Calculating the Average Generally Billed Amount

An individual who is determined not to be fully eligible for FAP but is eligible for a reduced time payment will never be charged more for medically necessary care than 45 percent of total hospital charges (both inpatient and outpatient) which is the average amount we are reimbursed from Medicare fee for service and our private payers.

To calculate the previous percentages MSK uses the “look back method” which includes dividing the sum of all of the amounts on all claims during a 12-month period allowed by Medicare fee for service and all private payers that pay claims to MSKCC by the sum of the associated gross charges for those claims. Whether a claim is used in calculating a hospital’s AGB (amount generally billed) depends on if the claim was allowed by a health insurer during the 12-month period and is not based on if the care resulting in the claim was provided during the 12-month period. If the amount a health insurer will allow for a claim has not been finalized as of the last day of the 12-month period we exclude the amount of the claim from the calculation and include it in the subsequent 12-month period or when a determination is made.

When including allowed claims in calculating the AGB (amount generally billed) percentages we include the full amount allowed by the health insurer which includes both the amount the insurer is expected to reimburse us as well as the amount a patient is responsible to pay; such as co-payments, co-insurance, and deductibles regardless if the full amount allowed was actually paid and does not take into account any discount applied to the amount a patient is responsible to pay.

A separate AGB is calculated for the physician claims using the same methodology and the calculated percentage is 44%.

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