## DEFINITIONS

AFDC: Includes recipients of Aid to Families with Dependent Children and all related categories, unless otherwise specified.

Any Willing Provider Clause: Provision compelling insurers to sign on any provider who agrees to abide by the same terms of the contract and to accept the same payment scheme as those providers currently in the managed care organization.

Capitation: A reimbursement system in which health care providers receive a fixed fee for every patient served, regardless of how many or how few services the patient uses.

Case Management: A technique used by third party payors and self-insured employers to monitor or coordinate treatment for specific diagnosis, particularly those involving high-cost or expensive services.

Certificate of Need (CON): State programs that regulate expenditures for the introduction or expansion of health facilities, institutional health services, and/or the purchase of major medical equipment.

Diagnostic-Related Group (DRG): This is a system in which the hospital receives a fixed fee for each type of medical procedure regardless of the hospital's cost of providing that service.

Fee-for-Service: The traditional way of billing for health care services. There is a separate charge for each patient visit and service provided.

Full Risk Plan: Medicaid enrollees must receive care from a provider who belongs to a participating HMO. Under this plan, if the cost of care rises above the stated capitation rate, the managed care organization or its doctors absorb the cost of care.

Gatekeeper: A component of an independent practice association HMO that requires its subscribers to see a primary physician before seeing a specialist.

Group Practice Association HMO: Type of HMO consisting of three or more physicians who formally align to provide health care to a group based on a pre-negotiated period for a fixed, prepaid rate.

The Centers for Medicare and Medicaid Services (CMS-- formerly HCFA): A federal agency within the Department of Health and Human Services. It was created in 1977 to administer the Medicare and Medicaid programs -- two national health care programs with more that 72 million beneficiaries. While CMS mainly acts as a purchaser of health care services for the Medicare and Medicaid beneficiaries, it also:

- Assures that Medicare and Medicaid are properly administered by its contractors and state agencies;
- Establishes policies for the reimbursement of health care providers;
- Conducts research on the effectiveness of various methods of health care management, treatment, and financing; and
- Assesses the quality of health care facilities and services.

Health Insuring Organization (HIO): An entity that either provides for or arranges for the provision of care and contracts on a prepaid capitated risk basis to provide a comprehensive set of services.

Health Maintenance Organization/Federally Qualified (HMO/FQ): A public or private organization that contracts on a prepaid capitated risk basis to provide a comprehensive set of services and is federally qualified.

Health Maintenance Organization/State Plan Defined (HMO/SPD): A public or private organization that contracts on a prepaid capitated risk basis to provide a comprehensive set of services and is a state defined plan.

Limited Risk Plan: A managed care plan in which the state contracts directly with providers on a per patient basis for certain services, but continues to pay on the fee-for-service for all other care. The state shares the financial risk of providing medical services with the managed care organization.

Managed Care Organization (MCO): A system of care under which a predetermined number of patients are enrolled, for a pre-determined rate for all or part of their care. The most common categories are health maintenance organizations and primary care case management.

Management Service Organization: An organization formed by one or more physician groups to manage their medical practices.

Medicaid Managed Care: A system of care in which a state has moved all or part of its Medicaid recipients into a managed care system. The most common categories are health maintenance organizations and primary care case management.

Medicaid: A national entitlement program funded by the federal government and operated by the individual states. It is designed to provide medical coverage for the poor and specific groups of uninsured.

Medical Saving Accounts: Individual and/or family health funds similar to individual retirement accounts into which employers and employees make tax-deferred contributions.

Network-Model HMO: An HMO that contracts with more than one independent multi-specialty group practice.

Open-Ended HMO: This type of HMO is similar to the traditional HMO. Its advantage is that the user is provided coverage for numerous procedures performed outside the HMO. A traditional HMO requires members to stay within the network for services. The point-of service (POS) plan is an example of an open-ended HMO.

Open Enrollment: One period of time each year when HMOs are required to take applications regardless of the applicants' pre-existing conditions.

Personal Responsibility and Work Opportunity Act of 1996: The recent Welfare Reform Bill signed into law. It provides for sweeping changes in the current welfare system, including the severing of the automatic link between AFDC benefits and Medicaid eligibility.

Physicians Enhanced Program (PEP): The PEP is a voluntary program that links Medicaid recipients to a primary care provider (PCP). The PCP will provide a basic set of services for recipients in their practice and be compensated at the end of each month based on the number of PEP members enrolled in the practice, according to their age, gender, and category of eligibility.

Point-of-Service (POS): A POS plan covers the health care services provided to members who use the network. It is similar to an HMO in that it utilizes a primary care "gatekeeper".

Preferred Provider Organization (PPO): Type of health insurance program in which a group of doctors and hospitals provide a broad range of medical care to a predetermined group of subscribers for a predetermined fee. Under this plan, a third party negotiates discounted rates for services with specific providers. Its members, however, may use providers outside the network but are encouraged by financial incentives to seek care from within the network.

Prepaid Health Plan (PHP): An entity that either contracts on a prepaid, capitated risk basis to provide services that are not risk-comprehensive, or contracts on a non-risk basis. Additionally, some entities that are defined as HMOs are treated as PHPs through statutory exemption.

Primary Care Case Management (PCCM): Programs that use a provider who receives a small fee to manage the individual's care but reimburses on a fee-for-service basis. The primary care case manager is responsible for health care utilization and access to service. This is a freedom of choice waiver program which can be authorized by 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.

Provider Taxes: Broad-based taxes on facilities, such as hospitals or nursing homes; and services such as pharmaceutical services which are used to generate state Medicaid funds.

Section 1915(b) Waivers: Provision of the Social Security Act that allows states to waive certain programmatic rules governing Medicaid. It is typically used in implementing managed care to implement provider choices. States have generally used one of the following two approaches; capitated or primary care management programs.

Section 1115 Waivers: Provision of the Social Security Act that allows states, subject to HCFA approval, to waive certain requirements of the Medicaid program, such as eligibility rules. These waivers can be used to create small-scale demonstration projects in order to test proposed broad changes in the Medicaid program.

SSI: Includes Supplemental Security Income recipients (or aged, blind and disabled individuals in those states which apply more restrictive eligibility requirements).

T19: All mandatory eligibility groups, as described by Title XIX of the Social Security Act.

Utilization Review: Involves medical professionals who are outside the managed care organization reviewing and evaluating the activities and diagnoses of the individuals within the organization.