ALPHABET SOUP FOR CARE MANAGERS

Below are a variety of acronyms frequently referenced in Medicare.

Many of the terms reference program components of the transition from a traditional fee for service payment model - where providers receive a fee for a specific service based upon the service code billed; to a value based payment model - where payment is based partially on the service, and partially utilization, quality and technology.

In some cases, providers, groups and/or health systems have formed integrated organizations to coordinate patient care. These integrated organizations can enter into new payment arrangements with CMS that include financial risk. In these arrangements, the total cost of care is estimated; if the actual cost of care is less, the organization shares in the savings with CMS; if cost is higher - the organization must pay CMS a portion of the loss.

In all cases, care managers can contribute to the success of the organization by:
• Understanding what quality/utilization metrics the organization has chosen to measure/report, and ensuring those are a key area of focus when working with patients.
• Knowing if the providers/practice they support are part of a larger integrated organization and if there is a desire for patient care to be coordinated care within the integrated network of providers with similar goals around quality, cost and utilization.
• Effectively applying the care management process to improve health outcomes, reduce utilization and reduce cost.

	ABREVIATION	WHAT IT STANDS FOR	DEFINITION
GENERAL	ACA	Affordable Care Act	Officially The Patient Protection and Affordable Care Act of 2010; aka "Obamacare". Goal of ACA was to increase the number of people with access to health care coverage
MEDICARE	ACI	Advancing Care Information	Currently known as Meaningful Use E.H.R incentive program - reflects the technology aspects of MIPS
GENERAL	ACO or CAN	Accountable Care Organization or Accountable Care Network	Groups of physicians hospitals and other health care providers who voluntarily come together to provide coordinated care for their Medicare patients. Goal - improve quality and outcomes, while reducing cost by avoiding duplication of services, reducing admissions/re-admissions, etc. ACOs are similar to Clinically Integrated Networks (CIN); however ACOs regulations are under the Center for Medicare and Medicaid Services (CMS) while CINs serve commercial/self-funded insurance programs
MEDICARE	Advanced APM	Advanced Alternative Payment Models	A subset of Alternative Payment Model (APM) where providers have higher degrees of financial risks and/or higher performance requirements. Providers in Advanced APMs will be eligible to receive additional financial incentives. For 2017 - eligible Advanced APM models include: CPC+, MSSP Tracks 2 and 3, Next Generation ACOs, 2 sided risk arrangemnts for Oncology and Comprehensive ESRD Care Models; Additional models may be added in future years.
MEDICARE	APM	Alternative Payment Models	One of 2 new payment incentive models under the Quality Payment Program (QPP) which provides payment incentives based on quality and value. Accredited PCMH Practices may qualify as an APM Newly announced in 2016; the program is expected to evolve over the next several years.
GENERAL	CAHPS	Consumer Assessment of Healthcare Providers and Systems	Survey that measures patient experience with health care encounters
MEDICAID	CHCP	Comprehensive Health Care Program	Formal name of program for Medicaid Managed Care in Michigan
GENERAL	CHIP	Children's Health Insurance Program	Provides health insurance to children through Medicaid and other programs such as MIChild; Administered by stated, funded jointly federal and state governments

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MEDICAID	CHW	Community Health Workers or Peer-Support Specialists	Frontline public health workers who are trusted members of and /or have an unusually close understanding of the community served. This trusting relationship enables CHWs to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery.
GENERAL	CIN	Clinically Integrated Network	Groups of physicians hospitals and other health care providers who voluntarily come together to provide coordinated care for their Medicare patients. Goal - improve quality and outcomes, while reducing cost by avoiding duplication of services, reducing admissions/re-admissions, etc. CINs are similar to Accountable Care Organization (ACO); however CINs serve commercial/self-funded insurance programs while ACO regulations are under the Center for Medicare and Medicaid Services (CMS).
MEDICAID	CMHSP	Community Mental Health Services Program	County or multi-county entity that provides services for individuals with developmental disabilities and severe persistent mental illness. For Medicaid, the CMHSPs also provide treatment for substance use disorders
GENERAL	CMMI	Center for Medicare and Medicaid Innovation	CMS unit that oversees demonstration and innovation models ex: ACOs
GENERAL	CMS	Center for Medicare and Medicaid Services	The federal entity accountable for the administration for Medicare and Medicaid programs at the national levels.
MEDICARE	CPC+	Comprehensive Primary Care Plus	CPC+ meets criteria for Advanced Alternative Payment Models (APM) 5 year model beginning 1/1/17 in 14 regions, including Michigan. Brings together Medicare, Medicaid and Commercial Payers (BCBSM and Priority Health) to support practices to make necessary changes in care delivery Based upon the Primary Care Medical Home (PCMH) model, there are 2 program tracks depending upon practices readiness for transformation. To support for practice transition to coordinated care and financial risk models CPC+ provides financial support for the following: • Care management • Performance Based Incentives (Quality and Utilization) • Payment Redesign (Financial Risk) CMS has targeted 2500 practices for each track for a total of 5000 practices nationally. As of 11/15/16 the practices approved for 2017 have not been released.
MEDICARE	CPIA	Clinical Practice Improvement Activities	One element of the total MIPS Composite Score; over 90 activities from which a practice can choose to implement from categories such as practice access, population management, care coordination, beneficiary engagement, patient safety, behavioral health integration. Practices that hold PCMH Accreditation from a state or national organization OR a payer organization that meets CMS criteria, will receive full credit for CPIA category. As of Nov. 2016- BCBSM PGIP program has been identified as meeting the CMS criteria.
MEDICARE	CPS	Composite Performance Score	and Clinical Practice Improvement Activities (CPIA) The category weights will change each year. With the weight for resource/utilization increasing from 10% to 30% over the next several years.
MEDICARE	CQM	Clinical Quality Measure	Measure and track aspects of patient care, including health outcomes, clinical processes, patient safety, efficent use of resources, care coordination, patient engagement, population health and adhearence to clincal guidelines

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MEDICAID	CSHCS	Children's Special Health Care Services	Eligibility is authorized by Title V of the Social Security Act. Individuals eligible for both CSHCS and Medicaid are mandatorily enrolled into a health plan.
GENERAL	FFS	Fee for Service	Payment model based on the services provided - claim submitted for a specific service code that identifies the service provide and payment is based on that service code. Traditional Medicare reimbursement is currently under a FFS model
MEDICAID	FQHC	Federally Qualified Health Center	Community-based organizations that provide comprehensive health care services to persons of all ages, regardless of their ability to pay or health insurance status with no authorization required.
MEDICARE	MA	Medicare Advantage	A type of Medicare health plan offered by a private company that contracts with Medicare to provide all Medicare Part A and Part B benefits. Medicare Advantage Plans include Health Maintenance Organizations, Preferred Provider Organizations, Private Fee-for-Service Plans, Special Needs Plans, and Medicare Medical Savings Account Plans. Medicare Advantage Plans must minimally offer the same coverage as original Medicare. Most Medicare Advantage Plans offer additional services, including prescription drug coverage.
MEDICARE	MACRA	Medicare Access and CHIP Reauthorization Act of 2015	Federal legislation which includes as the language which creates a new long term model for reimbursing professional services under Medicare resulting in transition from a fee for service model to a value based model. Many of the key elements fall under Quality Payment Program section of MACRA.
GENERAL	MDHHS	Michigan Department of Health and Human Services	Michigan entity responsible for administering Medicaid and other health and social services in Michigan. Previously referred to as the Dpartment of Community Health (DCH).
MEDICAID	MHP	Medicaid Health Plan	Managed care organizations that provide or arrange for the delivery of comprehensive health care services to Medicaid Enrollees in exchange for a fixed prepaid sum or Per Member Per Month prepaid payment without regard to the frequency, extent, or kind of health care services. A Medicaid Health Plan (MHP) must have a certificate of authority from the State as a Health Maintenance Organization (HMO). See also Contractor.
MEDICARE	MIPS	Merit-based Incentive Payment System	One of 2 reimbursement models under the Quality Payment Program. Medicare payments will be adjusted (increased or decreased) based on quality, technology, resource use (cost/utilization) and practice improvement. Data submitted in 2017 will determine 2019 payment adjustments. Current PQRS, MU, VBM programs will be consolidated to MIPS in 2019 Providers excluded from MIPS: • Newly enrolled providers during the measurement year; • Providers who have few Medicare Part B patients and Providers participating in • Advanced APMs • FQHC
MEDICARE	MSSP	Medicare Shared Savings Program	Created under the Affordable Care Act (ACA) to facilitate coordination and cooperation amoung providers to improve quality of care provided to Medicare FFS beneficiaries. MSSP is one of the early ACO models.
COMMERCIAL	P4P	Pay for Performance	Incentive program that sets a portion of provider reimbursement based on performance on specific quality metrics
GENERAL	PCMH	Patient Centered Medical Home	A model of care delivery where the physician practice coordinates all of the care of the patient - even for those with chronic conditions who may have multiple specialists involved. There are several accrediting bodies for PCMH - key elements of all include: • A care team that extends beyond the PCP • A functional disease management registry • Comprehensive care delivery that includes both preventive care and chronic disease management • Active patient engagement • Improved/expanded patient access • Care coordination across the care continuum
GENERAL	PDCM	Provider Delivered Care Management	Blue Cross Blue Shield of Michigan program to reimburse care management provided by highly trained care manager in a physician office

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COMMERCIAL	PGIP	Provider Group Incentive Program	Blue Cross Blue Shield of Michigan program that provides incentives to implement PCMH
MEDICAID	PIHP	Prepaid Inpatient Health Plan	Provides inpatient mental health services to Medicaid enrollees
MEDICAID	PIP	Physician Incentive Plan	Program that pays additional funds to providers who meet/exceed specific quality metrics
MEDICAID	PSHCN	Persons with Special Health Care Needs	Medicaid enrollees who have lost eligibility for the Children's Special Health Care Services (CSHCS) program due to the program's age requirements.
MEDICARE	QPP	Quality Payment Program	New payment program under MACRA Providers can choose to participate under one of two tracks: • Merit-based Incentive Payments OR • Advanced Payment Models Data collection begins in 2017 for reimbursement rates that begin in 2019. Failure to submit data in 2017 will automatically result in a negative 4% payment reduction in 2019
MEDICAID	SIM	State Innovation Model	Michigan Medicaid focused program funded by a federal grant to improve health care, health outcomes and reduce costs for Michigan Medicaid: 3 primary components • Improve care delivery through expansion of PCMH • Support for population health improvement through regional collaboration linkages between health and community based services • Increase adoption of Alternative Payment Models among Medicaid Health Plans and all Michigan payers/purchasers