Managed Care Community of Practice
Preparing the I/DD Field for Managed Care

Term	Description
Authorization/Preauthorization	Approval, granted by a managed care plan, for a consumer to receive a health care product or service, such as a specific medical, mental health and/or substance use treatment. Preauthorization is when prior approval by a managed care plan is required before services can be rendered.
Beneficiary	A consumer, or his or her dependent, who enrolls with a managed care plan, and is entitled to receive coverage and payment for health care products and services covered by the contract with the plan.
Capitation	A payment system in which health care providers (practitioners, hospitals, pharmacists, etc.) receive a fixed payment per member per month (or year), regardless of how many or few services the patient uses.
Case Management	The process managed care plans may use to review the care that patients receive. The goal of case management is to ensure that patients receive the appropriate service from the right provider, at the right time, and in the least costly setting.
Case Rate	A payment system in which the managed care plan pays health care providers an all-inclusive fee to provide care for a patient, based on the patient's diagnosis, or the medical treatments for an agreed upon episode of care.
Claims Form	Documentation (electronic or paperwork) that patients and health care providers file with managed care plans in order to receive payment for services.
Clinical Pathway	A medical "roadmap" that helps health care providers identify the most appropriate course of treatment for a specific patient, based on that patient's clinical situation.
Coinsurance	The portion of health care costs not paid by the managed care plan, for which the consumer is responsible. Coinsurance usually is expressed as a fixed proportion of the managed care plan's allowable charge. For example, if a plan pays 80 percent of its allowable charge for a covered service, the consumer is responsible for the remaining 20 percent as coinsurance.
Contracted Provider	A hospital, practitioner, network of hospitals and practitioners, or other healthcare providers who enter into a legal agreement with a managed care plan to care for the plan's members for negotiated prices.

Coverage	Decision making process that identifies what services or products are benefits under the employer's or consumer's contract with the plan. Covered products or services are eligible to be paid for by the plan.
Credentialing	A system used by managed care plans to assess the qualifications of practitioners or other health care providers who are contracted.
Deductible	A form of cost sharing in a managed care plan, in which a consumer pays a fixed dollar amount of covered expenses each year, before the plan begins paying its share of costs.
Fee-for-Service (FFS) Reimbursement	Payment system in which a provider gets paid the negotiated amount for specific services rendered. Payment may be made by an insurance company, the patient, or a government program such as Medicare or Medicaid.
Medical Necessity	New York law defines "medically necessary medical, dental, and remedial care, services, and supplies" in the Medicaid program as those "necessary to prevent, diagnose, correct, or cure conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity, or threaten some significant handicap and which are furnished an eligible person in accordance with state law."
Participating Provider	A hospital or practitioner who signs a contract with a managed care plan and agrees to care for plan members for negotiated fees and conditions specified in the contract. Typically, when plan members see participating providers, they have low co-payments and no paperwork to file with the plan. To become a participating provider, a provider must be a contracted provider and fully credentialed.
Revenue Cycle Management (RCM)	All administrative and clinical functions that contribute to the capture, management, and collection of client service revenue. This describes the life cycle of a client account from creation to payment collection and resolution. The client account cycle is supported by a number of additional activities necessary to assure that revenue collection is maximized and all encounters are billable and meet regulatory requirements.
Utilization Management (UM)	Procedures used to monitor or evaluate clinical necessity, appropriateness, efficacy, or efficiency of behavioral health care services, procedures, or settings and includes ambulatory review, prospective review, concurrent review, retrospective review, second opinions, care management, discharge planning, and service authorization.

Utilization Review (UR)	A review to determine whether health care services that have been provided, are being provided or are proposed to be provided to a patient, whether undertaken prior to, concurrent with or subsequent to the delivery of such services are medically necessary.