PUBLIC HEALTH DATA STANDARDS CONSORTIUM

PHDSC

Promoting Standards Through Partnerships

Payer Type Committee

USERS GUIDE FOR SOURCE OF PAYMENT TYPOLOGY

September 2015

Version 6

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Table of Contents

INTRODUCTION 3

Purpose of the Typology 3
Maintenance 4
Messaging Standard Support 4
Payer Typology Specifics and Rationale 5
Transition Issues 5

DEFINITIONS OF TERMS USED IN THE TYPOLOGY 6

APPENDIX A: CROSSWALK BETWEEN ASC X12 CLAIM FILING INDICATOR CODE LIST & PAYER TYPOLOGY 18

APPENDIX B: SOURCE OF PAYMENT TYPOLOGY USE HIERARCHY 19

APPENDIX C: EXAMPLES OF ANALYSES USING DATA ELEMENTS CODED WITH SOURCE OF PAYMENT TYPOLOGY 23

APPENDIX D: CHANGE SUMMARY IN VERSION 5.0 (OCTOBER 2011) 24

APPENDIX E: FREQUENTLY ASKED QUESTIONS 25

Section 1 Introduction

Purpose of the Typology

The development of a standard Payer Type classification system is a high priority for public health and research. Administrative healthcare databases are used for a wide variety of public health activities, such as: monitoring of healthcare access across payer categories, Medicaid disease management, and healthcare policy studies. The existing system of payer categories for administrative claims data are found in the X12N Subscriber section; these are currently neither mutually exclusive nor comprehensive, in part because they were not created for research or policy purposes. Regardless of the eventual X12N status, some States and researchers have indicated that they would welcome a standardized Payer Type typology that would enable them to compare data by payment category to data from other States (as well as to national benchmarks), to other data collection initiatives, and across different types of providers.

The proposed typology, developed by the Payer Subcommittee of the Standards Data Committee of the Public Health Data Standards Consortium (PHDSC) which is now the Public Health Data Standards Council of the American Health Information Management Association (AHIMA), incorporates typical state specific requirements, as well as being flexible enough to be used as a code set in surveys and other data collected for research or policy purposes. The Source of Payment Typology was developed to create a standard for reporting payer type data that will enhance the payer data classification; it is also intended for use by those collecting data, or analyzing healthcare claims information. Modeled loosely after the ICD typology for classifying medical conditions, the proposed typology identifies broad Payer categories with related subcategories that are more specific. This format provides analysts with flexibility to either use payer codes at a highly detailed level or to roll up codes to broader hierarchical categories for comparative analyses across payers and locations.

It should be noted that "source of payment" is a complex concept, encompassing both the funder and the mechanisms through which funds are distributed. In its purest form, the source of payment is determined solely by the funder—that is, the organization that provides payment, such as the Medicare or Medicaid programs, other government agencies such as the Department of Veteran's Affairs or the Health Resources and Services Administration, private insurance companies, charity care, or out-of-pocket payments by individuals. In recent years, however, the mechanisms through which funds are distributed to healthcare providers and through which healthcare providers bill patients have also become of policy and research interest. The study of differences in access to care, quality of care, and outcomes among different types of managed care organizations compared to each other and to fee-for-service ("pay-as-you-go") financing is of interest to those who pay for care. Therefore, this typology also provides the analyst with the ability to code the type of

financing structure used by each major payer—including fee-for-service, HMO, PPO, POS and other financing structures—when this information is available. For example, the typology allows analysts to code whether the source of payment is a Medicare HMO, or whether it is a standard fee-for-service Medicare payer. The first digit of each code is the organization that provides the funds for the care; additional digits provide more information about the specifics of the plan or mechanism through which these funds are provided. The typology is designed to be sufficiently flexible that information about specific payment programs or payment mechanisms can be added as additional digits to each code, if there is sufficient documented need for such information to be added to the code set.

Use of a standard source of payment typology will allow researchers, policymakers and analysts, health administrators, and practitioners to conduct analyses that compare the effects of different types of payment on access to care, quality of care, and treatment outcomes. See Appendix D for examples of questions that might be asked by analysts using the codes contained in the Source of Payment Typology (Appendix C).

Maintenance

The Source of Payment Typology is maintained by the American Health Information Association. Requests to change the typology should be directed to the Payer Typology Committee. (http://www.phdsc.org/standards/payer-typology.asp). Changes to the Source of Payment Typology are made annually in October. Any interested industry representative can make recommendations for additions or modifications by sending their comments via the PHDSC website at: http://www.phdsc.org/about/feedback.asp?cf=pt. These recommendations would be voted on by members of the Payer Typology Committee for possible inclusion in the Source of Payment Typology.

Messaging Standard Support

The Payer Typology can be used by any analyst who wishes to code source of payment data, including analysts who code administrative or claims data, survey data, clinical trials data, or any other dataset containing this type of data element. For those coding data under HIPAA standards, the Payer Typology is referenced as an external code list in the ASC X12 standards as a data element in the Subscriber Information Segment (SBR) in the Subscriber and the Patient loops. Because this change was made after Version 5010 of the ASC X12 was approved and published, this modification will be supported in post Version 5010 of the Health Service Data Reporting Guide.

Organizations needing or wanting to implement the Source of Payment Typology prior to the industry migration to implementation guide versions that support this external code list would be encouraged to use the File Information (K3) segment of the 837 standard. This is the recommended short term intermediate solution that would allow the data content to be standardized while the message standard “catches up” with that data content.

Payer Typology Specifics and Rationale

The payer classification is a hierarchical code list. It provides a range of codes from broad categories to related sub-categories that are more specific. Users should report the expected payer using the greatest level of detail without sacrificing accuracy of the information. Payer Type codes are defined as up to six left justified numeric characters. Each character from the left to the right represents a new hierarchical level in the value set. For example all prior existing code lists would have a code for HMO. That one code could not differentiate between the multiple "flavors" of HMO, such as Medicare, Medicaid, Commercial, Blue Cross, TRICARE, etc. In addition the code for Self Pay in prior code lists would not discriminate between charity care and other forms of non health coverage. The Source of Payment Typology was designed to address those deficiencies. Below are some of the situations that can be accommodated in the design of the hierarchical payer typology structure.

- *Coding with incomplete information (examples: you know the HMO name but not if it is Medicaid, Medicare or private)*
  (In some cases, it is not clear who the payer is from available information)
- *Coding multiple payers and hierarchies*
  (In some cases there will be multiple payers which are solely or partially responsible for payment based upon the services rendered or other factors. This applies to the situation when multiple sources of payment are being reported.)
- *"Local code" issues*-- Use of the payer classification could be adopted in states' discharge reporting systems. Additional more specific local payer codes could be used in conjunction with the payer classification's design. This will allow for broader application. (As an example, SCHIP may be administered by two different mechanisms within one state, and there may be a need to track these claims by type of mechanism.)

Transition Issues

<u>How to make these codes compatible with existing comparable code lists</u>

Use of the payer classification may require a crosswalk of previous code lists to the new hierarchical payer typology. Because of the expansion, classification for some payers may not have one direct replacement code but several. See Appendix A for the crosswalk of the ASC X12 Claim Filing Indicator to the PHDSC Source of Payment Typology.

Section 2 Definitions of Terms Used in the Typology

ASO (Administrative Services Only) – An arrangement in which an employer hires a third party to deliver administrative services to the employer such as claims processing and billing; the employer bears the risk for claims. This is common in self-insured health care plans.

Auto Insurance (includes no fault) – Medical coverage provided as part of an automobile liability insurance policy.

Blue Cross/Blue Shield - The **Blue Cross and Blue Shield Association** is a national organization made up of 39 independent, locally operated Blue Cross and Blue Shield companies that collectively provide healthcare coverage for more than 98 million - nearly one-in-three-Americans. Based in Chicago, Illinois, it was formed in the 1982 merger of the Blue Cross Association and the National Association of Blue Shield Plans.

CHAMPUS/CHAMPVA – Civilian Health and Medical Program of the Uniformed Services. CHAMPVA is a federal program that shares the cost of hospital and medical care for dependents of those 100% disabled as the result of a service connected disability and the dependents of those deceased who were 100% disabled as the result of a service connected disability.

Commercial Insurance – Insurance sold through a private business or organization.

Commercial Managed Care - Pharmacy Benefit Manager - Organization that administers and/or manages, or acts as processor for prescription drug coverage for commercial beneficiaries.

Dental Insurance-- Dental insurance is designed to pay a portion of the costs associated with dental care. There are several different types of individual, family, or group dental insurance plans grouped into three primary categories: (1) Indemnity (generally called: dental insurance) that allows you to see any dentist you want who accepts this type of coverage; (2) Preferred Provider Network dental plans (PPO); and (3) Dental Health Managed Organizations (DHMO) in which you are assigned or select an in-network dentist and/or in-network dental office and use the dental benefits in that network.

Department of Veterans Affairs (VA)--VA provides a Medical Benefits Package, a standard enhanced health benefits plan available to all enrolled veterans. This plan emphasizes preventive and primary care and offers a full range of outpatient and inpatient services within VA health care system. VA maintains an annual enrollment system to manage the provision of quality hospital and outpatient medical care and treatment to all enrolled veterans. A priority system ensures that veterans with service-connected disabilities and those below the low-income threshold are able to be enrolled in VA's health care system.

The VA also offers limited medical benefits for family members of eligible veterans under special programs. Below are the definitions for each of the Department of Veterans Affairs payer categories.

- **Veteran Care Provided to Veterans** -- VA health care programs for U.S. military veterans
- **Direct Care – Care Provided in VA Facilities** -- Medical care or services provided to eligible veterans in facilities of the VA Health Care System.
- **Indirect Care – Care provided outside of VA Facilities** -- Medical care or services provided in the community for veterans that are eligible for VA care.
- **Fee Basis --** VA program for veterans for necessary medical care and services. Medical care and services are approved/authorized in advance. The VA authorization will specify: Medical services that VA approves, Length of period for treatment, and amount that VA will pay.
- **Foreign Fee/Foreign Medical Program (FMP)** - The Foreign Medical Program (FMP) is a health benefits program designed for U.S. veterans with VA-rated service-connected conditions who are residing or traveling abroad. FMP assumes payment responsibility for all foreign provided, medically necessary services associated with the treatment of the VA adjudicated service-connected condition, or any disability associated with and held to be aggravating a service-connected disability, or care for a veteran participating in a rehabilitation program under 38 USC Chapter 31. The program benefits do not extend to treatment provided in the fifty United States, District of Columbia, Puerto Rico, and the U.S. Territories. The program also does not process claims for services received in the Philippines. Veterans receiving medical services provided in the Philippines should submit their claims to the VA Outpatient Clinic in Manila.
- **Contract Nursing Home/Community Nursing Home** - A Community Nursing Home (CNH) is a private or public nursing home that provides short and long-term institutional care services to eligible veterans at VA expense, under the conditions of a contract with the VA. VA Nursing home care units and state veterans homes are not included in this definition.
- **State Home -** A facility approved by the VA which includes facilities for domiciliary and/or nursing home care. Hospital care may be included when provided in conjunction with domiciliary or nursing home care. A State home may also provide care to veteran related family members, i.e., spouses, surviving spouses and/or gold star parents who are not entitled to payment of VA aid. A State home cannot admit or provide care to applicants other than those noted above.
- **Sharing Agreements -** A negotiated contract between VA and another federal (authority 8111) or non-federal (authority 8153) agency to either provide or receive services.
- **Other Federal Agency -** A federal agency other than the VA / DoD (authority – Economy Act)
- **Non-Veteran Care** -- VA health care program for spouses and children of U.S. military veterans
- **Civilian Health and Medical Program for VA (CHAMPVA) -** VA health care program for spouses and children of a veteran who: was rated permanently and totally

disabled due to a service connected disability, was rated permanently and totally disabled due to a service connected condition at time of death, was rated permanently and totally disabled due to a service connected condition at time of death, or died on active duty and the dependents are not eligible for DOD Tricare benefits.

- **Spina Bifida Health Care Program (SB) --** VA health care program for Vietnam veterans' birth children diagnosed with Spina Bifida and awarded VA Spina Bifida benefits.
- **Children of Women Vietnam Veterans (CWVV) --** VA health care program for children, of women veterans who served in the Republic of Vietnam from February 28, 1961 to May 7, 1975, with birth defects that resulted in a permanent physical or mental disability.
- **Other Non-Veteran Program --** VA health care program for spouses and/or children not otherwise specified.

Dual Eligibility Medicare/Medicaid Organization -Dual-eligible Organizations serve those qualifying for both Medicare and Medicaid benefits.
Dual-eligible organizations include a type of Medicare Advantage (MA) plan called a Dual-eligible Special Needs Plan (D-SNP). The Affordable Care Act (ACA) established Fully Integrated Dual Eligible (FIDE) SNP to integrate program benefits for dual-eligible beneficiaries through a single managed care organization, although payment is generally provided separately by each program.
Programs of All-Inclusive Care for the Elderly (PACE) provide comprehensive medical and social services to certain frail, community-dwelling elderly individuals, most of whom are dually eligible for Medicare and Medicaid benefits. PACE is a program under Medicare, and states can elect to provide PACE services to Medicaid beneficiaries as an optional benefit. The PACE program becomes the sole source of Medicaid and Medicare benefits for PACE participants. The PACE model of care is established as a provider in the Medicare program and so enables states to provide PACE services to Medicaid beneficiaries as a state option. The PACE program becomes the sole source of services for Medicare and Medicaid eligible enrollees.

Exclusive provider organization (EPO) plan - A more restrictive type of preferred provider organization plan under which employees must use providers from the specified network of physicians and hospitals to receive coverage; there is no coverage for care received from a non-network provider except in an emergency situation.

Fee for Service - In health care, a payment mechanism in which a provider is paid for each service rendered to a patient.

Flexible spending accounts or arrangements (FSA) - Accounts offered and administered by employers that provide a way for employees to set aside, out of their paycheck, pretax dollars to pay for the employee's share of insurance premiums or medical expenses not covered by the employer's health plan. The employer may also make contributions to a FSA. Typically, benefits or cash must be used within the given benefit year or the employee loses the money. Flexible spending accounts can also be provided to cover childcare expenses, but those accounts must be established separately from medical FSAs.

Flexible benefits plan (Cafeteria plan) (IRS 125 Plan) – A benefit program under Section 125 of the Internal Revenue Code that offers employees a choice between permissible taxable benefits, including cash, and nontaxable benefits such as life and health insurance, vacations, retirement plans and child care. Although a common core of benefits may be required, the employee can determine how his or her remaining benefit dollars are to be allocated for each type of benefit from the total amount promised by the employer. Sometimes employee contributions may be made for additional coverage.

Gatekeeper Provider Organization – A PPO in which a primary care provider is chosen from whom an enrollee shall obtain covered health care services,
a referral, or approval for covered, non-emergency health services as a precondition to receiving the highest level of coverage available under the managed care plan (PA def).

Health maintenance organization (HMO) - A health care system that assumes both the financial risks associated with providing comprehensive medical services
(insurance and service risk) and the responsibility for health care delivery in a
particular geographic area to HMO members, usually in return for a fixed, prepaid fee. Financial risk may be shared with the providers participating in the HMO.

- Group Model HMO - An HMO that contracts with a single multi-specialty medical group to provide care to the HMO's membership. The group practice may work exclusively with the HMO, or it may provide services to non-HMO patients as well. The HMO pays the medical group a negotiated, per capita rate, which the group distributes among its physicians, usually on a salaried basis.

- Staff Model HMO - A type of closed-panel HMO (where patients can receive services only through a limited number of providers) in which physicians are employees of the HMO. The physicians see patients in the HMO's own facilities.

- Network Model HMO - An HMO model that contracts with multiple physician groups to provide services to HMO members; may involve large single and multi-specialty groups. The physician groups may provide services to both HMO and non-HMO plan participants.

- Individual Practice Association (IPA) HMO- A type of health care provider organization composed of a group of independent practicing physicians who maintain their own offices and band together for the purpose of contracting their services to HMOs. An IPA may contract with and provide services to both HMO and non-HMO plan participants.

Health Resources and Services Administration (HRSA) Programs—HRSA provides direct care or funds for health care under the following programs:

- **Community Health Centers--** Health Centers are community-based providers of comprehensive primary and preventive health care and enabling services to medically

underserved populations. Many Health Centers also offer comprehensive dental care and mental health and substance abuse services. Health Centers is an all-encompassing term for a diverse range of public and non-profit organizations and programs. Many receive federal funding under section 330 of the Public Health Service Act (Consolidated Health Center Program) and may also be called Federally Qualified Health Centers. Others meet the requirements, but do not receive funds and are designated Federally Qualified Health Center "Look-alikes" by HRSA and the Centers for Medicare and Medicaid Services.

- The **Migrant Health Act** was enacted in September 1962 by Public Law 87-692, which added section 310 to the Public Health Service Act. The Health Resources and Services Administration (HRSA) provides grants to community nonprofit organizations for a broad array of culturally and linguistically competent medical and support services to migrant and seasonal farmworkers (MSFW) and their families. Migrant Health Centers are currently authorized under the Health Centers Consolidated Care Act of 1996, section 330(g) of the Public Health Service Act.

- The **Native Hawaiian Health Care Improvement Act (NHHCIA),** as amended (42 U.S.C. § 11701 and 11706), states that "it is the policy of the United States in fulfillment of its special responsibilities and legal obligations to the indigenous people of Hawaii… to (1) raise the health status of Native Hawaiians to the highest possible health level; and (2) provide existing Native Hawaiian health care programs with all resources necessary to effectuate this policy".

- The **Black Lung Benefits** Reform Act of 1977 (Public Law 95-239), as amended February 27, 1985, reinstated the authority of the Federal Mine Safety and Health Act for the Secretary of Health and Human Services to support clinics to evaluate and treat coal miners with respiratory impairments. Administrative jurisdiction for this authority, designated as the Black Lung Clinics Program, was delegated by the Secretary to the Health Resources and Services Administration. The overall goal of the program is to provide services to minimize the effects of respiratory impairments in coal miners and others with occupational related respiratory disease. The program provides funding to public and private non-profit entities for the operation of clinics that provide diagnosis, treatment, and rehabilitation of active and retired coal miners with respiratory and pulmonary impairments.

- The federal **Ryan White CARE Act** provides health care for people with HIV disease. Enacted in 1990, it fills gaps in care faced by those with low-incomes and little or no insurance. HRSA's HIV/AIDS Bureau administers the program through hundreds of grantees, which serve about 571,000 people each year.

- **Health Care for the Homeless --** In 1987, the Stewart B. McKinney Homeless Assistance Act, Public Law 100-77, was enacted to provide relief to the Nation's rapidly increasing homeless population. The intent of the Act was to provide funding for emergency food and shelter, education, and transitional and permanent housing, as well as address the multitude of health problems faced by people who are homeless.

Title VI of the McKinney Act added Section 340 to the Public Health Service (PHS) Act, authorizing the Secretary of Health and Human Services (HHS), acting through the Health Resources and Services Administration (HRSA), to award grants for the provision of health care to homeless individuals. Specifically, HCH programs provide for: 1) Primary health care and substance abuse services at locations accessible to people who are homeless; 2) Emergency care with referrals to hospitals for in-patient care services and/or other needed services; and 3) Outreach services to assist difficult-to-reach homeless persons in accessing care, and provide assistance in establishing eligibility for entitlement programs and housing.

- **Title V (MCH Block Grant) (SBR09 value - TV) --** The MCH Block Grant is at its core a public health program that reaches across economic lines to improve the health of all mothers and children. Created as a partnership with State MCH programs and with broad State discretion, State Title V programs use appropriated formula grant funds for: capacity and systems building, public information and education, knowledge development, outreach and program linkage, technical assistance, provider training, evaluation, support for newborn screening, and genetic services, lead poisoning and injury prevention, additional support services for children with special health care needs, and promotion of health and safety in child care settings. Special efforts are made to build community capacity to deliver such enabling services as care coordination, transportation, home visiting, and nutrition counseling. Where no services are available, States also use Title V to provide categorical direct care such as prenatal care or services for children with special health care needs.

Indemnity insurance – A conventional indemnity plan allows the participant the choice of any provider without effect on reimbursement. These plans reimburse the patient and/or provider as expenses are incurred.

Indian Health Service - Federally-recognized tribes and tribal organizations.
Beneficiary Eligibility: Individuals who are members of an eligible applicant tribe, band, or group or village and who may be regarded as within the scope of the Indian health and medical service program and who are regarded as an Indian by the community in which he lives as evidenced by such factors as tribal membership, enrollment, residence on tax exempt land, ownership of restricted property, active participation in tribal affairs or other relevant factors in keeping with general Bureau of Indian Affairs practices in the jurisdiction.

Legal Liability / Liability Insurance
Payment coming as a result of a legal decision, settlement or similar mechanism which holds a third party responsible for medical costs. This may include a corporation's or individual's liability insurance covering the insured against losses arising from injury to another.

Local Government —Health care funded by any government entity below the State level, including counties, municipalities, cities, parishes, etc. is considered to be funded by local government. Examples include public health clinics, or funds provided by cities for health care.

Managed care (commercial, Medicare, Medicaid, etc.) Managed care plans generally provide comprehensive health services to their members, and offer financial incentives for patients to use the providers who belong to the plan. Examples of managed care plans include:

- Health maintenance organizations (HMOs),
- Preferred provider organizations (PPOs),
- Point of Service Plans (POSs)
- Exclusive provider organizations (EPOs), and
- Gatekeeper Preferred Provider Organizations (GPPO)
- Managed Care, Other (non HMO)

Medicaid -Medicaid was authorized by Title XIX of the Social Security Act in 1965 as a jointly funded cooperative venture between the Federal and State Governments to assist States in the provision of adequate medical care to eligible needy persons. Within broad Federal guidelines, each of the States establishes its own eligibility standards; determines the type, amount, duration, and scope of services; sets the rate of payment for services; and administers its own program.

Medicaid is the largest program providing medical and health-related services to America's poorest people. However, Medicaid does not provide medical assistance for all poor persons. Under the broadest provisions of the Federal statute, Medicaid does *not* provide health care services even for very poor childless adults under age 65 years unless they are disabled. Except as noted, all States must provide Medicaid coverage to:

- Individuals who meet the requirements for the Aid to Families with Dependent Children (AFDC) program that were in effect in their State on July 16, 1996, or, at State option, more liberal criteria (with some exceptions).

- Children under age 6 whose family income is at or below 133 percent of the Federal poverty level.

- Pregnant women whose family income is below 133 percent of the Federal poverty level (services to these women are limited to those related to pregnancy, complications of pregnancy, delivery, and postpartum care).

- Supplemental Security Income (SSI) recipients in most States (some States use more restrictive Medicaid eligibility requirements that predate SSI).

- Recipients of adoption or foster care assistance under Title IV of the Social Security Act.

- Special protected groups (typically individuals who lose their cash assistance due to earnings from work or from increased Social Security benefits, but who may keep Medicaid for a period of time).

- All children under age 19 in families with incomes at or below the Federal poverty level.

- Certain Medicare beneficiaries (low income is only one test for Medicaid eligibility for those within these groups; their resources also are tested against threshold levels, as determined by each State within Federal guidelines).

States also have the option of providing Medicaid coverage for other groups.

Medicaid operates as a vendor payment program. States may pay health care providers directly on a fee-for-service basis, or States may pay for Medicaid services through various prepayment arrangements, such as health maintenance organizations (HMOs) or other forms of managed care. Within Federally imposed upper limits and specific restrictions, each State for the most part has broad discretion in determining the payment methodology and payment rate for services. Thus, the Medicaid program varies considerably from State to State, as well as within each State over time.

Medicaid Applicant –healthcare recipient has applied for Medicaid, but has not yet received approval.

Medicaid Long-Term Care—Long term care services are generally paid fee-for-service or indirectly, via capitation payments to managed care entities (e.g., PACE, Family Care). This is done through a separate Medicaid Long Term Care funding stream.

Medicaid Pharmacy Benefit Manager - Organization that administers and/or manages, or acts as processor for prescription drug coverage for Medicaid beneficiaries.

Medicaid Primary Care Case Management (PCCM) - PCCM programs enroll people in the following Medicaid categories of eligibility: AFDC/TANF, poverty level pregnant women, and poverty level children; programs pay initial fee to physicians for management and then pay traditional fee for service

Medicaid Out of State – Individual presents out-of-state Medicaid for payment of healthcare

Medical savings accounts (MSA) – (Also called "Consumer-Directed Health Plan") Savings accounts designated for out-of-pocket medical expenses. In an MSA, employers and individuals are allowed to contribute to a savings account on a pre-tax basis and carry over the unused funds at the end of the year. One major difference between a Flexible Spending Account (FSA) and a Medical Savings Account (MSA) is the ability under an MSA to carry over the unused funds for use in a future year, instead of losing unused funds at the end of the year. Most MSAs allow unused balances and earnings to accumulate. Unlike FSAs, most MSAs are combined with a high deductible or catastrophic health insurance plan.

Medicare -- This is a nationwide health insurance program providing health insurance protection to people 65 years of age and over, people entitled to Social Security disability payments for 2 years or more, and people with end-stage renal disease, regardless of income. The program was enacted July 30, 1965, as Title XVIII, Health Insurance for the Aged of the Social Security Act, and became effective on July 1, 1966. From its inception, it has included two separate but coordinated programs: hospital insurance (Part A) and supplementary medical insurance (Part B). In 1999, additional choices were allowed for

delivering Medicare Part A and Part B benefits. Medicare Advantage, previously Medicare+Choice, (Part C) is an expanded set of options for the delivery of health care under Medicare, created in the Balanced Budget Act passed by Congress in 1997. The term Medicare Advantage refers to options other than original Medicare. While all Medicare beneficiaries can receive their benefits through the original fee-for-service (FFS) program, most beneficiaries enrolled in both Part A and Part B can choose to participate in a Medicare Advantage plan instead. Organizations that seek to contract as Medicare Advantage plans must meet specific organizational, financial, and other requirements. Most Medicare Advantage plans are coordinated care plans, which include health maintenance organizations (HMOs), provider-sponsored organizations (PSOs), preferred provider organizations (PPOs), and other certified coordinated care plans and entities that meet the standards set forth in the law. The Medicare Advantage program also includes Medical savings account (MSA) plans, which provide benefits after a single high deductible is met, and private, unrestricted FFS plans, which allow beneficiaries to select certain private providers. These programs are available in only a limited number of states. For those providers who agree to accept the plan's payment terms and conditions, this option does not place the providers at risk, nor does it vary payment rates based on utilization. Only the coordinated care plans are considered managed care plans. Except for MSA plans, all Medicare Advantage plans are required to provide at least the current Medicare benefit package, excluding hospice services. Plans may offer additional covered services and are required to do so (or return excess payments) if plan costs are lower than the Medicare payments received by the plan.

The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) was passed on December 8, 2003. The MMA established a voluntary drug benefit for Medicare beneficiaries and created a new Medicare Part D. People eligible for Medicare can choose to enroll in Part D beginning in January of 2006. For more information see http://www.medicare.gov/Publications/Pubs/pdf/10050.pdf

Medicare Hospice - Medicare funded plan which provides supportive care for comport and pain relief for patients in the final phase of a terminal illness.

Medicare Pharmacy Benefit Manager - Organization that administers and/or manages, or acts as processor for prescription drug coverage for Medicare beneficiaries**.**

No Payment by any major insurer, payer, or government program—This category includes the following:

- **Self-Pay--** Payment directly by the patient, personal guarantor, relatives, or friends.
- **Charity** – Patients receiving care who meet the standards for charity care pursuant to the hospital's established charity care policy (CA definition)
- **Professional Courtesy** –no payment will be required by the facility, such as special research or courtesy
- **Refusal to Pay / Bad Debt** – health care provider has sought payment, but patient refuses to pay or patient cannot be located; healthcare provider has determined this is a bad debt based on inability to collect payment for any reason.

- **Hill Burton Free Care** –Patients receiving care pursuant to Hill-Burton obligations or who meet the standards for charity care pursuant to the hospital's established charity care policy. (CA definition)
- **Research / Donor/Clinical Trials** — cases where no payment will be required by the facility, because of special research funding: also includes live organ donor (CA definition)
- **Uncompensated care--** Service provided by physicians and hospitals for which no payment is received from the patient or from third-party payers. Some uncompensated care results from charity care. It also includes bad debts from persons who are not classified as charity cases but who are unable or unwilling to pay their bill.

Other specified but not otherwise classifiable (includes Hospice - Unspecified plan) – Payer category is not identified in this typology.

Pharmacy Benefit Manager (PBM) - Organization dedicated to providing prescription benefit management services to employers, health plans, third-party administrators, union groups and other plan sponsors. A full-service PBM maintains eligibility, processes and adjudicates prescription claims, provides clinical services, contracts a pharmacy network, pays the pharmacy, and provides management reports.

PPO Preferred provider organization (PPO) plan - An indemnity plan where coverage is provided to participants through a network of selected health care providers (such as hospitals and physicians). The enrollees may go outside the network, but would incur larger costs in the form of higher deductibles, higher coinsurance rates, or non discounted charges from the providers.

POS Point-of-service (POS) plan - A POS plan is an "HMO/PPO" hybrid; sometimes referred to as an "open-ended" HMO when offered by an HMO. POS plans resemble HMOs for in-network services. Services received outside of the network are usually reimbursed in a manner similar to conventional indemnity plans (e.g., provider reimbursement based on a fee schedule or usual, customary and reasonable charges).

Private Health Insurance -- Insurance that is not paid through any government source. Most private insurance is financed through a combination of employer and employee premiums. Individual insurance policies, sold directly to consumers, are also considered private insurance. Types of private health insurance include:

- Commercial Indemnity plans – (Insurance purchased by a business or organization for its employees)
- Self-insured (ERISA) ASO plans - Administrative services only (ASO) plans under which the employer retains the financial risk and contracts with the insurer to administer the plan. Large employers that are self-insured usually use ASO plans. Self-insured ASO plans are regulated by the U.S. Department of Labor under the Employee Retirement Income Security Act of 1974 (ERISA) statute.
- Medicare supplemental Policies (as second payer) – Medicare supplemental insurance, is also called Medigap insurance. This is health insurance that helps pay

for some of the costs in the Original Medicare program and for some care it doesn't cover. Medigap insurance is sold by private insurance companies.

- Organized Delivery Systems --An Organized Delivery System (ODS) is a legal entity that contracts with a carrier for the purpose of providing or arranging for the provision of health care services to those persons covered under a carrier's health benefits plan, but which is not a licensed health care facility or other health care provider. Examples of the types of entities that are an ODS include preferred provider organizations (PPOs), Physician Hospital Organizations (PHOs) and Independent Practice Associations (IPAs). In order to contract with a carrier, an ODS must become licensed or certified.
- Small Employer Purchasing Group plans– Health insurance coverage is available through a public or private pool for small employers.

Specialized Stand Alone Plan-- A separate standalone plan focused on a particular benefit (e.g., Dental or Vision).

State Children's Health Insurance Program (SCHIP)-- Title XXI of the Social Security Act, known as the State Children's Health Insurance Program (SCHIP), is a program initiated by the Balanced Budget Act of 1997 (BBA). SCHIP provides more Federal funds for States to provide health care coverage to low-income, uninsured children. SCHIP gives States broad flexibility in program design while protecting beneficiaries through Federal standards. Funds from SCHIP may be used to expand Medicaid or to provide medical assistance to children during a presumptive eligibility period for Medicaid. This is one of several options from which States may select to provide health care coverage for more children, as prescribed within the BBA's Title XXI program.

Title V. Defined by the Federal Medicare Act (PL 89-97) for Maternal and Child Health. Title V of the Social Security Act is administered by the Health Resources and Services Administration, Public Health Service, Department of Health and Human Services. Include a Maternal and Child Health program payment that is not covered under Medicaid.

TRICARE -- TRICARE is a federal program that shares the cost of hospital and medical care for dependents of those on active duty and of those retired from the Military Forces and their dependents, as well as some former Military spouses. TRICARE has several plan options:

- TRICARE PRIME -- A plan similar to a civilian Health Maintenance Organization (HMO) that provides the lowest out-of-pocket cost, in return for the requirement that enrollees use only doctors, hospitals and other health care providers who are part of the TRICARE network. .Enrollees are assigned a Primary Care Physician, known generally as a "Gatekeeper" who supervises all medical care and is the one who authorizes referrals for specialty care.

- TRICARE STANDARD – Fee for Service: TRICARE STANDARD is the new name for the health care option formerly known as CHAMPUS (Civilian Health and Medical Program of the Uniformed Services). With TRICARE STANDARD,

eligible beneficiaries have the greatest flexibility in choosing a health care provider and the government will pay a percentage of the cost. It is chosen most often by individuals and families who have established relationships they wish to maintain with civilian physicians.

- TRICARE EXTRA -- Preferred Provider Option (PPO): It offers choices of civilian physicians and specialists from a network of health care providers. It is chosen by individuals and families whose regular physician is a member of the network or who live too far away from a military hospital. As with TRICARE STANDARD, the government shares the costs of health care. For using this network of preferred physicians and specialists, the government will pay an additional 5% of medical costs incurred (85% for dependents of active duty members and 80% for retirees). Beneficiaries are free to switch back and forth among providers by using TRICARE STANDARD or TRICARE EXTRA.

Unavailable / No Payer Specified / Blank – This is the situation when data is unavailable or unknown (Code 9999). This differs from the situation when a payer source is known but no typology code currently exists (Code 99).

Vision Insurance -- Vision insurance is a type of health insurance that entitles you to specific eye care benefits defined in the policy. Vision insurance policies typically cover routine eye exams and other procedures, and provide specified dollar amounts or discounts for the purchase of eyeglasses and contact lenses.

Worker's Compensation –Payment from workers' compensation insurance, government or privately sponsored. (CA definition)

Appendix A: Crosswalk Between ASC X12 Claim Filing Indicator Code List & Payer Typology

X12 Code	X12 Description	Typology Code	Typology Description
09	Self-pay	81	Self Pay
10	Central Certification	n/a	No Equivalent Source of Payment Typology Definition
11	Other Non-Federal Programs	3 or 4	Other Government OR Corrections
12	Preferred Provider Organization (PPO)	512	Commercial Managed Care - PPO
13	Point of Service (POS)	513	Commercial Managed Care - POS
14	Exclusive Provider Organization (EPO)	514	Exclusive Provider Organization
15	Indemnity Insurance	52 or 53	Private Health Insurance – Indemnity OR Commercial Indemnity
16	Health Maintenance Organization (HMO) Medicare Risk	111	Medicare HMO
AM	Automobile Medical	96	Auto Insurance (Includes No Fault)
BL	Blue Cross/Blue Shield	6	Blue Cross / Blue Shield
CH	Champus	311	TRICARE (Champus)
CI	Commercial Insurance Co.	53	Commercial Indemnity
DS	Disability	93	Disability Insurance
HM	Health Maintenance Organization	511	Commercial Managed Care - HMO
LI	Liability	n/a	No Equivalent Source of Payment Typology Definition
LM	Liability Medical	n/a	No Equivalent Source of Payment Typology Definition
MA	Medicare Part A	1	Medicare
MB	Medicare Part B	1	Medicare
MC	Medicaid	2	Medicaid
OF	Other Federal Program	3 or 4	Other Government OR Corrections
TV	Title V	341	Title V (MCH Block Grant)
VA	Veteran Administration Plan	32	Department of Veterans Affairs
WC	Workers' Compensation Health Claim	95	Workers' Compensation
ZZ	Mutually Defined / Unknown	n/a	Ambiguous Definition

Notes:

- It should be noted that some ASC X12 codes (10, LI, LM, ZZ) lack sufficient definition to be mapped to the Payer Typology.
- It should be noted that some ASC X12 codes (11, 15, OF) are not specific enough to map to a single Payer Typology code.
- It should be noted that all Payer Typology codes define additional hierarchical levels to further define the payer concept.

Appendix B: Source of Payment Typology Use Hierarchy

Steps for plan classification using Source of Payment Typology

Plan needing typology classification	**Identify possible main categories for classification.**	**Determine main category.**	**Assess type of plan for subcategory assignment.**	**Determine subcategory**	**Assess additional breakdown within subcategory.**	**Determine subcategory breakdown.**	**Assign final source of payment classification**
Harvard Pilgrim HealthCare	Is it 1- Medicare, 2 - Medicaid, 3 – Other Government, 4 – Department of Corrections, 5 Private Health Insurance, 6 – BCBS, 7 - Unspecific Managed Care, 8 - No payment, or 9 - Other?	5 - Private Health Insurance	1 - Managed Care Private, 2 - Indemnity or Managed Care/Private Insurance NOS	1 - Managed Care (Private)	1 - HMO, 2 - PPO, 3 - POS, 4 - EPO 5 – GPPO, 6 - PBM or 9 - Other?	1 - HMO	511 – Commercial Managed Care - HMO
Blue Care Elect	Is it 1- Medicare, 2 - Medicaid, 3 – Other Government, 4 – Department of Corrections, 5 Private Health Insurance, 6 – BCBS, 7 - Unspecific Managed Care, 8 - No payment, or 9 - Other?	6 Blue Cross/Blue Shield	1 - BC Managed Care, 2 - BC Indemnity, 3 - BC Out of State, 4 - BC Unspecified, 9 -BC Other?	1 - BC Managed Care	1 - HMO, 2 - PPO, 3 - POS, or 9 - Other?	2 - PPO	612 BC Managed Care - PPO

Plan needing typology classification	Identify possible main categories for classification.	Determine main category.	Assess type of plan for subcategory assignment.	Determine subcategory	Assess additional breakdown within subcategory.	Determine subcategory breakdown.	Assign final source of payment classification
John Hancock Signature Preferred PPO	Is it 1- Medicare, 2 - Medicaid, 3 – Other Government, 4 – Department of Corrections, 5 Private Health Insurance, 6 – BCBS, 7 - Unspecific Managed Care, 8 - No payment, or 9 - Other?	5 - Private Health Insurance	1 - Managed Care Private, 2 - Indemnity or Managed Care/Private Insurance NOS	2 –Indemnity	1 - Commercial Indemnity, 2 - Self-insured (ERISA) or 3 - Medicare supplemental policy (second payer), 4 – Private other	1 - Commercial Indemnity	521 Commercial Indemnity
Medicare HMO Blue	Is it 1- Medicare, 2 - Medicaid, 3 – Other Government, 4 – Department of Corrections, 5 Private Health Insurance, 6 – BCBS, 7 - Unspecific Managed Care, 8 - No payment, or 9 - Other?	1 – Medicare	1 - Medicare Managed Care, 2 - Medicare Non-managed care or Medicare hospice?	1 - Medicare Managed Care	1 - Medicare HMO, 2 - Medicare PPO, 3 - Medicare POS, or 9 - Medicare Managed Care Other?	1 - Medicare HMO	111 Medicare HMO

Plan needing typology classification	Identify possible main categories for classification.	Determine main category.	Assess type of plan for subcategory assignment.	Determine subcategory	Assess additional breakdown within subcategory.	Determine subcategory breakdown.	Assign final source of payment classification
Medicaid Kaiser Foundation Plan	Is it 1- Medicare, 2 - Medicaid, 3 – Other Government, 4 – Department of Corrections, 5 Private Health Insurance, 6 – BCBS, 7 - Unspecific Managed Care, 8 - No payment, or 9 - Other?	2 – Medicaid	1 -Medicaid Managed Care, 2 - Medicaid Non-managed care, 3 - SCHIP, 4 -Medicaid Applicant, 5 - Medicaid Out of State, 6 – Medicaid long term care or 9 - Medicaid Other	1 - Medicaid Managed Care	1 - Medicaid HMO, 2 - Medicaid PPO, 3 - Medicaid Primary Care Case Management, or 9 - Medicaid Managed Care Other?	1 - Medicaid HMO	211 Medicaid HMO
Out of State Medicaid	Is it 1- Medicare, 2 - Medicaid, 3 – Other Government, 4 – Department of Corrections, 5 Private Health Insurance, 6 – BCBS, 7 - Unspecific Managed Care, 8 - No payment, or 9 - Other?	2 – Medicaid	1 -Medicaid Managed Care, 2 - Medicaid Non-managed care, 3 - SCHIP, 4 -Medicaid Applicant, 5 - Medicaid Out of State, 6 – Medicaid long term care or 9 - Medicaid Other	5 - Medicaid Out of State	No additional subcategories. Proceed to final assignment.	N/A	25 - Medicaid - Out of State

Plan needing typology classification	Identify possible main categories for classification.	Determine main category.	Assess type of plan for subcategory assignment.	Determine subcategory	Assess additional breakdown within subcategory.	Determine subcategory breakdown.	Assign final source of payment classification
Free Care	Is it 1- Medicare, 2 - Medicaid, 3 – Other Government, 4 – Department of Corrections, 5 Private Health Insurance, 6 – BCBS, 7 - Unspecific Managed Care, 8 - No payment, or 9 - Other?	8 – No Payment from an organization, agency, program or private payer.	1 -Self-pay, 2 - No charge (charity, professional, research), 3 -Refusal to Pay/Bad Debt, 4 - Hill Burton Free Care, 5 - Research/Donor, 9- No Payment other	2 -No charge	1 - Charity, 2 - Professional Courtesy, 3 - Research/Clinical Trial	1 - Charity	821 - No Charge - Charity
AARP – Medigap Supplement	Is it 1- Medicare, 2 - Medicaid, 3 – Other Government, 4 – Department of Corrections, 5 Private Health Insurance, 6 – BCBS, 7 - Unspecific Managed Care, 8 - No payment, or 9 - Other?	5 - Private Health Insurance	1 - Managed Care Private, 2 - Indemnity or Managed Care/Private Insurance NOS	2 – Indemnity	1 - Commercial Indemnity, 2 - Self-insured (ERISA) or 3 - Medicare supplemental policy (second payer) or 4 – Private other	3 - Medicare supplemental policy (as a second payer)	523 - Private Health Insurance - Medicare Supplemental Policy

APPENDIX C: Examples of Analyses Using Data Elements Coded with Source of Payment Typology

1. In a letter, dated August 23, 2004, to the Secretary of HHS, The National Committee on Vital and Health Statistics urged researchers to examine racial, ethnic and linguistic sub-populations' access to health care and health care treatment. Using hospital discharge data, a researcher could examine the prevalence of specific categories of payer type for various racial, ethnic and linguistic sub-populations. Further investigation would need to assess how well a particular payer covers preventive services, ongoing medical treatment for chronic conditions, and long-term care. Disparities among sub-groups could be identified by national, state or at local levels such as county or Zip code. More specifically, a researcher could examine within payer type the various arrangements that sub-groups are most likely found in, i.e., HMO, PPO, or FFS.

2. Using Medicaid claims data, **a specific** state or group of states could compare utilization of preventive services by Medicaid HMO enrollees with utilization by Medicaid FFS enrollees. The results of this type of analysis could drive changes in state policy in regard to either the cost or outcomes associated with the use of preventative services, and whether HMOs or FFS deliver better results. Using payer categories such as those found in the Payer Typology would make this type of research relatively easy to undertake.

3. Given widespread Federal adoption (in Federal surveys and databases) of the Payer Categories in the Payer Typology, analysts could compare reports of health status by Medicaid respondents in the National Health Interview survey who are in a state Medicaid HMO with the health status of Medicaid respondents in the Category of POS Insurance. Self-reported health status has been identified as an important indicator for utilization of health care services. If there is a self-selection of those in poor or fair health as opposed to good health in POS programs, cost projections could be crucial to assuring financial viability of programs.

4. Researchers at the behest of federal policymakers could assess utilization of specific services in the new Medicare programs, such as Medicare Advantage. Further, researchers could assess whether utilization varies by type of Medicare Advantage Plan, that is, whether it is a HMO, PPO, or PSO. These arrangements could impact on individual utilization for specific treatments or services in ways unknown at the time policies were developed.

Appendix D: Change Summary in Version 6.0 (October 2015)

Below is the summary of changes made in this version of the Source of Payment Typology.

- Added Medicare Hospice, Dual Eligibility Medicare/Medicaid Organization, Medicaid - Long Term Care,
- Added Medicare Pharmacy Benefit Manager under Medicare Other, and Medicaid Pharmacy Benefit Manager under Medicaid Other
- Added Commercial Managed Care - Pharmacy Benefit Manager under Managed Care (Private).
- Added Specialized Stand Alone Plan with sub-categories of Dental and Vision.
- Under Managed Care, Unspecified, added Other Managed Care
- Added Auto Insurance (includes no fault)
- Added Other specified but not otherwise classifiable

Included Definitions for all of the above in the Users' Guide

Appendix E: Frequently Asked Questions

Q: Who developed the Source of Payment Typology?

A: The Source of Payment Typology was developed by the Payer Type Subcommittee of the Data Standards Committee of the Public Health Data Standards Consortium (PHDSC). In 2015, PHDSC became part of the American Health Information Management Association and has been renamed the Public Health Data Standards Council.

Q: Is this a nationally recognized data element?

A: Yes. For those coding data under the HIPAA standards, the Payer Typology is referenced as an external code list in the ASC X12 standards as a data element in the Subscriber Information Segment in the Subscriber and the Patient Loops. Because this change was made after the October 2003 version of the ASC X12 was approved and published, this modification will be supported in post 5010 (October 2003) version of the Health Services Data Reporting Guide. It has been adopted by the National Uniform Billing Committee effective July 1, 2009.

Q: Are other States using this?

A: Yes. Georgia started in 2007. Oregon began in June, 2008. New York began in July, 2009.

Q: Who is maintaining this code set?

A: The Source of Payment Typology is maintained by the AHIMA/PHDSC. Any changes to the typology will be made annually in March

Q: Has PHDSC developed definitions for these values / code set?

A: Yes. The PHDSC has created a "Users Guide for Source of Payment Typology" for reporting. The link is http://www.phdsc.org/standards/pdfs/SourceofPaymentTypologyUsersGuideVersion6FINALSeptember2015.pdf

The PHDSC website is http://www.phdsc.org/.

Q: Will there be a cross walk to the other payer types?

A: Yes. The PHDSC has developed a crosswalk with the Source of Payment/Claim Filing Indicator.

Q: What would be the code for a Self-Insured/Self-Administered Insurance Plan that is administered by Blue Cross?

A: The idea behind the SOP is to capture the type of insurance product and the type of payer/payment. In this question, the type of insurance product (Self-Pay) is being confused with the typical payer (Blue Cross). Blue Cross has expanded its scope as a multidimensional insurance services and products company. In this instance, they are acting as the administrator of the product and not the payer. In the future, there could be another contracted administrator. You should use the code 522 = Self-Insured (ERISA) Administrative Services Only plan.