APPENDIX A. Glossary of Terms

As service delivery and financing arrangements have multiplied within the federal-state Medicaid program in recent years, the terminology used by program officials has evolved. The purpose of this glossary is to clarify for readers the meaning of terms that are widely used to describe the diverse service delivery and financing approaches adopted by state Medicaid agencies. Although some of the terms are used in other contexts, including private health insurance and Medicare, this glossary focuses on the meaning of terms in a Medicaid policy context, with an emphasis on managed care-related terminology.

Accountable Care Organization
A uniform federal definition of this term has not emerged, and the concept continues to evolve. But generally, an accountable care organization (ACO) is a group of health care providers that agree to share responsibility for delivering health care services and achieve specific outcomes for a defined group of people. The organizational structures of ACOs vary, but in concept all ACOs include primary and specialty care physicians and at least one hospital. Individual providers agree to coordinate care for shared patients in order to enhance the quality and efficiency of services, and the ACO as an entity is held accountable for the appropriateness and quality of care provided. Some states have begun developing Medicaid ACOs in conjunction with other service delivery reforms discussed below (e.g., primary care case management, medical homes, MCOs). States also may use different terminology for their Medicaid ACOs. For example, in Oregon ACOs are referred to as coordinated care organizations, while in Colorado they are called regional care collaborative organizations.

Bundled Payments
Increasingly, providers of health services, rather than being reimbursed on a per-visit or per-procedure basis, are receiving a fixed payment for care provided during a given period (e.g., a year) or for all services associated with a particular medical procedure (e.g., a knee replacement) or diagnosis (e.g., a sinus infection). These are called “bundled payments.” Medicaid agencies often differentiate between episodic bundled payments, where the provider receives a fixed amount for all procedures performed in connection with a particular episode of care (e.g., a coronary bypass graft), and global bundled payments, where the provider receives a single, pre-established payment for a wide range of services furnished over a period of time (e.g., caring for patients at high risk of hospitalization). Frequently the amount of the bundled payment is risk-adjusted to account for the demographic characteristics of the provider’s patients, such as age, gender, or general health status.

Capitation
Capitation refers to the fixed per-member, per-month (PMPM) amount that a state Medicaid agency pays to a managed care organization (MCO) for providing or arranging to provide services to enrolled beneficiaries. Because the capitation
amount is preestablished, the MCO is at financial risk if the cost of the services it provides exceeds the aggregate payments it receives from the state. Capitated payments may be risk-adjusted to take into account differences in the demographic characteristics of beneficiaries, such as age, gender, and health status.

**Care Coordination**

Although there is no standard definition of this term, most care coordination programs target high-risk (high-cost) beneficiaries with the goal of improving the coordination of both medical services and social supports provided by different health providers and support agencies to the same beneficiary. Care coordinators, for example, may assist beneficiaries in arranging transportation, preparing a self-directed or patient-centered plan, navigating the available care and support options, and brokering medical and social services. **Care management,** in contrast to care coordination, tends to focus primarily on the beneficiaries’ health care needs. Another distinction is that care coordination programs, unlike care management programs, often facilitate the delivery of services and supports whether they are Medicaid-reimbursable or not.

**Case Management**

For Medicaid purposes, case management refers to services designed to assist eligible enrollees to obtain medical and other services. States have the option of seeking reimbursement for case management functions as part of a separately defined service, called targeted case management services, or they may claim such costs as part of another covered services (e.g., as a nursing facility or intermediate care facility for the mentally retarded service) or as a cost of administering the state’s Medicaid program. When services are billed as targeted case management, either in a FFS or managed care context, states must specify the population group(s) eligible to receive such services. Some states, especially in Medicaid-funded disability services, may refer to case management as service coordination or support coordination.

**Disease Management**

In an attempt to improve the quality and cost-effectiveness of care for beneficiaries with chronic diseases, many states have organized disease management (DM) programs. The aim of DM programs is to identify chronic conditions early, treat them more effectively, and slow the progression of the disease. DM programs can be carried out by a **managed care organization** or integrated into a state’s **primary care case management** program. States that provide a DM program on a FFS basis can either operate the program itself or contract with a disease management organization. While the first DM programs tended to focus narrowly on the management of specific chronic conditions (e.g., asthma, diabetes, congestive heart failure), in recent years programs have evolved toward more comprehensive management of participants’ total health care needs.

**Fee-for-Service**

In a fee-for-service (FFS) system, the state Medicaid agency establishes fee levels for the various services covered under the state plan and pays providers for
each delivered service. Providers bear no financial risk. Medicaid beneficiaries must locate an FFS provider willing to accept Medicaid payments and to enroll new patients. Generally, there is no organized provider network similar to those found in a managed care system.

Health Home
The Medicaid health home builds on the traditional medical home model. Targeted to people with multiple chronic conditions, health homes are designed to be beneficiary-centered systems of care that facilitate access to and coordination of primary and acute physical health services, behavioral health services, and community-based health and social supports. Health homes develop a comprehensive care plan for each beneficiary and coordinate and integrate the provision of the beneficiary’s clinical and nonclinical services.

Managed Behavioral Health Organization
A managed behavioral health organization (MBHO) is a specialty managed care organization that provides mental health and substance abuse treatment services. A state Medicaid agency may contract directly with one or more MBHOs to provide and manage behavioral health services to Title XIX-eligible beneficiaries, or managed care organizations may subcontract with an MBHO. Under either approach, the MBHO maintains a distinct provider network, coverage policies, and administrative services and performs other insurance functions.

Managed Care Organization
A managed care organization (MCO) is a health plan that operates under a risk-based contract with a state to provide a specific set of benefits to plan enrollees for a fixed per-member, per-month (PMPM) payment, or capitation rate. The dynamics of a capitated payment system are different than those of a FFS system because the MCO is at financial risk should total expenditures exceed total PMPM payments. Although MCOs are at financial risk in providing a comprehensive array of Medicaid benefits included in their capitation rates, most states carve out of managed care contracts certain benefits, such as prescription medications or behavioral health services. These carved-out benefits in turn are provided either on an FFS basis or through a separate contractor (e.g., with a noncomprehensive prepaid health plan). Medicaid MCOs are required to meet an extensive array of federal requirements plus state-specific standards covering such areas as enrollment protocols, provider network adequacy, data gathering and reporting, and access and quality benchmarks.

Managed Long-Term Services and Supports
Risk-based arrangements for the delivery of long-term services and supports (LTSS) are referred to as managed LTSS (MLTSS), or managed long-term care, plans. MLTSS plans provide an array of home and community-based services and supports designed to assist targeted groups of beneficiaries to remain in their own homes, thereby avoiding institutional placements. Some MLTSS plans include institutional care costs, while others carve such expenditures out of the plan, choosing instead to reimburse long-term institutional costs on a FFS basis.
Some MLTSS plans are limited to LTSS, while others also cover primary, acute, and specialty medical services. Program for All-Inclusive Care for the Elderly sites, for example, provide a comprehensive array of medical, social, and long-term services to frail elderly enrollees who otherwise would need nursing home care. In addition, a number of states have submitted requests to initiate integrated care demonstration projects designed to co-manage Medicare and Medicaid-funded health care and LTSS for targeted groups of seniors and people with disabilities.

Medicaid Home
The medical home concept began in the 1960s as an effort to eliminate gaps and overlaps in pediatric services due to the lack of communication and coordination. In 2002, the American Academy of Pediatrics defined a medical home as an approach that is “accessible, continuous, comprehensive, family-centered, coordinated, compassionate and culturally effective.” Since then, the medical home model has continued to evolve and now includes the patient-centered medical home, where the personal physician leads a medical team in addressing the totality of a patient’s health needs over time, and the enhanced medical home, where the primary care provider assumes additional responsibilities for the care of people with chronic health conditions, such as providing case management services, round-the-clock access to care, nutritional interventions, and/or mental health services. With the passage of the ACA, these various approaches are considered to be part of the health home model.

Medical Loss Ratio
The medical loss ratio (MLR) is the share of premium revenues that an insurer or health plan spends on patient care and quality improvement activities, in contrast to administration and profits. Beginning in 2011, the ACA required insurers in the large-group market to meet an MLR standard of 85 percent annually, and insurers in the small-group market to meet an MLR of 80 percent annually. Health insurers are required to report the portion of premium dollars spent on health care and quality improvement in each state in which they operate, and those that fail to meet the applicable MLR standard are required to rebate the difference to insured individuals. The MLR requirements of the ACA do not apply to Medicaid recipients.

Pay-for-Performance
Pay-for-performance (P4P) is a health care payment model that rewards providers or MCOs financially for achieving or exceeding certain quality benchmarks. Under some P4P programs, physicians and hospitals are paid directly based on a variety of quality measures. A majority of states that contract with MCOs incorporate P4P components into their payment policies, such as withholding a portion of capitated payments, which an MCO can earn back through high performance or by offering performance-based bonuses as add-ons to the capitated payment.

Prepaid Ambulatory Health Plan
A prepaid ambulatory health plan (PAHP) is a noncomprehensive prepaid health plan that provides only certain outpatient services, such as dental services or
outpatient behavioral health care. PAHPs provide no inpatient services and are paid on an at-risk or capitated basis.

**Prepaid Health Plan**

Prepaid health plans (PHPs) provide either comprehensive or noncomprehensive benefits to Medicaid enrollees through risk-based contracts with the state Medicaid agency. *Medicaid managed care organizations* are comprehensive PHPs, while *prepaid inpatient health plans* (PIHPs) and *prepaid ambulatory health plans* (PAHPs) are noncomprehensive PHPs. PAHP and PIHP contractors frequently offer services that are carved out of the responsibilities of MCO contractors.

**Prepaid Inpatient Health Plan**

A prepaid inpatient health plan (PIHP) is a noncomprehensive *prepaid health plan* that offers only inpatient or institutional services, such as inpatient behavioral health care. PIHPs received fixed PMPM payments and are at risk of financial overruns.

**Primary Care Case Management**

In a primary care case management (PCCM) program, the state Medicaid agency contracts with primary care providers to provide, locate, coordinate, and/or monitor care for Medicaid beneficiaries who select them or are assigned to them. Providers of PCCM, in effect, serve as a *medical home* for their enrollees and are considered managed care providers. States generally require PCCM providers to meet certain requirements such as minimum hours of operation at each location, credentialing and training, and referrals to specialists. State agency staff perform, or sometimes contract out, administrative functions such as network development and credentialing. States pay PCCMs a small monthly fee for providing case management services, but all other services furnished by the provider are billed on a FFS basis. PCCMs that assume additional responsibilities or furnish other services are referred to as enhanced primary care case management programs.