Please note: The following managed care definitions reflect a general understanding of the terms. It will be important to read managed care contracts very carefully as they may define these terms differently within that context and will be the definition that will prevail.

GLOSSARY OF TERMS

Accountability: Physicians, as well as health plans, are more explicitly responsible for the cost and quality of health care in managed care compared to the traditional fee-for-service system. When physicians, individually and in groups, share in the responsibility for the costs of care, they accept financial accountability for resources utilized. This is in contrast to the traditional indemnity insurance system where the insurer, but not the provider, was accountable and faced losses if expenses exceeded revenues. Physicians become accountable for quality of care when their performance is subject to assessment and measurement, with the results made public in the health care marketplace to other providers, purchasers, health plans and consumers. As accountability increases, there is a decrease in physician autonomy; physicians face financial and competitive consequences of their clinical actions and decisions.

Accreditation: The process by which an organization recognizes an institution as meeting predetermined standards.

Actuarial Soundness: The requirement that the development of capitation rates meet common actuarial principles and rules.

Adjusted Average Per Capita Cost (AAPCC): The estimated average fee-for-service cost of Medicare benefits for an individual by county of residence. It is based on the following factors: age, sex, institutional status, Medicaid, disability, and end stage renal disease status. CMS uses the AAPCCs as a basis for making monthly payments to TEFRA contractors.

Adverse Selection: The problem of attracting members who are sicker than the general population, specifically, members who are sicker than was anticipated when developing the rates of reimbursement for medical costs.

Affiliated Provider: A health care provider or facility that is part of the Managed Care Organization’s network, usually having formal arrangements to provide services to the MCO’s member.

Alternative Delivery Systems: A phrase used to describe all forms of health care delivery except traditional fee-for-service, private practice. The term includes HMOs, PPOs, IPAs, and other systems of providing health care.

Ambulatory Care: All types of health services that are provided on an outpatient basis, in contrast to services provided in the home or to persons who are hospital inpatients.

Benefits: The payment for, or health care services provided under terms of a contract with a MCO.

Capitation: A fixed dollar amount established to cover the cost of health care services delivered for a person during a specified length of time. The term usually refers to a negotiated per capita rate to be paid periodically to a health care provider by a MCO. The provider is then responsible for delivering or arranging the delivery of
all health services required by the covered person under the conditions of the provider contract. This term may also refer to the amount paid to a MCO by CMS or a State.

**Care Coordination:** A function that supports information-sharing across providers, patients, types and levels of service, sites and time frames. Its goal is to ensure that patients’ needs and preferences are achieved and that care is efficient and of high quality. It is most needed by persons who have multiple needs that cannot be met by a single clinician or by a single clinical organization, and which are ongoing, with their mix and intensity subject to change over time.

**Carve Out:** One or more services excluded from those required to be provided under the capitation rates. These services may be paid on a fee-for-service or other basis.

**Case Management:** A process and technique to manage the care of specific health care needs (often multiple) in a way that is designed to achieve the optimum patient outcome in the most cost-effective manner.

**Case Manager:** A nurse, doctor, or social worker who works with patients, providers and insurers to coordinate all services deemed necessary to provide the patient with a plan of medically necessary and appropriate health care.

**Closed Access:** A managed health care arrangement in which covered persons are required to select providers only from the plan’s participating providers.

**Coinsurance:** A cost-sharing arrangement in which a member pays a certain percentage of the charges for a specified service (20% of negotiated rate for a hospital stay), after a deductible has been paid. The insurance company pays the remaining percentage.

**Competitive Medical Plan (CMP):** A status, established by TEFRA and granted by the Federal government, to an organization that meets specific requirements enabling that organization to obtain a Medicare risk or cost based contract.

**Complex case management:** The coordination of care and services provided to members to facilitate appropriate delivery of care and services. The goal is to help members regain optimum health or improved functional capability, in the right setting and in a cost-effective manner. It involves comprehensive assessment of the member’s condition; determination of available benefits and resources; and development and implementation of a case management plan with performance goals, monitoring and follow-up.

**Copayment:** A cost-sharing arrangement in which a member pays a fixed dollar amount for a specified service (e.g., $10 for an office visit). The member is usually responsible for payment at the time the service is rendered.

**Cost Contract:** A TEFRA contract payment methodology option by which CMS pays for the delivery of health services to members based on the HMO’s reasonable cost. The plan receives an interim amount derived from an estimated annual budget, which may be periodically adjusted during the course of the contract to reflect actual cost experience. The plan’s expenses are audited at the end of the contract to determine the final rate the plan should have been paid.

**Cost Sharing:** A general set of financing arrangements in which a covered member must pay a portion of the costs associated with receiving care. (See also copayment, coinsurance and deductible).
Credentialing: A review procedure where a potential or existing provider must meet certain standards in order to begin or continue participation in a given health care plan, on a panel, in a group, or in a hospital medical staff organization. The process of reviewing a practitioners credentials, i.e., training, experience, or demonstrated ability, for the purpose of determining if criteria for clinical privileging are met. The recognition of professional or technical competence. The credentialing process may include registration, certification, licensure, professional association membership, or the award of a degree in the field. Certification and licensure affect the supply of health personnel by controlling entry into practice and influence the stability of the labor force by affecting geographic distribution, mobility, and retention of workers. Credentialing also determines the quality of personnel by providing standards for evaluating competence and by defining the scope of functions and how personnel may be used. In managed care arenas, one hears of a new basis for credentialing, referred to as financial credentialing. This refers to an organization’s evaluation of a provider based on that provider’s ability to provide value, or high quality care at a reasonable cost.

Deductible: A specified amount of money a member must pay before insurance benefits begin. Usually expressed in terms of an "annual" amount.

Diagnosis Related Groups (DRG): A system of classification for inpatient hospital services based on diagnosis, age, sex, and the presence of complications. It is used as a means of identifying costs for providing services associated with a diagnosis and as a mechanism to reimburse hospital and selected other providers for services rendered.

Employer Mandate: Under the Federal HMO Act, describes conditions when federally qualified HMOs can mandate or require an employer to offer at least one federally qualified HMO plan of each type (IPA/network or group/staff). (Sunsetted in 1995).

EQRO (External Quality Review Organization): States are required to contract with an entity that is external to and independent of the State and its HMO and HIO contractors to perform an annual review of the quality of services furnished by each HMO or HIO contractor.

Exclusive Provider Organization (EPO): A term derived from the phrase preferred provider organization (PPO). However, where a PPO generally extends coverage for non-preferred provider services as well as preferred provider services, an EPO provides coverage only for contracted providers; hence, the term exclusive. Technically, many HMOs can also be described EPOs.

Experience Rating: The process of setting rates partially or in whole on evaluating previous claims experience for a specific group or pool of groups.

Federal Medicaid Managed Care Waiver Program: The process used by States to receive permission to implement managed care programs for their Medicaid or other categorically eligible beneficiaries.

Federal Qualification: A status defined by the HMO Act, conferred by CMS after conducting an extensive evaluation of the HMO’s organization and operations. An organization must be federally qualified or be designated as a CMP (competitive medical plan) to be eligible to participate in Medicare cost and risk contracts. Likewise, an HMO must be federally qualified or State plan defined to participate in the Medicaid managed care program.
**Fee-For-Service (FFS):** A payment system by which doctors, hospitals and other providers are paid a specific amount for each service performed as identified by a claim for payment.

**Fiscal Soundness:** The requirement that managed care organizations have sufficient operating funds, on hand or available in reserve, to cover all expenses associated with services for which they have assumed financial risk.

**Gatekeeper:** An arrangement, in which a primary care provider serves as the patient’s agent, arranges for and coordinates appropriate medical care and other necessary and appropriate referrals.

**Group or Network HMO:** An HMO that contracts with one or more independent group practice to provide services to its members in one or more locations.

**Guaranteed Eligibility:** A defined period of time (3-6 months) that all patients enrolled in prepaid health programs are considered eligible for Medicaid, regardless of their actual eligibility for Medicaid. A State may apply to CMS for a waiver to incorporate this into their contracts.

**Health Maintenance Organization (HMO):** An entity that provides, offers or arranges for coverage of designated health services needed by members for a fixed, prepaid premium. There are three basic models of HMOs: group model, individual practice association (IPA), and staff model.

**HEDIS:** The Health Plan Employer Data and Information Set is a set of performance measures developed to support health plan and Medicaid agency efforts to improve the health status of Medicaid beneficiaries, support the strengthening of health care delivery systems for the Medicaid population, promote standardization of managed care reporting across public and private sectors, and promote the application of performance measurement technology across Medicaid programs.

**HIO (Health Insuring Organization):** An entity that contracts on a prepaid, capitated risk basis to provide comprehensive health services to recipients. A hybrid of a state-funded health plan and a health maintenance organization, it is usually a public corporation that pays for medical services in exchange for payment of a premium or subscription charges paid for by the corporation that assumes the underwriting risk.

**Independent Practice Association (IPA) model HMO:** An HMO that contracts with individual practitioners or an association of individual practices to provide health care services in return for a negotiated fee. The individual practice association, in turn, compensates its physicians on a per capita, fee schedule, or other agreed basis.

**Insolvency:** A legal determination occurring when a managed care plan no longer has the financial reserves or other arrangements to meet its contractual obligations to patients and subcontractors.

**Licensing:** A process most States employ, which involves the review and approval of applications from HMOs prior to beginning operation in certain areas of the State. Areas examined by the licensing authority include: fiscal soundness, network capacity, MIS, and quality assurance. The applicant must demonstrate it can meet all existing statutory and regulatory requirements prior to beginning operations.

**Lock-in:** A contractual provision by which members, except in cases of urgent or emergency need, are required to receive all their care from the network health care providers.
Managed Care: A system of health care that combines delivery and payment; and influences utilization of services, by employing management techniques designed to promote the delivery of cost-effective health care.

Managed Care Organization: A health plan that seeks to manage care. Generally, this involves contracting with health care providers to deliver health care services on a capitated (per-member per-month) basis. For specific types of managed care organizations, see also health maintenance organization and independent practice association.

Managed Health Care Plan: An arrangement that integrates financing and management with the delivery of health care services to an enrolled population. It employs or contracts with an organized system of providers which delivers services and frequently shares financial risk.

Medical Home: The medical home, also known as the patient-centered medical home (PCMH), is a team-based health care delivery model led by a physician, physician assistant, or nurse practitioner. that provides comprehensive and continuous medical care to patients with the goal of obtaining maximized health outcomes (American College of Physicians) (American Academy of Family Physicians).

Medicare Supplement Policy: A health insurance policy that pays certain cost not covered by Medicare such as coinsurance, deductibles.

Network Model HMO: A health care model in which the HMO contracts with more that one physician group or IPA, and may contract with single and multi-specialty groups that work out of their own office facility. The network may or may not provide care exclusively for the HMO's members.

Open Access: A term describing a member’s ability to self-refer for specialty care. Open access arrangements allow a member to see a participating provider without a referral from another doctor. Also called open panel.

Open Enrollment Period: A period during which subscribers in a health benefit program have an opportunity to select among health plans being offered to them, usually without evidence of insurability or waiting periods.

Outcome measurement: A process of systematically measuring individual or collective clinical treatment and response to that treatment.

Out-of-pocket expenses: Costs borne by the member that are not covered by health care plan.

PCCM (Primary Care Case Management) program: A Freedom of Choice Waiver program under the authority of section 1915(b) of the Social Security Act. States contract directly with primary care providers who agree to be responsible for the provision and/or coordination of medical services to Medicaid recipients under their care. Currently, most PCCM programs pay the primary care physician a monthly case management fee in addition to receiving fee-for-services payment.

Peer Review: The evaluation of the quality of the total health care provided by Plan medical staff by equivalently trained medical personnel.

Peer Review Organization (PRO): An organization established by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) to review quality of care and appropriateness of admissions, readmissions and discharges for Medicare and Medicaid. PROs’ name was officially changed to QIOs in 2002.
PHP (Prepaid Health Plan): An entity that either contracts on a prepaid, capitated risk basis to provide services that are not risk-comprehensive services, or contracts on a non-risk basis. Additionally, some entities that meet the above definition of HMOs are treated as PHPs through special statutory exemptions.

Point-Of-Service Plan: Also identified as open-ended HMO. A plan combining the features of an HMO with an indemnity insurance option. The member uses the plan like an HMO and receives HMO coverage; but the member may exercise "freedom of choice" and seek care outside the HMO system with additional charges (higher copayments and deductibles, and submission of claims forms). Members choose how and from whom to receive services at the time they need them.

Preferred Providers: Physicians, hospitals, and other health care providers who contract to provide health services to persons covered by a particular health plan.

Preferred Provider Organization: A health care delivery system that contracts with providers of medical care to provide services at discounted fees to members. Members may seek care from non-participating providers but generally are financially penalized for doing so by the loss of the discount and subjection to copayments and deductibles.

Premium: Money paid out in advance for insurance coverage.

Prepayment: Negotiated and prospective payment made to a health care provider for specified services to a specified group of insured persons prior to the provision of medical care. Unlike fee-for-service reimbursement, prepayment rates are negotiated up front and not adjusted after the fact for actual service or resource consumption levels.

Preventive health care: Health care that seeks to prevent or foster early detection of disease and morbidity and focuses on keeping patients well in addition to health them while they are sick.

Primary Care Network (PCN): A group of primary care physicians who share the risk of providing care to members of a given health plan.

Primary Care Provider (PCP): The provider that serves as the initial interface between the member and the medical care system. The PCP is usually a physician, selected by the member upon enrollment, who is trained in one of the primary care specialties who treats and is responsible for coordinating the treatment of members assigned to his/her plan. (See Gatekeeper)

Professional Review Organization: An organization which reviews the services provided to patients in terms of medical necessity professional standards; and appropriateness of setting.

QARI (Quality Assurance Reform Initiative): Unveiled in 1993 to assist States in the development of continuous quality improvement systems, external quality assurance programs, internal quality assurance programs, and focused clinical studies.

QIO (Quality Improvement Organization): Originally known as Peer Review Organizations (PRO), their name was changed in 2002. QIOs monitor the appropriateness, effectiveness, and quality of care provided to Medicare beneficiaries. They are private contractor extensions of the federal government that work under the auspices of the Centers for Medicare and Medicaid Services (CMS).
Qualified Medicare Beneficiary (QMB): A person whose income level is such that the state pays the Medicare Part B Premiums, deductibles and copayments.

Quality Assurance: A formal methodology and set of activities designed to access the quality of services provided. Quality assurance includes formal review of care, problem identification, corrective actions to remedy any deficiencies and evaluation of actions taken.

Reinsurance: An insurance arrangement whereby the MCO or provider is reimbursed by a third party for costs exceeding a pre-set limit, usually an annual maximum.

Risk Adjustment: A system of adjusting rates paid to managed care providers to account for the differences in beneficiary demographics, such as age, gender, race, ethnicity. Medical condition, geographic location, at-risk population (i.e. homeless), etc.

Risk Contract: A contract payment methodology between CMS and an HMO or CMP that requires the delivery of (at least) all covered services to members as medically necessary in return for a fixed monthly payment rate from the government and (often) a premium paid by the enrollee. The HMO is then liable for those contractually offered services without regard to cost. (Note: Medicaid beneficiaries enrolled in risk contracts are not required to pay premiums.)

Risk-Sharing: A fundamental feature in managed care, whereby the managed care plan and its providers share financial risk for providing care to enrollees. The amount of risk incurred by the various parties depends on the specific contract between the health plan and its providers and the mechanisms for reimbursement.

Shared Savings: A provision of most prepaid health care plans where at least part of the providers’ income is directly linked to the financial performance of the plan. If costs are lower than projections, a percentage of these savings are referred to the providers.

Staff Model HMO: This model employs physicians to provide health care to its members. All premiums and other revenues accrue to the HMO, which compensates physicians by salary.

Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA): The Federal law that created the current risk and cost contract provisions under which health plans contract with CMS.

Total Cost of Care: The actual measurement of cost per member across the entire continuum of covered services. Through various attribution methodologies all of a member’s care costs are aggregated and assigned to a particular provider, provider site and/or system. TCOC is commonly subjected to risk adjustment. Catastrophic cases are usually truncated (maximum TCOC limit assigned or omitted from TCOC calculations in some arrangements). The costs for all attributed members for that provider are combined and an average per member per month (PMPM) or per member per year (PMPY) TCOC is determined.

Utilization Management (UM): A systematic approach used by many health insurance companies, managed care organizations, delivery systems, hospitals and physician practices to: evaluate the necessity, appropriateness and efficiency of health services; determine and implement best practices to achieve high quality, cost-effective health care; and lower costs by discouraging unnecessary treatment.
Utilization Review (UR): A formal review of utilization for appropriateness of health care services delivered to a member on a prospective, concurrent or retrospective basis.

References:


