 270- 745-7000. You must use Respondus will taking quizzes and exams.

Due Date:

This class is self-paced. All work must be completed by the last day of class at 5:00pm. NO EXTENSIONS WILL BE GRANTED. Do not wait until the last few days to complete the course. By following this advice, technical difficulties can be addressed. If you choose to wait to complete the course requirements right before each deadline there is no guarantee that technical difficulties will not occur or that they can be corrected prior to the deadline. Technical difficulties do not extend the course completion deadline.

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Disability Accommodations:

In compliance with university policy, students with disabilities who require accommodations (academic adjustments and/or auxiliary aids or services) for this course must contact the Office for Student Accessibility Services in DSU-1074 of the Student Success Center in Downing University Center. The OFSDS telephone number is (270) 745-5004 V/TDD.

Please DO NOT request accommodations directly from the professor or instructor without a letter of accommodation from the Office for Student Accessibility Services.

Once accessibility services/accommodations have been granted and initiated, please contact me with any questions or concerns. Also, if you believe that you are not receiving the disability services to which you are entitled, please address this concern with me immediately so discussion and/or adjustments can occur.

Disclaimer:

References to external websites are provided for the convenience of the student. These sites may contain articles on politically and socially controversial topics and are presented from the prospective of providing information. The instructor is not responsible for the content of these external sites and does not necessarily endorse the views or agree with the information held on these sites; the instructor does not take moral stances on issues.

Revised 2/2017

HIM 252 HEALTHCARE PAYMENT SYSTEMS RECOMMENDED CLASS SCHEDULE

DUE DATES: This class is self-paced. All class assignments, quizzes, midterm and final must be completed by 5:00 pm on the last day of class.

Weeks	**TOPIC**	**ASSIGNMENT**
Week 1	Ch. 1- Healthcare Reimbursement Methodologies	Complete Assignment "Affordable Care Act" Complete Quiz Chapter 1
	Ch. 2- Clinical Coding and Coding Compliance	Complete Assignment 1: CMS "Medicare Fraud and Abuse: Prevention, Detection, and Reporting" Complete Assignment 2: Compliance Plan Complete Quiz Chapter 2
Week 2	Ch. 3 - Voluntary Healthcare Insurance Plans	Complete CMS "HIPPA EDI" online training Complete Quiz Chapter 3
	Ch. 4- Government- Sponsored Healthcare Programs	Complete Assignment CMS "World of Medicare" online training Complete Quiz Chapter 4
Week 3	Ch. 5- Managed Care Plans	Complete Assignment "Managed Care Contract Evaluation" Complete Quiz Chapter 5
		Complete MIDTERM
	Ch. 6- Medicare-Medicaid PPS for Inpatients	Complete Assignment 1: CMS "Uniform Billing UB-04" online Training AND Assignment 2: Case Mix Calculations & Analysis Complete Quiz Chapter 6
Week 4	Ch. 7- Ambulatory and Other Medicare-Medicaid Reimbursement Systems	Complete Assignment 1: CMS "Your Office in the World of Medicare" AND Assignment 2: CMS "CMS Form: 1500" Online Training Complete Quiz Chapter 7
	Ch. 8- Medicare-Medicaid PPS for Postacute Care	Complete CMS "Acute Inpatient PPS Hospital" Complete Quiz Chapter 8

Week 5	Ch. 9- Revenue Cycle Management AND Ch. 10- Value-Based Purchasing	Complete Assignment 1: Revenue Cycle Part 1 Complete Assignment 2: Revenue Cycle Part 2 (EOB Analysis) Complete Quiz Chapter 9 Complete Quiz Chapter 10
		Complete FINAL by 5:00 PM on last day of class

Class Schedule Revised: 03/2017

Student Learning Outcomes:

At the conclusion of this course, the student should be able to meet the following 2011 AHIMA HIM Associate Degree Entry-Level Competencies, Domains, Subdomains, and Tasks:

Associate Degree

Domain I: Health Data Management

I.C. Clinical Classification Systems

- Use and Maintain electronic applications and work processes to support clinical classification and coding (I.C.1)
- Adhere to current regulations and established guidelines in code assignment. (I.C.4)
- Validate coding accuracy using clinical information found in the health record. (I.C.5)
- Use and maintain applications and processes to support other clinical classification and nomenclature systems (such as DSM IV, SNOMED-CT). (I.C.6)
- Resolve discrepancies between coded data and supporting documentation. (I.C.7)

I.D. Reimbursement Methodologies

- Apply policies and procedures for the use or clinical data required in reimbursement and prospective payment systems (PPS) in healthcare delivery. (I.D.1)
- Apply policies and procedures to comply with the changing regulations among various payment systems for healthcare services such as Medicare, Medicaid, managed care, and so forth. (I.D.2)
- Support accurate billing through coding, change master, claims management, and bill reconciliation processes. (I.D.3)
- Use established guidelines to comply with reimbursement and reporting requirements such as the National Correct Coding Initiative. (I.D.4)
- Compile patient data and perform data quality reviews to validate code assignment and compliance with reporting requirements such as outpatient prospective payment systems. (I.D.5)

Domain III: Health Services Organization and Delivery

III.B. Healthcare Privacy, Confidentiality, Legal and Ethical Issues

- Apply and promote ethical standards of practice. (III.B.5)

Domain IV: Information Technology & Systems

IV.A. Information and Communication Technologies

- Use technology, including hardware and software, to ensure data collection, storage, analysis, and reporting of information. (IV.A.1)
- Use common software apps such as spreadsheets, databases, word processing, graphics, presentation, e-mail, and so on in the execution of work processes. (IV.A.2)
- Use specialized software in the completion of HIM processes such as record tracking, release of information, coding, grouping, registries, billing, quality improvement, and imaging. (IV.A.3)

Domain V: Organizational Resources
V.B. Financial and Resource Management

- Monitor coding and revenue cycle processes. (V.B.3)

Baccalaureate Degree
Domain I: Health Data Management

I.C. Subdomain: Clinical Classification Systems

- Select electronic applications for clinical classification and coding. (I.C.1)
- Implement and manage applications and processes for clinical classification and coding. (I.C.2)
- Maintain processes, policies, and procedures to ensure the accuracy of coded data. (I.C.3)

I.D. Subdomain: Reimbursement Methodologies

- Manage the use of clinical data required in prospective payment systems (PPS) in healthcare delivery. (I.D.1)
- Manage the use of clinical data required in other reimbursement systems in healthcare delivery. (I.D.2)
- Participate in selection and development of applications and processes for chargemaster and claims management. (I.D.3)
- Participate in revenue cycle management. (I.D.5)

Domain III. Health Services Organization and Delivery
III.B. Subdomain: Healthcare Privacy, Confidentiality, Legal, and Ethical Issues

- Apply and promote ethical standards of practice. (III.B.7)

At the conclusion of this course, the student should be able to meet the following 2011 AHIMA Knowledge Clusters at the indicated taxonomic level. Blackboard Assignments for those clusters are also included below. Lack of a taxonomic level indicates that cluster is not taught at the highest taxonomic level in this course.

Curriculum Components:

Associate Degree
Domain I: Health Data Management
I.C. Clinical Classification Systems

- Diagnostic and procedural groupings (such as DRG, APC, RUGs, SNOMED)
- Casemix analysis and indexes (4) [Blackboard Assignment: Case Mix Analysis]
- Severity of illness systems
- Coding compliance strategies, auditing, and reporting (such as CCI, plans)
- (5) [Blackboard Assignments: Compliance Plan and Revenue Cycle Part 1]

I.D. Reimbursement Methodologies

- Commercial, managed care and federal insurance plans (4) [Blackboard
- Assignments: Affordable Care Act, CMS Tutorial World of Medicine,
- Medicaid Assignment, and Managed Care Contract Evaluation]
- Compliance strategies and reporting (3) [Blackboard Assignments:
- Compliance Plan and Blackboard Assignment: Revenue Cycle Part 1]
- Payment methodologies and systems (such as capitation, prospective payment systems PPS, RBRVS) (4) [Blackboard Assignments: CMS Tutorial Acute Inpatient PPS Hospital and Medicaid Assignment]
- Billing processes and procedures (such as claims, EOB, ABN, EDI) (4)
- [Blackboard Assignment: CMS Tutorial CMS Form 1500; CMS Tutorial
- HIPAA EDI; CMS Tutorial UB04, and Revenue Cycle Part 2]
- Chargemaster maintenance
- Regulatory guidelines (such as NCDs and QIOs) (3) [Blackboard
- Assignment: Revenue Cycle]
- Reimbursement monitoring and reporting (5) [Blackboard Assignment: Revenue Cycle Part 1 and Part 2]

Domain III. Health Services Organization and Delivery

III.B. Healthcare Privacy, Confidentiality, Legal and Ethical Issues

- Professional and practice-related ethical issues (5) [Blackboard Assignment: CMS Tutorial Fraud and Abuse]

Domain IV: Information Technology & Systems

Domain IV.A. Information and Communication Technologies

- Health information systems (such as administrative, patient registration,
- ADT, EHR, personal health record (PHR), lab, radiology, pharmacy)

Domain V. Organizational Resources

V.B. Financial and Resource Management

- Revenue cycle monitors (4) [Blackboard Assignment: Revenue Cycle Part 1 and Part 2]

Baccalaureate Degree

Domain I: Health Data Management

I.C. Subdomain: Clinical Classification Systems

- Severity of illness systems
- CCI, electronic billing, X12N, 5010 (Applying, 3) [Blackboard Assignment: CMS Tutorial CMS Form 1500; CMS Tutorial HIPAA EDI; and CMS Tutorial UB04]

I.D. Subdomain: Reimbursement Methodologies

- Clinical data and reimbursement management (Evaluating, 5) [Blackboard Assignment: Revenue Cycle Part 1 and Part 2]
- Chargemaster management
- Case mix management (Analyzing, 4) [Blackboard Assignment: Case Mix Analysis]
- Payment systems (such as PPS, DRGs, APCs, RBRVS, RUGs, MSDRGs) (Analyzing, 4) [Blackboard Assignments: CMS Tutorial Acute Inpatient PPS Hospital and Medicaid Assignment]
- Commercial, managed care, and federal insurance plans (Analyzing, 4) [Blackboard Assignments: Affordable Care Act, CMS Tutorial World of Medicine, Medicaid Assignment, and Managed Care Contract Evaluation]
- Revenue cycle process (Analyzing, 4) [Blackboard Assignment: Revenue Cycle Part 1 and Part 2]

Domain III: Health Services Organization and Delivery

III.B. Subdomain: Healthcare Privacy, Confidentiality, Legal, and Ethical Issues

- Professional ethical issues (Evaluating, 5) [Blackboard Assignment: CMS Tutorial Fraud and Abuse]

HIM 252 Course Content

I. Healthcare Reimbursement Methodologies

Introduction to Healthcare Reimbursement

- National Models of Healthcare Delivery
- US Healthcare Sector
- Dominance of Federal Healthcare Payment Methods
- Health Insurance
- Historical Perspectives
  - Health Insurance and Employment
  - Compensation for Healthcare
  - Third-Party Payment
  - Characteristics of Reimbursement Methods

Types of Healthcare Reimbursement Methodologies

- Fee-for-Service Reimbursement
  - Self-Pay
  - Traditional Retrospective Payment
    - Fee Schedule
    - Discounted Fee-for-Service Payment
    - Uncertainty for Third-Party Payers
    - Criticism of Fee-for-Service Reimbursement
  - Managed Care
    - Features of Managed Care
    - Purposes of Managed Care
    - Forms of Managed Care
    - Criticisms of Managed Care
- Episode-of-Care Reimbursement
  - Capitated Payment Method

- Global Payment Method
- Prospective Payment Method
  - Per Diem Payment
  - Case-Based Payment
- Criticisms of Episode-of-Care Reimbursement

Trends in Healthcare Reimbursement

- Constantly Increasing Healthcare Spending
- Healthcare Reform
  - Background
  - Affordable Care Act
    - Purposes
    - Provisions
    - Implementation
- Use of Health Information and Communication Technologies
- Medical Tourism
- Transparency

Clinical Coding and Coding Compliance

The Clinical Coding-Reimbursement Connection

- The *International Classification of Diseases*
  - ICD-10-CM/PCS
    - Structure of ICD-10-CM
    - Structure of ICD-10-PCS
    - Maintenance of ICD-10-CM/PCS
    - ICD-10-CM/PCS Coding Guidelines
- Healthcare Common Procedure Coding System
  - CPT (HCPCS Level I)
    - Structure of CPT
    - Maintenance of CPT
    - Requesting a Code Modification for CPT

- CPT Coding Guidelines
- HCPCS Level II
  - HCPCS Level II Permanent Codes
  - HCPCS Level II Temporary Codes
  - HCPCS Level II Modifiers
  - Maintenance of HCPCS Level II Coding System
  - Requesting a Code Modification for HCPCS Level II
  - HCPCS Level II Coding Guidelines
- Coding Systems as Communication Facilitators

Coding Compliance and Reimbursement

- Fraud and Abuse
  - Legislative Background
  - False Claims Act
  - Office of Inspector General (OIG) Compliance Program Guidance
  - Operation Restore Trust
  - Health Insurance Portability and Accountability Act of 1996
  - Balanced Budget Act of 1997
  - Improper Payments Legislation
- Oversight of Medicare Claims Payment
  - Comprehensive Error Rate Testing Program
  - Office of Inspector General Reports
  - National Recovery Audit Program
    - RAC Program
- Other Third-Party Payer Reviews
- Coding Compliance Plan
  - Policies and Procedures
  - Education and Training
  - Auditing and Monitoring

Voluntary Healthcare Insurance Plans

Chapter Outline

Objectives

Key Terms

Introduction to Voluntary Healthcare Insurance

- Types of Voluntary Healthcare Insurance
- Confusing Terminology
- Individual (Private) Healthcare Plans
- Employer-Based (Group) Healthcare Plans
- Blue Cross and Blue Shield Plans
  - Nonprofit v. Profit Status
  - Types of Blue Cross and Blue Shield Accounts
    - Geographic Plans
    - Federal Employee Program
- State Healthcare Plans for the Medically Uninsurable

Provisions and Functioning of Healthcare Insurance Plans

Sections of a Healthcare Insurance Policy

- Definitions
- Eligibility and Enrollment
- Benefits
- Limitations
  - Cost Sharing Provisions
    - Coinsurance
    - Copayment
    - Tiered Benefits
  - Benefit Cap
- Exclusions
- Riders and Endorsements
- Procedures

Prior Approval

Coordination of Benefits and Other Party Liability

Appeals Processes

Determination of Covered Services

Elements of Healthcare Insurance Identification Card

Filing a Healthcare Insurance Claim

Remittance Advice or Explanation of Benefits

Trends

Implementation of Affordable Care Act

Provisions Effective in 2014

Provisions Effective Beyond 2015

Increasing Costs in Voluntary Healthcare Insurance

Effects on Consumers

Effects on Providers

Effects on Healthcare Insurers

Consumer-Directed Healthcare Plan

Value-Based Insurance Design

Wellness Programs

Government-Sponsored Healthcare Programs

Medicare

Medicare Part A for Inpatients

Medicare Part B

Medicare Part C

Medicare Part D

Medigap

Medicare Market Basket Updates: Reductions and Productivity Adjustments

Medicaid

Other Government-Sponsored Healthcare Programs

The Temporary Assistance for Needy Families Program

Programs of All-Inclusive Care for the Elderly

Children's Health Insurance Program

TRICARE

Veterans Health Administration

CHAMPVA

The Indian Health Service

Workers' Compensation

Managed Care Programs

Managed Care Organizations

Benefits and Services of MCOs

Characteristics of MCOs

Quality Patient Care

Selection of Providers

Health of Populations

Care Management Tools

Quality Assessment and Improvement

Cost Controls

Medical Necessity and Utilization Management

Gatekeeper Role of Primary Care Provider

Prior Approval

Second and Third Opinions

Case Management

Prescription Management

Episode-of-Care Reimbursement

Capitation

Global Payment

Financial Incentives

Contract Management

Types of MCOs

Health Maintenance Organization

Staff Model

Group Practice Model

Network Model

Independent Practice Model

Preferred Provider Organization

Point-of-Service Plan

Exclusive Provider Organization

Managed Care and Medicaid and Children's Health Insurance Program

Medicare Advantage

Special Needs Plan

Integrated Delivery Systems

Integrated Provider Organization

Group (Practice) Without Walls

Physician-Hospital Organization

Management Service Organization

Medical Foundation

Consolidation

Medicare-Medicaid Prospective Payment Systems for Inpatients

Introduction to Inpatient Prospective Payment Systems (PPSs)

Acute-Care Prospective Payment System

- Conversion from Cost-Based Payment to Prospective Payment
  - Concept of Prospective Payment
  - Prospective Payment Legislation
- Diagnosis Related Group Classification System
  - Classification System Development
  - Severity Refinement to DRGs
  - Structure of the DRG System
- Assigning Medicare Severity Diagnosis Related Groups
  - Step One: Pre-MDC Assignment
  - Step Two: MDC Determination
  - Step Three: Medical/Surgical Determination
  - Step Four: Refinement
  - Invalid Coding and Data Abstraction
- Provisions of the MS-DRG System
  - Disproportionate Share Hospital
  - Indirect Medical Education
  - High-Cost Outlier Cases
  - New Medical Services and New Technologies
  - Transfer Cases
- IPPS Payment
  - Step One: Establishment of Initial Payment Rate
  - Step Two: Medicare-Severity Diagnosis-Related Group Assignment
  - Step Three: Policy Adjustments for Hospitals that Qualify
  - Step Four: Add-on for High Cost Outlier and New Medical Service and Technology
    - Pricer Software
  - Maintenance of the MS-DRG System

Inpatient Psychiatric Facility Prospective Payment System

- Patient-Level Adjustments
  - Length of Stay Adjustment
  - Medicare-Severity Diagnosis-Related Group Adjustment
  - Comorbid Conditions
  - Older Patients
  - Electroconvulsive Therapy
- Facility-Level Adjustments
  - Wage Index Adjustment
  - Cost-of-Living Adjustment
  - Rural Location Adjustment
  - Teaching Hospital Adjustment
  - Emergency Facility Adjustment
- Provisions of the Inpatient Psychiatric Facility Prospective Payment System
  - Outlier Payment Provision
  - Initial Stay and Readmission Provisions
  - Medical Necessity Provision
- Payment Steps

Ambulatory and Other Medicare-Medicaid Reimbursement Systems

Introduction to Prospective Payment Systems (PPSs) for Nonhospitalized Patients and for Physicians

Resource-Based Relative Value Scale for Physician and Professional Payments

- Background
- Structure of Payment
  - Relative Value Unit and Geographic Practice Cost Index
  - Conversion Factor
- Calculation
  - Potential Adjustments
    - Budget Neutrality

- Excluded Facilities
- Maintenance of the Hospital Outpatient Prospective Payment System

Ambulatory Payment Classification System

- Partially Packaged System Methodology
- Structure of the APC System
- Copayment
- New Technology Ambulatory Payment Classifications
- Composite Ambulatory Payment Classifications
  - Observation Services
- Partial Hospitalization
- Provisions of the APC System
  - Discounting
  - Interrupted Services
  - High-Cost Outlier
  - Rural Adjustment
  - Cancer Hospital Adjustment
  - Pass-Through Payments
  - Transitional Outpatient Payments and Hold-Harmless Payments
- APC Assignment

Payment Determination

Ambulatory Surgical Center (ASC) Prospective Payment System

Medicare Certification Standards

Payment for ASC Services

Criteria for ASC Procedures

Ambulatory Payment Classifications and Payment Rates

Separately Payable Services

- Radiology Services
- Brachytherapy Sources
- Drugs and Biological Agents

Medicare-Medicaid Prospective Payment Systems for Postacute Care

- Background
  - Benefit
  - Eligibility Criteria
  - Consolidated Payment
- Data Collection and Reporting
  - Outcome Assessment Information Set
  - Coding for Home Health
  - Other Data Collection
  - Electronic Collection and Transmission
- Structure of Payment
  - National Standardized Episode Rate
  - Adjustments to the National Standardized Episode Rate
    - Adjustments for Case Mix
    - Geographic Adjustments
    - Potential Adjustments for Special Circumstances
- Payment
  - Percentage Payments
  - Health Insurance Prospective Payment System (HIPPS) Code
  - Calculation
- Implementation

Revenue Cycle Management

Introduction to Revenue Cycle Management

Multidisciplinary Approach

Components of the Revenue Cycle

- Preclaims Submission Activities
- Claims Processing Activities
  - Order Entry
  - Charge Description Master

- CDM Maintenance
- Coding by HIM
- Auditing and Review
- Submission of Claims

Accounts Receivable

- Insurance Processing
- Benefits Statements
- Remittance Advice

Claims Reconciliation and Collection

CDM Structure, Maintenance, and Compliance

- CDM Structure
  - Charge Code
  - Department Code
  - Revenue Code
  - CPT/HCPCS Code
  - Charge Description
  - Charge (Price)
  - Modifier
  - Charge Status (Active or Inactive)
  - Payer Identifier
- CDM Maintenance
  - Maintenance Plan
  - Working with Hospital Departments
  - Understanding Services
  - Understanding the CDM
  - Components of a CDM Maintenance Plan
  - Ongoing Maintenance
  - CPT Updates
  - HCPCS Level II Updates

- Prospective Payment System Updates
- Policy Alerts
- Payer Updates
- Other Maintenance
- Monitoring Rejections and Denials
- Human Errors
- System Errors in Bill Production or Bill Transmission
- Automation of Chargemaster Maintenance

- Compliance
  - Compliance Guidance
  - Medicare Claims Processing Manual
  - CMS Program Transmittals
  - National and Local Coverage Determinations
  - National Correct Coding Initiative
  - Integrated Outpatient Code Editor
  - Payer-Specific Edits

Revenue Cycle Management Team

- Revenue Cycle Analysis
  - Case-Mix Index Analysis
  - MS-DRG Relationships Reporting
  - Site of Service: Inpatient versus Outpatient
  - Evaluation and Management Facility Coding in the Emergency Department
  - Outpatient Code Editor Edit Review for Hospital Outpatient Services
    - OCE Edit 41
    - OCE Edit 38

Value-Based Purchasing

Introduction to Value-Based Purchasing and Pay-for-Performance Systems

- Definitions

- Goals
- Background
  - Drivers
  - International Movement
  - Research on Impact
- Advantages and Disadvantages
- Models
  - Design Considerations
  - Patient-Centered Medical Home (PCMH)
  - Accountable Care Organization (ACO)
- Operations
  - Allocation and Reward of Incentives
  - Types of Incentives
  - Method of Implementation
  - Performance Dimensions and Targets
  - Performance Measures
  - Information Systems

Centers for Medicare and Medicaid Services-Linking Quality to Reimbursement

- Value-Based Purchasing
- Pay-for-Reporting
  - Hospital Inpatient Quality Reporting
  - Hospital Outpatient Quality Reporting
  - Ambulatory Surgical Center Quality Reporting Program
  - Long Term Care Hospital Quality Reporting Program
  - Inpatient Rehabilitation Hospital Quality Reporting Program
  - Hospice Quality Reporting Program
  - Home Health Quality Reporting
  - Physician Quality Reporting System
- Pay-for-Performance

Hospital Value Based Purchasing

ESRD Quality Incentive Program

Paying for Value

Hospital-Acquired Condition Reduction Program

Physician Feedback Program/Value-Based Payment

Revised: 2/2017

HIM 252 Course Objectives

I. Healthcare Reimbursement Methodologies
   - A. To differentiate common national models of healthcare delivery.
   - B. To appreciate the size and complexity of the US healthcare delivery sector
   - C. To appreciate the influence of the federal government in the US healthcare sector
   - D. To define health insurance
   - E. To differentiate payment methods on unit of payment, time frame, and risk
   - F. To identify types of healthcare reimbursement methodologies
   - G. To differentiate fee-for-service reimbursement from episode-of-care reimbursement
   - H. To describe trends in the healthcare sector
   - I. To define terms associated with healthcare reimbursement methodologies

II. Clinical Coding and Coding Compliance
   - A. To differentiate the different code sets approved by the Health Insurance Portability Act of 1996
   - B. To describe the structure of approved code sets
   - C. To examine coding compliance issues that influence reimbursement
   - D. To explain the roles of various Medicare improper payment review entities

III. Voluntary Healthcare Insurance Plans
   - A. To discuss major types of voluntary healthcare insurance plans
   - B. To differentiate individual healthcare plans from employer-based healthcare plans
   - C. To describe types of Blue Cross and Blue Shield plans
   - D. To describe state healthcare plans for the medically uninsurable
   - E. To explain the provisions of healthcare insurance policies and the elements of a healthcare insurance identification card

IV. Government-Sponsored Healthcare Programs
   - A. To differentiate among and to identify the various government-sponsored healthcare programs (Medicare Part A, B, C, and D, Medigap, Medicaid, TRICARE, CHAMPVA, Indian Health Services, and Federal and State Worker's Compensation)
   - B. To recall the history of the Medicare and Medicaid programs in America
   - C. To describe the effect that government-sponsored healthcare programs have on the American healthcare system

V. Managed Care Plans
   - A. To define managed care
   - B. To trace origins of managed care
   - C. To delineate characteristics of managed care in terms of quality and cost-effectiveness
   - D. To describe common care management tools used in managed care

E. To depict accreditation processes and performance improvement initiatives used in managed care
F. To define cost controls used in managed care
G. To discuss contract management and carve-outs
H. To define types of managed care plan s along a continuum of control
I. To describe the use of managed care in states' Medicaid programs, children's Health Insurance Program, and Medicare
J. To discuss types of integrated delivery systems
K. To define terms commonly used in managed care

VI. Medicare-Medicaid Prospective Payment Systems for Inpatients
A. To differentiate major types of Medicare prospective payment systems for acute-care inpatients
B. To define basic language associated with the IPPS
C. To explain common models and policies of payment for inpatient Medicare and Medicaid PPS.
D. To describe the elements of the IPPS
E. To explain the elements of the inpatient psychiatric PPS

VII. Ambulatory and Other Medicare-Medicaid Reimbursement Systems
A. To differentiate major types of Medicare and Medicaid reimbursement systems for beneficiaries
B. To define basic language associated with reimbursement under Medicare and Medicaid healthcare payment systems
C. To explain common models and polices of payment for Medicare and Medicaid healthcare payment systems for physicians and outpatient settings
D. To identify the elements of the relative value unit and the major components of the resource-based relative value scale payment systems
E. To describe the elements of the ambulance fee schedule
F. To explain the elements of the outpatient PPS and the ambulatory surgical center payment system
G. To describe the end-stage renal disease PPS
H. To describe the elements of the payment systems for federally qualified health centers and rural health clinics.
I. To explain the elements of the hospice services payment system

VIII. Medicare-Medicaid Prospective Payment Systems for Post-acute Care
A. To define the post-acute care settings
B. To differentiate Medicare and Medicaid prospective payment systems for healthcare services delivered to patients in post-acute care
C. To describe Medicare's all-inclusive per diem rate for skilled nursing facilities
D. To describe Medicare's prospective payment systems for long-term care hospitals and inpatient rehabilitation facilities
E. To describe Medicare's per-episode payment system for home health agencies

F. To differentiate the specialized collection instruments, standardized base rates, and case-mix groups that exist in post-acute care
G. To define basic language associated with reimbursement under Medicare and Medicaid prospective payment systems in post-acute care
H. To explain the grouping models and payment formulae associated with reimbursement under Medicare and Medicaid prospective payment systems in post-acute care

IX. Revenue Cycle Management
A. To describe the basic components of the revenue cycle
B. To define revenue cycle management (RCM)
C. To describe the importance of effective revenue cycle management for a provider's fiscal stability

X. Value-Based Purchasing
A. To describe the origins and evolution of value-based purchasing and pay for performance
B. To describe models of value-based purchasing and pay for performance
C. To explain models of value-based purchasing implemented by the Centers for Medicare and Medicaid Services for various healthcare settings and payment systems
D. To describe how compliance with the Centers for Medicare and Medicaid Services value-based purchasing programs affects healthcare reimbursement for a facility, entity, or professional