Accountable Care Organization (ACO): A network of health care providers that band together to provide the full continuum of health care services for patients. The network payment would receive a payment for all care provided to a patient, and would be held accountable for the quality and cost of care. (In Utah, the Legislature created a "Medicaid ACO" where managed care insurance companies in Utah assume the risk for a Medicaid population. Healthy U is the Medicaid managed care organization sponsored by UUHC.)

Capitation: A method of paying for health care services under which providers receive a set payment for each person or “covered life” instead of receiving payment based on the number of services provided or the costs of the services rendered.

Disproportionate Share Hospital (DSH) Payments: Payments made by the state’s Medicaid program to hospitals that the state designates as serving a “disproportionate share” of low-income or uninsured patients. These payments are in addition to the regular payments such hospitals receive for providing inpatient care to Medicaid beneficiaries. UUHC is a DSH “Hospital” System, but because of the unique national history of DSH funding levels, Utah receives less funds than any other State.

Federal Medical Assistance Percentage (FMAP): The statutory term for the federal Medicaid matching rate—i.e., the share of the costs of Medicaid services or administration that the federal government bears. The Federal share for Utah is one of the highest in the country at approximately 70%

Fee-for-Service: A traditional method of paying for medical services under which doctors and hospitals are paid for each service they provide.

Health Insurance Exchange/Connector: A purchasing arrangement through which insurers offer, and smaller employers and individuals purchase health insurance. State, regional, or national exchanges could be established to set standards for what benefits would be covered, how much insurers could charge, and the rules insurers must follow in order to participate in the insurance market. Utah has established an Exchange but has limited membership at this date.

Health Reimbursement Account (HRA): A tax-exempt savings account that can be used to pay for current or future qualified medical expenses. HRAs are established benefit plans funded solely by employer contributions, with no limits on the amount an employer can contribute.

Health Saving Accounts (HSA): A tax-exempt savings account that can be used to pay for current or future qualified medical expenses. Employers may make HSAs available to their employees, or individuals can obtain HSAs from qualified financial institutions. Only available to individuals covered under an HSA-qualified high deductible health plan.

Managed Care: A health delivery system that seeks to control access to and utilization of health care services both to limit health care costs and to improve the quality of the care provided. Managed care arrangements typically rely on primary care physicians to act as “gatekeepers” and manage the care their patients receive.

Meaningful Use: The American Recovery and Reinvestment Act of 2009 specifies three main components of Meaningful Use: the use of the Electronic Health Record (EHR) in a meaningful manner, such as e-prescribing; the use of certified EHR technology for electronic exchange of health information to improve quality of health care; and the use of certified EHR technology to submit clinical quality and other measures. (We must show Meaningful Use now to obtain stimulus dollars and avoid penalties in the future.)

Medicaid Waivers: Authority granted by the Secretary of Health and Human Services to allow a state to continue receiving federal Medicaid matching funds even though it is no longer in
compliance with certain requirements of Medicaid statute. Utah has several Medicaid waivers in place but the latest waiver submitted to HHS in 2011, met with Federal resistance and many of the requested exemptions were not approved.

**Medical Home:** A health care setting where patients receive comprehensive primary care services having an ongoing relationship with a primary care provider who directs and coordinate their care.

**Medical Loss Ratio:** The percentage of premium dollars an insurance company spends on medical care, as opposed to administrative costs or profits.

**Pay for Performance:** A health care payment system in which providers receive incentives for meeting or exceeding quality, and sometimes cost, benchmarks.

**Payment Bundling:** A mechanism of provider payment where providers or hospitals receive a single payment for all the care provided for an episode of illness, rather than per service.

**Public Plan Option:** A proposal to create a new insurance plan administered and funded by federal or state government that would be offered along with private plans in a newly-created health insurance exchange.

**Self-Insured Plan:** A plan where the employer assumes direct financial responsibility for the costs of enrollees’ medical claims. Employee sponsored self-insured plans typically contract with a third-party administrator or insurer to provide administrative services for the plan. The University of Utah manages a self-insurance plan for all of its employees. Recent changes are underway that will split the self-insurance plan into a UUHC plan and all other employees.

**Single-Payer System:** A health care system in which a single entity pays for health care services. This entity collects health care fees and pays for all health care costs, but is not involved in the delivery of health care.

**Triple Aim:** Improving the individual experience of care; improving the health of populations; and reducing the per capita costs of care for populations. (Health Affairs, 2008)

**Value-Based Purchasing Program (VBP):** Introduced by Centers for Medicare & Medicaid Services (CMS) as a Quality Incentive Program built on the Hospital Inpatient Quality Reporting (IQR) infrastructure. CMS will only pay for care that rewards better value and patient outcomes, instead of just volume of services. Hospitals will be evaluated on Clinical Process Domain Score which include 12 process care measures (70%) and Patient Experience Domain Score which include eight experiences of care dimensions (30%) which will equal the Total Performance Score. CMS payment percentage will be determined on the Total Performance Score.


**Website**

Refer to our website for a comprehensive glossary of terms published by the Kaiser Foundation.

http://healthsciences.utah.edu/hcr

- Resource Library
- PowerPoint Presentations