

Waiver Terms and Definitions

Agency With Choice (AWC)

One of the two models of Individual and Family Directed Supports in the Innovations Waiver. The individual or legally responsible person acts as the “Managing Employer” and is responsible to the degree they desire to be in all levels of managing the staff that provide services to the participant.

At Risk

An entity is considered to be “at risk” (or “at financial risk”) for all medically necessary services for enrollees within a per member per month capitation payment. The entity is “at risk” of losing money if services and funding are not well managed or if medically necessary services exceed the capitation payment. A MBHO can not deny medically necessary services to an eligible plan member as a risk management strategy. Usually the entity buys reinsurance or establishes a risk pool to protect against catastrophic claims which cannot be predicted by actuaries.

There is also an inherent “at-risk” component to manage administrative costs within the global amount included in the capitated payment.

Capitation

A method of payment for an array of services wherein a fixed payment is made (usually monthly) on behalf of each beneficiary who is enrolled in the health plan. Payments are made for all beneficiaries, whether they receive services or not. The capitated entity is responsible for all medically necessary services for all beneficiaries. Capitation payment methods are commonly employed in managed care arrangements and insurance models, where the entity is at risk for the cost of medically necessary care. Capitation rates for Medicaid capitation payments must be actuarially certified and approved by the Centers for Medicare and Medicaid.

Clean Claim

A Clean Claim is a claim that can be processed without obtaining additional information from the provider of the services or a third party. It does not include a claim under review for medical necessity, or a claim from a Provider that is under investigation by a governmental agency for fraud or abuse.

Comprehensive Community Provider

A long-term or outpatient provider agency, who serves at least two disability groups and five (5) different services, including emergency services. Comprehensive Providers are designated access sites, where people receive initial evaluations and where enrollment information is obtained.

Cross Functional Team (CFT)

A group of people with different functional expertise working toward a common goal. Cross Functional Teams at PBH

- Implement work plan goals identified by the team
- Monitor indicators assigned and carry out other assigned monitoring responsibilities
- Research and address problems, poor performance, barriers to success for assigned indicators and monitoring responsibilities

Electronic Content Management (ECM)

The technologies, strategies, methods and tools used for the capture, storage, retrieval and management of documents, records, emails, electronic communications and other documents created by organizations.

Employer of Record Model (EOR)

The Employer of Record Model allows the participant or the legally responsible person for the participant to be the individual who legally (with the IRS) can exercise authority over workers and assume other responsibilities associated with participant direction of services. This means that the individual or legally responsible person has the authority to hire, supervise, train, schedule or fire staff without the involvement of a provider agency. The participant or legally responsible person is known as the **Employer of Record**.

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Encounter Data

Detailed data about individual services provided by a capitated managed care entity. The level of detail about each service reported is similar to that of a standard claim form. Encounter data are also sometimes referred to as "shadow claims" or may be a combination of paid and shadow claims.

Enrollment

The process by which a Medicaid eligible person becomes a member of a managed care plan. Enrollment data refer to the managed care plan's information on Medicaid eligible individuals who are plan members. The managed care plan gets its enrollment data from the Medicaid program's eligibility system. In North Carolina, the Department of Social Services is the enrolling agency for the Medicaid program. The MBHO does not enroll plan members.

External Quality Review Organization (EQRO)

The organization with which the State contracts to evaluate the care provided to Medicaid managed eligibles. Typically the EQRO is a peer review organization. It may conduct focused medical record reviews (i.e. Reviews targeted at a particular clinical condition) or broader analyses on quality. While most EQRO contractors rely on medical records as the primary source of information, they may also use eligibility data and claims/encounter data to conduct specific analyses.

Fee-For-Service (FFS)

A method of making payment directly to health care providers enrolled in the Medicaid program for the provision of health care services to recipients based on the payment methods set forth in the State plan and the applicable policies and procedures of the Division.

Health Plan Employer Data and Information Sets (HEDIS)

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

Incurred But Not Reported (IBNR)

An estimation of services that are predicted to have been provided but which have not yet been reported on a 837 claim. The IBNR calculation is the basis for estimating the amount of an accrual for unpaid services that were delivered during the reporting period. The IBNR is reported on the MBHO's balance sheet as an accrued liability.

Key Performance Indicators (KPI / KPIs)

Quantifiable measurements, agreed to beforehand, that reflect the critical performance factors of an organization.

Medical Expense Ratio (MER)

(Also sometimes called Medical Loss Ratio) Medical expense ratio equals total service expense divided by operating service revenue. This ratio reveals the percentage of the organization's service revenue needed to meet its service cost for a particular period. It serves as a key financial risk management indicator.

National Committee for Quality Assurance (NCQA)

An independent 501(c)(3) non-profit organization whose mission is to improve health care quality through accreditation (a rigorous on-site review of key clinical and administrative processes); through the Health Plan Employer Data and Information Set (HEIDAS)- a tool used to measure performance in key areas; and through a comprehensive member satisfaction survey.

Per Member Per Month (PMPM)

The payment rate for each plan member covered under the plan for given month. Due to the fluctuation in the number of Medicaid eligible members that are covered under the Medicaid plan each month, MBHO's receive a fixed payment rate for each member covered under the plan for that month. The PMPM rates are developed for each Medicaid aid category and are adjusted annually based on an actuarial analysis of historical service cost; adjusted for projected increases and decreases in future costs.

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Performance Improvement Projects (PIPs)

Projects that examine and seek to achieve improvement in major areas of clinical and non-clinical services. These projects are usually based on information such as enrollee characteristics, standardized measures, utilization, diagnosis and outcome information, data from surveys, grievance and appeals processes, etc. They measure performance at two periods of time to ascertain if improvement has occurred. These projects are required by the State and can be of the MCO/PIHPs choosing or prescribed by the State.

Performance Measures

A gauge used to assess the performance of a process or function of any organization. Quantitative or qualitative measures of the care and services delivered to enrollees (process) or the end result of that care and services (outcomes). Performance measures can be used to assess other aspects of an individual or organization's performance such as access and availability of care, utilization of care, health plan stability, beneficiary characteristics, and other structural and operational aspect of health care services. Performance measures may include measures calculated by the State (from encounter data or another data source), or measures submitted by the MCO/PIHP.

Prepaid Inpatient Health Plan (PIHP)

An entity that provides medical services to eligible plan participants under contract with the State agency, and on the basis of prepaid capitation payments; which are made at the beginning of the service period, usually monthly. The PIHP provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services and alternative outpatient or community based services for its participants

Risk Pool

Funds that are set aside to be used in the event of catastrophic claims that cannot be forecast when capitation rates are set. Risk Pools are often used to protect an entity against such losses in lieu of reinsurance.

Shadow Claims

Shadow claims are generally used to report encounter data when a provider is reimbursed under a sub-capitation or case rate methodology. It is a way for providers to report services provided using a standard HIPAA 837 format. Shadow Claims are process for reporting purposes as any other claim, but not processed for payment.

Treatment Authorization Request (TAR)

LME authorization request form used to request initial or continuing services.

Utilization Management (UM)

Process of evaluating the medical necessity, appropriateness, and efficiency of services against established guidelines and criteria.

Utilization Review (UR)

Formal review of the appropriateness and medical necessity of services to determine if the service is appropriate, if the goals are being achieved, or of changes need to be made to the Person Centered Plan or services and supports provided.

Validation

The process by which the integrity and correctness of data are established. Validation processes can occur immediately after a data item is collected or after a complete set of data is collected.