Accountable Care Organization (ACO) Terms & Definitions

Effective Date: 7/28/2014 Draft/Review Date: 4/28/2014

Definitions – Quick Search

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Definitions

A

Accountable Care Organization (ACO) – a group of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their Medicare Fee-for-Service Beneficiaries (Beneficiaries).

1. The goal of coordinated care is to ensure that Beneficiaries, especially the chronically ill, get the right care at the right time while avoiding unnecessary duplication of services and preventing medical errors.
2. When an ACO succeeds in both delivering high-quality care and spending health care dollars more wisely, it will share in the savings it achieves for the Medicare program.

ACO Charter – a legal document that defines the overall roles and responsibilities of the ACO Subcommittees and Governing Body. The charter highlights specific responsibilities, meeting frequency, member and Subcommittee criteria, goals, and reports for which the Governing Body and Subcommittee are responsible.

Activities of Daily Living (ADL) – everyday routines generally involving functional mobility and personal care such as bathing, dressing, toileting, and meal preparation.

Administrative and Management Service Agreement (AMSA) – an agreement between Collaborative Health Systems and the ACO that defines who will perform management services.

After Hours – any time that is outside a facility's normal operating hours.

Aggregate Reports – data that is compiled from several measurements, made available in report format.

Agreement Period – the term of the participation agreement which begins at the start of the first performance year and concludes at the end of the final performance year.

AHRQ – Agency for Healthcare Research and Quality.

Antitrust Agency – the Department of Justice or Federal Trade Commission.

Assignment – process by which Beneficiaries will be preliminarily assigned by CMS to ACOs (prospectively) based on the most recent available data at the beginning of the performance year. The list will be updated on a quarterly basis. However, final assignment, for the purposes of determining an ACO's quality and financial performance under the program, will be made at the end of the performance year (retrospectively). Each ACO will be held accountable for Beneficiaries that receive primary care services from the physicians that bill under the practice's TIN.

At-Risk Beneficiary – a Beneficiary who:

1. has a high risk score on the CMS Hierarchal Condition Category (CMS-HCC) risk adjustment model;
2. is considered high cost due to having two or more hospitalizations or emergency room visits each year;
3. is dually eligible for Medicare and Medicaid;

4. has a high utilization pattern;
5. has one or more chronic conditions;
6. has had a recent diagnosis that is expected to result in increased cost;
7. is entitled to Medicaid because of disability; or,
8. is diagnosed with a mental health or substance abuse disorder.

The care coordination tool, Percolator (proprietary scoring model), will be the "risk adjustment model" used by the ACO.

Authorized Representative – a person identified by the Beneficiary, in an Advance Directive, Medical Power of Attorney, or other legal document, to have authority on the Beneficiary's behalf or to serve as the legal conservator for the Beneficiary.

Availability – the ease with which a Beneficiary may obtain the following, within established time frames:

1. an appointment with a practitioner;
2. access to emergency care;
3. access to after-hours care; and,
4. a response from the Patient Services department.

B

Balance Billing – the practice of billing a Beneficiary for the fee amount remaining after plan payment and co-payment have been made. Under Medicare, the excess amount cannot be more than 15 percent (15%) above the approved charge.

All Medicare physicians, providers, and suppliers who submit claims to Medicare for services and supplies provided to Qualified Medicare Beneficiaries (QMBs) are affected.

Benchmark – an estimate of what the total Original Medicare Parts A and B expenditures for Beneficiaries would otherwise have been in the absence of the ACO, even if all of those services were not provided by providers in the ACO.

Beneficiary – Medicare Fee-for-Service Beneficiary assigned to the ACO. *(See Medicare Fee-for-Service Beneficiary).*

Beneficiary Notification (aka Notice to Patients) – notifications sent to Beneficiaries notifying them that their Primary Care Provider (PCP) is participating in an ACO along with a Decline to Share Personal Health Information form that can be submitted if they choose not share their PHI.

Business – a corporation, partnership, trust, unincorporated association, firm, sole proprietorship, or any other organization.

Business Associate Agreement (BAA) – a contract between a Health Insurance Portability and Accountability Act (HIPAA) covered entity and a HIPAA Business Associate (BA). The contract safeguards Protected Health Information (PHI) in accordance with HIPAA guidelines.

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C

CMS Certification Number (CCN) – formerly the OSCAR Provider Number, Medicare Identification Number, or Provider Number. The CCN continues to serve a critical role in verifying that a provider has been Medicare certified and for what type of services.

Care Coordination – a collaborative process that promotes quality care and cost-effective outcomes that enhance the physical, psychosocial, and emotional health of individuals. Care coordination is designed to be a collaborative effort that engages Beneficiaries, Participants, and community resources with the care coordination staff to address the needs of the population served by the ACO.

Care Coordination Request – is a notification from a Participant and/or Provider/Supplier requesting care coordination assistance for inpatient or outpatient follow-up, social needs, Beneficiary education, or other activities that can help meet Beneficiary needs.

Care Coordination System – a technology supported, integrated care coordination program that automatically provides clinical information to the care coordination staff, thus facilitating Beneficiary engagement.

Centers for Medicare & Medicaid Services (CMS) – the federal agency that runs the Medicare program. ACOs contract directly with CMS for participation in the Medicare Shared Savings Program.

Chronic Heart Failure (CHF) – a condition marked by weakness, edema, and shortness of breath that is caused by the inability of the heart to maintain adequate blood circulation in the peripheral tissues and the lungs.

Chronic Obstructive Pulmonary Disease (COPD) – a lung disease that makes it hard to breathe. It is caused by damage to the lungs over many years.

Clinical Care Connection (C3) – CHS's proprietary clinical documentation and population health management system.

Collaborative Health Systems (CHS) – a wholly-owned subsidiary of Universal American Corp., established specifically for the Medicare Shared Savings Program and ACO development.

Community Health Center (CHC) – also known as Federally Qualified Health Centers (FQHC); non-profit clinics located in medically underserved areas, both rural and urban.

Competitive Business – owning, operating or being employed as an employee or consultant by any business that competes, directly or indirectly, with the ACO.

Complaint – any oral or written expression of dissatisfaction to the ACO made by an individual. This can include concerns about the operations of providers or the ACO, such as: waiting times, the demeanor of healthcare personnel, the adequacy of facilities, and the respect paid to Beneficiaries. It also can include the ACO's refusal to provide services to which the Beneficiary believes he or she is entitled. Every complaint must be handled under the appropriate complaint process.

Complex Care Coordination – the facilitation of care and services provided to Beneficiaries who have experienced a critical event or diagnosis that requires extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services. Programs may relate to unhealthy behaviors, mental health, or substance abuse.

Compliance Officer – the person responsible for implementation and oversight of the Compliance Program and adherence to all applicable state and federal laws and regulations, including the Medicare Shared Savings Program requirements.

Compliance Program – an organizational, value-based, and actionable system that identifies, prevents, detects, corrects, and reports suspected non-compliance with state and federal regulatory requirements.

Conflict of Interest – when an individual's private interest interferes in any way – **or even appears to interfere** – with the interest of the ACO as a whole.

Consumer Assessment of Health Providers and Systems (CAHPS) – surveys that ask consumers and Beneficiaries to report on and evaluate their experiences with health care.

Continuously Assigned Beneficiary – a Beneficiary assigned to the ACO in the current performance year that was either assigned to or received a primary care service from any of the ACO's Participants during the most recent prior calendar year.

Consumer – a person who purchases goods and services for personal use.

Coronary Artery Disease (CAD) – a condition in which plaque builds up inside the coronary arteries.

Corrective Action Plan (CAP) – a written document issued to an affected area in response to a compliance/operational deficiency identified in connection with the activities necessary to support the Medicare Shared Savings Program and to prevent future misconduct.

Covered Professional Services – has the same meaning given these terms under section 1848(k)(3)(A) of the Social Security Act.

Critical Access Hospital (CAH) – rural community hospitals that receive cost-based reimbursement and has the same meaning given this term under section 400.202 of the Social Security Act.

Cultural Competence – the ability to interact effectively with people of different cultures. Cultural competence contains four components: awareness of one's own cultural world view, attitude toward cultural differences, knowledge of different cultural practices and world views, and cross-cultural skills.

1. Developing cultural competence results in an ability to understand, communicate with, and effectively interact with people across cultures.

D

Data Use Agreement (DUA) – the agreement ensuring compliance with the Privacy Act which must be completed and signed by the requestor(s) and CMS prior to the release or use of specified data files.

Data Warehouse – a HIPAA-compliant, secure, scalable data repository**.**

Database Administration (DBA) – the function of managing and maintaining database management systems (DBMS).

Designated Record Set – a Designated Record Set means, any item, collection or grouping of information maintained by or for the Organization that includes:

1. enrollment, payment, claims adjudication, case or medical management records; and,

2. any other records used, in whole or in part, by or for the Organization to make decisions about individuals.

Determination – when the Compliance Officer determines whether the investigation outcome is Substantiated, Unsubstantiated, or Inconclusive.

Durable Medical Equipment (DME) – a term used to describe any medical equipment used in the home to aid in a better quality of living such as wheelchairs, walkers, crutches, etc.

E

Electronic Health Record (EHR) or Electronic Medical Record (EMR) – an electronic record of a Beneficiary and their history of health and medical care that is used by practitioners, including physicians and healthcare facilities.

Emergency Care – healthcare services provided in response to a recent onset illness that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that his/her condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in placing the Beneficiary's health in serious jeopardy; serious impairment to bodily functions; serious dysfunction of any bodily organ; serious disfigurement; or in the care of pregnant woman, serious jeopardy to the health of the fetus. Examples include:

1. Chest Pain;
2. Possible fractured limb;
3. Fever of 102 degrees in a child under two months of age; or,
4. No fetal movement in 24 hours.

End-stage Renal Disease (ESRD) – also known as chronic renal disease, a progressive loss in renal (kidney) function over a period of months or years.

Evidence-Based Medicine (EBM) – the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual Beneficiaries. The practice of evidence-based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research.

Executive Director (ED) – the person who provides the operational leadership to achieve the quality and financial performance goals for an ACO.

F

Federally Qualified Health Center (FQHC) – indicates a reimbursement designation from the Bureau of Primary Healthcare and CMS of the United States Department of Health and Human Services (DHHS). This designation is significant for several health programs funded under the Health Center Consolidation Act (Section 330 of the Public Health Service Act) Procedure.

Other Definitions:

1. a facility located in a medically underserved area that provides Medicare Beneficiaries preventive primary medical care under the general supervision of a physician.

File & Use Material – a process that allows ACOs to submit certain marketing and other Beneficiary materials for immediate use five (5) calendar days after the material is submitted to CMS but no earlier than any date established by CMS for use of specific document/materials, certifying that the materials are compliant with the File & Use guidelines. Examples may be certain general advertising materials; model provider and/or pharmacy directories; and certain CMS model letters utilized without modifications such as organization determinations, appeals, grievances, exception letters, and television and radio ads.

Other definitions:

1. specific documents/materials that are compliant with CMS' File & Use guidelines and are allowed to be used by an ACO five (5) calendar days after it has been submitted to CMS, no earlier.

File Transfer Protocol (FTP) – a protocol through which internet users can upload files to or download files from their computers to a secure portal in order to exchange information.

Financial Interest – an interest that includes, without limitation, ownership (including beneficial ownership under a trust) of stock or securities, stock options, warrants, convertible instruments, units of a limited partnership, or any other instrument used to convey an interest in a company, joint venture, limited partnership or other commercial or non–commercial entity.

First Tier Entity – any third party that enters into a written agreement, acceptable to CMS, with a Medicare-contracted organization or applicant to provide administrative and/or support services or healthcare services for a Medicare-eligible individual.

Fraud, Waste & Abuse (FWA) –

1. **Fraud** – knowingly and willfully executing, or attempting to execute a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program as defined under 18 U.S.C. § 1347.
2. **Waste** – the needless, careless, or extravagant expenditure of state funds incurring of unnecessary expenses, or mismanagement of state resources or property. Waste does not necessarily involve private use or personal gain, but almost always signifies poor management decisions, practices or controls.
3. **Abuse** – includes actions that may directly or indirectly, result in unnecessary costs to the Medicare/Medicaid Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary.

G

Gifts – cash or any other item or service given, without proper compensation, to a Participant or Provider/Supplier, whether a person or company. The acceptance of gifts can create the appearance that business decisions are being influenced by other factors. Accordingly, Participants and

Providers/Suppliers should not seek or accept any gifts from vendors, customers, politicians, political candidates, or anyone seeking to have a business relationship with the ACO in their professional capacity. Exceptions to this policy include common promotional items as well as reasonable meals and entertainment. Unless otherwise prohibited by the nature of the contract or relationship, an individual can accept meals, refreshments, tickets, or other entertainment paid for by third parties as long as:

1. the acceptance of such is related to a bona fide business cause;
2. the acceptance of such does not violate any law or ethical standards otherwise imposed upon the Individual; and,
3. the cost, extent and frequency of such meals, refreshments and/or entertainment received from a third party is reasonable and does not become excessive, as determined in the sole discretion of the ACO.

Good Faith – an honest belief, absent of malice or design to gain an unfair advantage.

Governing Body – a general term for the Board of Directors, board of managers, or Management Committee who provides a mechanism for shared governance and decision-making for all Participants and has authority to execute the statutory functions of an ACO. Created and defined within the Operating Agreement and is comprised of three classes of membership:

1. Class I Members, each of whom shall constitute an ACO Participant and shall be appointed by the Nominating Committee;
2. One Class II Member who shall constitute a Medicare Beneficiary having the qualifications described in the MSSP Final Rule and who shall be appointed by the Nominating Committee; and
3. Class III Members, each of whom shall be an employee of CHS or its Affiliate and who shall be appointed by the Nominating Committee.

The Governing Body provides leadership to the ACO and ensures that governance objectives and shared values are met.

Group Practice Reporting Option (GPRO) – a reporting option for Physician Quality Reporting (PQRS) that incorporates some characteristics and methods from the demonstration projects Medicare Care Management Performance (MCMP) and Physician Group Practice (PGP).

H

Health Information Technology for Economic and Clinical Health (HITECH) Act - legislation enacted as part of the American Recovery and Reinvestment Act of 2009 (ARRA) to promote the adoption and meaningful use of health information technology.

Health Insurance Portability and Accountability Act (HIPAA) – establishes national standards to protect individuals' medical records and other personally identifiable information and applies to covered entities as defined by HIPAA as those healthcare providers that conduct certain healthcare transactions electronically.

HICN - Health Insurance Claim Number.

HIE – Health Information Exchange.

Hierarchical Condition Category (HCC) codes – codes used in the CMS payment model, implemented in 2004, to adjust Medicare capitation payments to private healthcare plans for the health expenditure risk of their enrollees.

I

Immediate Family – immediate family may include, for example, spouses and such persons as parents, siblings, offspring (including adopted offspring), and spouses of such persons.

Implementation and Integration Team (IIT) – the team comprised of Implementation and Integration Managers (IIM) and Support Managers (SM) in CHS Operations. IIT works with CHS External and Internal support teams as well as the ACO to ensure the successful implementation, integration of work done by the several teams together, and ongoing management of the ACO processes with the ultimate goal of facilitating efficient and satisfying care coordination.

Improper Dealings – situations that create actual or potential conflicts in which an Individual's actions or loyalties are divided between personal and Company interests or between Company interests and those of another. All Participants, Providers/Suppliers, and individuals must avoid any activity, agreement, business investment, or interest that constitutes a conflict, or may pose a potential conflict, with the Company's interests or that may interfere with the Individual's duty and ability to best serve the ACO.

Incorporated (Inc.) – formed or combined into a legal corporation.

Independent Practice Association (IPA) – a U.S. type of physician alliance in which the physicians own the practice, as opposed to physicians employed by an entity such as a health maintenance organization (HMO).

Individual(s) – a collective term to apply to all persons providing services to Beneficiaries under the ACO and/or involved in prohibited activities, which include, but are not limited to, the following:

1. Trade Secrets;
2. Competitive Business;
3. Financial Conflict;
4. Non-Work Activity;
5. Improper Dealings; and,
6. Gifts.

See Conflict of Interest Policy Template for more information regarding the prohibited activities listed above.

Initial Beneficiary Notifications – a communication mailed to the Beneficiary by the ACO and/or discussed during the first office visit. The notifications provide Beneficiaries with information regarding the ACO and related processes for data sharing.

In-Kind Services – financial incentives provided to an individual or group that are not cash.

In loco parentis – legal responsibility to take on the obligations and duties of a parent for a minor without a parent.

International Classification of Diseases (ICD) – an official list of categories of diseases, physical and mental, issued by the World Health Organization (WHO). It is used primarily for statistical purposes in the classification of morbidity and mortality data.

Involved Person - any person who holds a responsible executive position, supervising an important unit or activity of the ACO; all individuals in the executive, accounting, and operating departments of the ACO who have access to the ACO's results prior to publication; and, any other person who regularly attends or is entitled to attend, meetings of the Board of Directors, Governing Body, or Subcommittee of the ACO.

J

K

L

Length of Stay (LOS) – the period of time a Beneficiary remains in a hospital or other health care facility as an inpatient.

Letter of Agreement (LOA) – an agreement between CHS and the Member/Partner. The terms and conditions set forth in the agreement are legally binding.

Limited Liability Company (LLC) – a business structure allowed by state statute. Each state may use different regulations.

Linguistics – language structure (grammar) and meaning (semantics). Grammar includes the formation and composition of words and how to combine phrases and sounds.

Long-Term Acute Care Hospital (LTACH) – a facility that provides diagnostic and medical treatment or rehabilitation to Beneficiaries with chronic illness or complex medical conditions.

M

Marketing Materials and Activities – include, but are not limited to, general audience materials such as brochures, advertisements, outreach events, letters to Beneficiaries, Web pages, data sharing opt-out letters, mailings, social media, or other activities conducted by or on behalf of the ACO, by Participants or Providers/Suppliers participating in the ACO, when used to educate, solicit, notify, or contact Beneficiaries or Providers/Suppliers regarding the Medicare Shared Savings Program.

1. The following Beneficiary communications are not considered marketing materials and activities: certain informational materials customized or limited to a subset of Beneficiaries;

materials that do not include information about the ACO, its Participants, or its Providers/Suppliers; materials that cover Beneficiary-specific billing and claims issues or other specific individual health-related issues; educational information on specific medical conditions (for example, flu shot reminders), written referrals for healthcare items and services, and materials or activities that do not constitute "marketing" under 45 CFR §§ 164.501 and 164.508(a)(3)(i).

Material – the quality of evidence that would tend to influence the Compliance Officer's determination that a report is substantiated.

Material Non-Public Information –

1. "Non-public information" – information that is known within the Company that has not been publicly released or circulated.
2. "Material" – information that a reasonable investor would consider important in deciding to buy, sell or hold stock of the Company.
3. "Material information" – can be favorable or unfavorable.
    a. Some examples of information that could be considered material include, but are not limited to:
        i. material changes in sales volumes, or product market shares;
        ii. changes in debt rates or analyst upgrades or downgrades of stock;
        iii. earnings and dividends;
        iv. major business acquisitions, dispositions, and marketing; developments of very significant outreach;
        v. financial, sales and other significant internal business forecasts;
        vi. significant changes in accounting treatment;
        vii. changes in top management; and,
        viii. stock splits.

Medical Record – a chronological written account of a Beneficiary's examination and/or treatment that includes the Beneficiary's medical history and complaints, the physician's findings, the results of diagnostic tests and procedures, therapeutic procedures, and medications.

Medicare Fee-For-Service Beneficiary – an individual who is—

1. enrolled in the original Medicare fee-for-service program under both parts A and B; and,
2. not enrolled in any of the following:
    a. an MA plan under part C.
    b. an eligible organization under section 1876 of the Social Security Act.
    c. a PACE program under section 1894 of the Social Security Act.

Medicare Shared Savings Program (Shared Savings Program) – the program established by CMS under section 1899 of the Affordable Care Act to facilitate coordination and cooperation among Providers to improve the quality of care for Beneficiaries and reduce unnecessary costs. Eligible providers, hospitals, and suppliers may participate in the Shared Savings Program by creating or participating in an Accountable Care Organization (ACO).

Minimum Savings Rate (MSR) – a percentage of the benchmark that ACO expenditure savings must exceed in order for an ACO to quality for shared savings in any given year. For two-sided models, CMS uses a sliding scale, based on the number of Beneficiaries assigned to the ACO that ranges from 2-3.9%. The one-sided model is a flat 2%.

N

National Quality Forum (NQF) – a nonprofit organization that operates under a three-part mission to improve the quality of American healthcare by:

1. building consensus on national priorities and goals for performance improvement and working in partnership to achieve them;
2. endorsing national consensus standards for measuring and publicly reporting on performance; and,
3. promoting the attainment of national goals through education and outreach programs.

Network Administrator (NA) – provides education, training, guidance, and other duties as assigned for providers in the assigned Independent Provider Association (IPA), Local Provider Organization (LPO) and/or networks.

Newly Assigned Beneficiary – a Beneficiary that is assigned in the current performance year who was neither assigned to nor receives a primary care service from any of the ACO's Participants during the most recent prior calendar year.

Non-public Information – information that is known within the ACO that has not been publicly released or circulated

Non-Work Activity – engaging in any other employment or non-work-related activities during your work–hours, or using ACO supplies or equipment in other employment or non-work related activities.

Notice of Intent (NOI) – a form used to apply for participation in the Medicare Shared Savings Program with CMS that is only accepted electronically.

Notice to Patients – *see Beneficiary Notification*.

Notifications – a communication sent by the ACO to doctors, hospitals, or other healthcare providers, and/or Beneficiaries with information regarding the ACO activities. Notifications include, but are not limited to, requests, referrals and Opt-Out letters.

NPI - National Provider Identifier.

O

Office of the Inspector General (OIG) – protects the integrity of Department of Health & Human Services (DHHS) programs as well as the health and welfare of program Beneficiaries.

Officers – individuals duly elected as officers of the organization (referred to as "Officers"), i.e., President, Executive and Senior Vice President, and Vice President.

OIG Exclusion database – the OIG database for individuals and businesses excluded or sanctioned from participating in Medicare, Medicaid or other federally funded health care programs. The revised database is available monthly, generally around the 10th of the month, for download.

OIG/GSA Check – established by Congress to prevent certain individuals and businesses from participating in Federally-funded healthcare programs. Providers and contracting entities have an affirmative duty to check the exclusion status of individuals and entities prior to entering into employment or contractual relationships. Status should be checked monthly.

One-Sided Model – a model under which the ACO may share savings with the Medicare program, if it meets the requirements for doing so, but is not liable for sharing any losses incurred under subpart G of the MSSP.

Organization – any individual or entity under the contractual obligations of the ACO.

P

Participant – an individual or group of ACO Providers/Suppliers that is identified by a Medicare-enrolled tax ID number (TIN), that alone or together with one or more other ACO Participants comprises the ACO, and that is included on the list of ACO participants that is:

1. included on the list of ACO Participants that is required under § 425.204(c)(5).
2. required to be submitted as part of the application and updated at the start of each performance year and at other times as specified by the Centers for Medicare and Medicaid Services (CMS). An ACO participant bills Medicare for services through its Medicare-enrolled TIN, or CMS Certification Number (CCN). ACO participant billing TINs (or CCNs) are the basis for establishing eligibility, assignment of Beneficiaries, computation of the benchmark, and quality assessment.

Percolator – proprietary algorithms used to stratify and prioritize targeted outreach efforts to eligible Beneficiaries for care coordination. Percolator produces two different ranking queues for CHS: one that assures that Beneficiaries with the most urgent needs are reached first and one on a Beneficiary-specific basis to ensure that a Beneficiary's individuals issued are addressed in priority of their urgency.

Performance Year – the 12-month period beginning on January 1 of each year during the agreement period, unless otherwise noted in the ACO's agreement. For an ACO with a start date of April 1, 2012 or July 1, 2012, the ACO's first performance year is defined as 21 months and 18 months, respectively.

Personal Health Assessment (PHA) – the ACO's initial health assessment screening tool that facilitates identification of Beneficiary healthcare needs.

Personal Health Information – an individual's information about his/her demographics; medical history including clinical information, medical tests, and laboratory results; health insurance information; and,

other data that is collected by a healthcare professional to identify an individual and determine appropriate care.

Personal Identity Information (PII) – unique individual identifiers such as name, address, telephone number, social security number, birthdate, and financial information.

Physician Group Practices (PGP) – two or more physicians legally organized as a partnership, professional corporation, foundation, not-for-profit-corporation, faculty practice plan, or similar association.

Physician Quality Reporting System (PQRS) – the quality reporting system established under section 1848(k) of the Social Security Act.

1. A reporting program mandated by federal legislation that uses a combination of incentive payments and payment adjustments to promote reporting of quality information by eligible professionals.

Preventive Care – medical care including, but not limited to, services provided for periodic health assessment, routine physical examinations as medically recommended based on the Beneficiary's age and sex, immunizations and inoculations (including injectable) in accordance with accepted medical practice, vision and hearing screening as ordinary preformed, routine hearing examinations and annual well woman examinations.

Primary Care Physician (PCP) – a physician who has a primary specialty designation of internal medicine, general practice, family practice, or geriatric medicine, or, for services furnished in an FQHC or RHC, a physician included in an attestation by the ACO as provided under § 425.404.

Primary Care Services – the set of services identified by the following HCPCS codes:

1. 99201 through 99215.
2. 99304 through 99340, and 99341 through 99350, G0402 (the code for the Welcome to Medicare visit), G0438 and G0439 (codes for the annual wellness visits);
3. Revenue center codes 0521, 0522, 0524, 0525 submitted by FQHCs (for services furnished prior to January 1, 2011), or by RHCs.

Primary Service Area (PSA) – a rural hospital as the smaller of either a radius of 25 miles from the rural hospital main campus or the number of postal zip codes, commencing with the rural hospital's zip code, in which 75 percent of a rural hospital's Beneficiaries reside, as determined by using data derived from the hospital's most recent 12 month Medicare cost reporting period.

Protected Health Information (PHI) – information that is transmitted by, or maintained in, electronic media or any other form or medium that is related to:

1. past, present, or future physical or mental health or condition of an individual;
2. provision of healthcare to an individual; or,
3. payment for the provision of healthcare information to an individual.

Provider – a hospital, a critical access hospital (CAH), a skilled nursing facility, a comprehensive outpatient rehabilitation facility, a home health agency, or a hospice that has in effect an agreement to participate in Medicare, or a clinic, a rehabilitation agency, or a public health agency that has in effect a

similar agreement but only to furnish outpatient physical therapy or speech pathology services, or a community mental health center that has in effect a similar agreement but only to furnish partial hospitalization services.

Provider Relations Representative – works with and supports Executive Directors and Network Administrators to provide education, training, guidance, and other duties as assigned for providers in the assigned Independent Provider Association (IPA), Local Provider Organization (LPO), and/or networks.

Provider/Supplier – an individual or entity that is a Medicare Provider or Supplier enrolled in Medicare and bills for services under an ACO Participant TIN. For example, a large group practice may qualify as a Participant. A Medicare enrolled physician billing under the practice TIN would be a Provider/Supplier.

1. an individual or entity that –
    a. is a Provider (as defined at § 400.202 of the Shared Savings Program) or a Supplier (as defined at § 400.202 of the Shared Savings Program);
    b. is enrolled in Medicare;
    c. bills for items and services it furnishes to Beneficiaries under a Medicare billing number assigned to the TIN of an ACO Participant in accordance with CMS-1345-F 628 applicable Medicare regulations; and,
    d. is included on the list of ACO Provider/Supplier that is required under § 425.204(c)(5).

Proxy – a power of attorney given by an individual to another to vote in their stead. While it is preferable that proxy be given to another Committee member, proxy can be given to a person who is not a member of such Committee. The term "proxy" may mean both (i) the power to vote; and (ii) the individual in whom the power to vote is vested, as the context may require.

Q

QI – Quality Improvement.

QIP – Quality Improvement Program.

Quality Improvement Program Description – describes the QIP's purpose, objectives, scope, and governance structure, quality performance monitoring and reporting.

Quality Improvement Work Plan – outlines key QI activities for the upcoming year. It is reviewed and approved by the QI Subcommittee and the Governing Body on an annual basis. The Work Plan indicates the quality improvement activities, objectives, scope, reporting responsibility, measurement and reporting timeliness expectations, goals, and outcomes.

Quality of Care Issue – a complaint filed regarding the quality of services (including both inpatient and outpatient) received. Services must meet the professionally recognized standards of healthcare, including whether appropriate healthcare services have been provided and whether services have been provided in an appropriate setting. A quality of care issue may be filed through the plan or the Quality Improvement (QI) Subcommittee applicable to the service area in which the Beneficiary resides. All QI Subcommittee complaints must be responded to in writing whether filed orally or via hard copy. There is no time limit for a Beneficiary to file a quality of care complaint or issue with the ACO.

Quality Measures – the measures defined by the Secretary, under section 1899 of the Social Security Act, to assess the quality of care furnished by an ACO, such as measures of clinical processes and outcomes, Beneficiary and, where practicable, caregiver experience of care and utilization.

Quorum – a meeting at which (i) at least a majority (51%) of the eligible voting members are in attendance, either in person, telephonically, or through other electronic means; and (ii) at least one (1) Committee member representing CHS is also present. Proxy does not count towards quorum.

R

Referral – direct communication between a physician and a specialist or specialty company to provide specific care or service to a Beneficiary to meet their needs.

Reportable Breach – the unauthorized acquisition, access, use, or disclosure of Protected Health Information (PHI) in a manner not permitted by the HIPAA privacy regulations which compromises the security or privacy of PHI, unless it is demonstrated that there is a low probability that the PHI has been compromised based on a risk assessment.

Reporting Period – the calendar year from January 1 to December 31.

Request – notification from a Participant and/or Provider requesting care coordination assistance for inpatient or outpatient follow-up, social needs, Beneficiary education, or other activities that can help meet Beneficiary needs.

Rural Health Clinic (RHC) – an outpatient facility that is primarily engaged in furnishing physicians' and other medical and health services and that meets other requirements designated to ensure the health and safety of individuals served by the clinic. The clinic must be located in a medically under-served area that is not urbanized as defined by the U.S. Bureau of Census.

S

Shared Losses – a portion of the ACO's performance year Medicare fee-for-service Parts A and B expenditures, above the applicable benchmark, it must repay to CMS. An ACO's eligibility for shared losses will be determined for each performance year. For an ACO requesting interim payment, shared losses may result from the interim payment calculation.

Shared Savings – a portion of the ACO's performance year Medicare fee-for-service Parts A and B expenditures, below the applicable benchmark; it is eligible to receive payment for from CMS. An ACO's eligibility for shared savings will be determined for each performance year. For an ACO requesting interim payment, shared savings may result from the interim payment system calculation.

Significant Incident – an incident that causes harm or potential harm to a Beneficiary.

Skilled Nursing Facility (SNF) – a nursing facility with the staff and equipment to give skilled nursing care and/or skilled rehabilitation services and other related health services.

Standardized Language – language developed by CMS or other Federal agencies which is mandatory for use by the ACO and cannot be modified.

Supplier – a physician or other practitioner, or an entity other than a provider that furnishes healthcare services under Medicare.

T

Taxpayer Identification Number (TIN) – a Federal taxpayer identification number or employer identification number as defined by the IRS in 26 CFR § 301.6109-1.

Template Materials – materials drafted by CMS as templates for use in some circumstances, which may not be modified (except within bracketed areas). Template materials are not required to be submitted to CMS before use.

Third Party Authorization – document permitting another to receive information on behalf of the Beneficiary. This third party may only receive information and cannot effectuate any changes to the Beneficiary's record.

Threshold Language – a language identified as the primary language or the language of understanding of 5% of the Beneficiary population within an identified geographic area or as defined by CMS.

Trade Secrets – disclosing any trade secrets or confidential, sensitive or proprietary information about the ACO, its clients, its products or its programs to persons outside the ACO.

Trustee or estate – allows an individual to administer the estate of a deceased Beneficiary.

Two-Sided Model – a model under which the ACO may share savings with the Medicare program, if it meets the requirements for doing so, and is also liable for sharing any losses incurred under subpart G of this part.

U

Unanimous Written Consent (UWC) – a legal document used by the Nominating Committee or the Governing Body to implement a change/motion for the ACO. It is used when an actual meeting cannot occur. All members of the committee must sign the document for the change or motion to be implemented.

Unknown Beneficiaries – Beneficiaries listed on the CMS roster that are not recognized or claimed by a participating provider.

Unsecured Protected Health Information – Protected Health Information that has not been rendered unusable, unreadable or indecipherable to unauthorized individuals through the use of a technology or methodology specified by the Secretary of the U.S. Department of Health and Human Services.

Urgent Care – medical services provided in response to a medical condition that does not present emergent symptoms and does not need the immediate attention of a provider unless condition persist or worsen.

V

W

Wellness and Health Promotion Program – a comprehensive plan that helps Beneficiaries change their lifestyles and move toward a state of optimal health. This program may include assessments, interventions, and activities.

"With Cause" – an aspect of a Participant or Provider/Supplier competence or professional conduct which is reasonably likely to be detrimental to member safety, health or welfare.

X

Y

Z

Additional Guidance

Federal Definition Lists

42 CFR §425.20

Medicare Glossary – http://www.medicare.gov/glossary/c.html

Social Security Act – http://www.ssa.gov/OP_Home/ssact/title18/1861.htm

ACO FAQs – http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/MSSP_FAQs.pdf