Health Plans Benefits & Networks

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Agenda

- **Objectives**
- **Topics**
- **Concepts**

Objectives

- **After completing this module, you will be able to learn:**
  - **Define *primary care and describe its role in a health plan.***
  - **Define *copayment.***
  - **Define *network and explain its importance in a health plan.***
  - **Describe how health plans influence and affect availability of healthcare.**

Topics

B	Health Plans - Benefits & Networks
1	Primary Care, Network & It's importance in Health Plan
2	Accessibility of Healthcare, Health Plan - MCOs
3	Types of Services, Managed Care Workflow
4	Financing Health Plans, Copayment, FFS, Capitation
5	Fee Schedule, UCR Fee Schedule
6	RBS, RBRVS, Withhold
7	Prospective Payment System - DRG
8	Per Diems, CPT

Primary Care & Its Role in Health Plan

- ***Primary care*** **is general medical care that is provided directly to a patient without a referral from another physician. It is focused on preventive care and the treatment of routine injuries and illnesses.**
- **With some types of health plans, each member selects one doctor or other medical professional from the network to be his or her *primary care provider (PCP)*.**
- **In a health plan, a primary care provider (PCP) or *primary care physician* is a physician or other medical professional who serves as a member's first contact with the plan's healthcare system.**
- **Most often, the PCP is a physician — either a general practitioner, family practitioner, internist, pediatrician, or obstetrician/gynecologist (OB/GYN).**

Network & Its Importance in Health Plan

- **A *network* is the group of physicians, hospitals, and other medical care professionals that a health plan has contracted with to deliver medical services to its members.**

- **The importance of a network is the integration of the provider and financing mechanisms which results in an organized system of healthcare delivery in which providers share in the financial risk of providing healthcare to a certain group of persons.**

Accessibility of Healthcare

- **Health plan. Any entity that utilizes certain concepts of techniques to manage accessibility, cost, and quality of healthcare.**
- **PCP – Primary Care Physician - A physician or other medical professional who serves as a group member's first contact with a plan's healthcare system.**
- **Ways to enhance Accessibility of Healthcare**
  - **--- Cost / Pricing structure**
  - **--- Emphasis on primary care, prevention and wellness**
  - **--- Location and availability of providers**
  - **--- By offering comprehensive benefits.**

Health Plan - MCOs

- **A fundamental concept of managed healthcare is that healthcare is delivered through an integrated system of healthcare providers and healthcare plans.**

Traditional indemnity plans with health plan components

- **Health maintenance organizations (HMOs)**
- **Preferred provider organizations (PPOs)**
- **Point-of-service (POS) products**
- **Physician-hospital organizations (PHOs)**
- **Physician groups**
- **Physician Practice Management (PPM) companies**
- **Utilization review organizations (UROs**

Figure 2A-2. Typical Benefits in a Managed Care Plan.

- ✓ Physician services
- ✓ Hospitalization
- ✓ Well child care
- ✓ Prenatal care
- ✓ Periodic health evaluations/ examinations
- ✓ Eye and ear exams for children under 18
- ✓ Immunizations
- ✓ Home nursing care
- ✓ Emergency care inside and outside the service area
- ✓ Diagnostic services and lab tests
- ✓ Many outpatient services, including mental health benefits
- ✓ Inpatient and short-term rehabilitation services
- ✓ Physical, occupational, and speech therapy

Types of Services

Figure 2A-3. Services Provided by MCOs.

Ancillary services—Outpatient or auxiliary services to support diagnosis and treatment of a patient's condition; supplemental services needed as part of providing other care.[1] Includes healthcare services such as lab work, pharmacy, radiology, physical therapy, medical supplies, and other items that are performed or provided to the patient during the course of diagnosis and treatment.[2]

Outpatient services—Services provided by a hospital or other qualified ambulatory care facility which do not require admission to the facility for an overnight stay.[3]

Primary care—General medical care that is provided directly to a patient without referral from another physician. It is focused on preventive care and the treatment of routine injuries and illnesses.[4]

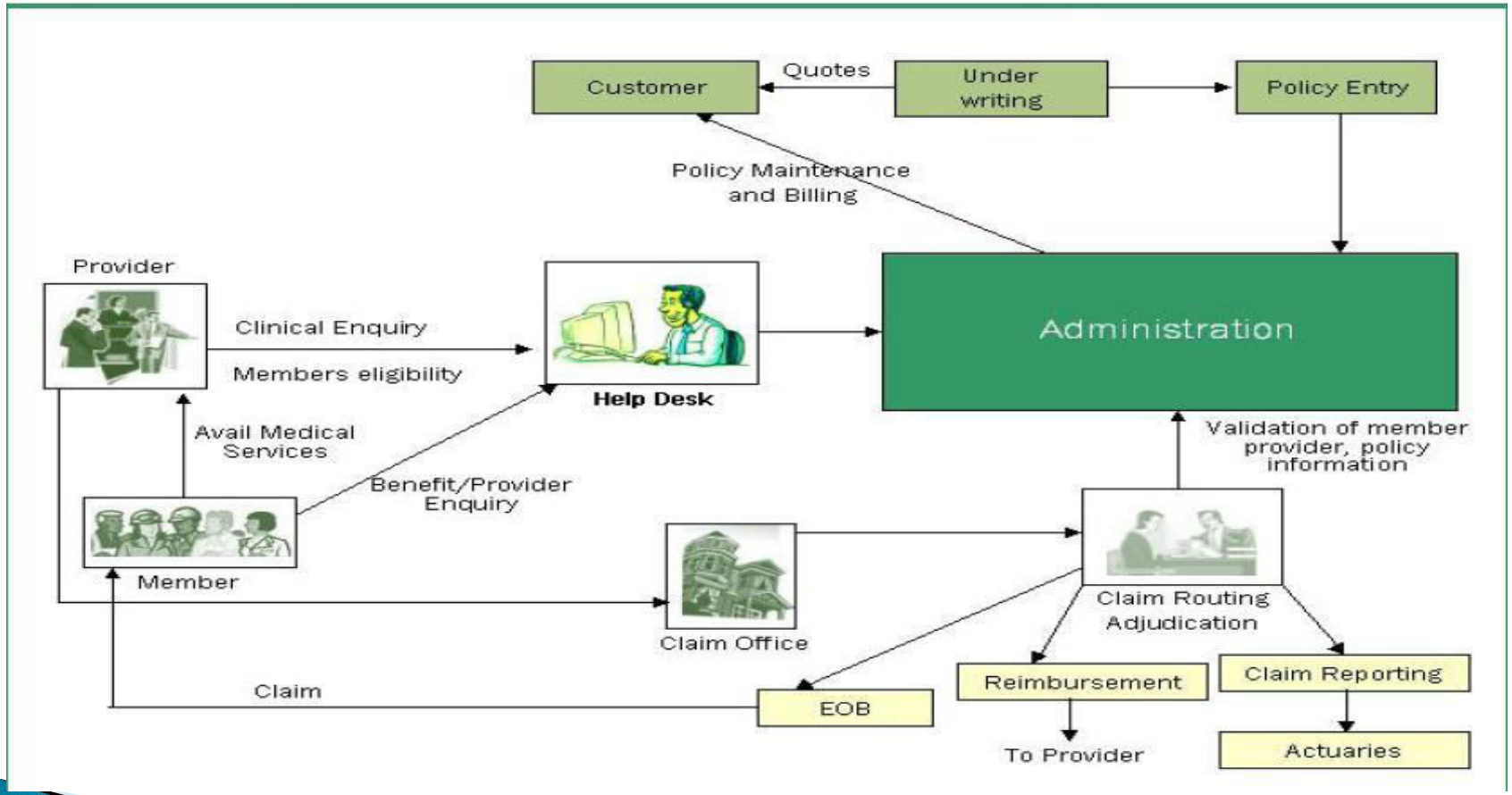
Referral—A recommendation by a physician and/or managed care plan for a member to be evaluated and/or treated by a different physician or other medical professional. The referral physician (the physician to whom the member is referred) could be another primary care physician or a specialist.[5]

Specialty care—Also known as secondary care. Medical care that is delivered by specialists. Also includes outpatient and inpatient services provided by acute care hospitals.[6]

Specialist—Usually refers to a physician, but also may refer to a dentist or other health professional, who voluntarily limits his or her practice to a certain branch of medicine related to specific services or procedures, certain age categories of patients, specific body systems, and certain types of diseases.[7]

Managed Care Workflow

A typical managed care workflow is shown in the following figure.



Financing Health Plans

- Health plans combine the financing and delivery aspects of healthcare -
- By Risk sharing – between member/provider/employer/payer
- How ?
- Provider – through FFS/Capitation
  - Capitation – (Predetermined amount)
  - A method of paying for healthcare services on the basis of the number of patients who are covered for specific services over a specified period of time rather than the cost or the number of services that are actually provided. In other words, the healthcare provider is compensated per person—per capita—rather than per service.
  - Health plan takes on a predictable amount of risk using above method

Copayment

- **A *copayment* is a specified dollar amount that a member must pay out-of-pocket for a specified service at the time the service is rendered.**

Figure 2A-4. Copayments.

Valerie Waters is a member of a managed care organization that requires a $10 copayment for physician office visits and a $5 copayment for prescriptions.

Valerie goes to see her physician because she has a sore throat. During the office visit, she is tested for and diagnosed with strep throat, and the physician writes a prescription for an antibiotic.

As Valerie leaves the doctor's office, she pays a $10 copayment to the office receptionist. The remaining charges for the office visit and the strep throat test are covered by the health plan.

Then Valerie takes her prescription to one of the pharmacies in the plan's pharmacy network. When the pharmacist fills her prescription, Valerie pays a $5 prescription copayment. The remaining cost of the prescription is covered by the health plan.

Difference Between Capitation & FFS

Fee For Service	Capitation
A physician is paid after the fact for services that have been performed. The physician's income thus increases with the volume and variety of the services that he or she generates.	A physician is paid in advance for all of the services that he or she has agreed to be responsible for.
Physicians have little financial incentive to practice preventive care or to focus on improving health, because it is only when people get sick that most fees are generated.	There is a positive incentive to help people stay healthy and to treat illness promptly.
Provider assumes little or no risk	Provider assumes most or all risk

Capitation Types

- **Global capitation** is a payment that covers virtually all of a member's inpatient and outpatient medical expenses, including physicians, hospitals, specialists, and some ancillary services.

- **Partial capitation** may include primary care only, or may include primary and secondary care, but not ancillary services.

- **A carve-out** is a medical service that is removed from the scope of services covered by the basic capitation payment and is reimbursed as a separate payment
- Basically capitations covers primary care services.
  - Primary care services typically include preventive services, outpatient care, and hospital visits, immunizations, diagnostic testing, and some surgical procedures.

Fee Schedule , UCR Fee Schedule

- **Also known as a *fee allowance, fee maximum, or capped fee*, *the health plan* determines what it considers to be the acceptable fee for a service or procedure, and the physician agrees to accept that amount as payment in full for the procedure.**

- **Usual Customary Reference Fee Schedule –**

  The amount commonly charged for a particular medical service by physicians within a particular geographic region. UCR fees are used by traditional health insurance companies as the basis for physician reimbursement.

Note - A fee schedule reimbursement system is similar to a discounted fee-for-service system.

RVS, RBRVS, Withhold

- **RVS – Relative Value Scale / Services** - When a health plan uses RVS it assigns a weighted value to each medical procedure or service. To determine the amount the health plan will pay to the physician, the weighted value is multiplied by a money multiplier.
- **RBRVS – Resource Based RVS** – Same as RVS but also take into account all resources that physicians use in providing care to patients, including physical or procedural, educational, mental (cognitive), and financial resources.
- **Withhold –**

  A percentage of a provider's payment that is "**held back**" during the plan year to offset or pay for any cost overruns for referral or hospital services. Any part of the withhold not used for these purposes is distributed to providers.

Weighted value for service
x
Money multiplier
=
Amount reimbursed
to physician

Prospective Payment System - DRG

- **DRG – Diagnosis Related Group – PPS refers to the system of reimbursing hospitals on the basis of *Diagnosis-Related Groups (DRGs).***

- **The DRG system classifies hundreds of hospital services based on a number of criteria, ---**
  1. **Primary and secondary diagnosis,**
  2. **Surgical procedures,**
  3. **Age, gender, and**
  4. **The presence of complications**

- **The hospital is paid a fixed rate for each DRG. The payment will be based on the average expected use of hospital resources in a given geographical area for that DRG.**

Per Diems

- **Using per diem charges, a health plan pays a specific negotiated charge to a hospital for each inpatient day.**
- **A health plan typically reimburses per diem charges at a percentage discount using a sliding scale, in which the discount increases with patient volume. The health plan may make adjustments quarterly, semiannually, or annually to account for variances in hospital utilization.**
- **Per diem charges work best in hospitals with predictable utilization patterns.**

Current Procedural Terminology (CPT)

- **The CPT is a classification system established by the American Medical Association for medical services and procedures.**
- **In the CPT system, each service or procedure is identified by a five-digit number known as a CPT code.**
- **Use of CPT codes is standard in the healthcare industry and provides a uniform method of identifying, communicating about, and billing for services and procedures performed by healthcare providers.**
- **The data on services based on their CPT codes are used to determine the UCR fees for the services.**

Questions?

Thank You!