The Health Care Transformation Glossary

The Health Care Transformation Glossary—which was compiled using a variety of sources—helps to educate your staff, governance and community about the new language associated with transformation. Using a common language that everyone understands is a key step toward transformative collaboration.

**1115 Waivers** are used by states to provide federal funding to test and implement Medicaid coverage approaches that do not meet federal program rules. States can apply for program flexibility to test new or existing approaches to financing and delivering Medicaid and the Children’s Health Insurance Program.

**Accountable Care Entity (ACE)**
An Accountable Care Entity is a new entity created under the Medicaid program to coordinate care for the Illinois Medicaid population in 2014. An ACE can be either a single corporation or a network of providers organized through contracts with a single corporate entity and have the following attributes and capabilities:

- Be an integrated delivery system that is able to provide the full range of services needed to serve Medicaid beneficiaries;
- Provide hospital, primary, specialty, and behavioral health care;
- Have the capacity to securely share clinical information with its participating providers;
- Be able to aggregate and analyze such shared data to coordinate the care of its Medicaid beneficiaries;
- Be able to provide both care coordination and complex case management;
- Have a plan to reduce the cost of care; and
- Be able to process claims and encounter data, and implement utilization control and quality assurance.

**Aid to the Aged, Blind and Disabled (AABD)**
A program that provides state supplemental payments to persons who meet the aged, blind and disabled requirements of the Supplemental Security Income (SSI) program, but who need income in excess of the SSI level.

**Accountable Care Organization (ACO)**
Accountable Care Organizations are health care providers (doctors, hospitals, etc.) who together voluntarily provide coordinated, high-quality care while sharing savings or risk.
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**Bundled Payment**
The bundled payments initiative is a payment structure that provides a fixed payment for an episode of care (e.g., hip replacement) that covers all the services associated with that episode to produce better outcomes at a lower cost to Medicare.

**Capitation**
Capitation payments manage health care costs by paying providers a fixed amount using a per member per month formula. Care organizations measure patient outcomes and resource utilization by physicians to reduce risk of suboptimal care through underutilization of health care services.

**Care Continuum**
The care continuum is the full spectrum of health care services spanning all levels of care available to comprehensively address the health care needs of patient populations.

**Care Coordination**
Care coordination is a coordinated effort between two or more participants in the delivery of a patient’s health care services to ensure that the patient receives the right care, at the right time, in the right setting, to achieve the best and most efficient outcomes.

**Care Coordination Entity (CCE)**
A Care Coordination Entity is a collaboration of providers that builds and implements a care coordination model that meets the state’s guidelines for managing the care of assigned Medicaid patients. In order to be effective, CCE program collaborators must include hospitals, primary care providers, and mental health and substance abuse providers.

**Center for Medicare and Medicaid Innovation (CMMI)**
The Center for Medicare & Medicaid Innovation supports the development and testing of innovative health care payment and service delivery models aimed at reducing government program expenditures while preserving or enhancing the quality of care.

**Clinical Integration**
Clinical integration facilitates the coordination of patient care across conditions, providers, settings, and time, in order to achieve care that is safe, timely, effective, efficient, equitable and patient-focused. To achieve clinical integration, our nation’s health care system needs to promote changes in provider culture, redesign payment methods and incentives, and modernize federal laws.

**Community-Based Care Transitions Program (CCTP)**
The Community-based Care Transitions Program tests pilot projects for improving care transitions from the hospital to other settings and lessening the likelihood of readmissions for high-risk Medicare beneficiaries.
eHealth (mHealth)
eHealth is health services supported by mobile devices, such as cellular phones or tablets.

Electronic Health Record (EHR)
An electronic health record is a digitally formatted collection of health information about individual patients, as well as large populations, that has the capability of being shared across different health care settings.

End-Of-Life Care
End-of-life care involves all critical decisions that must be made and actions taken during the last stages of care a patient receives. Decisions involving a patient’s right to refuse or accept certain care must be addressed.

Federally Qualified Health Center (FQHC)
Federally Qualified Health Centers are community-based organizations that provide comprehensive primary and preventive care, including oral and mental health and substance abuse services to persons of all ages, regardless of their ability to pay or health insurance status.

Health Care Transformation
Health care transformation is the effort to improve health outcomes, access to health services, the way patient care is delivered, and ultimately, changing from a volume-based to a value-based health care system.

Health Care Transparency
Health care transparency involves providing reliable and accurate cost and quality information to empower consumers to make informed and value-based health care choices.

Health Information Exchange (HIE)
Health Information Exchange is an electronic patient information repository that allows protected electronic transmission and sharing of health care information about patients within a region, community or hospital system.

Health Insurance Marketplace
A Health Insurance Marketplace is a new entity under the Affordable Care Act, designed to help expand health insurance coverage. Individuals and small businesses in Illinois will be able to purchase private health insurance from a set of government-regulated and standardized health care plans approved to offer plans through the entity and access the subsidies for low-income individuals.
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**High-Quality Health Care**
High-quality health care is the approach and extent to which health care is optimally delivered to patients and patient populations throughout an entire organization.

**In-Person Assistor**
In-Person Assistors will work to educate the public and small business about qualified health plans available via the Health Insurance Marketplace.

**Integrated Care Program (ICP)**
The Integrated Care Program is a program for older adults and adults with disabilities who are eligible for Medicaid, but not eligible for Medicare. The ICP organizes medical care by involving primary care providers, specialists, hospitals, nursing homes and other providers, to facilitate care around a patient’s needs for a predetermined monthly fee coordinated through a specific network of providers.

**Managed Care Community Network (MCCN)**
A Managed Care Community Network provides or arranges primary, secondary and tertiary managed health care services through health care providers under a full-risk capitation contract with the Illinois Department of Healthcare and Family Services.

**Managed Care Organization (MCO)**
A Managed Care Organization is a health care delivery system consisting of affiliated and/or owned hospitals, physicians and others which provide coordinated health services to assigned patients in return for a predetermined monthly fee or other shared risk or savings incentives.

**Medicare-Medicaid Alignment Initiative (MMAI)**
Medicare-Medicaid Alignment Initiative is a federally funded opportunity for states to participate in demonstration projects to align financing between Medicare and Medicaid to support improvements in quality and cost of care to individuals who qualify for care under both the Medicare and Medicaid programs—also known as dual eligible.

**Mid-Level Practitioner**
A mid-level practitioner is a licensed health care professional other than a physician such as advanced practice nurses and physician assistants.
Minimum Essential Health Benefits
The minimum essential health benefits are the minimum coverage that health plans offered on the state Marketplaces must provide. Those minimum standards are intended to mirror the typical employer-sponsored health plan.

Navigator
The Navigator program will help enroll individuals in health plans available via the state Marketplaces. Navigators are also responsible for providing unbiased education on health care coverage.

Network (or Participating) Provider
A network or participating provider is a physician, hospital and other provider that has agreed to offer health care services to members of a specific health insurance plan.

Open Enrollment
Open enrollment is the period of time consumers are allotted to choose from or change available insurance plans, usually once a year.

Patient-Centered Medical Home
The Patient-Centered Medical Home is a health care setting that facilitates partnerships among individual patients and their personal physicians, and when appropriate, the patient’s family. Care is managed through a registry, information technology, and health information exchange to assure patients get the indicated care, when and where they need and want it, in a culturally and linguistically suitable method.

Personal Responsibility
Personal responsibility is the patient’s capacity to harness the full benefits of health care services by being accountable for one’s health by taking actions to stay healthy and managing one’s own wellness.

Physician Alignment (Engagement)
Physician alignment is the efficient synergy of physicians with their working environment. It is founded on a common mission that drives successful engagement by establishing goals that are equally beneficial to hospitals, health care organizations and physicians.
Population Health
Population health aims to improve the overall health of a specific population by addressing the range of factors that affect a population and aiming to reduce health inequities among populations.

Primary Care Case Management (PCCM)
Primary Care Case Management is a system of care used by state Medicaid agencies in which a primary care provider is accountable for approving and monitoring the care of enrolled Medicaid beneficiaries and is paid a monthly fee for doing so.

Provider Network
A provider network is the collection of physicians, hospitals and other providers that offer health care services to members of a specific health insurance plan.

Qualified Health Plan (QHP)
A qualified health plan is a certified insurance plan that will be made available via a Marketplace. The qualified health plan must meet all the requirements put in place by the state for plans offered on the Marketplace.

Shared Decision-Making
Shared decision-making is a collaborative effort between patients and doctors to make health care decisions, taking into account scientific evidence as well as the patient’s own values.

Shared Risk
Shared risk payment models rely upon providers taking on whole or partial financial risk for the care of an assigned patient population.

Shared Savings
Shared savings payment models rely upon providers sharing in some portion of the savings they can generate through better and more efficient care compared to the cost of the volume-based, fee-for-service payment model.

State Innovations Model (SIM) Grant
The State Innovations Model Grant is funding that will support the design and development of new and better health system approaches for residents of participating states.
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Telemedicine
Telemedicine is the combined use of information and telecommunication technology to provide clinical care to patients who are not in the physical presence of the treating physician. It helps to improve access to medical services that would often not be available to individuals who reside in distant rural, medically-underserved communities.

Uncompensated Care
Uncompensated care is health care services for which providers are not reimbursed or compensated.

Upper Payment Limit (UPL)
The upper payment limit is the cap on federal matching funds related primarily to hospital services based on the volume of fee-for-service care provided to Medicaid beneficiaries.

Value-Based Payment
Value-based payment is a payment model that rewards physicians, hospitals, medical groups, and other providers for meeting certain quality and efficiency performance measures.