

**APPENDIX B**  
**GLOSSARY OF TERMS**

The Alpha Center maintains a comprehensive general glossary of healthcare terms on its Website, <http://www.ac.org>. Another glossary specific to Medicaid reform can be found at <http://www.hhsc.texas.gov/glossary.html>. This list present terms commonly used in this guide.

**Administrative data** refers to information that are collected, processed and stored in automated information systems. Administrative data include enrollment or eligibility information, claims information, and managed care encounters. The claims and encounters may be for hospital and other facility services, professional services, prescription drug services, laboratory services, and so on.

**Capitation** is a comprehensive payment by an insurer to a provider of health care services, designed to compensate that provider prospectively for the total amount of enumerated services rendered to an individual during a specified period of time. This form of payment places the provider at risk for the price and volume of health care services rendered to patients. Capitation payments are typically quoted on a "per member per month" basis. Partial capitation implies that the enumerated services are a subset of all services provided to the patient and that the services not included are reimbursed on a fee-for-service basis.

**Eligibility** refers to the process whereby an individual is determined to be eligible for health care coverage through the Medicaid program. Eligibility is determined by the State. Eligibility data are collected and managed by the State or by its Fiscal Agent. In some managed care waiver programs, eligibility records are updated by an Enrollment Broker, who assists the individual in choosing a managed care plan to enroll in.

**Encounter data** definitions are provided in Chapter I of the Guide. Please refer to Chapter III for options for defining encounter data.

**Enrollment** is the process by which a Medicaid-eligible person becomes a member of a managed care plan. In this Guide, enrollment data refer to the managed care plan's information on Medicaid eligible individuals who are plan members. The managed care plan gets its *enrollment* data from the Medicaid program's *eligibility* system.

**Electronic Data Interchange (EDI)** refers to the exchange of routine business transactions from one computer to another in a standard format, using standard communications protocols.

**External Quality Review Organization (EQRO)** is the organization with which the State contracts to evaluate the quality of care provided to Medicaid managed care eligibles. Typically, the EQRO is a peer review organization. It may conduct focused medical record reviews (i.e., reviews targeted at particular clinical conditions) or broader analyses on quality. While most EQRO contractors rely on medical records as the primary source of information, they also may use eligibility data and claims/encounter data to conduct specific analyses.

**False positives** occur when the encounter data contain evidence of a service that is not documented in the patient's medical record. If we assume that the medical record contains complete information on the patient's medical history, a false positive may be considered a fraudulent service. In a fully capitated environment, however, the provider would receive no additional reimbursement for the submission of a false positive encounter.

**False negatives** occur when the medical record contains evidence of a service that does not exist in the encounter data. This is the most common problem in partially or fully capitated plans because the provider does not need to submit an encounter in order to receive payment for the service, and therefore may have a weaker incentive to conform to data collection standards.

**Managed Care systems** integrate the financing and delivery of appropriate health care services to covered individuals by means of: (1) arrangements with selected providers to furnish a comprehensive set of health care services to members; (2) explicit criteria for the selection of health care providers; and (3) significant financial incentives for members to use providers and procedures associated with the plan. Managed care plans typically are labeled as HMOs (staff, group, IPA, and mixed models), PPOs, or Point of Service plans. Managed care services are reimbursed via a variety of methods, including capitation, fee-for-service, and a combination of the two. (definition derived from HIAA's Source Book of Health Insurance Data, 1993)

**MCO** stands for "managed care organization." The term generally includes HMOs, PPOs, and Point of Service plans. In the Medicaid world, other organizations may set up managed care programs to respond to Medicaid managed care. These organizations include Federally Qualified Health Centers, integrated delivery systems, and public health clinics.

**Medicaid Management Information System (MMIS)** is a HCFA-approved system that supports the operation of the Medicaid program. The MMIS includes the following types of sub-systems or files: recipient eligibility, Medicaid provider, claims processing, pricing, SURS, MARS, and potentially encounter processing.

**True negatives** are eligibles who have not received any services through the managed care plan, as evidenced by the absence of a medical record and any encounter data. True negatives signify potential access problems, and should be investigated by the managed care plan.