



## MASSACHUSETTS HEALTH COUNCIL

### GLOSSARY OF HEALTH TERMS

**Accountable Care Organization (ACO)** – An organization of coordinated health care providers that agrees to be accountable for the quality, cost, and overall care for an assigned population of patients. This type of delivery and payment model seeks to tie provider reimbursements to quality metrics and reductions in the total cost of care.

**Administrative Services Only (ASO)** – An arrangement in which an employer hires a third party to deliver administrative services to the employer such as claims processing and billing; the employer or a third party bears the risk for claims. ASO's are most commonly used in self-insured health care plans.

**Affordable Care Act (ACA) or Patient Protection and Affordable Care Act (PPACA)** - The Patient Protection and Affordable Care Act (PPACA), commonly called the Affordable Care Act (ACA) or "Obamacare", is a United States federal statute signed into law by President Barack Obama on March 23, 2010. Together with the Health Care and Education Reconciliation Act, it represents the most significant regulatory overhaul of the U.S. healthcare system since the passage of Medicare and Medicaid in 1965. The ACA was enacted with the goals of increasing the quality and affordability of health insurance, lowering the uninsured rate by expanding public and private insurance coverage, and reducing the costs of healthcare for individuals and the government. It introduced a number of mechanisms—including mandates, subsidies, and insurance exchanges—meant to increase coverage and affordability. The law also requires insurance companies to cover all applicants within new minimum standards and offer the same rates regardless of pre-existing conditions or sex. Additional reforms aimed to reduce costs and improve healthcare outcomes by shifting the system towards quality over quantity through increased competition, regulation, and incentives to streamline the delivery of healthcare.

**Alternative Payment Models (APM's)** – These vest financial responsibility and performance accountability with providers.

**Alternative Quality Contracts/Alternative Payment Contracts (AQC/APC)** - methods of payment that are not fee-for-service based and compensate ACOs and other providers for the provision of health care services, including but not limited to shared savings arrangements, bundled payments, episode- based payments, and global payments.

**Americans with Disabilities Act (ADA)** – The Americans with Disabilities Act (ADA) gives civil rights protections to individuals with disabilities that are like those provided to individuals on the basis of race, sex, national

origin, and religion. It guarantees equal opportunity for individuals with disabilities in employment, public accommodations, transportation, State and local government services, and telecommunications.

**Bundled Payment** - Bundled payment systems (also known as “case rates” or “episode-based payment”) involve a single payment for all services related to a treatment or condition, possibly spanning multiple providers in multiple settings. For example, a single payment could be made for coronary artery bypass graft (CABG) surgery, including pre-surgical services, facility and physician fees for the inpatient surgical procedure, and follow-up care, including monitoring and cardiac rehabilitation. Providers assume financial risk for the cost of services for a particular treatment or condition as well as costs associated with preventable complications.

**Capitation** - A specified amount of money paid to a health plan or doctor. This is used to cover the cost of a health plan member’s health care services for a certain length of time.

**Carrier**- Term for an insurer or insurance company

**Carved-out** - A program that excludes certain services—usually from the capitated rate—and tends to focus on one disease in depth. It can also refer to an arrangement in which some benefits (ie, mental health) are removed from the coverage provided by an insurance plan but are provided through a contract with a separate set of providers. Generally, a population subgroup for whom separate health care arrangements are made.

**Center for Health Information and Analysis (CHIA)** - CHIA is a government agency that serves as the hub of information and data analysis for the Massachusetts health care system. Massachusetts hospital financial performance information includes annual and quarterly reports with aggregate data and individual hospital fact sheets for Massachusetts hospitals.

**Centers for Medicare and Medicaid (CMS)** - The Centers for Medicare & Medicaid Services (CMS) is an agency within the US Department of Health & Human Services responsible for administration of several key federal health care programs. In addition to Medicare (the federal health insurance program for seniors) and Medicaid (the federal needs-based program), CMS oversees the Children’s Health Insurance Program (CHIP), the Health Insurance Portability and Accountability Act (HIPAA) and the Clinical Laboratory Improvement Amendments (CLIA), among other services.

**Commonwealth Care** – A health connector program that offers subsidized insurance to Massachusetts residents who have annual incomes of up to 300% of the federal poverty level. Commonwealth Care members get free or low cost health services through managed care health plans. There are several health plans to choose from. The plans are offered by private health insurance companies.

**Commonwealth Choice** - A health connector program that certifies and provides commercial health products to Massachusetts residents and small business. It also serves large employers that want to provide health insurance options to classes of employees that are not eligible for the employer’s regular plan. Commonwealth Choice is a health insurance program for uninsured adult Massachusetts residents whose incomes are too high for Commonwealth Care. The program offers “good value” private unsubsidized health insurance that meets the requirements of the state’s mandatory health insurance law. The private health plans are approved by the Commonwealth Connector Authority.

**Consolidated Omnibus Budget Reconciliation (COBRA)** – A federal law that allows some people to continue coverage through a former employer’s health insurance plan for a limited time.

**Mini-COBRA - (State Continuation of Coverage Law)** – Continues health benefits to employees of small businesses with 2-19 employees. Employees can elect to take COBRA benefits when they leave employment permanently or for a defined period (leave of absence), or other qualifying event. The employee remains on the employer’s records and enrolled in the employer’s group benefit.

**Co-Insurance** - Having a health plan that requires the patient to pay a coinsurance, or percentage participation, rate means that they will essentially be splitting the cost of their healthcare with their insurance carrier. For instance, if their health plan has an 80/20 co-insurance rate, (coinsurance rates of 70/30 90/10, and flat rates of \$5.00 to \$20.00 per doctor’s office visit are also common) their insurance plan pays for 80% of the eligible medical expenses and they are responsible for the remaining 20%.

**Conditions of Participation (CoP)/ Conditions for Coverage (CfC)** - CMS develops Conditions of Participation (CoPs) and Conditions for Coverage (CfCs) that health care organizations must meet in order to begin and continue participating in the Medicare and Medicaid programs. These health and safety standards are the foundation for improving quality and protecting the health and safety of beneficiaries. CMS also ensures that the standards of accrediting organizations recognized by CMS (through a process called “deeming”) meet or exceed the Medicare standards set forth in the CoPs / CfCs.

**Copayment/copay**- a payment made by a beneficiary for health services in addition to that made by an insurer. A copayment or copay is a fixed payment for a covered service, paid when an individual receives service. The copayment is a payment defined in an insurance policy and paid by an insured person each time a medical service is accessed.

**Coinsurance** - coinsurance is a percentage of the total charge that the patient must pay after the deductible, up to a certain limit. It must be paid before any policy benefit is payable by an insurance company. Coinsurance usually contribute towards any policy out-of-pocket maxima whereas copayments do not.

**Deductible**- The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your deductible is \$1,000, your plan won’t pay anything until you’ve met your \$1,000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.

**Determination of Need (DON)/Certificate of Need (CON)** — DON was established by the Massachusetts Legislature in 1971 to encourage equitable geographic and socioeconomic access to health care services, help maintain standards of quality, and constrain overall health care costs by eliminating duplication of expensive technologies, facilities and services. The program is housed in the Department of Public Health.

**Diagnostic Related Group (DRG)** — is a system to classify hospital cases into one of originally 467 groups. The system was developed for reimbursement, to replace “cost based” reimbursement that had been used up to that point. DRGs are assigned by a “grouper” program based on ICD (International Classification of Diseases) diagnoses, procedures, age, sex, discharge status, and the presence of complications or comorbidities. DRGs have been used in the US since 1982 to determine how much Medicare pays the hospital for each “product”,

since patients within each category are clinically similar and are expected to use the same level of hospital resources.[3] DRGs may be further grouped into Major Diagnostic Categories (MDCs). DRGs are also standard practice for establishing reimbursements for other Medicare related reimbursements such as to home healthcare providers.

**Disproportionate Share Hospital (DSH)** — The United States government provides funding to hospitals that treat indigent patients through the Disproportionate Share Hospital (DSH) programs, under which facilities are able to receive at least partial compensation. Although 3,109 hospitals receive this adjustment, Medicare DSH payments are highly concentrated. Ninety three percent of total DSH payments go to large hospitals in urban areas and teaching hospitals receive about 65 percent of all DSH payments. Additionally, because Medicaid eligibility and coverage vary widely across states, Medicare DSH payments are distributed unevenly across geographic areas: the Middle Atlantic, South Atlantic, and Pacific regions account for 60 percent of all DSH payments but only 46 percent of Medicare discharges.

**Dual-eligible beneficiaries (Medicare dual eligible)** — those qualifying for both Medicare and Medicaid benefits—accounted for under one-fifth of each program’s population but over one-third of each program’s spending. These dual eligible beneficiaries have complex and often costly health care needs, and have been the focus of many recent initiatives and proposals to improve the coordination of their care aimed at both raising the quality of their care while reducing its costs. An example is the One Care pilot program in MassHealth for adult “dual-eligible” disabled population.

**Electronic Health Record (EHR)/Electronic Medical Record (EMR)** – An electronic health record (EHR), or electronic medical record (EMR), is a systematic collection of electronic health information about an individual patient or population. It is a record in digital format that is theoretically capable of being shared across different health care settings. In some cases this sharing can occur by way of network-connected, enterprise-wide information systems and other information networks or exchanges. EHRs may include a range of data, including demographics, medical history, medication and allergies, immunization status, laboratory test results, radiology images, vital signs, personal statistics like age and weight, and billing information. The system is designed to represent data that accurately captures the state of the patient at all times. It allows for an entire patient history to be viewed without the need to track down the patient’s previous medical record volume and assists in ensuring data is accurate, appropriate and legible. It reduces the chances of data replication as there is only one modifiable file, which means the file is constantly up to date when viewed at a later date and eliminates the issue of lost forms or paperwork. Due to all the information being in a single file, it makes it much more effective when extracting medical data for the examination of possible trends and long term changes in the patient.

**Exclusive Provider Organization (EPO)** – a type of managed care organization in which no coverage is typically provided for services received outside the EPO.

**Federal Poverty Level (FPL)** – The Federal Poverty Line (FPL) is the set minimum amount of gross income that a family needs for food, clothing, transportation, shelter and other necessities. In the United States, this level is determined by the Department of Health and Human Services (HHS). The Federal Poverty Line varies according to household size, and the number is adjusted for inflation and reported annually in the form of poverty level guidelines. The 2014 guidelines are a single person household has an income of \$ 11,670 and a household of 4 people has an income of \$23,850 per year.

**Fee-For-Service (FFS)** – is a payment model where services are unbundled and paid for separately. In health care, it is believed it gives an incentive for physicians to provide more treatments because payment is dependent on the quantity of care, rather than quality of care. Similarly, when patients are shielded from paying (cost-sharing) by health insurance coverage, they are incentivized to welcome any medical service that might do some good. FFS is the dominant physician payment method in the United States. It raises costs, discourages the efficiencies of integrated care, and a variety of reform efforts have been attempted, recommended, or initiated to reduce its influence (such as moving towards bundled payments and capitation). It is believed; however, that in capitation, physicians are discouraged from performing procedures, including necessary ones, because they are not paid anything extra for performing them.

**Fully Insured Plan** – A plan where the employer contracts with another organization to assume financial responsibility for the enrollees’ medical claims and for all incurred administrative costs.

**Global Payment** - Global payments prospectively compensate providers for all or most of the care that their patients may require over a contract period, such as a month or year. Usually estimated from past cost experience and an actuarial assessment of future risk related to patient demographics and known medical conditions, global payments reflect the expected costs of covered services. As with episode-based payments, providers hold performance risk in a global payment system. To protect providers from also holding insurance risk, global payments must be risk-adjusted so that they reflect the underlying health conditions and predictable probability of illness among each provider’s patients. Carriers might also develop stop loss or risk corridor arrangements with providers to further protect them from insurance risk. Insurance carriers retain insurance risk for unpredictable illness and also adjust the level of global payments to reflect expected cost of consumer incentives (such as cost sharing for particular services or providers) in their benefit designs.

**Gross State Products (GSP)** - A measurement of the economic output of a state. It is the sum of all value added by industries within the state and serves as a counterpart to the Gross Domestic Product (GDP).

**Gross Domestic Product (GDP)** -The gross domestic product (GDP) is one the primary indicators used to gauge the health of a country’s economy. It represents the total dollar value of all goods and services produced over a specific time period - you can think of it as the size of the economy. Usually, GDP is expressed as a comparison to the previous quarter or year. For example, if the year-to-year GDP is up 3%, this is thought to mean that the economy has grown by 3% over the last year.

**Health Insurance Portability and Accountability Act (HIPAA)** – A US law designed to provide privacy standards to protect patients’ medical records and other health information provided to health plan, doctors, hospitals, and other health care providers.

**Health Maintenance Organization (HMO)** – A health care plan that assumes both the financial risks associated with providing comprehensive medical services (insurance and service risk) and the responsibility for health care delivery in a particular geographic area to HMO members, usually in return for a fixed, prepaid fee.

**Health Plan Employer Data and Information Set (HEDIS)**- is a widely used set of performance measures in the managed care industry, developed and maintained by the National Committee for Quality Assurance (NCQA). HEDIS was designed to allow consumers to compare health plan performance to other plans and to national or regional benchmarks. Although not originally intended for trending, HEDIS results are

increasingly used to track year-to-year performance. HEDIS is one component of NCQA's accreditation process, although some plans submit HEDIS data without seeking accreditation. An incentive for many health plans to collect HEDIS data is a Centers for Medicare and Medicaid Services (CMS) requirement that health maintenance organizations (HMOs) submit Medicare HEDIS data in order to provide HMO services for Medicare enrollees under a program called Medicare Advantage.

**Health Policy Commission (HPC)** - Commission established in Chapter 224 of the Acts of 2012 to improve the quality of health care and reduce costs.

**In-Network** – when covered individuals select a provider that has contracted with the health plan. This can impact the out-of-pocket costs to the patient. Out-of-network visits often cost the patient more.

**Indemnity Plan** – A type of medical plan that reimburses the patient and/or provider as expenses are incurred. The plans may include deductibles, copayments, coinsurance, and maximum out of pocket or other cost sharing elements to its reimbursement structure.

**Individual Practice Association (IPA)** – A type of health care provider organization composed of a group of independent practicing physicians who maintain their own offices and band together for the purposes of contracting their services.

**Length of Stay (LOS)** - is a term to describe the duration of a single episode of hospitalization. Inpatient days are calculated by subtracting day of admission from day of discharge. (However, persons entering and leaving a hospital on the same day have a length of stay of one.)

**Limited Network** – Also called a **Select Network** a Limited Network is an exclusive provider network providing health care services to members. Generally, there is no coverage for care received from a non-network (out-of-network) provider except in an emergency situation.

**Long Term Care (LTC)** - Long term care is care that you need if you can no longer perform everyday tasks (activities of daily living) by yourself due to a chronic illness, injury, disability or the aging process. Long term care also includes the supervision you might need due to a severe cognitive impairment (such as Alzheimer's disease). This type of care is not intended to cure you. It is chronic care that you might need for the rest of your life. You can receive long term care in your own home, a nursing home or another long term care facility, such as an assisted living facility. People often confuse long term care with disability or short-term medical care. Long term care is not care that you receive in the hospital or your doctor's office, care you need to get well from a sickness or an injury, short-term rehabilitation from an accident, recuperation from surgery.

**Mandated Benefit** - A benefit that a health plan is required by law to provide in their plans.

**Managed Care**- Managed care plans provide comprehensive health services to their members, and offer financial incentives for patients to use the providers offered by the plan (In-network providers). Examples of managed care plans include:

- Exclusive Provider Organizations (EPO's)
- Health Maintenance Organizations (HMO's)

- Managed Care Organizations (MCO's)
- Point of Service Plans (POS's)
- Preferred Provider Organizations (PPO's)

**MassHealth** – MassHealth is the name for the Medicaid program in Massachusetts. It is a public health insurance program for low- to medium-income residents of Massachusetts, including a program for individuals who are HIV positive. Because of the Affordable Care Act, more Massachusetts residents qualify for MassHealth. MassHealth also manages the Insurance Partnership for small businesses, the Children's Medical Security Plan, Healthy Start, and the Special Kids/Special Care Pilot Program, cosponsored with the Department of Social Services.

**Medicare** – a federal program of health care coverage for the elderly and disabled.

- **Medicare Part A** – Medicare Part A does not cover all medical situations. It is specifically for inpatient hospital care, home health care, hospice services and treatment in a skilled nursing facility. Skilled nursing facility care is not the same as custodial care in a long-term facility such as a nursing home. You must first have been a hospital inpatient, and the skilled nursing facility stay must be fairly short-term. In fact, no part of Medicare offers long-term or custodial care benefits.
- **Medicare Part B** - Medicare Part B covers services (like lab tests, surgeries, and doctor visits) and supplies (like wheelchairs and walkers) considered medically necessary to treat a disease or condition. Part B covers services or supplies that are needed to diagnose or treat a medical condition. Also, it covers preventive services to prevent illness (like the flu) and screening to detect diseases at early stages.
- **Medicare Part C** – also known as Medicare Advantage Plans are offered by private companies approved by Medicare. An individual with a Medicare Advantage Plan still has Medicare. They get their Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance) coverage from the Medicare Advantage Plan and not original Medicare. Medicare Advantage Plans cover all Medicare services. Medicare Advantage Plans may also offer extra or more coverage than original Medicare. Medicare pays a fixed amount for care each month to the companies offering Medicare Advantage Plans. These companies must follow rules set by Medicare. However, each Medicare Advantage Plan can charge different out-of-pocket costs and have different rules for how one get services (like whether a referral is needed to see a specialist or if the patient has to go to only doctors, facilities, or suppliers that belong to the plan for non-emergency or non-urgent care). These rules can change each year.
- **Medicare Part D** – is the drug prescription coverage plan. Each Medicare Prescription Drug Plan has its own list of covered drugs (called a formulary). Many Medicare drug plans place drugs into different “tiers” on their formularies. Drugs in each tier have a different cost. A drug in a lower tier will generally cost less than a drug in a higher tier. In some cases, if the drug is on a higher tier and the prescriber thinks the patient needs that drug instead of a similar drug on a lower tier, the prescriber can ask for an exception to get a lower copayment.

**Medical Savings Accounts (MSA)** – savings accounts designated for out-of-pocket medical expenses. In an MSA, employers and individuals are allowed to contribute to a savings account on a pre-tax basis and carry over the unused funds at the end of the year. One major difference between a Flexible Spending Account (FSA) and MSA is the ability to carry over the unused funds for use in a future year instead of losing unused funds at the end of the year.

**Medicaid Managed Care Organization (MMCO)** – The MMCO program administered through MassHealth (MA Medicaid Program) sets up contracts with certain payors. The MMCO payor plans are at full financial risk to arrange health care for their enrollees through contracted provider networks. MMCO’s are responsible for the physical health, behavioral health, and pharmacy services their members require (not long term care or dental care which MassHealth covers on a fee-for-service (FFS) basis).

**Minimum Premium Plan (MPP)** – A plan where the employer and the insurer agree that the employer will be responsible for paying all claims up to an agreed-upon aggregate level, with the insurer responsible for the excess. The insurer usually is also responsible for processing claims and administrative services.

**Multiple Employer Welfare Arrangement (MEWA)** – MEWA is a technical term under federal law that encompasses any arrangement not maintained pursuant to a collective bargaining agreement (other than a state licensed insurance company or HMO) that provides health insurance to the employees of two or more private employers.

**National Institute of Health (NIH)** - The National Institutes of Health (NIH), a part of the U.S. Department of Health and Human Services, is the nation’s medical research agency—making important discoveries that improve health and save lives. NIH is the largest source of funding for medical research in the world, creating hundreds of thousands of high-quality jobs by funding thousands of scientists in universities and research institutions in every state across America and around the globe. NIH is made up of 27 Institutes and Centers, each with a specific research agenda, often focusing on particular diseases or body systems. NIH leadership plays an active role in shaping the agency’s research planning, activities, and outlook.

**National Committee for Quality Assurance (NCQA)** - The National Committee for Quality Assurance is a private, 501(c)(3) not-for-profit organization dedicated to improving health care quality. NCQA has been a central figure in driving improvement throughout the health care system, helping to elevate the issue of health care quality to the top of the national agenda. The NCQA seal is a widely recognized symbol of quality. Organizations incorporating the seal into advertising and marketing materials must first pass a rigorous, comprehensive review and must annually report on their performance. For consumers and employers, the seal is a reliable indicator that an organization is well-managed and delivers high quality care and service.

**Nurse Practitioner (NP)** – A nurse practitioner (NP) is an advanced practice registered nurse (APRN) who has completed advanced coursework and clinical education beyond that required of the generalist registered nurse (RN) role. According to the International Council of Nurses, an NP/advanced practice registered nurse is “a registered nurse who has acquired the knowledge base, decision-making skills, and clinical competencies for expanded practice beyond that of an RN, the characteristics of which would be determined by the context in which he or she is credentialed to practice.

**Out-of-Network** – a provider that has not contracted with a particular health plan is out-of-network.

**Out-of-Pocket** – Expenses incurred by the patient that are not covered by any insurance plan. Out-of-pocket costs include deductibles, coinsurance, and copayments for covered services plus all costs for services that aren’t covered.

**Out-of-pocket maximum** – The most a patient will have to pay for covered medical expenses in a plan year through deductible and coinsurance before your insurance plan begins to pay 100 percent of covered medical expenses.

**Partial Capitation** – A plan is paid for providing services to enrollees through a combination of capitation and fee for service reimbursements.

**Patient Centered Medical Home /Advanced or Medical Home (PCMH)** – The medical home, also known as the patient-centered medical home is an approach to providing comprehensive primary care that facilitates partnerships between individual patients, and their personal providers, and when appropriate, the patient’s family.

**Payer** – In health care, an entity that assumes the risk of paying for medical treatments. This can be an uninsured patient, a self-insured employer, a health plan, or an HMO.

**Pay for Performance** – financial incentives that reward providers for the achievement of a range of payer objectives, including delivery efficiencies, submission of data and measures to payer, and improved quality and patient safety.” Health plans, large employers, and other purchasers of health care services, including Medicare and Medicaid, seek evidence on what works and what does not work in AHRQ Resources on Pay for Performance (P4P), including what benchmarks to use and how to structure incentives to promote and sustain quality improvement.

**Personal Health Information (PHI)** – also referred to as protected health information, generally refers to demographic information, medical history, test and laboratory results, insurance information and other data that is collected by a health care professional to identify an individual and determine appropriate care.

**Physician Assistant (PA)** – A Physician Assistant is a healthcare professional who is licensed to practice medicine as part of a team with physicians. PAs are concerned with preventing and treating human illness and injury by providing a broad range of health care services under the supervision of physician or surgeon.

**Physician-Hospital Organization (PHO)** – A joint venture between hospitals and physician groups. These entities sell their services to managed care organizations or directly to employees

**Point-of-Service Plan (POS)** – A POS plan is an HMO/PPO hybrid sometimes referred to as an open-ended HMO. POS plans resemble HMO’s for in-network services. Services received outside of the network are usually reimbursed in a manner similar to conventional indemnity plans (e.g. provider reimbursement based on a fee schedule or usual, customary and reasonable charges).

**Pre-existing Condition** – A medical condition that was discovered or treated before the application or effective date or an insurance policy or plan.

**Prescription Monitoring Program (PMP)** – The Massachusetts Prescription Monitoring Program (MA PMP) is a tool that supports safe prescribing and dispensing and assists in addressing prescription drug misuse, abuse and diversion. The MA PMP collects dispensing information on Massachusetts Schedule II through V controlled substances dispensed pursuant to a prescription. Schedules II through V consist of those prescription

drug products with recognized potential for abuse or dependence (e.g., narcotics, stimulants, sedatives). Consequently they are among those most sought for illicit and non-medical use. The Drug Control Program (DCP) analyzes the PMP data to determine prescribing and dispensing trends; provide patient prescription history information to prescribers and dispensers; provide educational information to health care providers and the public; and to provide case information to regulatory and law enforcement agencies concerning drug distribution and diversion.

**Preferred Provider Organization (PPO)** – a preferred provider organization (sometimes referred to as a participating provider organization or preferred provider option) is a managed care organization of medical doctors, hospitals, and other health care providers who have agreed with an insurer or a third-party administrator to provide health care at reduced rates to the insurer’s or administrator’s clients.

**Prescription Tier** – Tiering is used to establish payment or authorization for prescription drugs. Tiers separate Generic, Preferred Brand Name and Non-Preferred Brand Name drugs into groups with differing reimbursement rates or allowance without a prior authorization. Health plans set the lowest co-pays for the Generic Tier and the highest co-pays for the Non-Preferred Brand Name tier. A number of factors are considered when classifying drugs into tiers, including, but not limited to the absolute cost of the drug, the cost of the drug relative to other drugs in the same therapeutic class, the availability of the over-the-counter alternatives, and certain clinical and economic factors.

**Primary Care Clinician (PCC)** – Primary Care Clinician is a primary health care provider often also referred to as a Primary Care Provider (PCP). This is usually a physician, but can also be a nurse practitioner or physician’s assistant who works under the direction of a physician. The following provider types are eligible to become PCCs under the MassHealth PCC Plan; a physician, an independent nurse practitioner, a community health center, an acute outpatient hospital, a hospital licensed health center, a group practice organization.

**Primary Care Physician (PCP)** - A primary care physician also referred to as a primary care provider (PCP) is a physician who provides both the first contact for a person with an undiagnosed health concern as well as continuing care of varied medical conditions, not limited by cause, organ system, or diagnosis.

**Primary Care Payment Reform Initiative (PCPRI)** – a three-year program targeted to transitioning PCC Plan providers to APM arrangements, accelerating their transformation into primary care medical homes and promoting the integration of behavioral health and primary care services. Among its participation standards, PCPRI requires providers to achieve NCQA medical home certificates, meaningful use of health information technology and meaningful reporting standards for access, care management and quality.

**Program of All-inclusive Care for the Elderly (PACE)** – PACE elder service plans provide comprehensive medical and social services to frail elders so they can live in their communities instead of in nursing homes.

**Provider** – A provider of health care services such as a physician, nurse, hospital, skilled nursing facility, home health agency.

**Provider Network** – A group of medical providers who have agreed to serve a health plan or medical facility’s members or patients.

**Self-insured Plan** – A plan offered by employers who directly assume the major cost of health insurance for their employees. Some self-insured plans bear the entire risk. Other self-insured employers insure against large claims by purchasing stop-loss coverage.

**Senior Care Option (SCO)** – A program in MassHealth that is a partnership between MassHealth and Medicare that provides an integrated and complete package of health care and social services for low-income seniors

**Stop-Loss Coverage** – A form of reinsurance for self-insured employers that limits the amount the employers will have to pay for each person’s health care (individual limit) or for the total expenses of the employer (group limit).

**Supplemental Nutrition Assistance Program (SNAP)** - formerly known as Food Stamps. SNAP offers nutrition assistance to millions of eligible, low-income individuals and families and provides economic benefits to communities. SNAP is the largest program in the domestic hunger safety net. The Food and Nutrition Service (FNS) works with State agencies, nutrition educators, and neighborhood and faith-based organizations to ensure that those eligible for nutrition assistance can make informed decisions about applying for the program and can access benefits.

**Third Party Administrator (TPA)** - is an organization that processes insurance claims or certain aspects of employee benefit plans for a separate entity. This can be viewed as “outsourcing” the administration of the claims processing, since the TPA is performing a task traditionally handled by the company providing the insurance or the company itself. Often, in the case of insurance claims, a TPA handles the claims processing for an employer that self-insures its employees. Thus, the employer is acting as an insurance company and underwrites the risk. The risk of loss remains with the employer, and not with the TPA. An insurance company may also use a TPA to manage its claims processing, provider networks, utilization review, or membership functions. While some third-party administrators may operate as units of insurance companies, they are often independent.

**The Triple Aim** is a framework developed by the Institute for Healthcare Improvement that describes an approach to optimizing health system performance. It is IHI’s belief that new designs must be developed to simultaneously pursue three dimensions, which are called the “Triple Aim”:

- Improving the patient experience of care (including quality and satisfaction)
- Improving the health of populations
- Reducing the per capita cost of health care

**Value-Based Purchasing (VBP)** - Hospital Value-Based Purchasing is part of the Centers for Medicare & Medicaid Services’ (CMS) long-standing effort to link Medicare’s payment system to a value-based system to improve healthcare quality, including the quality of care provided in the inpatient hospital setting. The program attaches value-based purchasing to the payment system that accounts for the largest share of Medicare spending, affecting payment for inpatient stays in over 3,500 hospitals across the country. Participating hospitals are paid for inpatient acute care services based on the quality of care, not just quantity of the services they provide.



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