MyNursePal Inc

# Module 6 How Healthcare Is Paid for in the United States?

**Section 1**

How Medicare Works: Coverage, Payment Models, and Documentation Requirements

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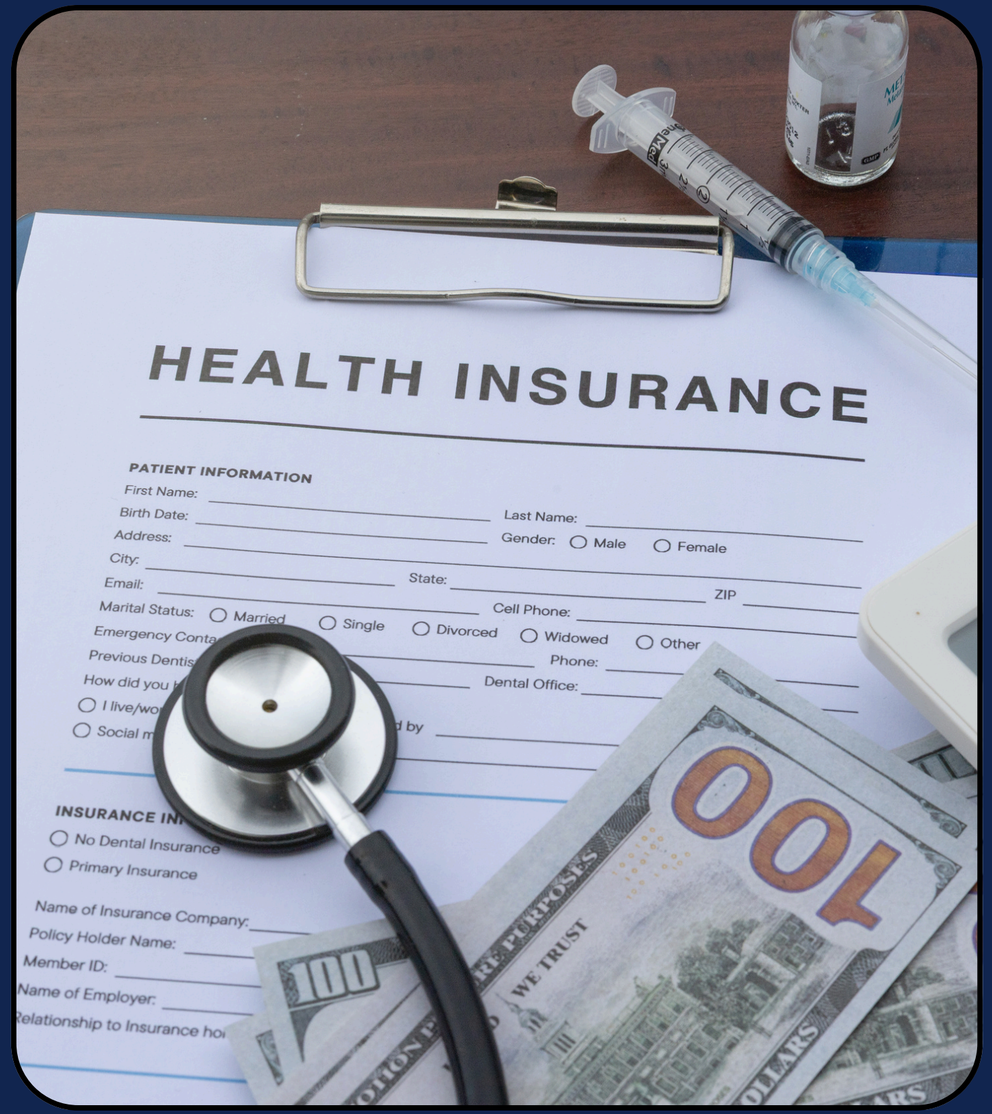

# Objectives

## By the end of this module, learners will be able to:

1. Explain the structure of the U.S. healthcare financing system and the interplay between public and private payers.
2. Identify the major Medicare Parts (A, B, C, and D ) and their roles in funding care.
3. Describe how Medicare Parts influence clinical workflows, documentation standards, and billing processes.

# Why U.S. Healthcare Financing Is Complex

- The U.S. blends public and private systems, creating multiple payment models.
- Medicare, Medicaid, private insurance, and managed care operate simultaneously
- Each system uses different rules, documentation, and reimbursement methods
- Impacts eligibility, billing workflows, and required data structures

# US Healthcare as Multiple Systems

- U.S. healthcare is not one system. It is many interconnected systems.
- Different payers define access, documentation, and payment rules
- Providers often handle several payer types for the same patient
- Creates variation across hospitals, clinics, home health, and community care

# Examples of Payment Variation

- A single patient may trigger multiple payment systems.
- Hospital stay → Medicare Part A (*DRG fixed rate)
- Home health → *PDGM (needs OASIS + visit data)
- Outpatient visits → Part B (CPT-coded fee-for-service)
- Prescription drugs → Part D (formulary-based)

# Why This Matters for Developers & Designers

- Understanding reimbursement is essential in health-tech.
- Influences data models and required clinical fields
- impacts billing workflows and API integrations
- insures accurate, compliant, and efficient system design
- Reduces claim denials and supports interoperability

# What Is Medicare?

- Federal insurance program for:
  - Adults 65+
  - Younger individuals with disabilities
  - People with End Stage Renal Disease (ESRD) requiring dialysis or transplant

# Medicare Structure

- Four main parts:
- Part A – Hospital Insurance
- Part B – Medical Insurance
- Part C – Medicare Advantage
- Part D – Prescription Drug Coverage

# Medicare Structure Cont'd

Each part covers different types of care and has its own billing rules and regulations. Together, these components are crucial to the way U.S. healthcare finances hospitals, home health services, hospice care, and other related expenses.

# Medicare Part A — Hospital Insurance

- What it covers:
  - Inpatient hospital stays
  - Skilled nursing facility rehab
  - Hospice care
  - Limited home health

# Medicare Part A — How It Works

- Key features:
- Most beneficiaries pay no premium (paid through payroll taxes)
- Hospitals reimbursed under Diagnosis-Related Groups (DRGs) (fixed payment per diagnosis)

# Medicare Part A — How It Works

- Most eligible people get Part A for free because they paid Medicare taxes while working.
- When a patient is admitted to a hospital, the facility is reimbursed under a Diagnosis-Related Group (DRG)—a preset payment amount based on the diagnosis and procedures.

# Developer Relevance

- Hospital and post-acute care modules must capture:
  - Admission/discharge dates
  - Primary and secondary diagnoses (ICD-10 codes)
  - Procedures and length of stay
- DRG data drives billing exports and reporting, so clean, structured data from EHR integrations is essential.

# Example

If a patient has a hip replacement (DRG 470), Medicare Part A pays a fixed rate for that diagnosis, not for every test or X-ray performed.

# Medicare Part B — Medical Insurance

What it covers:

- Outpatient services (doctor visits, clinic visits, tests, imaging)
- Preventive care (flu shots, checkups)
- Durable medical equipment (wheelchairs, oxygen)
- Some home health care (if the patient meets criteria and isn’t covered by Part A)

# Medicare Part B- How it works

Patients pay a monthly premium for Part B.
Providers are reimbursed on a per-service basis, using CPT (Current Procedural Terminology (CPT) codes.
Medicare Part B typically covers 80% of the approved amount, with patients responsible for the remaining 20% (coinsurance).

# What is CPT

CPT stands for Current Procedural Terminology.
It is a standardized coding system used in the United States to describe medical, surgical, and diagnostic procedures and services.
CPT codes are maintained and published by the American Medical Association (AMA) and are used by:

- Medicare
- Medicaid
- Private insurance companies
- Hospitals
- Physician offices
- Home health and therapy providers
- Billing and EHR systems

# Developer Relevance

- Outpatient or community care modules must store service-level data (CPT codes, provider NPI, time, and place).
- APIs must handle real-time eligibility checks to confirm Part B coverage.
- Data models must link each encounter to a billable CPT code for accurate claims.

# Example

When a doctor requests an X-ray and a follow-up appointment, each service is assigned a separate billing code under Part B.

# Medicare Part C

Medicare Advantage (Managed Care Option)

**What is it?**

Part C is Medicare offered through private insurance companies that contract with the Centers for Medicare and Medicaid Services (CMS).
It combines Parts A and B, and often Part D (drug coverage), into a single managed plan.

# Medicare Part C — How It Works

**Key features:**

- CMS pays insurer per member (capitation)
- Plans use Health Maintenance Organization(HMO)/Preferred Provider Organization(PPO) networks
- Insurer manages approvals & payments

# What is HMO

- An HMO (Health Maintenance Organization) is a type of health insurance plan that provides healthcare services through a restricted network of doctors, hospitals, and clinics.
- Members must use these in-network providers to receive coverage, except in emergencies.
- HMOs are among the most common forms of managed care, designed to control costs while ensuring coordinated, preventive care.

# What is PPO

- A PPO (Preferred Provider Organization) is a type of health insurance plan that offers greater flexibility in choosing doctors and hospitals. Unlike an HMO, members can see any provider, both in-network and out-of-network—although out-of-network care costs more.
- PPOs are one of the most common private insurance models and are widely used in employer-sponsored health plans.

# Developer Considerations for Managed Care

- Systems must support:
  - Preauthorization workflows
  - Payer-specific API integrations
  - Custom claim fields & plan IDs

# Example

A nurse working for a home health agency may need to submit visit notes to Humana Medicare Advantage, rather than directly to CMS, so the documentation must meet the insurer's custom portal format.

# Part D — Prescription Drug Coverage

- What it covers:
- Helps cover the cost of prescription medications, vaccines, and certain medical supplies.
- Offered by private insurance companies approved by CMS.

# Part D — How It Works

Key features:

- Enrollment through private drug plans
- Formularies define approved drugs & costs
- CMS pays plan → plan pays pharmacy

# Developer Relevance

1. EHR integrations and medication modules must support drug formulary lookups.
2. Systems should flag if a prescribed medication is covered under the patient's Part D plan or needs prior authorization.
3. Maintain NDC (National Drug Code) and dosage data for billing and clinical accuracy.

# Example:

If a hospice nurse prescribes pain medication, the pharmacy bills the Part D plan; however, hospice documentation (from MyNursePal Pro) must clearly indicate that the medication is related to symptom control.

Mrs. Lee is a 68-year-old Medicare beneficiary who falls at home and breaks her hip. Her journey through care illustrates how the four Medicare parts are interconnected, and how MyNursePal Pro supports each transition.

Refer to the module handout and follow Mrs Lee's journey before proceeding

# Summary

For developers and designers, Medicare's four parts translate into different data structures, workflows, and APIs.
Each part has its own:
Payment logic (flat rate, per service, capitation, or formulary),
Documentation rules (ICD codes, CPT codes, OASIS assessments, or medication data), and
Compliance risks (incomplete documentation = denied claims).
MyNursePal Pro must therefore:

- Store payer and coverage details at the client level,
- Adapt its billing logic to the correct Medicare part, and
- Ensure interoperability with both CMS and private Medicare Advantage plans.

# Coming Up

**Module 6 Section 2**

## UNDERSTANDING MEDICAID

Stay tuned ....