Definitions

Accountable Care Organization: An entity made up of health care providers that agree to share responsibility for the delivery of care and the health outcomes of a defined group of people, as well as for the cost of the care delivered; also known as Coordinated Care Organizations, Regional Care Coordination Organizations, or Regional Care Organizations.

Administrative Services Organization: An entity, usually an insurance company, which is contracted with the state to perform certain administrative tasks, such as member services, as well as care coordination and care management tasks. Data analysis and identification of high-needs enrollees is a common requirement.

Bundled Payment: A single payment made for a defined set of services (episode of care) delivered by two or more providers, usually delivered within a certain period of time. Examples: joint replacement surgery and organ transplants; one payment is made for services provided by the hospital, surgeon, and anesthesiologist, rather than three separate payments. Case rate and episode of care payment are types of bundled payments.

Capitation: A payment method in which the provider is paid a fixed amount for each person served, usually per member per month (PMPM). The fixed payment covers the full range of contracted services, such as hospital, doctor, and lab services.

Care Coordination: A set of activities through which teams of health care professionals work together to ensure that the patient receives needed care and services at the right time and in the right setting.

Carve-outs: An approach in which a portion of benefits are separated from the benefits package the insurance company or other entity is required to cover; usually mental health and/or long-term care benefits.

Care Management: A set of activities designed to engage providers, patients, and their caregivers in a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's comprehensive needs and to help them manage their health and well-being; also known as case management.

Coordination of Benefits: A set of activities performed to ensure that an enrollee receives the full extent of coverage for services under two or more forms of insurance (i.e. Medicaid and Medicare).

Disease Management: A system of coordinated health care services, education, and self-management training for populations with chronic conditions, such as diabetes or COPD.

Enrollee: Any person eligible for and receiving coverage from Medicaid.

Fee-for-Service (FFS): A method of reimbursement based on payment for services rendered.

Global Payment: A single payment made to a group of providers for all services delivered to a defined patient population over a defined period of time. This is similar to, but different from, capitation because it is paid to a group of providers rather than a single provider or practice, and the providers together agree to be accountable for the total cost of care for a patient population.

Resources: Managed Care Terms and Definitions available at http://www.mcres.com/mcrdef.htm; Case Management Society of America available at http://www.cmsa.org/, Care Continuum Alliance available at http://www.carecontinuumalliance.org/dm_definition.asp, and National Coalition on Care Coordination available at http://www.nyam.org/social-work-leadership-institute-v2/care-coordination/.

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.

Medicaid: The federal-state program that provides medical assistance for low-income and medically vulnerable citizens.

Patient-Centered Medical Home: The organization of primary care so that it delivers the core functions of primary health care, prevention and wellness, and comprehensive care coordination and care management.

Pay-for-Performance (P4P): A payment mechanism that pays providers a bonus payments (or sometimes payment reductions) for meeting (or missing) specified performance requirements (i.e. quality measures).

Primary Care Case Management (PCCM): A system in which enrollees are assigned to a primary care provider who provides primary and preventive care, as well as care coordination and care management services. Providers are paid fee-for-service for the health care services provided and a fee (usually PMPM) for care coordination/management services.

Risk: The chance or possibility of financial loss.

Risk-Based Managed Care: The most common type of Medicaid managed care in which an entity, usually an insurance company, is contracted with the state to provide coverage for a defined set of Medicaid benefits; paid on a capitated basis.

Shared Savings: A payment mechanism that pays providers fee-for-service and a bonus payment if the provider delivers care under an established threshold budget. The bonus payment is usually a percentage of the amount below the threshold (i.e. the savings).

Shared Losses: A payment mechanism that pays providers fee-for-service and are required to pay back a portion of any expenditures above an established threshold budget. The payment is usually a percentage of the amount above the threshold (i.e. losses).