Pennsylvania Medicaid Glossary & Acronym List

PAMCO
PA Medicaid Managed Care Organizations

Affordable Care Act (ACA): The federal health care reform law enacted in March 2010, sometimes known as "Obamacare."

Behavioral Health Managed Care Organizations (BHMCOs): Specialized Managed Care Organizations specific to Behavioral Health, which provide access to appropriate mental health and/or drug and alcohol services. This component of Health Choices is overseen by the Department of Human Service's Office of Mental Health and Substance Abuse Services (OMHSAS).

Capitation: A fixed dollar amount per member, paid to Medicaid MCOs for the delivery of Medical Assistance services to HealthChoices recipients.

Care Coordination: The organization of a person's treatment across several health care providers. Medical homes and Accountable Care Organizations are two common ways to coordinate care.

Centers for Medicare & Medicaid Services (CMS): The federal agency that runs the Medicare, Medicaid, Children's Health Insurance Programs (CHIP).

Children's Health Insurance Program (CHIP): Federal and State financed insurance "block grant" program that provides low-cost health coverage to children in families that earn too much money to qualify for Medicaid but not enough to buy private insurance.

Community HealthChoices (CHC): A managed care program designed for older Pennsylvanians and individuals with physical disabilities to remain in their homes. Under CHC, managed care organizations (MCOs) coordinate physical health care and long-term services and supports (LTSS) for older people, people with physical disabilities, and people who are eligible for both Medicare and Medicaid.

Consumer Assessment of Healthcare Providers and Systems (CAHPS): Patient experience surveys which focus on how patients experienced or perceived key aspects of their health care. Overseen by the federal Agency for Healthcare Research and Quality (AHRQ), this is a formal source of data used to evaluate MCO performance in PA.

Department of Human Services (DHS): The state agency which administers and oversees the HealthChoices program, and includes offices such as the Office of Medical Assistance Programs (OMAP) and the Office of Mental Health and Substance Abuse Services (OMHSAS).

Disproportionate Share Hospital (DSH) Payments: Medicaid payments to qualifying hospitals that serve a large number of Medicaid and uninsured individuals.

Dual Eligibles: Individuals who are entitled to Medicare and are eligible for some form of Medicaid benefit.

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Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT): A term used to refer to the comprehensive set of benefits covered for children in Medicaid.

Federal Medical Assistance Percentage (FMAP): Medicaid is jointly funded by the federal government and states. The federal government's matching share of most Medicaid expenditures is referred to as the FMAP.

Federal Poverty Level (FPL): A measure of income issued every year by the U.S. Department of Health and Human Services. Federal poverty levels are used to determine eligibility for Medicaid and other programs.

Federally Qualified Health Center (FQHC): Federally funded nonprofit health centers or clinics that serve designated medically underserved areas and populations. Federally qualified health centers provide primary care services regardless of ability to pay, and require community member serve on the governing board.

Fee for Service (FFS): A method in which doctors and other health care providers are paid for each service performed. Examples of services include tests and office visits. Individuals on Medicaid who are not enrolled in an MCO are in the state run FFS program.

Formulary: A list of prescription drugs covered by a prescription drug plan or another insurance plan offering prescription drug benefits. Also called a Preferred Drug List (PDL)

Health Insurance Portability and Accountability Act (HIPAA): A law that was passed by Congress in 1996. It provides workers the ability to transfer and continue health insurance coverage, mandates industry-wide standards for health care information on electronic billing and other processes; and requires the protection and confidential handling of protected health information (PHI).

Healthcare Effectiveness Data and Information Set (HEDIS): An evaluation tool set widely used in the health care industry to measure performance on a large number of measures of quality of care and services. This is a formal source of data used to evaluate managed care organizations (MCO) performance. Pennsylvania requires that MCOs submit HEDIS data, which DHS uses to monitor quality of care, and provide performance comparison information to plans, consumers, and other stakeholders.

HealthChoices: The name of Pennsylvania's mandatory managed care programs for Medical Assistance, providing health care access to over 2.5 million recipients in the Commonwealth.

Home and Community Based Services (HCBS): Supports and services beyond those covered by Medicaid to enable an individual to remain in a community setting rather than be admitted to a long-term care facility such as a nursing home. Also called Waiver services.

Long Term Services and Supports (LTSS): Services to assist individuals to perform routine daily activities such as bathing, dressing, preparing meals and taking medications.

Managed Care: A health care delivery system, organized to manage cost, utilization, and improve quality and consumer experience. Medicaid managed care provides for the delivery of Medicaid health benefits and additional services through contracted arrangements between

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state Medicaid agencies and Managed Care Organizations (MCOs) that accept a set per member per month payment for these services (capitation).

Managed Care Organization (MCO): A health insurance organization that contracts with states to provide access to a specific set of health care services for Medicaid beneficiaries. Each MCO uses its own provider network, assumes risk, and is paid a set amount by the state (capitation).

Managed Long Term Services and Supports (MLTSS): When a Managed Care Organization (MCO) coordinates LTSS services for individuals in through MCOs in Community Health Choices program, Pennsylvania's MLTSS program. Each MCO uses its own provider network, assumes risk, and is paid a set amount by the state (capitation).

Medicaid: A health insurance program for individuals including eligible low-income adults, children, pregnant women, and people with disabilities. Medicaid is administered by states, according to federal requirements. The program is funded jointly by states and the federal government. As of October 2018, 66.3 million people, including 2.2 million Pennsylvanians, rely on Medicaid for their health insurance coverage.

Medicaid Expansion: Allowed by the Affordable Care Act, States had the option to expand Medicaid eligibility to cover all people with household incomes below a 138% of the federal poverty level, which is $33,465 for a family of 4. Pennsylvania, along with 32 other states (including DC) expanded their Medicaid programs. Over 700,000 Commonwealth residents have gained coverage under Pennsylvania's expansion.

Medical Assistance (MA): Another term for Medicaid in Pennsylvania.

Medical Assistance Transportation Program (MATP): A program which provides transportation to medical appointments for Medical Assistance recipients who do not have transportation available.

Medical Home: A partnership among practitioners, patients, and their families in which a team of care providers is accountable for a patient's physical and mental health care needs, across the health care system.

Medical Loss Ratio (MLR): A financial measurement in insurance, which through the Affordable Care Act (ACA) requires MCOs to use 85 cents out of every premium dollar to pay for members medical claims and for activities that improve the quality of care. A medical loss ratio of 85 percent indicates the MCO is using the remaining 15 cents of each premium dollar to pay overhead expenses, such as salaries, administrative costs, taxes, fees, etc.

Medicare: A federally run and financed insurance program, administered by the Centers for Medicare and Medicaid Services. It primarily provides health insurance for those over 65, and certain people with disabilities. It has several "Parts" which cover hospital services (Part A), physician services (Part B), and prescription drugs (Part D).

Modified Adjusted Gross Income (MAGI): The figure used to determine eligibility for premium tax credits and other savings for Marketplace health insurance plans and for Medicaid and the Children's Health Insurance Program (CHIP).

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National Committee for Quality Assurance (NCQA): An independent accreditation organization which develops quality standard and measures used widely throughout the healthcare industry. Many NCQA developed measures serve as formal source of data used to evaluate MCO performance in PA.

Network: The facilities, providers and suppliers an MCO has contracted with to provide health care services to their members.

Office of Medical Assistance Programs (OMAP): Under the Department of Human, this office oversees the Physical Health component of the HealthChoices Program.
Physical Health Managed Care Organizations (PHMCO): Through these private sector managed care organizations, HealthChoices recipients receive quality medical care and timely access to all appropriate physical health services, including primary care, pharmacy, and inpatient/outpatient hospital services.

Office of Mental Health and Substance Abuse Services (OMHSAS): Under the Department of Human Services OMHSAS oversees the BHMCOs.

Patient Centered Medical Home (PCMH): The PCMH model provides comprehensive care in a primary care setting. It is a health care setting that facilitates partnerships between patients and their personal physician and the patient's family when appropriate. Patient care focuses on the whole person, taking into account both the physical and behavioral health of the individual. Care is arranged and coordinated with a team of other qualified professionals as needed.

Pharmacy Benefit Manager (PBM): PBMs administer prescription drug programs for insurance companies, including Medicaid MCOs. They set compensation formulas for pharmacy payments, arrange and collect rebates from manufacturers, assist in establishing formularies (Preferred Drug Lists).

Preferred Drug List (PDL): Also known as a drug "formulary," a PDL contains the drugs that are determined to be the best in a particular class based on clinical effectiveness, safety and outcomes. Each MCO maintains a PDL to ensure their members have access to clinically effective care with an emphasis on quality, patient safety and optimal results from the drugs prescribed for them.

Primary Care Physician (PCP): A physician who directly provides or coordinates a range of health care services for a patient. HealthChoices members select a PCP when joining an MCO.

Protected Health Information (PHI): Individually identifiable health information, protected under HIPPA.

Regional Accountable Health Council (RAHC): A forum for regional strategic health planning and coordination of community-wide efforts to improve health outcomes and address racial disparities across each HealthChoices Zone in the state.

RISE PA: A resource and referral online platform which will allow people to access information and be referred to organizations which address a person's social determinants of health (SDoH) needs, and allow for follow-up and care management.

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Risk Adjustment: A statistical process that takes into account the underlying health status and health spending of a member, when looking at their health care outcomes or health care costs.

Social Determinants of Health (SDoH): Non-medical factors that influence health outcomes, which include the conditions & environments in which people are born, live, learn, work, etc. that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

Supplemental Nutrition Assistance Program (SNAP): Formerly known as "food stamps," SNAP offers nutrition assistance to eligible, low-income individuals and families in Pennsylvania.

Value-Based Purchasing (VBP): Linking provider payments to improved performance by health care providers. This form of payment holds health care providers accountable for both the cost and quality of care they provide. It attempts to reduce inappropriate care and to identify and reward the best-performing providers.