Opportunities for UCEDDs/LENDs in Health Care Transformation

ACRONYMS

ACO	Accountable Care Organizations (ACOs) are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to the Medicare patients they serve. Coordinated care helps ensure that patients, especially the chronically ill, get the right care at the right time, with the goal of avoiding unnecessary duplication of services and preventing medical errors. 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.
BHO	Behavioral Health Organizations (BHOs) are a type of managed care organization providing mental health and substance use services, and is intended to better coordinate care for people with co-occurring disorders.
DSRIP	Delivery System Reform Incentive Payment (DSRIP) programs are another piece of the dynamic and evolving Medicaid delivery system reform landscape. DSRIP initiatives are part of broader Section 1115 Waiver programs and provide states with significant funding that can be used to support hospitals and other providers in changing how they provide care to Medicaid beneficiaries.
FIDA	The Fully Integrated Duals Advantage (FIDA) program provides managed care for individuals enrolled in Medicare and Medicaid (also known as dual-eligibles) who need long-term services and supports. FIDA is one of several demonstration programs in the U.S. with the goal of providing better care for dual-eligible individuals while reducing health care expenditures where possible. If someone is enrolled in a FIDA plan, one plan is responsible for paying for all health services.
HMO	Health Maintenance Organizations (HMOs) are a type of managed care plan where a group of doctors, hospitals, and other health care providers agree to give health care to Medicare beneficiaries for a set amount of money from Medicare every month. Patients usually must get care from the providers in the plan.
Health Home	Health Homes providers will integrate and coordinate all primary, acute, behavioral health, and long-term services and supports to treat the whole person. The Affordable Care Act of 2010, Section 2703, created an optional Medicaid State Plan benefit for states to establish Health Homes to coordinate care for people with Medicaid who have chronic conditions by adding Section 1945 of the Social Security Act. CMS expects states health home providers to operate under a "whole-person" philosophy. (Not to be confused with PCMH.)
MACRA	Medicare Access and CHIP Reauthorization Act (MACRA) is the historic Medicare reform law that repealed the Sustainable Growth Rate (SGR) formula and reauthorized the Children's Health Insurance Program. The law also supports the next generation of ACOs through 2 different payment pathways for physicians—**alternative payment models (APMs)** and the **Merit-Based Incentive Payment System (MIPS)**. These incorporate quality and performance metrics which are largely unrelated to the needs of persons with disabilities.

MCO	Managed Care Organizations (MCOs) are entities that serve Medicare or Medicaid beneficiaries on a risk basis through a network of employed or affiliated providers. 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. An MCO can be a health maintenance organization, an eligible organization with a contract under 1876 or a Medicare-Choice organization, a provider-sponsored organization, or any other private or public organization which meets the requirements of 1902 (w) to provide comprehensive services.
PCMH	Person-Centered Medical Home (PCMH) is a model of care that emphasizes care coordination and communication to transform primary care. PCMH recognizes clinician practices functioning as medical homes by using systematic, patient-centered and coordinated care management processes. PCMH is a proprietary brand of the National Center for Quality Assurance (NCQA), an organization which also certifies HMOs and other health care organizations. PCMH designation for primary care practices is sometimes associated with higher levels of reimbursement.
RAND HIE	The RAND HIE was begun in 1971 and set out to answer this question (among others): "Does free medical care lead to better health than insurance plans that require the patient to shoulder part of the cost?" The team established an insurance company using funding from the then-United States Department of Health, Education, and Welfare. The company randomly assigned 5809 people to insurance plans that either had no cost-sharing, 25%, 50% or 95% coinsurance rates with a maximum annual payment of $1000. It also randomly assigned 1,149 persons to a staff model health maintenance organization (HMO), the Group Health Cooperative of Puget Sound. That group faced no cost sharing and was compared with those in the fee-for-service system with no cost sharing as well as an additional 733 members of the Cooperative who were already enrolled in it. Newhouse, summarizing the RAND HIE in 2004, wrote "For most people enrolled in the RAND experiment, who were typical of Americans covered by employment-based insurance, the variation in use across the plans appeared to have minimal to no effects on health status. By contrast, for those who were both poor and sick -- people who might be found among those covered by Medicaid or lacking insurance -- the reduction in use was harmful, on average". This research has served as the theoretical basis for using copays and deductibles to change patient behavior and contain cost.
SIM	The State Innovation Models (SIM) Initiative is providing financial and technical support to states for the development and testing of state-led, multi-payer health care payment and service delivery models that will improve health system performance, increase quality of care, and decrease costs for Medicare, Medicaid and Children's Health Insurance Program (CHIP) beneficiaries—and for all residents of participating states.