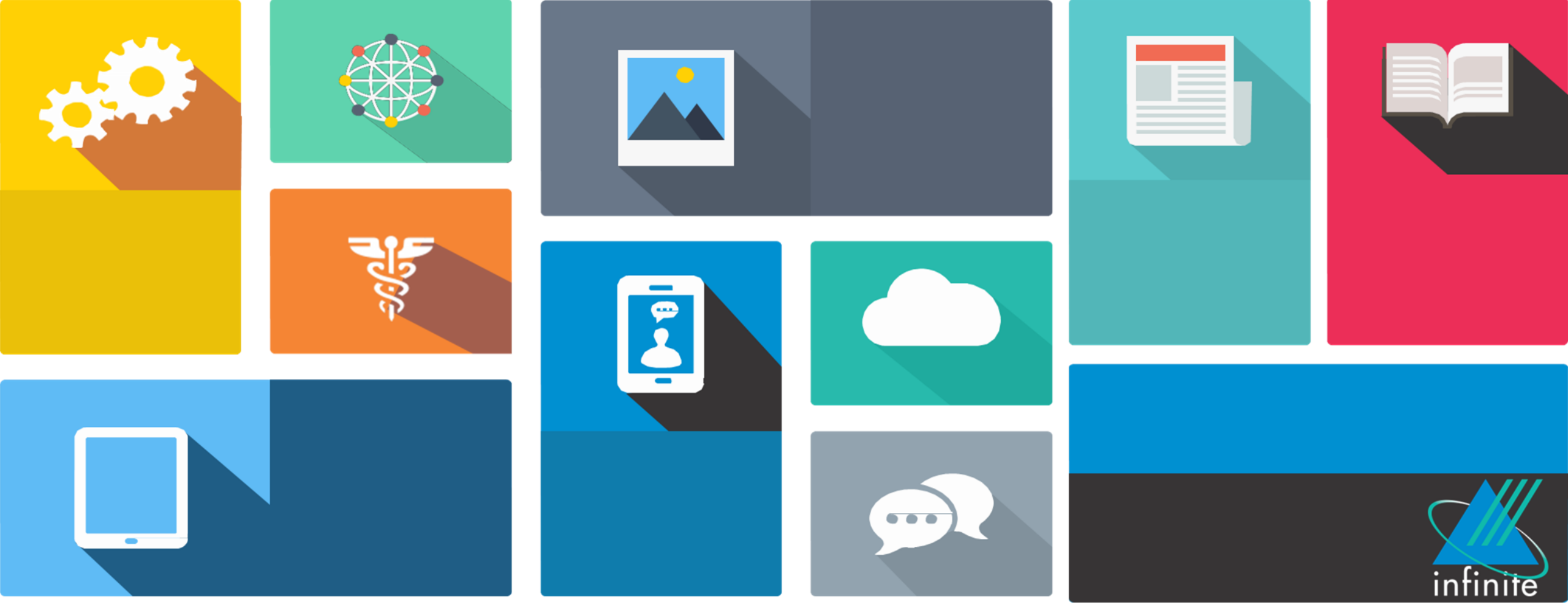


US HEALTHCARE OVERVIEW

Healthcare

Health :

Health is a "State of complete physical, mental, and social well being, and not merely the absence of disease or infirmity.

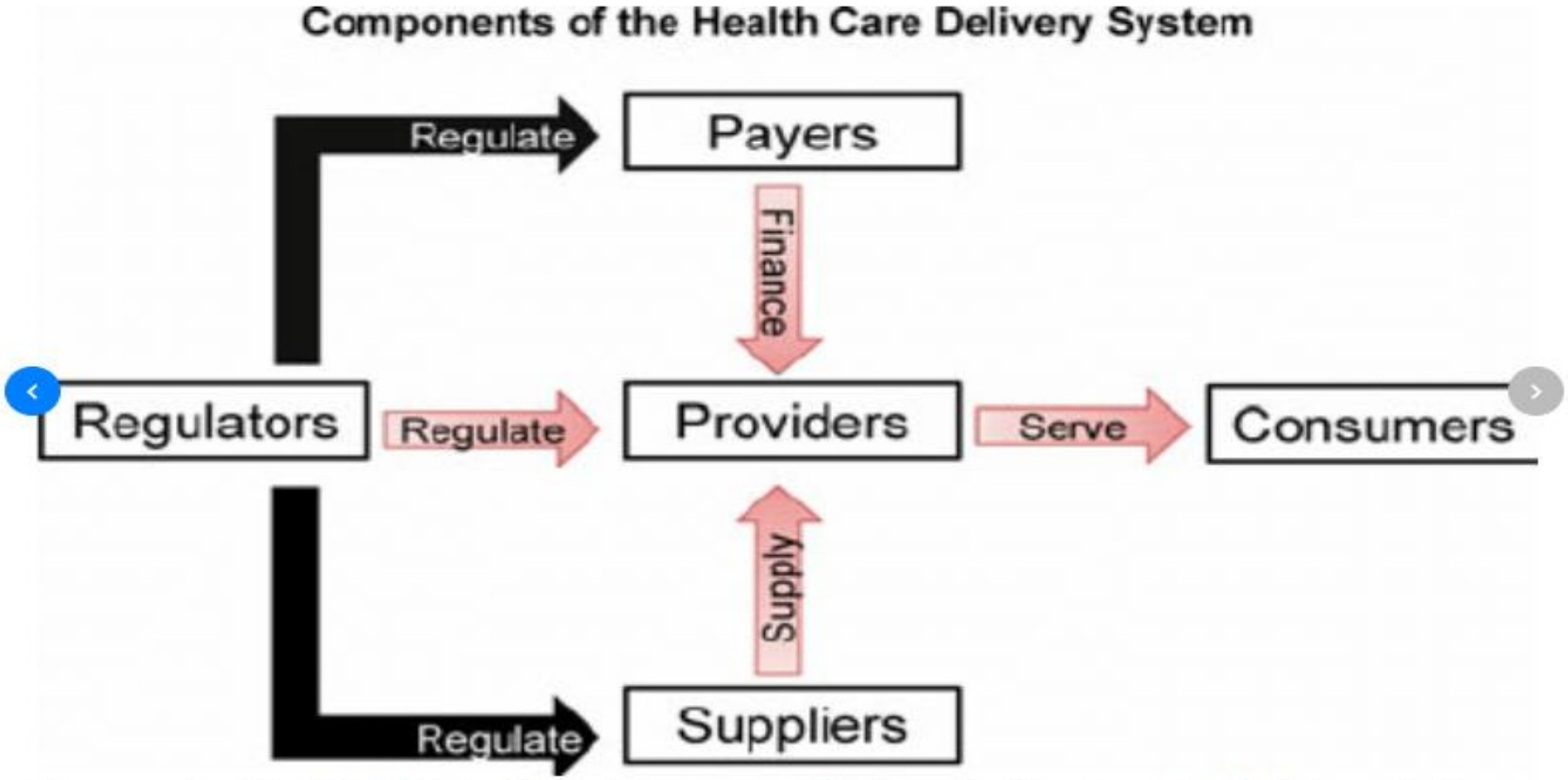
Healthcare:

Health care (or healthcare) is the diagnosis, treatment, and prevention of disease, illness, injury, and other physical and mental impairments in human beings. A organized procedure for an individual or for a group.

Insurance :

Insurance is a way of protecting against the risk of financial loss. An individual or business enters into a contract with an insurance company by purchasing an insurance policy. The person or business pays a relatively small, fixed amount (a premium) to the insurer at regular intervals (such as monthly or yearly). In exchange, if the person or business incurs a financial loss covered by the insurance policy, the insurer makes a payment (a benefit) or payments to cover or help cover this loss.

US Healthcare Delivery System



4 Components of the United State health care delivery system. This fi gure identifi es the relationship between the four major components of the health care delivery system: Payer Providers, Regulators, and Supplies

Components

Regulators and Policy Makers

- Federal Government
- HHS (*US Department of Health and Human Services)*
- CMS (*Centres for Medicare and Medicaid Services)*
- FDA (*Food and Drug Administration)*
- CDC (*Centres for Disease Control and Prevention*)

Payers

- Public
- Private
- Consumer

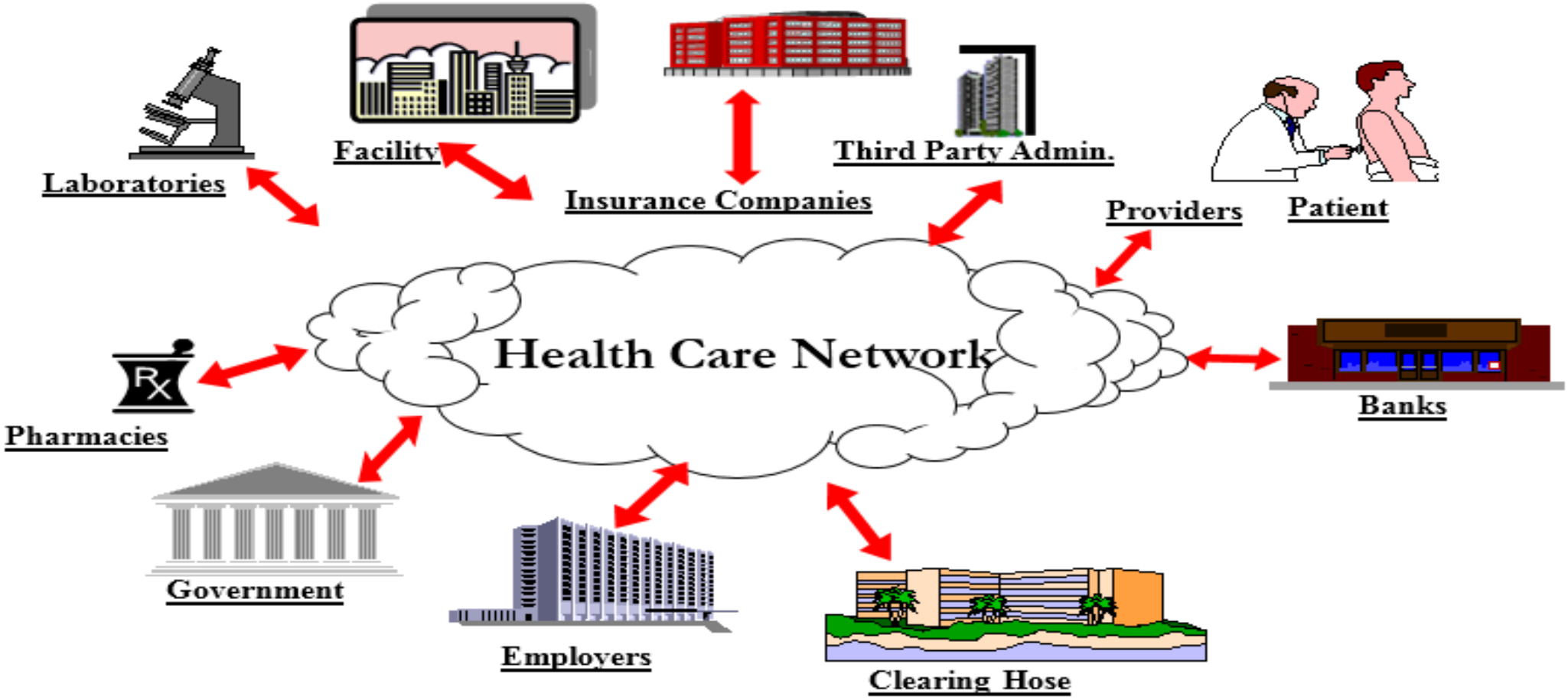
Providers

- Individual Providers
- Hospitals
- Nursing Homes
- Emergency Care Centres

Suppliers

- Pharmaceuticals
- Medical Equipment
- Medical Consumables

Entities in Healthcare system



Healthcare Systems

1. Hospital systems
   A. Public Hospitals:
   B. Non-profit Hospitals
   C. Private Hospitals
2. Continuum of Care
   - Covers the delivery of healthcare over a period of time
   - Homecare, Rehab centres, Wellness care, Palliative care, Research, Behavioural Healthcare etc
3. Types of patient care
   A. Primary Care
   B. Speciality Care
   C. Emergency Care
   D. Urgent Care
   E. Long Term care
   F. Hospice Care
   G. Behavioural Health

Healthcare Team

- Doctors
- Physician Assistants
- Nurses
- Pharmacists
- Dentists
- Technologists and technicians
- Therapists and rehabilitation specialists
- Emotional, social and spiritual support providers
- Administrative and support staff
- Community health workers and patient navigators

Providers

- Individual providers
- Group Or Entity
- IPA or PORG (Independent Practice/Physician Association or Provider Organization)

Providers

- PCP
- Specialist
- Preferred Provider
- Non- Preferred Provider
- Backup-Provider

Allied healthcare professionals

- Medical laboratory scientist (Lab technicians)
- Clinical psychologist
- Medical assistant
- Billing & Software vendors.
- Physical therapist

Public /Commercial Health Payer

Public Health payers

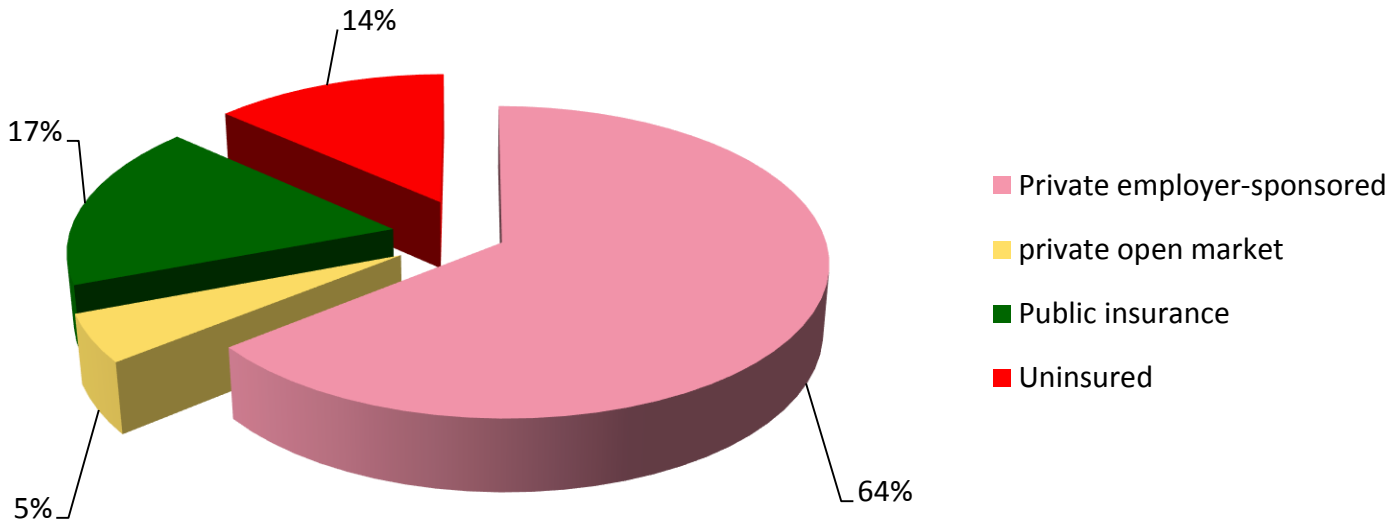
1. Medicare
2. Medicaid
3. S-CHIP (State Children's Health Insurance Program)
4. VA (Veteran's Administration)
5. CHAMPUS (Civilian Health and Medical Program of the Uniformed Services)

Commercial Health payers

1. Aetna
2. Cigna
3. Humana
4. More than 2000 Commercial payers are available on US market

US Healthcare system

- US has both private and public insurers in the U.S. health care system.



2014: Almost everyone will be required to have health insurance.

U.S. citizens must have health insurance or pay a penalty tax, Those who choose to go without insurance may face a tax penalty that starts at 1% of income and go up to 2.5% of income in 2014 year.

Medicare

Medicare is a federal program that covers individuals

- People age 65 or older,
- People under age 65 with certain disabilities, and
- People of all ages with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

- Medicare Part A
- Medicare Part B
- Medicare part D - Prescription drug benefit.
- Medicare Part C - Medicare advantage program

Medicaid

Medicaid is a program designed for the low-income and disabled. By federal law, states must cover very poor, pregnant women, children and elderly peoples.

States have the option of expanding eligibility

- [For example, states can choose to increase income eligibility levels.]

Financing: Medicaid is financed jointly by the states and federal government

through taxes.

Note : Every dollar that a state spends on Medicaid is matched by the federal government at least 100%.

Benefits: Medicaid offers a fairly comprehensive set of benefits, including prescription drugs.

Despite this, many members have difficulty finding providers that accept Medicaid due to its low reimbursement rate.

Other public systems

S-CHIP: The State Children's Health Insurance Program (S-CHIP) was designed in 1997 to cover children whose families make too much money to qualify for Medicaid but make too little to purchase private health insurance.

S-CHIP and Medicaid often share similar administrative and financing structures.

VA: The Veteran's Administration is a federally administered program for veterans of the military. Health care is delivered in government-owned VA hospitals and clinics. The VA is funded by taxpayer dollars and generally offers extremely affordable (if not free) care to veterans.

CHAMPUS- (Civilian Health and Medical Program of the Uniformed Services) A health plan that serves the dependents of active duty military personnel and retired military personnel and their dependents

Private health Insurance

1. Employer-sponsored insurance
2. Private non-group (open market)

Employer-sponsored insurance

Employers provide health insurance as part of the benefits package for employees.

Benefits vary widely with the specific health insurance plan. Some plans cover prescription drugs, while others do not.

Private non-group (open market)

Individual market covers part of the population that is self-employed or retired. Also covers people unable to obtain insurance through employers. (the individual market allows health insurance companies to deny people coverage based on **pre-existing conditions**)

- Benefits vary widely with the specific health insurance plan.

Subscriber

Subscriber/Member : The subscriber is the person whose name is listed in the health insurance policy, or who has a unique member identification number.

Dependent : Health insurance coverage extended to the spouse and unmarried children of the primary insured member.

Relationship :

- **Spouse**
- **Child**
- **Employee**
- **Unknown**
- **Organ Donor –** is a person offers to allow some or all of their organs to be used to save or improve the lives of others.
- **Cadaver Donor -** is a person who makes the decision to donate his or her body after death for the sake of scientific experiment and discovery
- **Other**

Code sets & Provider Identifiers

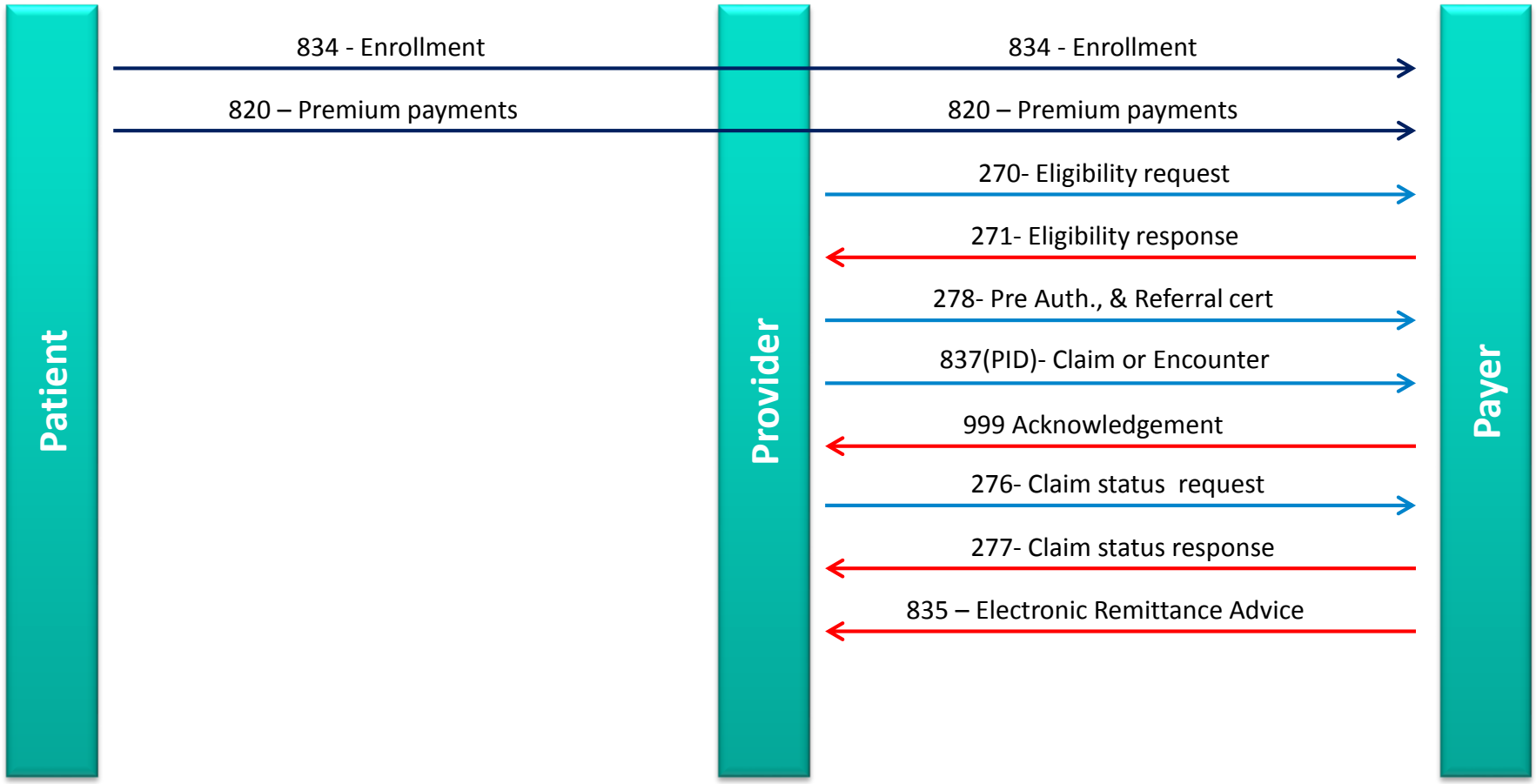
Medical codes are used for encoding data, medical diagnosis codes, or medical procedure codes. Codes are used for statistical and medical billing purposes.

- ICD 9 & 10 Codes
- HCPCS (CMS's Healthcare Common Procedure Coding System) - used primarily to identify products, supplies, and services not included in the CPT
- CPT codes (American Medical Association's Current Procedural Terminology) – For Medical, Surgical, diagnostic procedures
- NDC Codes (Universal Product identifier for human drugs)
- Revenue Codes (where the procedure or service was provided)
- DRG codes (500 Diagnosis related groups)

Provider ID's

- NPI
- Tax ID
- SSN
- Legacy Id's

Healthcare Transactions



Claim

Claim:

A bill for medical services rendered, typically submitted to the insurance company by a healthcare provider.

Claim submissions

- Paper claims
- EDI claims

Type of claims

- CMS1500 (837P)
- UB04 (837I)
- ADA (837D)

EOB/ERA

- An explanation of benefits (EOB form) is a statement sent by a payer to covered individuals explaining what medical treatments and/or services were paid for on their behalf.
- ERA : An electronic remittance advice is an electronic version of a payment explanation which provides details about providers' claims payment.

Patient Responsibility

- **Copay :** A fixed amount (for example, $15) you pay for a covered health care service, usually when you get the service. The amount can vary by the type of covered health care service.
- **Deductible :** The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay.
- **Co-Insurance :** Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service.

PHI

Protected Health Information (PHI) is considered "Restricted"

- Name
- Address including city and zip code
- Telephone number
- Fax number
- E-mail address
- Social security number
- Date of birth
- Medical record number
- Health plan ID number
- Dates of treatment
- Account number
- Full face photo and other comparable image
- Certificate/license number
- Device identifiers and serial number
- Vehicle identifiers and serial number
- Provider ID number
- Application Tracking Number
- Internal Control Number
- URL
- IP address
- Biometric identifiers including finger prints

Accountable Care Organizations (ACOs)

Accountable Care Organizations (ACOs) are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to the Medicare patients they serve

Benefits

- Improved population health. One fundamental goal of ACOs is that they will improve the health and wellness of a defined population for which the ACO is accountable.
- Improved patient quality of care. ...
- A focus on the patient. ...
- Physician leadership. ...
- Lower costs. ...
- Shared savings

Accountable Care Organizations (ACOs)

- **Shared Savings Program**

Under the Shared Savings Program, the ACO providers and suppliers continue to be paid for services rendered to Fee-For-Service Medicare beneficiaries in the same manner as they would otherwise. In addition, the participating ACO may receive a shared savings payment if the ACO meets the quality performance standards and has generated shareable savings under the performance-based payment methodology described in the regulations.

Healthcare standards

DICOM -Digital Imaging and Communications in Medicine – provides for handling, storing, printing, and transmitting information in medical imaging.

HL7 -Health Level Seven – provides standards for exchanging clinical data.

LOINC - Logical Observation Identifiers Names and Codes – applies universal code names and identifiers to medical terminology related to the Electronic Health Record and assists in the electronic exchange and gathering of clinical results (such as laboratory tests, clinical observations, outcomes management and research).

ELINCS -EHR-Lab Interoperability and Connectivity Standards – an emerging standard for reporting lab test results.

SNOMED - Systematized Nomenclature of Medicine Clinical Terms – provides comprehensive computerized clinical terminology covering clinical data for diseases, clinical findings, and procedures.

NCPDP -National Council for Prescription Drug Programs – governs prescription transactions.

Hospital Information System (HIS)

A hospital information systems (HIS) is a computer system that is designed to manage all the hospital's medical and administrative information in order to enable health professional perform their jobs effectively and efficiently.

Hospital information systems focus on the integration of all clinical, financial and administrative applications and thus could also be called an Integrated Hospital Information Processing System

Components of a hospital information system consist of two or more of the following:

- Clinical Information System (CIS)
- Financial Information System (FIS)
- Laboratory Information System (LIS)
- Nursing Information Systems (NIS)
- Pharmacy Information System (PIS)
- Picture Archiving Communication System (PACS)
- Radiology Information System (RIS)

Molina Healthcare

Molina healthcare provides health insurance to individuals through government programs such as Medicaid and Medicare.

Molina Healthcare entered the Medicare market in 2006. The company currently offers Medicare health plan options in: California, Florida, Idaho, Illinois, Michigan, New Mexico, Ohio, South Carolina, Texas, Utah, Virginia, Washington and Wisconsin

Entering **MMIS** - Molina Healthcare acquired Unisys' health information management business in December 2010 to create Molina Medicaid Solutions (MMS).MMS has Medicaid Management Information Systems (MMIS) contracts with Idaho, Louisiana, Maine, New Jersey, West Virginia and the U.S. Virgin Islands.

Moline Healthcare

Dual Eligibility

Molina was selected to participate in dual eligible demonstration projects in California, Ohio, Illinois, Michigan, South Carolina and Texas to serve patients who are eligible for both Medicare and Medicaid.

Commitment to Quality

Molina Healthcare continues to be among the national leaders in Medicaid health plan quality accreditation. The goal is for all Molina health plans to become accredited by the National Committee for Quality Assurance (NCQA)

Quality Improvement Program

Our Quality Improvement Program is designed to improve quality of care, member safety and quality of service

Healthcare Effectiveness Data and Information Set (HEDIS®)

Molina Healthcare uses HEDIS® each year as a way to measure the organization's quality of care - both clinical and non-clinical - and services. Maintained by the NCQA, HEDIS® also shows where plans can improve. Molina's goal is to be better than 75 percent of other Medicaid health plans in the nation

Questions???

Thank You