Payer Engagement Glossary

- **ABD –** Aged, Blind, and Disabled
- **Accelerated Approval** – The FDA's Accelerated Approval Program allows for faster approval of drugs for serious conditions that address an unmet medical need. This is achieved by using surrogate endpoints in clinical trials, which are markers that are thought to predict clinical benefit but are not themselves a measure of clinical benefit (like tumor shrinkage instead of overall survival). While accelerated approval offers earlier access to potentially beneficial drugs, it requires post-approval studies to confirm the anticipated clinical benefit.
- **Beneficiary Advisory Council (BAC)** – An advisory group, often comprised of Medicaid beneficiaries, their families, and caregivers, which provides feedback to state Medicaid agencies on policies and programs. The BAC's primary function is to ensure that the voices of those directly impacted by Medicaid services are heard, helping to improve access, quality, and effectiveness of care.
- **Cell and Gene Therapies (CGT)** – The FDA defines cell and gene therapies (CGT) as innovative medical approaches that involve modifying a patient's genetic material or using cells to treat or prevent diseases.
- **Centers for Medicare and Medicaid Services (CMS) –** The federal agency that runs the Medicare program. In addition, CMS works with the States to run the Medicaid program. CMS works to make sure that the beneficiaries in these programs are able to get high quality health care.
- **Capitation Arrangement** – a compensation plan used in connection with some managed care contracts where a physician or other medical provider is paid a flat amount, usually on a monthly basis, for each subscriber who has elected to use that physician or medical provider. Capitated payments are sometimes expressed in terms of a "per member/per month" payment. The capitated provider is generally responsible, under the conditions of the contract, for delivering or arranging for the delivery of all contracted health services required by the covered person.
- **Conflict of Interest (CoI)** – When a member's personal or financial interests could potentially influence their decisions or actions in a way that benefits them or their close associates, rather than the broader Medicaid beneficiary population.
- **(DUR) –** It's a structured and ongoing review of prescribing, dispensing, and use of medications to ensure they are appropriate, medically necessary, and don't lead to adverse outcomes. DURs are often used in managed care and pharmacy benefit management to optimize medication use and potentially reduce costs.
- **Durable Medical Equipment (DME)** – Equipment and supplies ordered by a health care provider for everyday or extended use. DME may include respiratory equipment, wheelchairs, and orthotics
- **Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)** – A program of preventive health care and well child examinations with tests and immunizations for children and teens from birth up to age 21. Medically necessary services needed to correct or improve defects, and physical or mental illnesses (discovered during a screening examination) may be covered as a part of the EPSDT program even if they are not covered under the State's Medicaid benefit plan.
- **Fair Hearing** – Because Medicaid is an entitlement, individuals have a statutory right to appeal denials or terminations of Medicaid benefits to an independent arbiter. The fair hearing is the administrative procedure that provides this independent review with respect to individuals who apply for Medicaid and are denied enrollment, individuals enrolled in Medicaid whose enrollment is terminated, and Medicaid beneficiaries who are denied a covered benefit or service.

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- **Fee-For-Service (FFS)** – A traditional method of paying for medical services under which doctors and hospitals are paid for each service they provide. Bills are either paid by the patient who then submits them to the insurance company or are submitted by the provider to the patient's insurance carrier for reimbursement.
- **Formulary** – A list of prescription drugs covered by a prescription drug plan or another insurance plan offering prescription drug benefits.
- **Federal Poverty Level (FPL)** – A measure of income updated yearly by the Department of Health and Human Services (HHS) that's used to determine eligibility for certain programs and benefits, like Marketplace savings, and Medicaid and the Children's Health Insurance Program (CHIP) coverage.
- **Federally Qualified Health Center (FQHC)** – A Federally Qualified Health Center (FQHC) is a public health center that provides comprehensive primary and preventive care services to underserved communities, regardless of a patient's ability to pay. FQHCs serve a broad range of people, including those in rural areas, homeless individuals, and migrant farmworkers, and are located in all U.S. states and territories.
- **Home and Community-Based Waiver Programs (HCBS)** – The HCBS programs offer different choices to some people with Medicaid. If you qualify, you will get care in your home and community so you can stay independent and close to your family and friends. HCBS programs help the elderly and disabled, developmentally disabled, and certain other disabled individuals.
- **Katie Beckett Waiver/ Tax Equity and Fiscal Responsibility Act (TEFRA)** - Katie Beckett refers to a Medicaid waiver program, named after a young girl who was unable to go home from the hospital due to her parents' income exceeding Medicaid eligibility. The program allows children with significant disabilities or complex medical needs to receive Medicaid benefits while living at home, regardless of their parents' income or assets. The program helps families avoid the high cost of institutional care by providing comprehensive medical services and some home and community-based services in the child's own home.
- **Medicaid Advisory Committee (MAC)** – An advisory body established by state Medicaid agencies to provide input on policy development and program administration related to health and medical care services provided under the Medicaid program. The MAC helps ensure that services offered under the program meet the needs of beneficiaries.
- **Managed Care Organization (MCO)** – like HMOs, these companies agree to provide most Medicaid benefits to people in exchange for a monthly payment from the state. Private insurance companies may offer health plans for Medicaid recipients, and these are considered Medicaid MCOs.
- **Medicaid** – A joint federal and state program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid.
- **Office for Civil Rights (OCR)** – OCR enforces the Privacy and Security Rules. The agency within the Department of Health and Human Services with responsibility for monitoring and enforcing compliance with federal anti-discrimination laws by providers and managed care entities participating in Medicaid as well as state Medicaid agencies and their contractors.
- **Office of Inspector General (OIG)** – The agency within the Department of Health and Human Services with responsibility for monitoring and enforcing compliance with federal fraud and abuse laws by providers and managed care entities participating in Medicaid.

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- **P&T Committee –** Pharmacy and Therapeutic committees evaluate the clinical use of medications and develop policies for managing access to them and for ensuring effective drug use and administration.
- **PME –** People with Medicaid lived experience
- **Patient-Reported Outcomes (PROs)** – Reports of a patient's health status that come directly from the patient, without interpretation by a clinician or anyone else. These reports can cover various aspects of a patient's health, including their symptoms, functional status, health behaviors, and overall health-related quality of life.
- **Payer Engagement –** The strategic process of communicating and collaborating with healthcare payers (like insurance companies or government healthcare programs) to secure favorable coverage, reimbursement, and market access for a product, service, or treatment. It involves demonstrating value and cost-effectiveness to payers, aligning with their needs and decision-making processes, and ultimately facilitating patient access.
- **Prescription Drugs –** Drugs and medication that by law require a prescription.
- **Prior Authorization** – A decision by your health insurer or plan that a health care service is medically necessary. Sometimes it is called preauthorization, prior approval, PA, or precertification. Your health insurance or plan may require prior auth for certain services before you receive them, except in an emergency. PA doesn't promise your health insurance or plan will cover the cost.
- **Specialty Drug** – A type of prescription drug that, in general, requires special handling or ongoing monitoring and assessment by a health care professional, or is difficult to dispense, Specialty drugs are typically the most expensive drugs on a formulary.
- **Specialty Pharmacy –** A pharmacy that deals with specialty drugs. Typically, the medication must be delivered to the home or facility via USPS/UPS/Fed ex.
- **State Children's Health Insurance Program (CHIP)** – Policies issued in association with the Federal/State partnership created by title XXI of the Social Security Act.
- **Step Therapy** – A coverage rule used by some health and prescription drug insurance plans that requires you to try one or more similar, lower cost drugs to treat your condition before the plan will pay for the prescribed drug.
- **Temporary Assistance for Needy Families (TANF)** – Temporary Assistance for Needy Families is a federal program that provides cash assistance, job training, and other support to low-income families with children. Administered by states, the program is designed to promote economic self-sufficiency by offering a range of services like childcare, housing, and work-related activities. Eligibility, benefits, and specific program names vary by state, and applicants must meet work requirements and other criteria, often including time limits on receiving benefits.
- **Waiver –** A Medicaid waiver does as its name implies: waives a Medicaid rule or law to deliver a certain benefit or expansion of coverage that isn't normally covered within a state's Medicaid plan. Waivers are commonly used to deliver Home and Community-Based Services (HCBS), such as at-home caretaking, transportation or providing medical equipment. Common waivers are: 1115, 1915(b), 1915(c), 1915(i), and 1915 (k).

Resources

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