Introduction to CMS

CMS - Centers for Medicare & Medicaid Services

- The Centers for Medicare & Medicaid Services (CMS) is part of the U.S. Department of Health and Human Services
- Oversees many federal healthcare programs, including those that involve health information technology such as the meaningful use incentive program for electronic health records (EHR)
- Administers the Children's Health Insurance Program (CHIP), the Health Insurance Portability and Accountability Act (HIPAA) and key portions of the 2015 Medicare Access and CHIP Reauthorization Act (MACRA) law
- CMS also administers alternative payment models (APMs) for healthcare providers such as bundled payments for groups of healthcare organizations, and accountable care organizations, which are reimbursed based on positive medical outcomes
- Since passage of the Health Information Technology for Economic and Clinical Health Act in 2009, CMS has been charged with running the meaningful use program
- Under meaningful use, and now the Merit-based Incentive Payment System (MIPS) part of MACRA, CMS determines whether healthcare providers have successfully used health IT systems, and sets Medicare and Medicaid reimbursement rates for healthcare providers that use federally certified health IT systems

Managed Care Organization(MCO)

- Managed care plans are a type of health insurance. They have contracts with health care providers and medical facilities to provide care for members at reduced costs. These providers make up the plan's network. How much of your care the plan will pay for depends on the network's rules
- There are five main types of insurance plans
  - Health Maintenance Organization (HMO)
  - Preferred Provider Organization (PPO)
  - Exclusive Provider Organization (EPO)
  - Point of Service (POS)
  - High-Deductible Plans With a Health Savings Account (HSA)

HMO

- A health maintenance organization (HMO) plan is a type of health insurance plan that limits coverage to health care providers who are contracted with the HMO network.
- This means that the plan covers care only from providers specifically indicated as being in-network and does not pay for care outside of the HMO network, except in the case of an emergency.
- HMOs require you to choose a primary care physician (PCP), who must then give you a referral to see any specialists. Without this referral from your PCP, HMO plans do not cover care from a specialist and you will be responsible for most, if not all, of the associated costs. In addition, an HMO may require you to live or work in its service area to be eligible for coverage.
- The primary benefit of HMOs is that they have lower premiums and may not have a deductible
- In addition, co-payments for doctor or emergency-room visits will likely be minimal.
- Although HMO plans may feature lower health insurance costs up front, they can also be more restrictive in terms of which services are covered and how you can access them. This means that you may have fewer options in terms of coverage, care, and providers, but you may still be able to get the care you need.

PPO and EPO

- A preferred provider organization (PPO) plan is a type of health plan that allows for relative freedom when choosing providers outside of a plan's network. With PPO plans, you pay less for care from in-network providers but can still receive coverage for out-of-network care without a referral or PCP, at an additional cost
- Therefore, PPO plans generally give you more freedom and flexibility than HMO plans. However, they often cost more, too. If you do decide to enroll in a PPO plan, you will pay higher monthly premiums and out-of-pocket costs in exchange for the flexibility to choose providers both in- and out-of-network
- Exclusive provider organization (EPO) plans combine the flexibility of a PPO plan with the cost-saving benefits of an HMO plan by giving you the freedom to choose any provider within an EPO network without selecting a PCP. In addition, EPO plans do not require referrals to see a specialist.
- However, it is important to note that EPOs do still offer a limited network of health care providers to choose from, so it is important to confirm that your care center is in-network before enrolling in an EPO plan. If you do go to a doctor or hospital that doesn't accept your plan, you will ultimately be responsible for paying all costs associated with that care.

POS and HDHP(HSA)

- A point-of-service plan (POS) is a hybrid of HMO and PPO plans. Like an HMO, participants designate an in-network physician to be their primary care provider. But like a PPO, patients may go outside of the provider network for health care services. When patients venture out of the network, they'll have to pay most of the cost, unless the primary care provider has made a referral to the out-of-network provider.

- A health savings account (HSA) is a tax-exempt medical savings account that is paired with a high-deductible health plan. HSAs are similar to personal savings accounts, but the funds are limited to health care expenses.

HMO vs PPO vs POS vs EPO

	PPO Preferred Provider Organization	EPO Exclusive Provider Organization	POS Point-of-service	HMO Health Maintenance Organization
Primary Care Physician (PCP) required?	No	Sometimes	Yes	Yes
Referral required to see a specialist?	No	No	Sometimes	Yes
“In-network” benefits	Yes	Yes	Yes	Yes
“Out-of-network” benefits	Yes	No	Yes	No
Flexibility	Highest	High	Medium	Low
Cost	$$$$	$$$	$$	$

Indemnity Plan

Also called “Freedom of Choice” Members can access care through any licensed provider; there are no networks in this plan.

- Freedom of choice
- No referrals
- No PCP

Basic Features of Indemnity Health Insurance:

- **Provider Choice**

In traditional indemnity health insurance, when an insured needs healthcare, he/she can go to any physician, specialist, hospital, or other healthcare provider she chooses. He/She does not have to use a provider affiliated with a network, nor will he/she pay more if she uses a non-network provider, as is the case in some health plans.

- **Benefit Payment**

Under an indemnity policy, an insured receives care from a provider, the provider charges her for the services rendered, she submits to her insurer a claim (a request for payment based on the terms of the policy), and the insurer reimburses her. Or more commonly, the insured assigns benefits to the provider—under assignment of benefits, the provider bills the insurer directly, and the insurer reimburses the provider.

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

Key Terms

- There are several health insurance terms to understand:
  - In-Network vs Out-of-Network providers
  - Premium: The monthly fee for your insurance
  - Deductible: How much you must kick in for care first, before your insurer pays anything
  - Co-pay: Your cost for routine services to which your deductible does not apply
  - Co-insurance: The percentage you must pay for care after you've met your deductible
  - Out-of-pocket maximum: The absolute max you'll pay annually

Provider Networks

- A provider network is a set of doctors, hospitals, clinics, and other health care providers that are contracted with your health insurance plan to provide care at a reduced cost
- Not all health care providers are contracted under a plan's provider network, so it is important to know what is considered in-network and the policies regarding out-of-network coverage before enrolling in a plan
- “In-network” health care providers have contracted with your insurance company to accept certain negotiated (i.e., discounted) rates. You’re correct that you will typically pay less with an in-network provider. “Out-of-network” providers have not agreed to the discounted rates
- The way that a provider network works depends largely on the type of health insurance plan you select. You will typically find that a single health insurance company will offer several different plan options.
- The plan you choose will ultimately determine the size of your provider network, the rules for seeing a specialist, and how much you will pay each time you receive care.

Premium and Co-pay

- Your premium is the amount you pay into the insurance plan on a regular basis. If you belong to an employer-sponsored plan, the premium is likely deducted from each paycheck as pre-tax dollars.
- If you purchase your own health insurance plan, you may have the option to pay your premium annually, quarterly, or monthly
- Your co-pay is the fixed amount you pay for using routine services defined by your plan. For example, some plans charge you a co-pay for visiting your primary care physician, or an emergency room, or purchasing a prescription drug.
- In most cases, the payment is the same regardless of the extent of the visit or the cost of the drug. For example, a plan may require co-pays of $20 for office visits, $100 for emergency room visits, $15 for generic prescriptions, or $30 for name-brand drugs

Deductible

- Your health insurance deductible is the amount that you will have to pay annually for your healthcare (such as surgical procedures, blood tests, or hospitalizations—but not some routine care) before the health insurance pays anything.
- For example, if you have a $2,500 deductible and undergo three $1,000 procedures in a year, you will have to pay the full bill for the first two procedures and $500 of the third … your insurance will cover half of the third procedure.
- Increasing your deductible is the easiest way to lower your premiums and, if you're mostly healthy, might be a good idea. Just understand, however, that if you have a $10,000 deductible and get sick, you could end up with $10,000 in medical bills in a year.
- Typically, your deductible does not apply for preventative health checkups and many routine health services … you'll just pay a co-pay instead

Deductible…continued

- Embedded vs. aggregate deductibleIf you're on a family plan, then you'll want to know whether you have an aggregate or an embedded deductible.
- An aggregate deductible means that's the amount that has to be paid out of pocket on any (or all) of the people covered by the plan before insurance starts paying for anything. If that overall deductible is $10,000 then it doesn't really matter how the family gets to $10,000 in spending, whether from one person or from several different people's medical care.
- An embedded deductible, on the other hand, means there's the overall deductible for the entire group (the family deductible), but then there's also an embedded deductible for each individual. Let's say the overall deductible is $10,000, but the deductible for each individual is $5,000.
- If Person A has a major emergency and gets at least $5,000 in care, then any further care for Person A will be covered by insurance (and won't apply to the family deductible, though any co-insurance will apply to out-of-pocket max). If Person B then gets a $1,000 bill for something else, the family will still have to pay that $1,000 out of pocket, and will still have $4,000 left on the overall deductible.
- With an embedded deductible, insurance kicks in sooner for individuals who rack up large bills. However, under such a plan, it may take longer for the family to meet its overall deductible.

Co-Insurance and Out-of-Pocket

- Co-insurance is similar to a co-pay, although co-insurance generally applies to less routine expenses, and is expressed as a percentage rather than a fixed dollar amount.
- Your co-insurance kicks in after you hit your deductible.
- If your plan has a $100 deductible and 30 percent co-insurance and you use $1,000 in services, you'll pay the $100 plus 30 percent of the remaining $900, up to your out-of-pocket maximum.
- You may find plans with no co-insurance requirements, some with 20/80 or 50/50 coinsurance, or other combinations
- Your out-of-pocket maximum is an important feature of your health plan because it limits the total amount you pay each calendar year for healthcare including co-pays, deductibles, and co-insurance.
- If your policy carries a $2,500 out-of-pocket maximum and you get sick and require a lot of healthcare services, the most you will pay in a year is $2,500. After that, insurance picks up the rest of the tab, presuming you stay in-network.

Capitation

- Capitation payments are used by managed care organizations to control health care costs
- Capitation payments control use of health care resources by putting the physician at financial risk for services provided to patients
- Capitation is a fixed amount of money per patient per unit of time paid in advance to the physician for the delivery of health care services. It pays the doctor, known as the primary care physician (PCP), a set amount for each enrolled patient whether a patient seeks care or not.
- When the primary care provider signs a capitation agreement, a list of specific services that must be provided to patients is included in the contract
- The amount of the capitation will be determined in part by the number of services provided and will vary from health plan to health plan, but most capitation payment plans for primary care services include the following
    - Preventive, diagnostic, and treatment services
    - Injections, immunizations, and medications administered in the office
    - Outpatient laboratory tests done either in the office or at a designated laboratory
    - Health education and counseling services performed in the office
    - Routine vision and hearing screening