# Glossary of Common Managed Care Terms

**Managed Care:** In general, this refers to efforts to coordinate and channel the use of services to achieve desired access, service, and outcomes while controlling costs. It combines the responsibility for paying for a defined set of health service with an active program to control the costs associated with providing those services, while at the same time attempting to control the quality of and access to those services. A Managed Care Organization (MCO) undertakes to offer a broad range of services and supports. The MCO receives a fixed sum of money to pay for the benefits in the plans for the defined population of enrollees. Managed care attempts to change the way health care is financed by changing the incentives in the health care system and repolarizes health care. Fee-for-service (a provider is paid a unit rate to deliver the service) encourages the provision of health care while managed care discourages use of care unless absolutely necessary. Fee-for-service providers profit when individuals are sick and use health services. Managed care providers make a profit when the health of members is maintained through preventive measures and access to needed services.[[1]](#endnote-1)

**Medicaid Managed Long-Term Services and Supports (MLTSS):** A significant number of states either have or plan to implement Medicaid Managed Long-Term Services and Supports with 12 states reporting existing programs and another 11 reporting plans for implementation in 2012 and 2013. About half of them (11) have definite plans to implement statewide. Many states (13) have definite plans to implement statewide. Many states (13) have or will require mandatory enrollment in Medicaid managed LTSS, while some states (4) have not yet determined whether the enrollment will be voluntary or mandatory.[[2]](#endnote-2)

**Dual Eligibles:** Individuals who are eligible for both Medicaid and Medicare. There has been recent interest in integrating services and supports for the 9 million people who are dually eligible. These individuals typically are poorer and sicker than other Medicare beneficiaries, use more health care services, and thus account for a disproportionate share of Medicare and Medicaid spending. The focus of integrating services is to deal with the current system, which is fragmented, has misaligned payments and incentives, and offers a lack of continuity of care for consumers between acute and long term services. Ultimately, the vision for an integrated care model would be that the consumer would receive appropriate, high-quality services and supports regardless of payer.[[3]](#endnote-3)

## (Remainder of the Glossary is in Alphabetical Format)

**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. The Actuary develops the amount that will become the capitated fee (see capitation, below).

**Acute Care:** A pattern of health care in which an individual 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.

**Capitation:** 1) method of payment in which the provider is paid a fixed amount for each person serviced 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.

**Chronic Care:**  Long-term services and supports of individuals with long standing, persistent diseases or conditions.

**Encounter Data:** The Managed Care organization’s report of participant actual utilization of services. This can be used in several ways, but most often to adjust capitated rates going forward.

**Fee for Service:** A method of reimbursement based on payment for services rendered. Payment may be made by an insurance company, the individual or a government program such as Medicaid. With respect to physicians or other supplier of service, this refers to payment in specific amounts for specific services rendered. In relation to individual, it refers to payment in specific amounts for specific services received, in contrast to a set per member per month or other advance payment of an insurance premium or membership fee for coverage.

**Financial Management Services (FMS):**  With choice and control come responsibilities, including those associated with being an employer, securing and paying invoices for goods and services,  and tracking the individual budget. FMS refers to the entity or entities that assist participants with these duties. Included in the duties of an FMS are:  1) managing the distribution of funds contained in the participant-directed budget; 2)  facilitating the employment of participant-selected staff; 3) serving as the agent for employer responsibilities; and 4) performing fiscal accounting and creating expenditure reports for the participant and the funder.

**Hold Harmless Clause:** A clause frequently found in managed care contracts whereby the MCO 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 individual if their managed care company becomes insolvent. State and federal regulations may require this language.

**Health Plan Employer Data and Information Set (HEDIS):** 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 individual satisfaction, membership and utilization, finance, and descriptive information on health plan management. These measures are widely seen as medical in nature and not sensitive to long term services and supports desired outcomes.

**Medical Loss Ratio (MLR):** The amount of revenues from health insurance premiums that is spent to pay for the medial services covered by the plan. Excludes administrative costs, marketing, etc. 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 ration below 1.00 – preferably in the 0.80 range. Currently successful MCOs have MLRs in the 0.70 – 0.80 range.

**Methodology to Determine Payment to the MCO:** MCOs agree to provide a package of services for a fixed fee. Typically, methodologies specify the degree of risks the MCO absorbs. The following explains this degree of risk:

Full Risk: Most, but not all, MCOs are placed at financial risk for all or a substantial part of the services and supports provided. This results in a fixed, prepaid price to deliver services to the stated population. This methodology is considered full risk or accepting all the financial risk for providing services (all the possible profits as well as the losses).

Partial Risk: Accepting a portion of the financial risk of service provision.

No Direct Risk: the MCO does not absorb any risk but incentives are present for controlling cost.[[4]](#endnote-4)

**Participant-Direction:** Participant-directed services are home and community-based services that help people of all ages, across all types of disabilities, maintain their independence and determine for themselves what mix of personal assistance supports and services work best for them. Participant-directed services are sometimes referred to as consumer-directed, self-directed or Veteran-directed services. Typically classified as a service delivery model, participant direction empowers each program participant to expand his or her degree of choice and control over decisions made about his or her services and supports in a highly personalized manner. This system represents a major paradigm shift from traditionally-provided services. In the traditional service delivery model, decision-making and managing authority is vested in the professional using a medical model. Participant direction transfers a substantial portion of the decision-making and authority to the participant sometimes with assistance from his or her family or a representative.

**Program of All-Inclusive Care for the Elderly (PACE):** Since the early 1980s, states have been operating PACE demonstration sites as Section 1115 demonstrations. As of June 2000, PACE sites had been approved in 12 states. The PACE demonstration programs are modeled after the integrated system of acute and long-term care services developed by On Lok Senior Health Services in San Francisco, California. The Balanced Budget Act of 1997 (BBA) established the PACE model of care as a permanent provider entity within the Medicare/Medicaid program and enables states to provide PACE services to Medicaid beneficiaries as a state option rather than a demonstration. PACE is a capitated benefit that features a comprehensive service delivery system and integrated Medicare and Medicaid financing. Participants in PACE must be at least 55 years old, live in the PACE service area, and be certified by the appropriate state agency as eligible for a nursing home level of care. The PACE program becomes the sole source of services for its Medicare and Medicaid enrollees. The program is voluntary; beneficiaries may disenroll at any time.[[5]](#endnote-5)

**Per member per Month:** Applies to a revenue or cost for each enrolled member each month.

**Risk:** The change or possibility of loss.

**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 the only payment providers receive: proves powerful incentive to be parsimonious with care.[[6]](#endnote-6)

**Section 1915 (b):** A provision of the Social Security Act that authorizes the Secretary of HHS to grant certain waivers of Medicaid statutory requirements. The §1915(b) authority may be used to: (a) mandate the enrollment of Medicaid beneficiaries into managed care plans (§1915(b)(1)); (b) employ a central enrollment broker (§1915(b)(2)); (c) use cost savings to provide additional services to enrollees (§1915(b)(3); and/or, (d) limit the number of providers through selective contracting (§1915(b)(4)). Waivers granted under the provisions of §1915(b) may be effective for a period of two years and may be renewed for subsequent two year periods.

**Sections 1915(b) & (c):** Simultaneous use of the §1915(b) and §1915(c) waiver authorities may be used to integrate delivery of home and community-based services with State plan services in order to provide a coordinated array of services to beneficiaries. States also use the §1915(b) authority to limit freedom of choice of provider while employing the §1915(c) authority to provide the home and community-based services. A state can implement a §1915(b)/§1915(c) concurrent waiver as long as all Federal requirements for both waiver programs are met. Therefore, when submitting applications for concurrent §1915(b)/(c) programs, a state must submit a separate application for each waiver type and satisfy all of the applicable requirements under each authority.[[7]](#endnote-7)

1. Kane, R., Kane, R., Kaye. N., Mollica,R., Riley,T., Saucier, P., Snow, K., Starr, L. (1995). *The Basics of Managed Care*. Washington, D.C.: ASPE. Available at: http://www. <http://aspe.hhs.gov/Progsys/Forum/basics.htm>. [↑](#endnote-ref-1)
2. Cheek, M., Roherty, M., Finnan, L., Cho, E., Walls, J., Gifford, K., Fox-Grage, W., Ujvari,K. (2012). *On the Verge: The Transformation of Long-Term Services and Supports.* Washington, D.C.: AARP. Available at: <http://www.aarp.org/health/health-care-reform/info-02-2012/On-the-Verge-The-Transformation-of-Long-Term-Services-and-Supports-AARP-ppi-ltc.html>. [↑](#endnote-ref-2)
3. Cheek, M., et al. Op.Cit. [↑](#endnote-ref-3)
4. Kane, R., et al. Op Cit. [↑](#endnote-ref-4)
5. O’Keefe, J., Saucier, P., Jackson, B., Cooper, R., McKenney, E., Crisp, S., Mosley, C. (2010). *Understanding Medicaid Home and Community Services; A Primer.* Washington, D.C.: ASPE. [↑](#endnote-ref-5)
6. Kane, R., et al. Op Cit. [↑](#endnote-ref-6)
7. Centers for Medicare & Medicaid Services. (2008). *Application for Section 1915(c) Home and Community-Based Waiver.* Baltimore, MD: CMS*.*

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