

Adjusted Average Per Capita Cost (AAPCC)

HCFA's best estimate of the amount of money care costs for Medicare recipients under fee-for-service Medicare in a given area. The AAPCC is made up of 122 different rate cells; 120 of them are factored for age, sex, Medicaid eligibility, institutional status, and whether a person has both part A and part B of Medicare.

Access

The patient's ability to obtain medical care. The ease of access is determined by such components as the availability of medical services and their acceptability to the patient, the location of health care facilities, transportation, hours of operation and cost of care.

Accountable Health Plan (AHP)

A joint venture between practitioners and institutions (insurance companies, HMO's, or hospitals) that would assume responsibility for delivering medical care. Physicians and other providers would either work for or contract with these health plans. As IDSs form and demonstrate their ability to managed capitated care, they begin to struggle with issues of ownership or alliance partnerships with health maintenance organizations (HMOs), insurance companies, or other financing entities. An Accountable Healthcare System describes an IDS with a financing component. When an IDS operates one or more health insurance benefit products, or a managed care organization acquires a large scale medical delivery component, it qualifies as an Accountable Health System or Accountable Health Plan. In the 1994 debate on healthcare reform, the proposed system of managed competition provided for an Accountable Health Plan that would have combined delivery and financing, and assumed accountability for patient care.

Actuarial

Refers to the statistical calculations used to determine the managed care company's rates and premiums charged their customers based on projections of utilization and cost for a defined population.

Actuary

A person who determines insurance policy rates, reserves and dividends, as well as conducts various other statistical studies. You don't develop capitated rates, or agree to a capitated contract without one of these working for you in some capacity.

Acute Care

A pattern of health care in which a patient is treated for an acute (immediate and severe) episode of illness, for the subsequent treatment of injuries related to an accident or other trauma, or during recovery from surgery. Acute care is usually given in a hospital by specialized personnel using complex and sophisticated technical equipment and

materials. Unlike chronic care, acute care is often necessary for only a short time.

Adjudication

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Processing claims according to contract.

Administrative Costs

Costs related to utilization review, insurance marketing, medical underwriting, agents' commissions, premium collection, claims processing, insurer profit, quality assurance programs, and risk management.

Administrative Services Organization (ASO)

A contract between an insurance company and a self-funded plan where the insurance company performs administrative services only and the self-funded entity assumes all risk.

Admission Certification

A method of assuring that only those patients who need hospital care are admitted. Certification can be granted before admission (preadmission) or shortly after (concurrent). Length-of-stay for the patient's diagnosed problem is usually assigned upon admission under a certification program.

Admissions Per 1,000

An indicator calculated by taking the total number of inpatient and/or outpatient admissions from a specific group, e.g., employer group, HMO population at risk, for a specific period of time (usually one year), dividing it by the average number of covered members in that group during the same period, and multiplying the result by 1,000. This indicator can be calculated for behavioral health or any disease in the aggregate and by modality of treatment, e.g., inpatient, residential, and partial hospitalization, etc.

Adverse Selection

- (a) Occurs when premium doesn't cover cost. Some populations, perhaps due to age or health status, have a great potential for high utilization.
- (b) Some population parameter such as age (e.g., a much greater number of 65-year-olds or older to young population) that increases the potential for higher utilization and often increases costs above those covered by a payers capitation rate.

Allowed Amount

Maximum dollar amount assigned for a procedure based on various pricing mechanisms. Also known as a maximum allowable.

Ambulatory Care

Health services provided without the patient being admitted. The services of ambulatory care centers, hospital outpatient departments, physicians' offices and home health care services fall under this heading.

Ancillary Services

Professional charges for x-ray, laboratory tests, and other similar patient services.

Anniversary Date

The beginning of an employer group's benefit year. The first day of effective coverage as contained in the policy Group Application and subsequent annual anniversaries of that date. An insured has the option to transfer from an indemnity plan (which may have maximum benefit levels) to an HMO.

Audit of Provider Treatment or Charges

A qualitative or quantitative review of services rendered or proposed by a health provider. The review can be carried out in a number of ways: a comparison of patient records and claim form information, a patient questionnaire, a review of hospital and practitioner records, or a pre- or post-treatment clinical examination of a patient. Some audits may involve fee verification. Something we had better get used to being subjected to since this is usually first type or "first generation" managed care approach.

Average Wholesale Price (AWP)

Commonly used in pharmacy contracting, the AWP is generally determined through reference to a common source of information.

Balance billing

The practice of billing a patient for the fee amount remaining after insurer payment and co-payment have been made.

Base year costs

In Medicare, the amount a hospital actually spent to render care in a previous time period. Depending on the hospital's Medicare cost reporting period, the base year was the fiscal year ending on or after September 30, 1982 and before September 30, 1983

for hospitals in operation at that time.

Beneficiary (Also eligible; enrollee; member)

Any person eligible as either a subscriber or a dependent for a managed care service in accordance with a contract.

Benefit Limitations

Any provision, other than an exclusion, which restricts coverage in the Evidence of Coverage, regardless of medical necessity

Benefit Package

The services a payer offers to a group or individual.

Benefit Payment Schedule

List of amounts an insurance plan will pay for covered health care services.

Benefits

Benefits are specific areas of Plan coverage's, i.e., outpatient visits, hospitalization and so forth, that make up the range of medical services that a payer markets to its subscribers. Also, a contractual agreement, specified in an Evidence of Coverage, determining covered services provided by insurers to members.

Board Certified (Boarded, Diplomate)

Describes a physician who has passed a written and oral examination given by a medical specialty board and who has been certified as a specialist in that area.

Board Eligible

Describes a physician who is eligible to take the specialty board examination by virtue of being graduated from an approved medical school, completing a specific type and length of training, and practicing for a specified amount of time. Some HMOs and other health facilities accept board eligibility as equivalent to board certification, significant in that many managed care companies restrict referrals to physicians without certification..

Capitation

(1) The method of payment in which the provider is paid a fixed amount for each person served no matter what the actual number or nature of services delivered.

(2) The cost of providing an individual with a specific set of services over a set period of time, usually a month or a year.

Carrier

An insurer; an underwriter of risk.

Carve-Outs

A payer strategy in which a payer separates ("carves-out") a portion of the benefit and hires an MCO to provide these benefits. This permits the payer to create a health benefits package, get to market quicker with such a package, and greater control of their costs. Many HMOs and insurance companies adopt this strategy because they do not have in-house expertise related to the service "carved out."

Case Management

The process by which all health-related matters of a case are managed by a physician or nurse or designated health professional. Physician case managers coordinate designated components of health care, such as appropriate referral to consultants, specialists,

hospitals, ancillary providers and services. Case management is intended to ensure continuity of services and accessibility to overcome rigidity, fragmented services, and the misutilization of facilities and resources. It also attempts to match the appropriate intensity of services with the patient's needs over time.

Case mix

The types of inpatients a hospital or post acute facility treats. The more complex the patients' needs, the greater the amount spent for patient care.

Case-mix index:

A measure of the relative costliness of treating in an inpatient setting. An index of 1.05 means that the facility's patients are 5 % more costly than average.

Case Rate

Flat fee paid for a client's treatment based on their diagnosis and/or presenting problem. For this fee the provider covers all of the services the client requires for a specific period of time. Also bundled rate, or Flat Fee-Per-Case. Very often used as an intervening step prior to capitation. In this model, the provider is accepting some significant risk, but does have considerable flexibility in how it meets the client's needs. Keys to success in this mode: (1) properly pricing case rate, if provider has control over it, and (2) securing a large volume of eligible clients.

Certificate of Need (CON)

A state agency must review and approve certain proposed capital expenditures, changes in health services provided, and purchases of expensive medical equipment. Before the request goes to the state, a local review panel (the health systems agency or HSA) must evaluate the proposal and make a recommendation.

Chronic Care

Long term care of individuals with long standing, persistent diseases or conditions. It includes care specific to the problem as well as other measures to encourage self-care,

to promote health, and to prevent loss of function.

Claims Review

The method by which an enrollee's health care service claims are reviewed prior to reimbursement. The purpose is to validate the medical necessity of the provided services and to be sure the cost of the service is not excessive.

Clinical Data Repository

That component of a computer-based patient record (CPR) which accepts, files, and stores clinical data over time from a variety of supplemental treatment and intervention systems for such purposes as practice guidelines, outcomes management, and clinical research. May also be called a data warehouse.

Clinical Decision Support

The capability of a data system to provide key data to physicians and other clinicians in response to "flags" or triggers which are functions of embedded, provider-created rules. A system that would alert case managers that a client's eligibility for a certain service is about to be exhausted would be one example of this type of capacity. Also a key functional requirement to support clinical or critical pathways.

Clinical or Critical Pathways

A "map" of preferred treatment/intervention activities. Outlines the types of information needed to make decisions, the timelines for applying that information, and what action needs to be taken by whom. Provides a way to monitor care "in real time." These pathways are developed by clinicians for specific diseases or events. Proactive providers are working now to develop these pathways for the majority of their interventions and developing the software capacity to distribute and store this information.

Closed Panel

Medical services are delivered in the HMO-owned health center or satellite clinic by physicians who belong to a specially formed, but legally separate, medical group that only serves the HMO. This term usually refers to a group or staff HMO models.

Co-Insurance

A policy provision frequently found in major medical insurance policies under which the insured individual and the insurer share hospital and medical expenses according to a specified ratio.

Community Care Network (CCN)

This vehicle provides coordinated, organized, and comprehensive care to a community's population. Hospitals, primary care physicians, and specialists link preventive and treatment services through contractual and financial arrangements, producing a network which provides coordinated care with continuous monitoring of quality and

accountability to the public. While the term, Community Care Network (CCN), often is used interchangeably with Integrated Delivery System (IDS), the CCN tends to be community based and non-profit

Community Health Information Network (CHIN)

An integrated collection of computer and telecommunication capabilities that permit multiple providers, payers, employers, and related healthcare entities within a geographic area to share and communicate client, clinical, and payment information. Also known as community health management information system.

Community Rating

Under the HMO Act, community rating is defined as a system of fixing rates of payment for health services which may be determined on a per person or per family basis and may vary with the number of persons in a family, but must be equivalent for all individuals and for all families of similar composition. With community rating, premiums do not vary for different groups of subscribers or with such variables as the group's claims experience, age, sex or health status. Although there are certain exceptions, in general, federally-qualified HMOs must community rate. The intent of community rating is to spread the cost of illness evenly over all subscribers rather than charging the sick more than the healthy for coverage.

Comorbid condition

A medical condition that, along with the principal diagnosis, exists at admission and is expected to increase hospital length of stay by at least one day for most patients.

Complication

A medical condition that arises during a course of treatment and is expected to increase the length of stay by at least one day for most patients.

Comprehensive Major Medical Insurance

A policy designed to provide the protection offered by both a basic and major medical health insurance policy. It is generally characterized by a low deductible, a co-insurance feature, and high maximum benefits.

Computer-based Patient Record (CPR)

A term for the process of replacing the traditional paper-based chart through automated electronic means; generally includes the collection of patient-specific information from various supplemental treatment systems, i.e., a day program and a personal care provider; its display in graphical format; and its storage for individual and aggregate purposes. Also called Electronic Medical Record, On-Line Medical Record, Paperless Patient Chart.

Concurrent Review

Review of a procedure or hospital admission done by a health care professional (usually a nurse) other than the one providing the care.

Consumer Health Alliance

Regional cooperatives between government and the public that will oversee the new payment system. Once all health insurance purchasing cooperatives (HIPPC's), the alliance would make sure health plans within a region conformed to federal coverage and quality standards, and oversee costs within any mandated budget.

Continued Stay Review

A review conducted by an internal or external auditor to determine if the current place of service is still the most appropriate to provide the level of care required by the client.

Contract

A legal agreement between a payer and a subscribing group or individual which specifies rates, performance covenants, the relationship among the parties, schedule of benefits and other pertinent conditions. The contract usually is limited to a 12-month period and is subject to renewal thereafter. Contracts are not required by statute or regulation, and less formal agreements may be made.

Contract Year

A period of twelve (12) consecutive months, commencing with each Anniversary Date. May or may not coincide with a calendar year.

Contract Provider

Any hospital, skilled nursing facility, extended care facility, individual, organization, or agency licensed that has a contractual arrangement with an insurer for the provision of services under an insurance contract.

Conversion

In group health insurance, the opportunity given the insured and any covered dependents to change his or her group insurance to some form of individual insurance, without medical evaluation upon termination of his group insurance

Conversion Factor (CF)

The dollar amount used to multiply the Relative Value Schedule (RVS) of a procedure to arrive at the maximum allowable for that procedure.

Conversion Privilege

The right of an individual insured under a group policy to certain kinds of individual coverage, without a medical examination, upon termination of his association with the group.

Coordination of Benefits (COB)

The procedures set forth in a Subscription Agreement to determine which coverage is primary for payment of benefits to Members with duplicate coverage.

Co-Payment

A cost-sharing arrangement in which the HMO enrollee pays a specified flat amount for a specific service (such as \$2.00 for an office visit or \$1.00 for each prescription drug). The amount paid must be nominal to avoid becoming a barrier to care. It does not vary with the cost of the service, unlike co-insurance which is based on some percentage of cost.

Cost outlier

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In Medicare, a patient who is more costly to treat compared with other patients in a particular diagnosis related group.

Cost Sharing

The general set of financing arrangements whereby the consumer must pay out-of-pocket to receive care, either at the time of initiating care, or during the provision of health care services, or both. Cost sharing can also occur when an insured pays a portion of the monthly premium for health care insurance.

Cost Shifting

Charging one group of patients more in order to make up for underpayment by others. Most commonly, charging some privately insured patients more in order to make up for underpayment by Medicaid or Medicare.

Covered Benefit

A medically necessary service that is specifically provided for under the provisions of an Evidence of Coverage. A covered benefit must always be medically necessary, but not every medically necessary service is a covered benefit. For example, some elements of custodial or maintenance care, which are excluded from coverage, may be medically necessary, but are not covered.

Coverage

Health care services provided or authorized by the payer's Medical Staff or payment for health care services.

Credentia lling

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.

Current Procedural Terminology (CPT)

A standardized mechanism of reporting services using numeric codes as established and updated annually by the AMA.

Days (Or Visits) Per 1,000

An indicator calculated by taking the total number of days (for inpatient, residential, or partial hospitalization) or visits (for outpatient) received by a specific group for a specific period of time (usually one year). This number is then divided by the average number of covered members or lives in that group during the same period and multiplied by 1,000. A measure used to evaluate utilization management performance.

Day outlier

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A patient with an atypically long length of stay compared with other patients in a particular diagnosis related group.

Deductibles

Amounts required to be paid by the insured under a health insurance contract, before benefits become payable.

Dependent

In a payer's policy of insurance, a person other than the subscriber eligible to receive care because of a subscriber's contract.

Diagnosis related groups (DRGs)

A patient classification scheme used by Medicare that clusters patients into 468 categories on the basis of patients' illnesses, diseases and medical problems.

Direct Contracting

Providing health services to members of a health plan by a group of providers contracting directly with an employer, thereby butting out the middleman or third party insurance carrier. This can be provider heaven, since middleman-MCO-is cut out and provider gets some portion of the money usually made by it. Key is to price services correctly, since provider is usually at full risk in this situation. Takes a strong IDS or AHP to pull this off.

Direct Payment Subscriber

A person enrolled in a prepayment plan who makes individual premium payments directly to the plan rather than through a group. Rates of payment are generally higher, and benefits may not be as extensive as for the subscriber enrolled and paying as a member of the group.

Discounted Fee-For-Service

An agreed upon rate for service between the provider and payer that is usually less than the provider's full fee. This may be a fixed amount per service, or a percentage discount.

Providers generally accept such contracts because they represent a means to increase their volume or reduce their chances of losing volume.

Disease Management

A type of product or service now being offered by many large pharmaceutical companies to get them into broader healthcare services. Bundles use of prescription drugs with physician and allied professionals, linked to large databases created by the pharmaceutical companies, to treat people with specific diseases. The claim is that this type of service provides higher quality of care at more reasonable price than alternative, presumably more fragmented, care. The development of such products by hugely capitalized companies should be all the indicator necessary to convince a provider of how the healthcare market is changing. Competition is coming from every direction-- other providers of all types, payers, employers (who are developing their own in-house service systems), the drug companies.

Dual Choice (Multiple Choice, Dual Option)

The opportunity for an individual within an employed group to choose from two or more types of health care coverage such as an HMO and a traditional insurance plan. Section 1310 of the HMO Act provides for dual choice.

Durable Medical Equipment (DME)

Items of medical equipment owned or rented which are placed in the home of an insured to facilitate treatment and/or rehabilitation. DME generally consist of items which can withstand repeated use. DME is primarily and customarily used to serve a medical purpose and is usually not useful to a person in the absence of illness or injury.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

EPSDT program covers screening and diagnostic services to determine physical or mental defects in recipients under age 21, as well as health care and other measures to correct or ameliorate any defects and chronic conditions discovered.

Effective Date

The date on which a policy's coverage of a risk goes into effect.

Emergency

Sudden unexpected onset of illness or injury which requires the immediate care and attention of a qualified physician, and which, if not treated immediately, would jeopardize or impair the health of the Member, as determined by the payer's Medical Staff. Significant in that Emergency may be the only acceptable reason for admission without pre-certification.

Employee Retirement Income Security Act of 1974 (ERISA)

Also called the Pension Reform Act, this act regulates the majority of private pension and welfare group benefit plans in the U.S.. It sets forth requirements governing, among many areas, participation, crediting of service, vesting, communication and disclosure, funding, and fiduciary conduct. Key legislative battleground now, because ERISA

exempts most large self-funded plans from State regulation and, hence, from any reform activities undertaken at state level--which is now the arena for much healthcare reform.

Enrolled Group

Persons with the same employer or with membership in an organization in common, who are enrolled collectively in a health plan. Often, there are stipulations regarding the minimum size of the group and the minimum percentage of the group that must enroll before the coverage is available. Same as Contract group.

Enrollee (Also beneficiary; individual; member)

Any person eligible as either a subscriber or a dependent for service in accordance with a contract.

Evidence or Explanation of Coverage (EOC) or Explanation of Benefits (EOB)

A booklet provided by the carrier to the insured summarizing benefits under an insurance plan.

Exclusions

Clauses in an insurance contract that deny coverage for select individuals, groups, locations, properties or risks.

Exclusive Provider Organization (EPO)

A managed care organization that is organized similarly to PPOs in that physicians do not receive capitated payments, but that only allows patients to choose medical care from network providers. If a patient elects to seek care outside of the network, then he or she will not be reimbursed for the cost of the treatment.

Exclusivity Clause

A part of a contract which prohibits physicians from contracting with more than one managed care organization (HMO, PPO, IPA, etc.)

Expansion

Some HMOs compute Plan expansion as part of the capitation rate in order to provide the necessary capital for growth.

Experience Rating

(a) The rating system by which the Plan determines the capitation rate by the experience of the individual group enrolled. Each group will have a different capitation rate based on utilization. This system tends to penalize small groups with high utilization.

(b) A method of determining the premium based on a group's claims experience, age, sex or health status. Experience rating is not allowed for federally-qualified HMOs.

Experience-Rated Premium

A premium which is based upon the anticipated claims experience of, or utilization of service by, a contract group according to its age, sex, constitution, and any other attributes expected to affect its health service utilization, and which is subject to

periodic adjustment in line with actual claims or utilization experience.

Explanation of Benefits (EOB)

A summary of benefits provided subscribers by the carrier.

Extended Care Facility (ECF)

A nursing or convalescent home offering skilled nursing care and rehabilitation services.

Federally-Qualified HMO

A prepaid health plan that has met strict federal standards and has been granted qualification status. A federally-qualified HMO is eligible for loans and loan guarantees not available to non-qualified plans. Employers of 25 or more workers were, until recently, required to offer a federally-qualified HMO if the plan requested to be included in the company's health benefits program.

Fee Disclosure

Physicians and caregivers discussing their charges with patients prior to treatment.

Fee-For-Service

(a) A method of reimbursement based on payment for services rendered. Payment may be made by an insurance company, the patient or a government program such as Medicare or Medicaid.

(b) With respect to the physicians or other supplier of service, this refers to payment in specific amounts for specific services rendered--as opposed to retainer, salary, or other contract arrangements. In relation to the patient, it refers to payment in specific amounts for specific services received, in contrast to the advance payment of an insurance premium or membership fee for coverage, through which the services or payment to the supplier are provided.

Fee Schedule

A listing of accepted fees or established allowances for specified medical procedures. As used in medical care plans, it usually represents the maximum amounts the program will pay for the specified procedures.

First-dollar coverage

Insurance coverage with no front-end deductible where coverage begins with the first dollar of expense incurred by the insured for any covered benefit.

Fiscal Intermediary

The agent (e.g., Blue Cross) that has contracted with providers of service to process claims for reimbursement under health care coverage. In addition to handling financial matters, it may perform other functions such as providing consultative services or serving as a center for communication with providers and making audits of providers' needs.

Fixed Costs

Costs which do not change with fluctuations in census or in utilization of services.

Flat Fee-Per-Case

Flat fee paid for a client's treatment based on their diagnosis and/or presenting problem. For this fee the provider covers all of the services the client requires for a specific period of time. Often characterizes "second generation" managed care systems. After the MCOs squeeze out costs by discounting fees, they often come to this method. If provider is still standing after discount blitz, this approach can be good for provider and clients, since it permits a lot of flexibility for provider in meeting client needs.

Formulary

A list of selected pharmaceuticals and their appropriate dosages felt to be the most useful and cost effective for patient care. Organizations often develop a formulary under the aegis of a pharmacy and therapeutics committee. In HMOs, physicians are often required to prescribe from the formulary.

Gatekeeper

A primary care physician responsible for overseeing and coordinating all aspects of a patient's medical care. In order for a patient to receive a specialty care referral or hospital admission, the gatekeeper must preauthorize the visit, unless there is an emergency.

Grievance Procedures

The process by which an insured can air complaints and seek remedies.

Gross Charges Per 1,000

An indicator calculated by taking the gross charges incurred by a specific group for a specific period of time, dividing it by the average number of covered members or lives in that group during the same period, and multiplying the result by 1,000. This is calculated in the aggregate and by modality of treatment, e.g., inpatient, residential, partial hospitalization, and outpatient. A measure used to evaluate utilization management performance.

Gross Costs Per 1,000

An indicator calculated by taking the gross costs incurred for services received by a specific group for a specific period of time, dividing it by the average number of covered members or lives in that group during the same period, and multiplying the result by 1,000. This is calculated in the aggregate and by modality of treatment, e.g. inpatient, residential, partial hospitalization, and outpatient. A measure used to evaluate utilization management performance. This is the key concept for the provider. What matters is our cost and, in managed care, we must control this indicator and make sure it is below our Collections per 1,000.

Group Insurance

Any insurance policy or health services contract by which groups of employees (and often their dependents) are covered under a single policy or contract, issued by their employer or other group entity.

Group Model HMO

(a) An HMO model in which the HMO contracts with one or more medical groups to provide services to members. As with the staff model, all services except hospital care are generally provided under one roof. Both group and staff models are known collectively as prepaid group practice plans.

(b) (Also direct service plan, group practice prepayment plan; prepaid health care): A plan which provides health services to persons covered by a prepayment program through a group of physicians usually working in a group clinic or center.

Group Practice

A group of persons licensed to practice medicine in the State, who, as their principal professional activity, and as a group responsibility, engage or undertake to engage in the coordinated practice of their profession primarily in one or more group practice facilities, and who (in their connection) share common overhead expenses (if and to the extent such expenses are paid by members of the group), medical and other records, and substantial portions of the equipment and the professional, technical, and administrative staffs.

Group Practice without Walls

Similar to an independent practice association, this type of physician group represents a legal and formal entity where certain services are provided to each physician by the entity, and the physician continues to practice in his/her own facility. It can include marketing, billing and collection, staffing, management, and the like.

HCFA 1500

The Health Care Finance Administration's standard form for submitting physician service claims to third party (insurance) companies.

Health Maintenance Organization (HMO)

HMOs offer prepaid, comprehensive health coverage for both hospital and physician services. An HMO contracts with health care providers, e.g., physicians, hospitals, and other health professionals, and members are required to use participating providers for all health services. Members are enrolled for a specified period of time. Model types include staff, group practice, network and IPA (for additional information, see staff, group, network and IPA model definitions)

Health Plan Employer Data and Information Set (HEDIS)

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A set of performance measures designed to standardize the way health plans report data to employers. HEDIS currently measures five major areas of health plan performance: quality, access and patient satisfaction, membership and utilization, finance, and

descriptive information on health plan management.

HHS

The Department of Health and Human Services which is responsible for health-related programs and issues. Formerly HEW, the Department of Health, Education, and Welfare. The Office of Health Maintenance Organizations (OHMO) is part of HHS and detailed information on most companies is available here through the Freedom of Information Act.

Hold Harmless Clause

A clause frequently found in managed care contracts whereby the HMO and the physician hold each other not liable for malpractice or corporate malfeasance if either of the parties is found to be liable. Many insurance carriers exclude this type of liability from coverage. It may also refer to language that prohibits the provider from billing patients if their managed care company becomes insolvent. State and federal regulations may require this language.

Home Health Care

Full range of medical and other health related services such as physical therapy, nursing, counseling, and social services that are delivered in the home of a patient, by a provider.

Hospital

Any institution duly licensed, certified, and operated as a Hospital. In no event shall the term "Hospital" include a convalescent facility, nursing home, or any institution or part thereof which is used principally as a convalescence facility, rest facility, nursing facility, or facility for the aged.

Hospital Affiliation

A contractual agreement between an HMO and one or more hospitals whereby the hospital provides the inpatient benefits offered by the HMO.

Hospital Audit Companies

Retrospective audit providers that typically achieve a 15-20 percent savings of billed Claims

Hospital Days (per 1,000)

A measurement of the number of days of hospital care HMO members use in a year. It is calculated as follows: Total Number Of Days Spent In A Hospital By Members divided by Total Members. This information is available through HHS, OHMO and a variety of sources.

Incurred But Not Reported (IBNR)

Refers to claims which reflect services already delivered, but, for whatever reason, have

not yet been reimbursed. These are bills "in the pipeline." This is a crucial concept for proactive providers who are beginning to explore arrangements that put them in the role of adjudicating claims--as the result, perhaps, of operating in a sub-capitated system (see below). Failure to account for these potential claims could lead to some very bad decisions. Good administrative operations have fairly sophisticated mathematical models to estimate this amount at any given time.

Indemnity Carrier

Usually an insurance company or insurance group that provides marketing, management, claims payment and review, and agrees to assume risk for its subscribers at some pre-determined rate.

Indemnity Plan (Indemnity health insurance)

A plan which reimburses physicians for services performed, or beneficiaries for medical expenses incurred. Such plans are contrasted with group health plans, which provide service benefits through group medical practice.

Individual Plans

A type of insurance plan for individuals and their dependents who are not eligible for coverage through an employer group (group coverage).

Individual Practice Association (IPA)

An HMO model in which the HMO contracts with a physician organization that in turn contracts with individual physicians. The IPA physicians provide care to HMO members from their private offices and continue to see their fee-for-service patients.

Inpatient Care

Care given a registered bed patient in a hospital, nursing home or other medical or post acute institution.

Internal Medicine

Generally, that branch of medicine that is concerned with diseases that do not require surgery, specifically, the study and treatment of internal organs and body systems; it encompasses many subspecialties; internists, the doctors who practice internal medicine, often serve as family physicians to supervise general medical care.

International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)

A coding scheme used to document the incidence of disease, injury, mortality and illness.

Major Medical Expense Insurance

Policies designed to help offset the heavy medical expenses resulting from catastrophic or prolonged illness or injury. They generally provide benefits payments for 75 to 80 percent of most types of medical expenses above a deductible paid by the insured.

Malpractice Insurance

Insurance against the risk of suffering financial damage due to professional misconduct or lack of ordinary skill. Malpractice requires that the patient prove some injury and that the injury was the result of negligence on the part of the professional.

Managed Care

A general term for organizing doctors, hospitals, and other providers into groups in order to enhance the quality and cost-effectiveness of health care. Managed Care Organizations include HMOs, PPOs, POSs, EPOs, etc.

Managed competition

A health insurance system that bands together employers, labor groups and others to create insurance purchasing groups; employers and other collective purchasers would make a specified contribution toward insurance purchase for the individuals in their group; the employer's set contribution acts as an incentive for insurers and providers to compete

Market Area

The targeted geographic area or areas of greatest market potential. The market area does not have to be the same as the post acute facility's catchment area.

Master Patient/Member Index

An index or file with a unique identifier for each patient or member that serves as a key to a patient's or member's health record.

Medical Allied Manpower

This category includes some sixty occupations or specialties that can be divided into two large categories based on time required for occupational training. The first category includes those occupations that require at least a baccalaureate degree, for example, clinical laboratory scientists and technologists, dietitians and nutritionists, health educators, medical record librarians, and occupational speech and rehabilitation therapists. The second group includes those occupations that require less than a baccalaureate degree, such as aides for each of the above categories as well as physician assistants and radiological technicians.

Medical Care Evaluation Studies (MCE)

The name given to a generic form of health care review in which problems in the quality of the delivery and organization of health care services are addressed and monitored. A program based on MCEs is recommended as a way of meeting the federal government's requirements for an internal quality assurance program for federally-qualified HMOs.

Medical Group Practice

The American Group Practice Association, the American Medical Association, and the Medical Group Management Association define medical group practice as: "provision of health care services by a group of at least three licensed physicians engaged in a

formally organized and legally recognized entity sharing equipment, facilities, common records and personnel involved in both patient care and business management."

Medically Necessary

Services or supplies which meet the following tests:

- they are appropriate and necessary for the symptoms, diagnosis, or treatment of the medical condition;
- they are provided for the diagnosis or direct care and treatment of the medical condition;
- they meet the standards of good medical practice within the medical community in the service area;
- they are not primarily for the convenience of the plan member or a plan provider; and
- they are the most appropriate level or supply of service which can safely be provided.

Medical Loss Ratio (MLR)

The amount of revenues from health insurance premiums that is spent to pay for the medical services covered by the plan. Usually referred to by a ratio, such as 0.96--which means that 96% of premiums were spent on purchasing medical services. The goal is to keep this ratio below 1.00--preferably in the 0.80 range, since the MCO's or insurance company's profit comes from premiums. Currently, successful HMOs do have MLRs in the 0.70-0.80 range.

Medicaid

A federal program, run and partially funded by individual states to provide medical benefits to certain low income people. The state, under broad federal guidelines, determines what benefits are covered, who is eligible and how much providers will be paid. All states but Arizona have Medicaid programs.

Medicare

A nationwide, federal health insurance program for people age 65 and older. It also

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<http://www.mcred.com/mcrdef.htm> 1/28/2010

covers certain people under 65 who are disabled or have chronic kidney disease.

Medicare Part A is the hospital insurance program; Part B covers physicians' services.

Medigap

Private health insurance plans that supplement Medicare benefits by covering some costs not paid for by Medicare.

Midlevel Practitioner

Nurse practitioners, certified nurse-midwives and physicians' assistants who have been trained to provide medical services that otherwise might be performed by a physician.

Midlevel practitioners practice under the supervision of a doctor of medicine or osteopathy who takes responsibility for the care they provide. Physician extender is

another term for these personnel.

Miscellaneous Expenses

Hospital charges, other than room and board, such as those for x-rays, drugs, laboratory fees, and other ancillary services.

MSO

One of the following:

- **Medical Staff Organization** An organized group of physicians, usually from one hospital, into an entity able to contract with others for the provision of services, or
- **Management (or Medical) Services Organization** An entity formed by, for example, a hospital, a group of physicians or an independent entity, to provide business-related services such as marketing and data collection to a grouping of providers like an IPA, PHO or CWW. This second definition is becoming the almost exclusive usage.

Multiple Employer Trust (MET)

A legal trust established by a plan sponsor that brings together a number of small, unrelated employers for the purpose of providing group medical coverage on an insured or self-funded basis. Not quite a Health Plan Purchasing Cooperative, but along the same lines. More market-oriented and usually smaller in scale.

Multi-specialty Group

A group of doctors who represent various medical specialties and who work together in a group practice.

National Committee for Quality Assurance (NCQA)

A non-profit organization created to improve patient care quality and health plan performance in partnership with managed care plans, purchasers, consumers, and the public sector.

Network Model HMO

A health plan that contracts with multiple physician groups to deliver health care to members. Generally limited to large single or multi-specialty groups. Distinguished from group model plans that contract with a single medical group, IPA's that contract through an intermediary, and direct contract model plans that contract with individual physicians in the community.

Neonatal Intensive Care Unit (Neo ICU)

A hospital unit with special equipment for the care of premature and seriously ill newborn infants.

Non-Plan Provider

A health care provider without a contract with an insurer. Similar to a nonparticipating provider under Medicare.

Open Enrollment

A period of time which eligible subscribers may elect to enroll in, or transfer between, available programs providing health care coverage.

Organized Care System

Often used to discuss a more evolved form of IDSs and CCNs, this relatively new term describes the result of mergers and alliances between and among physicians, health systems, and managed care organizations. These systems often have the same performance imperatives as IDSs and CCNs: improve health status, integrate delivery, demonstrate value, improve efficiency of care delivery and prevention, and meet patient and community needs.

Outcomes Management

A clinical outcome is the result of medical or surgical intervention or nonintervention. It is thought that through a database of outcomes experience, caregivers will know better which treatment modalities result in consistently better outcomes for patients. Outcomes management may lead to the development of clinical protocols.

Outlier

A patient whose length of stay or treatment cost differs substantially from the stays or costs of most other patients in a diagnosis related group.

Outlier thresholds

The day and cost cutoff points that separate inlier patients from outlier patients.

Outpatient Care

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Patient Liability

The dollar amount which an insured is legally obligated to pay for services rendered by a provider.

Participating Physician

A primary care physician in practice in the payer's managed care service area who has entered into a contract.

Participating Provider

Any provider licensed in the state of provision and contracted with an insurer.

Primary Care Provider (PCP)

A primary care provider such as a family practitioner, general internist, pediatrician and sometimes an ob/gyn. Generally, a PCP supervises, coordinates and provides medical care to members of a plan. The PCP may initiate all referrals for specialty care.

PCP Capitation

A reimbursement system for healthcare providers of primary care services who receive a pre-payment every month. The payment amount is based on age, sex and plan of every member assigned to that physician for that month. Specialty capitation plans also exist but are little used.

Peer Review

The mechanism used by the medical staff to evaluate the quality of total health care provided by the Managed Care Organization. The evaluation covers how well services are performed by all health personnel and how appropriate the services are to meet the patients' needs.

Performance Standards

Standards an individual provider is expected to meet, especially with respect to quality of care. The standards may define volume of care delivered per time period. Thus, performance standards for obstetrician/gynecologist may specify some or all of the following office hours and office visits per week or month, on-call days, deliveries per year, gynecological operations per year, etc.

Per Member Per Month (PMPM)

Specifically applies to a revenue or cost for each enrolled member each month.

Per Thousand Members Per Year (PTMPY)

A common way of reporting utilization. The most common example of hospital utilization, expressed as days PTMPY.

Physician attestation

The requirement that the attending physician certify, in writing, the accuracy and completion of the clinical information used for DRG assignment.

Physician Organization

This term describes physician linkages and alliances that allow physicians to manage risk and capitation. Information systems, physician relationships, and financial integration allow these organizations to be more integrated than the traditional solo practice or IPA relationship between healthcare providers and/or managed care organizations that are working to develop a "seamless" continuum of healthcare services.

Physician-Hospital Organization (PHO)

A contracted arrangement among physicians and hospital(s) wherein a single entity, the PHO, agrees to provide services to insurers' subscribers.

Plan Administration

A term often used to describe the management unit with responsibility to run and control a managed care plan - includes accounting, billing, personnel, marketing, legal,

purchasing, possibly underwriting, management information, facility maintenance, servicing of accounts. This group normally contracts for medical services and hospital care.

Point-of-Service Plan (POS)

Also known as an open-ended HMO, POS plans encourage, but do not require, members to choose a primary care physician. As in traditional HMOs, the primary care physician acts as a "gatekeeper" when making referrals; plan members may, however, opt to visit non-network providers at their discretion. Subscribers choosing not to use the primary care physician must pay higher deductibles and copays than those using network physicians.

Practical Nurses

Practical nurses, also known as vocational nurses, provide nursing care and treatment of patients under the supervision of a licensed physician or registered nurse. Licensure as a licensed practical nurse (L.P.N.) or in California and Texas as a licensed vocational nurse (L.V.N.), is required.

Practice Parameters

The American Medical Association defines practice parameters as strategies for patient management, developed to assist physicians in clinical decision making. Practice parameters may also be referred to as practice options, practice guidelines, practice policies, or practice standards.

Preadmission Review

The practice of reviewing claims for inpatient admission prior to the patient entering the hospital in order to assure that the admission is medically necessary.

Preauthorization

A method of monitoring and controlling utilization by evaluating the need for medical service prior to it being performed.

Pre-certification

The process of notification and approval of elective inpatient admission and identified outpatient services before the service is rendered.

Predetermination

An administrative procedure whereby a health provider submits a treatment plan to a third party before treatment is initiated. The third party usually reviews the treatment plan, monitoring one or more of the following: patient's eligibility, covered service, amounts payable, application of appropriate deductibles, copayment factors and maximums. Under some programs, for instance, predetermination by the third party is required when covered charges are expected to exceed a certain amount. Similar processes: pre-authorization, pre-certification, pre-estimate of cost, pretreatment estimate, prior authorization.

Pre-existing Condition

(a) A physical condition of an insured person which existed prior to the issuance of his policy or his enrollment in a Plan, and which may result in the limitation in the contract on coverage or benefits.

(b) A physical condition including an injury or disease that was contracted or occurred prior to enrollment in the HMO. Federally-qualified HMOs cannot limit coverage for pre-existing conditions.

Preferred provider organization (PPO)

Some combination of hospitals and physicians that agrees to render particular services to a group of people, perhaps under contract with a private insurer. The services may be furnished at discounted rates and the insured population may incur out-of-pocket expenses for covered services received outside the PPO if the outside charge exceeds the PPO payment rate.

Prepaid Group Practice

Prepaid Group Practice Plans involve multi-specialty associations of physicians and other health professionals, who contract to provide a wide range of preventive, diagnostic and treatment services on a continuing basis for enrolled participants.

Prepayment

A method providing in advance for the cost of predetermined benefits for a population group, through regular periodic payments in the form of premiums, dues, or contributions, including those contributions which are made to a Health and Welfare Fund by employers on behalf of their employees.

Principal diagnosis

The medical condition that is ultimately determined to have caused a patient's admission to the hospital. The principal diagnosis is used to assign every patient to a diagnosis related group. This diagnosis may differ from the admitting and major diagnoses.

Profile

Aggregated data in formats that display patterns of health care services over a defined period of time.

Profile Analysis

Review and analysis of profiles to identify and assess patterns of health care services.

Prospective payment system (PPS)

A payment method that establishes rates, prices or budgets before services are rendered and costs are incurred. Providers retain or absorb at least a portion of the difference

between established revenues and actual costs.

Primary Care

(a) Basic or general health care usually rendered by general practitioners, family practitioners, internists, obstetricians and pediatricians -- often referred to as primary care practitioners.

(b) Professional and related services administered by an internist, family practitioner, obstetrician-gynecologist or pediatrician in an ambulatory setting, with referral to secondary care specialists, as necessary.

Primary Physician Capitation

The amount paid to each physician monthly for services based on the age, sex and number of the Members selecting that physician.

Professional Standards Review (PSRO)

A physician-sponsored organization charged with reviewing the services provided patients who are covered by Medicare, Medicaid and maternal and child health programs. The purpose of the review is to determine if the services rendered are medically necessary; provided in accordance with professional criteria, norms and standards; and provided in the appropriate setting.

Purchaser

This entity not only pays the premium, but also controls the premium dollar before paying it to the provider. Included in the category of purchasers or payers are patients, businesses and managed care organizations. While patients and businesses function as ultimate purchasers, managed care organizations and insurance companies serve a processing or payer function.

Quality Assurance (QA)

Activities and programs intended to assure the quality of care in a defined medical setting. Such programs include peer or utilization review components to identify and remedy deficiencies in quality. The program must have a mechanism for assessing its effectiveness and may measure care against pre-established standards.

Referral Pool

An amount set aside to pay for non-capitated services provided by a PCP, services provided by a referral specialist and/or emergency services.

Referral Services

Medical Services arranged for by the physician and provided outside the physician's office other than Hospital Services.

Registered Nurses (R.N.'s)

Registered nurses are responsible for carrying out the physician's instructions. They

supervise practical nurses and other auxiliary personnel who perform routine care and treatment of patients. Registered nurses provide nursing care to patients or perform specialized duties in a variety of settings from hospital and clinics to schools and public health departments. A license to practice nursing is required in all states. For licensure as a registered nurse (R.N.), an applicant must have graduated from a school of nursing approved by the state board for nursing and have passed a state board examination.

Reinsurance

- (a) A contract by which an insurer procures a third party to insure it against loss or liability by reason of such original insurance.
- (b) The practice of an HMO or insurance company of purchasing insurance from another company to protect itself against part or all the losses incurred in the process of honoring the claims of policy-holders. Also referred to as "stop loss" or "risk control" insurance.

Reserves

- (a) A fiscal method of withholding a certain percentage of premium to provide a fund for committed but undelivered health care and such uncertainties as: longer hospital utilization levels than expected, overutilization of referrals, accidental catastrophes and the like.
- (b) The fiscal method of providing a fund for committed but undelivered health services or other financial liabilities. A percentage of the premiums supports this fund.

Resource-Based Relative Value Scale (RBRVS)

A Medicare weighting system to assign units of value to each CPT code (procedure) performed by physicians and other providers. The number of units or value for each procedure includes a portion for physician skill, expenses associated with the procedure, and geographic area.

Retrospective Review Process

A review that is conducted after services are provided to a patient. The review focuses on determining the appropriateness, necessity, quality, and reasonableness of health care services provided. Becoming seen as least desirable method; supplanted by concurrent reviews.

Risk

The chance or possibility of loss. For example, physicians may be held at risk if hospitalization rates exceed agreed upon thresholds. The sharing of risk is often employed as a utilization control mechanism within the HMO setting. Risk is also defined in insurance terms as the possibility of loss associated with a given population.

Risk Load

In underwriting, a factor that is multiplied into the rate to offset some adverse parameter of the group.

Risk Sharing

A method by which medical insurance premiums are shared by plan sponsors and participants. In contrast to traditional indemnity plans in which insurance premiums belonged solely to insurance company that assumed all risk of using these premiums. Key to this approach is that the premiums are only payment providers receive; provides powerful incentive to be parsimonious with care.

Self-Funding

The practice of an employer or organization assuming responsibility for health care losses of its employees. This usually includes setting up a fund against which claim payments are drawn and claims processing is often handled through an administrative services contract with an independent organization.

Shared Risk Pool for Referral Services

In capitation, the pool established for the purpose of sharing the risk of costs for Referral Services among all Participating Physicians.

Skilled Nursing Facility

A licensed institution, as defined by Medicare, which is primarily engaged in the provision of skilled nursing care.

Staff Model HMO

A model in which the HMO hires its own physicians. Very much like the group model, except the doctors are employees of the HMO. Generally, all ambulatory health services are provided under one roof in the staff model.

Stop Loss Insurance

Insuring with a third party against a risk which an MCO cannot financially and totally manage. For example, a comprehensive prepaid health plan can self-insure hospitalization costs with one or more insurance carriers.

Sub-Capitation

An arrangement that exists when an organization being paid under a capitated system contracts with other providers on a capitated basis, sharing a portion of the original capitated premium. Can be done under Carve Out, with the providers being paid on a PMPM basis.

Subrogation

The recovery of the cost of services and benefits provided to the insured of one MCO which other parties are liable.

Tertiary Care

Services provided by highly specialized providers such as neurosurgeons, thoracic surgeons and intensive care units. These services often require highly sophisticated technology and facilities.

Third Party Administrator (TPA)

Organizations with expertise and capability to administer all or a portion of the claims Process

Third-Party Payment

(a) Payment by a financial agent such as an HMO, insurance company or government rather than direct payment by the patient for medical care services.

(b) The payment for health care when the beneficiary is not making payment, in whole or in part, in his own behalf.

Total Budget

Otherwise known as a "global" budget, a cap on overall health spending.

Transfer

Movement of a patient between hospitals or between units in a given hospital. In Medicare, a full DRG rate is paid only for transferred patients that are defined as discharged.

Treatment Episode

The period of treatment between admission and discharge from a modality, e.g., inpatient, residential, partial hospitalization, and outpatient. Many healthcare statistics and profiles use this unit as a base for comparisons.

UB-92 Uniform Bill 1992

Bill form used to submit hospital insurance claims for payment by third parties. Similar to HCFA 1500, but reserved for the inpatient component of health services.

Underwriting

(1) The insurance function bearing the risk of adverse price fluctuations during a particular period.

(2) Analysis of a group that is done to determine rates or to determine whether the group should be offered coverage at all. A related definition refers to health screening of each individual applicant for insurance and refusing to provide coverage for preexisting conditions.

Urgent Services

Benefits covered in an Evidence of Coverage that are required in order to prevent serious deterioration of an insured's health that results from an unforeseen illness or injury

Usual, Customary and Reasonable (UCR)

Health insurance plans that pay a physician's full charge if it is reasonable and does not exceed his or her usual charges and the amount customarily charged for the service by other physicians in the area.

Utilization

Use of services. Utilization is commonly examined in terms of patterns or rates of use of a single service or type of service such as hospital care, physician visits, prescription drugs. Measurement of utilization of all medical services in combination is usually done in terms of dollar expenditures. Use is expressed in rates per unit of population at risk for a given period such as the number of admissions to the hospital per 1,000 persons over age 65 per year, or the number of visits to a physician per person per year for an annual physical.

Waiting periods

The length of time an individual must wait to become eligible for benefits for a specific condition after overall coverage has begun.

Wellness

Preventive medicine associated with lifestyle and preventive care that can reduce health-care utilization and costs.

Workers' compensation

A state-mandated program providing insurance coverage for work-related injuries and disabilities.

Withhold pool

The amount withheld from a PCP's capitation payment or a specialists payment amount to cover excess expenditures of his or a groups referral or other pool.