

Glossary of Terms

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MANAGED CARE GLOSSARY OF TERMS

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

ACRONYMS

AAPCC: Adjusted Average Per Capita Cost
ACO: Accountable Care Organization
ASC: Ambulatory Sensitive Condition
BPCI: Bundled Payment for Care Improvement
BPCI-A: Bundled Payment for Care Improvement Advanced
CISN: Clinically Integrated Service Network
CMS: Centers for Medicare and Medicaid Services
CMMI: Center for Medicare and Medicaid Innovation
DSNP: Dual Eligible Special Needs Plan
EQRO: External Quality Review Organization
EPO: Exclusive Provider Organization
FFS: Fee-For-Service
FIDE SNP: Financially Integrated Dual Eligible Special Needs Plan
HEDIS: Health Plan Employer Data and Information Set
HIDE SNP: Highly Integrated Dual Eligible Special Needs Plan
HMO: Health Maintenance Organizations
HMO POS: HMOs with a Point of Service option
HRRP: Hospital Readmission Reduction Program
HVBP: Hospital Value-Based Payment Program
IPA: Independent Practice Association
ISNP: Institutional Special Needs Plan
LTSS: Long-Term Services and Supports
MA: Medicare Advantage
MAO: Medicare Advantage Organization
MCO: Managed Care Organization
MIPS: Merit-based Incentive Payment System
MLR: Medical Loss Ratio
MLTSS: Medicaid Managed Long-Term Services and Supports
MMP: Medicare-Medicaid Plan
MOC: Model of Care

MOOP: Maximum Out-of-Pocket
MSSP: Medicare Shared Savings Program Accountable Care Organization
NP: Nurse Practitioner
OON: Out of Network
OOP: Out-of-pocket
PA: Physician Assistant
PAC: Post-Acute Care
PCCM: Primary Care Case Management
PCP: Primary Care Provider
PDPM: Patient Driven Payment Model for Skilled Nursing Facilities
PDGM: Patient Driven Groupings Model for Home Health Agencies
PPO: Preferred Provider Organizations (this includes both local PPOs and regional PPOs)
PMPM: Per Member Per Month
PRO: Peer Review Organization
SDOH: Social Determinants of Health
SLMB: Specified Low-Income Medicare Beneficiary
SNP: Medicare Advantage Special Needs Plans
TEFRA: Tax Equity and Fiscal Responsibility Act of 1982
UM: Utilization Management
UR: Utilization Review
VBID: Value-Based Insurance Design

DEFINITIONS

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.

Accountable Care Organization (ACO): A group of health care providers or entities working together to manage and coordinate care for a defined population that share in the financial risk and reward relative to the total cost of care and patient outcomes. ACOs may be established by Medicare, Medicaid, commercial health plans or sometimes even health systems. Each has its own set of rules about which populations or services are covered, what type of providers can lead the coordination and management of care, and how the ACO gets paid. For example, the Centers for Medicare and Medicaid Services have created ACOs that manage and coordinate Medicare services for attributed Medicare fee-for-service beneficiaries. These ACOs can only be led by hospitals, health systems and physicians.

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. This is the basis for HMO and Competitive Medical Plan reimbursement under Medicare-risk contracts. See 42 CFR 417.588.

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 (MCO) network, usually having formal arrangements to provide services to the MCO's member.

Aligned enrollment refers to when full-benefit, dual eligible individuals are enrolled in a dual eligible special needs plan (DSNP) and the individual's Medicaid benefits are provided under a Medicaid managed care organization contract between the applicable State and: 1) the DSNP's MA organization, 2) the DSNP's parent organization, or 3) another entity that is owned and controlled by the DSNP's parent organization. When a State's policy limits a DSNP's enrollees to those individuals with aligned enrollment, this condition is referred to as **exclusively aligned enrollment**. Enrollment is not aligned when a dual eligible enrolls in Medicare and Medicaid managed care plans operated by different companies, which is permitted in some states.

Alternative Delivery Systems: A phrase used to describe all forms of health care delivery except traditional fee-for-service and 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.

Ambulatory Sensitive Conditions (ASC): ASC conditions are illnesses that can often be managed effectively on an outpatient basis and generally do not result in hospitalization if managed properly.

Balance billing: When a provider bills you for the difference between the provider's charge and the allowed amount under paid by the insurer or payer for the claim.

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

Bundled Payment: Bundled payment arrangements, in general, are designed to pay multiple providers for coordinating the total amount of services required for a single, pre-defined episode of care. Under a bundled payment model, providers and/or healthcare facilities are paid a single payment for all the services performed to treat a patient undergoing a specific episode of care. An "episode of care" is the care delivery process for a certain condition or care delivered within a defined period of time.

Bundled Payment for Care Improvement (BPCI): This is a demonstration program initiated by CMMI in 2012 and continued until September 30, 2018 at which point it was replaced by the BPCI Advanced program. BPCI originally comprised 4 broadly defined models of care, which link payments for the multiple services beneficiaries receive during 1 of 48 episodes of care. Under the initiative, organizations enter into payment arrangements that include financial and performance accountability for episodes of care. These models may lead to higher quality and more coordinated care at a lower cost to Medicare. Providers under these arrangements agreed to a 2-3% discount off of FFS spending for a similar episode. If they achieved greater savings through their management of the episode, they were able to retain the additional dollars for the episode and distribute the gain share among the participating providers. This model allowed post-acute providers to lead BPCI initiatives for a post-acute care episode.

Bundled Payment for Care Improvement-Advanced (BPCI-A): Unlike BPCI, BPCI-A is a new, voluntary episodic payment model that will test a new iteration of bundled payments for 32 Clinical Episodes and aim to align incentives among participating health care providers for reducing expenditures and improving quality of care for Medicare beneficiaries. BPCI-A will qualify as an Advanced Alternative Payment Model under the Quality Payment Program. The first cohort of participants will begin operating under BPCI-A model on October 1, 2018, and continue through December 31, 2023. CMS will provide a second application opportunity in January 2020.

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.

Chronically Ill: For the purposes of Special Supplemental Benefits for Chronically Ill under the CHRONIC Care Act passed in 2018, a chronically ill enrollee is defined as an individual who: 1) has one or more comorbid and medically complex chronic conditions that is life threatening or significantly limits the overall health or function of the enrollee; 2) has a high risk of hospitalization or other adverse health outcomes; and 3) requires intensive care coordination.

Clean Claim: A clean claim has no defect, impropriety, or special circumstance, including incomplete documentation that delays timely payment.

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.

Coordinated Care Plan: Coordinated Care Plans are Medicare Advantage plans or Medicare Health plans that offer health care through an established provider network and are approved by the CMS. Medicare Advantage plans that are classified as Coordinated Care Plans include:

- Health Maintenance Organizations
- HMOs with a Point of Service option
- Preferred Provider Organizations (This includes both local PPOs and regional PPOs)
- Medicare Advantage Special Needs Plans

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 Sharing: A general set of financing arrangements in which a person enrolled in a health insurance plan must pay a portion of the costs associated with receiving care or services. Types of cost sharing include: copayment, coinsurance, and deductible.

Credentialing: Credentialing is the review of qualifications and other relevant information pertaining to a health care professional who seeks appointment (for directly-employed health care professionals in the case of an MA organization) or who seeks a contract or participation agreement with the MA organization. This procedure is used for both a potential or existing provider or organization. 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.

Dual Eligible Special Needs Plan (DSNP): Is a type of Medicare Advantage Special Needs Plan that contracts with the applicable state and coordinates the delivery of Medicare and Medicaid services for beneficiaries who are entitled to both Medicare (Title XVIII) and Medical Assistance from a State Plan under Title XIX (Medicaid). Beginning January 1, 2021, DSNPs must also satisfy one or more of the following integration criteria: 1) Notify the state Medicaid agency, or individuals or entities designated by the state Medicaid agency, of hospital and skilled nursing facility (SNF) admissions for at least one group of high-risk full-benefit dual eligible individuals, as determined by the state Medicaid agency; 2) be a highly-integrated dual eligible special needs plan (HIDE SNP); or 3) be a fully integrated dual eligible special needs plan (FIDE SNP).

External Quality Review Organization (EQRO): 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 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 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.

Financially Integrated Dual Eligible (FIDE) Special Needs Plan: A type of dual eligible special needs plan: (1) that provides dual eligible individuals access to Medicare and Medicaid benefits under a single entity that holds both an MA contract with CMS and a Medicaid managed care organization contract with the applicable State; (2) that under the capitated contract with the State Medicaid agency provides coverage, consistent with State policy, of specified primary care, acute care, behavioral health, and long term services and supports, and provides coverage of nursing facility services for a period of at least 180 days during the plan year; (3) that coordinates the delivery

of covered Medicare and Medicaid services using aligned care management and specialty care network methods for high-risk beneficiaries; and (4) that employs policies and procedures approved by CMS and the State to coordinate or integrate beneficiary communication materials, enrollment, communications, grievance and appeals, and quality improvement.

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.

Functional Impairment: Functional Impairment refers to the need for non-medical supports and services that help with basic activities of daily living (ADLs) like bathing, dressing, eating and Instrumental Activities of Daily Living (IADLs) such as managing medications, grocery shopping and meal prep and managing finances. It's highly associated with being over age 80 and having multiple chronic conditions.

Gainsharing: A contractual arrangement that sets up a formal financial reward system in which participating providers share in a portion of the cost savings resulting directly from either productivity gains or increased efficiency achieved. Thus, participating providers in a gainsharing arrangement will have a financial stake in controlling costs. Gainsharing is being used in some accountable care organizations and bundled payment models. These payments are structured in a variety of ways, including hourly payments for services performed by the provider or as a percentage of the cost savings realized under the arrangement.

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 practices to provide services to its members in one or more locations.

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.

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, IPA, and staff model. An HMO model is generally the most restrictive of the Medicare Advantage Coordinated Care Plan. It may control enrollees' utilization of services by requiring enrollees to go through a gatekeeper, usually the enrollees PCP, to obtain referrals for services the PCP does not furnish and to obtain all services from network providers (42 CFR 417.448(a)).

Highly Integrated Dual Eligible (HIDE) Special Needs Plan: a dual eligible special needs plan offered by an MA organization that provides coverage, consistent with State policy, of long-term services and supports, behavioral health services, or both, under a capitated contract that meets one of the following arrangements—

(1) the capitated contract is between the MA organization and the Medicaid agency; or (2) the capitated contract is between the MA organization's parent organization (or another entity that is owned and controlled by its parent organization) and the Medicaid agency.

HMO Point-Of-Service Plan: Also identified as open-ended HMOs. This is a plan combining the features of an HMO with an indemnity insurance option. These HMOs allow plan members to access certain specified plan-covered services outside of the plan network. This practice requires the HMO offer a point -of-service (POS) supplemental benefit and may also require the HMO to obtain state licensure to offer an HMO-POS. The HMO-POS must specify in writing which services it offers out-of-network, maximum enrollee out-of-pocket cost sharing, and any annual limits on the benefits offered under the POS benefit.

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 independent 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.

Institutional Special Needs Plan (ISNP): ISNPs are SNPs that restrict enrollment to MA eligible individuals who, for 90 days or longer, have had or are expected to need the level of services provided in a long-term care (LTC) skilled nursing facility (SNF), a LTC nursing facility (NF), a SNF/NF, an intermediate care facility for individuals with intellectual disabilities, or an inpatient psychiatric facility, or an assisted living facility. ISNPs may also enroll MA eligible individuals living in the community, but requiring an institutional level of care, known as Institutional Equivalent SNPs. When an ISNP opts to enroll individuals prior to having at least 90 days of institutional level care, a CMS-approved needs-assessment must be conducted. Results of the assessment must demonstrate that the individual's condition makes it likely that either the length of stay or the need for an institutional level-of-care will be at least 90 days. (Source: CMS)

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 (MCO): 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 HMO and IPA.

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 that deliver services and frequently shares financial risk.

Medicaid Managed Long-Term Services and Supports (MLTSS): MLTSS refers to an arrangement between state Medicaid programs and managed care plans through which the managed care plans receive capitated payments for LTSS including both home and community-based services and/or institutional-based services. In fully integrated models, these payments for MLTSS are combined with payments for primary, acute, and behavioral health services, and the capitation payment is more comprehensive. MLTSS programs have grown significantly over the past decade and are expected to increase even more in the coming years.

Medical Home: The medical home, also known as the patient-centered medical home, 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.

Medical Loss Ratio: The Affordable Care Act requires health insurance issuers to submit data on the proportion of premium revenues spent on clinical services and quality improvement, also known as the Medical Loss Ratio (MLR). It is a basic financial measurement to encourage health plans to provide value to enrollees. If an insurer uses 80 cents out of every premium dollar to pay its customers' medical claims and activities that improve the quality of care, the company has a medical loss ratio of 80%.

Medicare Advantage plan (MA plan): MA plans, sometimes called "Part C" or "MA Plans," are offered by private companies approved by Medicare. MA plans like original Medicare fee-for-service, cover both Medicare Part A (hospital insurance) and Medicare Part B (medical insurance), services. Many MA plans also offer Part D prescription drug coverage, in which case they are called MA-PD plans. Most MA plans also offer extra coverage or supplemental benefits, like vision, hearing, and dental coverage. Medicare pays a fixed amount for an enrollee's care each month to the companies offering MA Plans. These companies must follow rules set by Medicare.

Each MA plan can charge different out-of-pocket costs and establish different rules for how services are accessed, like:

- Whether the enrollee needs a referral to see a specialist
- If enrollees are limited to receiving services only from doctors, facilities, or suppliers that belong to the plan for non-emergency or non-urgent care

These rules can change annually.

Medicare-Medicaid Plans: Plans established by CMS through a demonstration called the Financial Alignment Initiative. This initiative seeks to test models that better integrate primary, acute, behavioral health and LTSS, while allowing participating states to share in some of the savings generated. The Initiative began in 2013 originally including 15 states, as of July 2018, nine states continue to participate.

Medicare Supplemental Insurance: A health insurance policy that pays certain cost not covered by original Medicare such as coinsurance and deductibles.

Network Model HMO: A health care model in which the HMO contracts with more than 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 (OOP) expenses: Costs borne by the health plan member that are not covered by the plan.

Primary Care Case Management (PCCM): 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.

PMPM (Per Member Per Month): This is a term typically used to describe how a plan or provider is paid a specified amount for each of its enrollees to be accountable for delivering the care needs covered by the plan (e.g., Medicare benefit or Medicaid waiver services, etc.).

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 to review quality of care and appropriateness of admissions, readmissions, and discharges for Medicare and Medicaid. PRO's 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.

Population Health: Generally defined as the health outcomes of a group of individuals, including the distribution of such outcomes within the group. It is an approach that aims to improve the health of an entire population. Providers may define this differently within their organizations. Population health often seeks to affect the health

outcomes of a population by impacting the social determinants of health which include: housing, nutrition, poverty, and environment.

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 (PPO): 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 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)

Prior Authorization: A process used by health plans or insurance companies requiring providers to contact them prior to initiating a procedure, service, or medication to determine if they will cover its cost. It is a technique for minimizing costs wherein claims are paid only if they are preapproved. Failure to obtain the necessary prior authorization can result in a provider not being reimbursed by the plan.

QAPI: Quality Assurance Performance Improvement required by law.

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 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 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 assess 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.

Social Determinants of Health are the conditions and situations in which a person is born, lives, grows, works and ages that influence their health. (World Health Organization) They include factors such as an individual's socioeconomic status, their education, and access to housing, nutrition and other social supports.

Specified Low-Income Medicare Beneficiary (SLMB): This is one type of Medicare savings program, which is defined as a Medicaid program that pays for Medicare Part B premiums for individuals who have Medicare Part A, a low monthly income, and limited resources.

Special Needs Plan (SNP): Medicare SNPs are a type of Medicare Advantage Plan (like an HMO or PPO). Medicare SNPs limit membership to people with specific diseases or characteristics. Medicare SNPs tailor their benefits, provider choices, and drug formularies to best meet the specific needs of the groups they serve. Generally,

enrollees must access care and services from doctors or hospitals in the Medicare SNP provider network, except in cases of:

- Emergency or urgent care - care for a sudden illness or injury that needs medical care right away
- Enrollees with a diagnosis of End-Stage Renal Disease (ESRD) that need out-of-area dialysis

Medicare SNPs typically have specialists in the diseases or conditions that affect their members. All SNPs must provide Medicare prescription drug coverage.

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.

Step Therapy: Step therapy is a type of prior authorization. In most cases, you must first try a less expensive drug on the Medicare Prescription Drug Plan's formulary (also called a drug list) that has been proven effective for most people with your condition before you can move up a "step" to a more expensive drug. This might mean trying a similar, more affordable generic drug instead of a more expensive, brand-name medication. The more affordable drugs in the first phase are known as "Step 1" prescription drugs.

Stop-Loss Insurance: Stop-loss insurance (also known as excess insurance or reinsurance) is a product that provides protection against catastrophic or unpredictable losses. It is purchased by employers who have decided to self-fund their employee benefit plans or payers (health plans) that do not want to assume 100% of the liability for losses arising from the plans. Under a stop-loss policy, the insurance company becomes liable for losses that exceed certain limits called deductibles. There are two types of self-funded insurance:

- Specific Stop-Loss is the form of excess risk coverage that provides protection for the employer or health plan against a high claim on any one individual. This is protection against abnormal severity of a single claim rather than abnormal frequency of claims in total. Specific stop-loss is also known as individual stop-loss.
- Aggregate Stop-Loss provides a ceiling on the dollar amount of eligible expenses that an employer or health plan would pay, in total, during a contract period. The carrier reimburses the employer after the end of the contract period for aggregate claims.

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.

VBID: Value-Based Insurance Design