

KONTIKI STRATEGIC HEALTH ADVISORS

# Managed Care and Value-Based Care Terminology Reference Guide

A Professional Reference for Clinical, Operational, and Administrative Teams in

---

Medicare, Medicare Advantage, Medicaid, Managed Medicaid, Commercial HMO, Commercial PPO, ACO, and Risk-Based Care Environments

## **Michele Kadlec**

Kontiki Strategic Health Advisors

630-624-3024

2026 Revised



Copyright © 2026 Kontiki Strategic Health Advisors | Michele Kadlec

Confidential and Proprietary. Do Not Copy, Reproduce, Distribute, or Use Without Written Permission.

# Introduction

Healthcare organizations competing in managed care and value-based care environments operate under a shared financial and clinical language that spans payer contracting, risk adjustment, population health management, revenue cycle operations, and quality performance. Fluency in this language is not optional — it is foundational to decision-making, operational alignment, and financial performance.

This reference guide is organized into twelve sections covering the full spectrum of managed care and value-based care terminology. Each term is defined for practical operational use and, where applicable, includes a clinical or financial example illustrating how the concept applies in day-to-day practice.

## How to Use This Guide

This guide is designed for clinical staff entering value-based care environments, practice administrators managing payer contracts and revenue cycle operations, operational leaders overseeing population health and care management programs, and physician and APP teams navigating documentation and compensation models tied to quality and risk adjustment performance.

Section	Topics Covered	Primary Audience
<b>I. Managed Care Fundamentals</b>	Payers, networks, capitation, authorization, risk pools	All staff
<b>II. Value-Based Care Models</b>	ACO, CIN, bundled payment, APMs, shared savings	Physicians, leadership, administrators
<b>III. Risk Adjustment (RAF/HCC)</b>	RAF, HCC, MEAT, supplemental submissions, v28/v29	Physicians, coders, navigators
<b>IV. Population Health</b>	Attribution, care gaps, CCM, TCM, RPM, SDOH	Physicians, care coordinators, administrators, CMAs
<b>V. Medicare and Medicaid</b>	MA, ACO REACH, MMAI, dual eligibles, CMS programs	All clinical staff
<b>VI. Quality and Performance</b>	HEDIS, Star Ratings, QIP, CAHPS, gap closure	All staff
<b>VII. Revenue Cycle Management</b>	Charge capture, denials, wRVU, A/R, clean claims	All staff
<b>VIII. Financial and Contract Metrics</b>	MLR, PMPM, TCOC, benchmarks, risk corridors	Executives, finance
<b>IX. Operational Leadership</b>	Leakage, throughput, network integrity, attribution	Directors, administrators
<b>X. Advanced RCM</b>	Gross charges, net revenue, remittance, reconciliation	Directors, billing, revenue cycle directors
<b>XI. Patient Collections and OOP</b>	Deductible, co-insurance, OOP max, ABN, HDHP, HSA	Registration, front desk, financial counselors, revenue cycle directors
<b>XII. Epic EMR Terminology</b>	Hyperspace, MyChart, WQ, SmartSets, DAR, Clarity	All Epic users

## I MANAGED CARE FUNDAMENTALS

### Managed Care

A healthcare delivery model that integrates the financing and delivery of care to manage cost, utilization, and quality outcomes. Replaces unlimited fee-for-service with structured oversight of appropriateness, access, and cost.

**Example:** *A commercial insurer offering an HMO plan contracts with a PCP network, requires referrals for specialist care, and reviews hospital admissions for medical necessity.*

### **Payer**

An entity that finances healthcare services on behalf of patients. Includes commercial insurers, Medicare, Medicaid, and self-insured employer groups.

**Example:** *United Healthcare, Aetna, Humana, CMS, and a large employer that self-funds employee health benefits are all payers.*

### **Network**

A contracted group of providers — physicians, hospitals, imaging centers, and ancillary services — delivering services to plan members at negotiated rates.

**Example:** *A Medicare Advantage plan's network includes all participating PCPs, specialists, hospitals, and laboratories contracted at defined reimbursement rates.*

### **In-Network vs. Out-of-Network**

In-network providers are contracted with the payer at defined rates. Out-of-network providers are not contracted; patients bear higher cost-sharing and the provider may receive no payment in certain plan types. In a VBC arrangement, out-of-network use is a leakage event with financial and quality consequences.

**Example:** *A patient attributed to a CIN PCP who receives an MRI at a non-contracted imaging center creates leakage: lost revenue, no quality data, and no care coordination.*

### **Capitation**

A fixed per-member-per-month (PMPM) payment to a provider or organization for a defined set of services, regardless of the actual volume of services used. Transfers financial risk to the provider.

**Example:** *A primary care group receives \$35 PMPM to manage all primary care services for 5,000 attributed MA members, regardless of visit volume.*

### **Per Member Per Month (PMPM)**

The monthly payment amount paid for each enrolled member in a capitated or care management program. Used to track cost, revenue, and care management investment on a per-patient basis.

**Example:** *A CCM program generates \$42 PMPM for enrolled patients. With 300 enrolled members, the monthly CCM revenue is \$12,600.*

### **Utilization Management (UM)**

The process of evaluating the medical necessity, appropriateness, and efficiency of healthcare services before (prior authorization), during (concurrent review), or after delivery (retrospective review).

**Example:** *A UM team reviews a request for an inpatient rehabilitation stay to confirm the patient meets criteria for SNF-level care versus home health.*

### **Prior Authorization (PA)**

A payer requirement that certain services — specialty referrals, imaging, procedures, high-cost drugs — be approved before they are performed. Denial of authorization is the largest single category of healthcare claim denials.

**Example:** *Before administering a biologic injection, the practice submits a PA request including the diagnosis, failed therapies, and supporting clinical documentation.*

### **Referral**

A PCP's order directing a patient to a specialist or ancillary provider for evaluation or services. In managed care, referrals must typically stay in-network. Closed-loop referral management ensures the appointment is scheduled and completed within the network.

**Example:** *A PCP places a referral order for cardiology after identifying atrial fibrillation. The referral navigator schedules the appointment in-network before the patient leaves the office.*

### **Risk Pool**

A shared financial arrangement where providers assume accountability for the total cost of care for a defined population. Positive risk pool results are shared as bonuses; negative results may require refunds depending on the contract.

**Example:** *A PCP group participates in a shared risk arrangement where savings below the MA benchmark are distributed quarterly.*

### **Stop Loss**

Reinsurance protection that limits a provider's financial exposure for catastrophic or unexpectedly high-cost patients. Defined as an individual or aggregate threshold above which the payer absorbs costs.

**Example:** *A capitated PCP group carries stop loss coverage at \$50,000 per member per year, protecting against outlier cases such as premature births or transplant patients.*

### **Shared Savings**

A payment model in which providers receive a percentage of savings achieved when total cost of care falls below the actuarial benchmark. The proportion shared depends on quality performance and contract terms.

**Example:** *An ACO achieving 8% cost reduction below benchmark on a \$120M total cost target generates \$9.6M in savings. The organization retains 40–50%, distributing \$3.8–4.8M among participating providers.*

### **Shared Risk**

A VBC contract arrangement where providers share in both upside savings when costs fall below benchmark and downside losses when costs exceed benchmark. Higher financial risk; higher potential reward.

**Example:** *In a two-sided ACO REACH model, the organization earns 50% of savings below benchmark but repays 30% of losses above benchmark, creating strong incentives for cost management.*

### **Medical Necessity**

The clinical standard that a service, procedure, or level of care is appropriate, reasonable, and required for the diagnosis or treatment of an illness or injury according to evidence-based guidelines.

**Example:** *A payer denies a lumbar MRI because the patient has not had six weeks of conservative therapy, which is required under the medical necessity criteria for imaging.*

### **Level of Care**

The intensity and setting of care appropriate for a patient's clinical condition: outpatient, observation, inpatient, ICU, SNF, home health, or hospice. Inappropriate level of care is a common denial trigger.

**Example:** *Admitting a patient to inpatient status when observation criteria are met results in a claim denial and potential downcoding to observation reimbursement.*

### **Coordination of Benefits (COB)**

The process of determining the correct payment order when a patient has more than one insurance policy. The primary payer pays first; the secondary payer covers remaining balances up to its allowed amount.

**Example:** *A Medicare-Medicaid dual eligible patient has Medicare as primary payer and Medicaid as secondary. Filing order errors create claim denials and delayed payment.*

## **II VALUE-BASED CARE MODELS AND STRATEGY**

### **Value-Based Care (VBC)**

A healthcare delivery and payment model that ties reimbursement to quality outcomes and cost efficiency rather than service volume. Replaces the fee-for-service incentive of doing more with an incentive for doing better.

**Example:** *A PCP group shifts from pure FFS billing to an ACO model where a portion of compensation is tied to HbA1c control rates, AWV completion, and total cost of care per attributed patient.*

### **Alternative Payment Model (APM)**

A payment structure that departs from traditional FFS by incorporating quality metrics, cost targets, episode-based payments, or capitation. CMS and commercial payers offer a range of APMs with varying levels of risk.

**Example:** *A bundled payment program pays a single rate for a hip replacement surgery, covering the surgical case, hospital stay, rehabilitation, and 90-day follow-up period.*

### **Accountable Care Organization (ACO)**

A provider organization — a network of physicians, hospitals, and other providers — jointly accountable for the total cost and quality of care for an attributed patient population. Shares savings when costs fall below the benchmark.

**Example:** *An ACO REACH organization manages 40,000 attributed Medicare beneficiaries. It earns shared savings by improving chronic disease management, reducing avoidable admissions, and capturing accurate RAF scores.*

### **ACO REACH**

A CMS-administered Medicare ACO model (Realizing Equity, Access, and Community Health) with higher risk and savings potential than the earlier MSSP model. Organizations assume direct beneficiary risk under a prospective payment approach.

**Example:** *A medical group in ACO REACH receives monthly prospective payments per attributed beneficiary and earns or repays shared savings/losses at the end of the performance year.*

### **Clinically Integrated Network (CIN)**

A physician-led and hospital-aligned network that coordinates care across settings under shared clinical standards, data infrastructure, referral management, and quality governance. Enables value-based contracting and population health management.

**Example:** *A CIN allows independent PCPs and employed specialists to coordinate care for a shared MA panel, ensuring referrals stay in-network, quality gaps are addressed, and RAF data is captured consistently.*

### **Medicare Advantage (MA)**

A privately administered Medicare plan offered by approved insurers. Members receive Medicare benefits through the plan, which receives risk-adjusted PMPM payments from CMS based on enrollee demographics and RAF scores.

**Example:** *Humana Gold Plus and Aetna Medicare Select are MA plans. The insurer receives higher PMPM payments for members with higher RAF scores, creating a strong financial incentive for complete chronic condition documentation.*

### **Attribution**

The process of assigning patients to a specific provider or organization for accountability in cost, quality, and risk-adjusted payment. Attribution determines who receives credit for care and who bears financial responsibility for outcomes.

**Example:** *A patient attributed to a PCP generates RAF-adjusted revenue credited to that PCP's panel. If the patient migrates to a competing PCP without formal re-attribution, the original organization loses RAF revenue but may still bear cost responsibility.*

### **Panel Management**

The active oversight and management of a defined patient population assigned to a provider. Includes proactive outreach for preventive care, chronic disease monitoring, care gap closure, and risk stratification.

**Example:** A PCP's panel manager identifies 47 diabetic patients overdue for A1c testing and schedules outreach calls to schedule labs before their next appointment.

### Bundled Payment

A single payment covering all services for a defined episode of care, distributed among the providers involved. Creates shared accountability for cost and quality across settings.

**Example:** A total knee replacement bundle covers the surgical case, hospital stay, anesthesia, physical therapy, and 90-day post-operative care under a single payment, incentivizing coordination across providers.

### Shared Savings Program (SSP)

A contract structure where a provider organization earns a share of the savings it generates below the actuarial cost benchmark. Quality performance determines the savings rate retained.

**Example:** Under an MSSP Track 1 arrangement, an ACO that reduces total cost by \$5M below benchmark earns up to 50% of the savings, or \$2.5M, based on quality score.

### Two-Sided Risk Model

A VBC contract where providers share in both savings below benchmark (upside) and losses above benchmark (downside). Provides the highest savings potential but also the highest financial exposure.

**Example:** An MA plan offers a two-sided capitation contract: if the provider group keeps costs 5% below benchmark, they keep 40% of savings; if costs exceed benchmark by 5%, they repay 20% of the overage.

### Total Cost of Care (TCOC)

The aggregate cost of all healthcare services delivered to an attributed population over a defined period. Includes primary care, specialty, hospital, pharmacy, and ancillary services. The benchmark against which shared savings is measured.

**Example:** An ACO's TCOC for 20,000 attributed lives is \$240M annually. The benchmark is \$252M. The \$12M difference is subject to the shared savings calculation.

### Benchmark

The projected or historical cost target set by the payer or CMS against which actual spending is measured to determine shared savings or losses. Typically based on prior-year spending, trended forward and adjusted for RAF.

**Example:** CMS sets an ACO's benchmark at \$11,800 PMPM based on historical claims. If the organization achieves \$11,200 PMPM actual cost, it has generated \$600 PMPM in savings on each attributed life.

### Care Coordination Fee (CCF)

A PMPM payment made to a provider organization to support the infrastructure of population health management: care coordinators, navigators, analytics, and outreach programs.

**Example:** An MA plan pays a \$6 PMPM care coordination fee to a CIN for managing quality gap closure, CCM enrollment, and preventive care outreach across 8,000 attributed members.

### Quality Metrics

Performance indicators that payers and CMS use to evaluate the quality of care delivered. Tied to shared savings rates, star ratings, and contract bonuses.

**Example:** Diabetes HbA1c control, colorectal cancer screening rates, and blood pressure management are quality metrics that affect both Star Ratings and an ACO's shared savings percentage.

### HEDIS

Healthcare Effectiveness Data and Information Set. A standardized set of performance measures used by health plans to evaluate clinical quality, patient experience, and access. Required for NCQA accreditation and MA Star Ratings.

**Example:** A PCP practice's HEDIS performance on breast cancer screening affects the plan's Star Rating. Low screening rates in the practice reduce the plan's quality score and the organization's quality bonus.

**Star Ratings**

CMS's quality rating system for Medicare Advantage plans, scored on a 1–5 star scale. Plans with 4–5 stars receive quality bonus payments and can attract more enrollees. Provider performance directly affects plan-level Star Ratings.

**Example:** *A plan achieving 4.5 Stars receives an MA quality bonus of approximately 5% above baseline payment, which it can pass through to high-performing provider organizations.*

**Fee-for-Service (FFS)**

The traditional payment model in which providers are paid for each service rendered. Rewards volume over value. FFS revenue typically continues alongside VBC arrangements during the transition to risk-based contracts.

**Example:** *A PCP earns \$74 per 99214 visit regardless of the patient's outcome, readmission rate, or RAF score. FFS does not reward documentation accuracy or care coordination.*

**III RISK ADJUSTMENT — RAF, HCC, AND MLR****Risk Adjustment Factor (RAF)**

A score assigned to each attributed patient that reflects predicted healthcare costs based on documented diagnosis burden and demographic factors. Higher RAF = higher risk-adjusted payment to the responsible organization. Used in Medicare Advantage and ACO REACH to set per-member payment levels.

**Example:** *A patient with CHF, CKD Stage 3, Type 2 diabetes with neuropathy, and COPD may have a RAF score of 1.65, meaning the plan receives 65% above the benchmark payment to care for this patient.*

**Hierarchical Condition Category (HCC)**

The CMS risk adjustment model that groups related diagnoses into condition categories predictive of future healthcare costs. Each HCC category carries a specific weight that contributes to the patient's total RAF score. Multiple HCCs can be captured per patient annually.

**Example:** *HCC 85 (Congestive Heart Failure) carries a RAF weight of approximately 0.32. If the patient's CHF is not documented in the current year, that 0.32 RAF points — worth approximately \$3,200 in annual revenue — is lost.*

**CMS-HCC**

The specific risk scoring methodology maintained by CMS for Medicare Advantage. The model version in use determines which diagnoses carry HCC weight and how much. CMS-HCC v24 was the baseline model; v28 was implemented in 2025 with increased specificity requirements; v29 is anticipated in 2026.

**Example:** *Under v28, a generic diabetes code (E11.9) no longer carries meaningful HCC weight. The provider must specify the complication (E11.22 for diabetes with CKD) to receive full RAF credit.*

**MEAT Documentation**

The CMS documentation standard required for a chronic condition to count toward RAF. MEAT stands for Monitor, Evaluate, Assess, Treat. The provider must document at least one of these elements for each condition during the encounter. Generic problem list carryforward does not satisfy MEAT.

**Example:** *For a patient with COPD, MEAT documentation means: monitoring oxygen saturation and spirometry (Monitor), reviewing pulmonary function test results (Evaluate), assessing disease stability or exacerbation (Assess), and adjusting bronchodilator therapy (Treat).*

**HCC Recapture**

The annual re-documentation of prior-year HCC conditions to maintain their contribution to RAF. Chronic conditions must be actively addressed and documented with MEAT criteria every calendar year — prior-year documentation alone does not carry forward.

**Example:** *A patient with prior-year HCCs for heart failure, CKD, and diabetes must have each of those conditions addressed, documented, and coded in the current year to maintain the RAF score.*

### Suspect Conditions

Chronic conditions that are clinically likely based on pharmacy, laboratory, or claims data but have not yet been formally documented and coded in the current year. Used to prepare pre-visit HCC checklists for providers.

**Example:** *A patient on metformin and SGLT2 inhibitor with an A1c of 8.4 is a suspect for diabetes with complications, even if the current-year note has not yet specified the complication type.*

### ICD-10 Specificity

The level of detail required in an ICD-10 diagnosis code to accurately represent the patient's condition. Under CMS-HCC v28 and v29, specificity is required to receive HCC credit — generic or unspecified codes may carry no weight.

**Example:** *E11.9 (Type 2 diabetes, unspecified) carries minimal HCC weight. E11.22 (Type 2 diabetes with diabetic CKD, Stage 3) captures both the diabetes HCC and the CKD HCC, producing significantly higher RAF contribution.*

### Medical Loss Ratio (MLR)

The percentage of premium revenue spent on direct patient care versus administrative costs and profit. CMS requires MA plans to maintain at least 85% MLR. For provider organizations, MLR reflects care efficiency — low MLR indicates cost-efficient, well-coordinated care.

**Example:** *A medical group with \$100M in total attributed revenue spends \$88M on patient care. Its MLR is 88%. If RAF is also high, the organization is efficient, well-documented, and positioned for shared savings.*

### High MLR / Low RAF

The highest-risk financial position in value-based care. High MLR means the organization is spending heavily on patient care. Low RAF means the documentation does not reflect the patient's true complexity, so reimbursement is inadequate. This combination produces losses.

**Example:** *A PCP panel with an average RAF of 0.82 and MLR of 92% is spending significantly more than it receives in risk-adjusted revenue. Documentation improvement to bring RAF to 1.10 would generate approximately \$280K in additional annual revenue on a 1,000-patient panel.*

### 837-B Supplemental Submission

A supplemental data file submitted outside the standard 837P claim to capture additional HCC diagnoses that were documented at the encounter but could not fit on the 12-diagnosis CMS-1500 form. High-performing organizations submit 837-S files weekly.

**Example:** *A complex patient with 18 active chronic conditions can only have 12 diagnoses submitted on the CMS-1500 claim. A weekly 837-B supplemental submission captures the remaining 6 diagnoses and their HCC weights.*

### Prospective Risk Adjustment

The method of using prior-year documented diagnoses to set the current-year risk-adjusted payment. Emphasizes annual recapture of all chronic conditions because missing a diagnosis in Year 1 reduces payment in Year 2.

**Example:** *If a patient's CHF is not documented in 2025, the 2026 MA payment for that patient will not include the CHF HCC weight, reducing annual revenue by approximately \$3,200–3,800 per patient.*

### RAF Erosion

The year-over-year decline in average panel RAF score caused by failure to recapture prior-year HCCs, inadequate MEAT documentation, or ICD-10 specificity gaps. RAF erosion silently reduces risk-adjusted revenue annually.

**Example:** *A practice that completed AWVs in 2024 but failed to pair them with E/M visits or MEAT documentation may see panel RAF decline by 0.12–0.18 in 2025, representing \$1.2M–1.8M in revenue loss on a 1,000-patient panel.*

## IV POPULATION HEALTH AND CARE MANAGEMENT

### Population Health

The systematic management of health outcomes across a defined patient population through proactive identification, stratification, outreach, and coordinated care delivery. Foundational to value-based care performance.

**Example:** *A population health program identifies 340 diabetic patients with A1c above 9.0 and deploys a nurse navigator to schedule lab reviews, medication adjustments, and diabetic eye exams before year-end quality measurement.*

### **Risk Stratification**

Categorizing patients by predicted utilization and cost based on clinical complexity, chronic conditions, prior utilization, and social risk factors. Determines priority for care management, outreach, and clinical intervention.

**Example:** *Patients are stratified into low, medium, high, and ultra-high risk tiers. High-risk patients receive monthly CCM calls. Ultra-high-risk patients receive dedicated care coordinator outreach and weekly touchpoints.*

### **Care Gap**

A missing preventive or chronic care service that should have been delivered based on clinical guidelines, payer quality requirements, or HEDIS standards. Open care gaps reduce Star Ratings and quality bonus performance.

**Example:** *A 58-year-old female patient attributed to a PCP is overdue for colorectal screening, mammogram, and A1c testing. All three are open HEDIS care gaps that must be closed before the measurement period ends.*

### **Annual Wellness Visit (AWV)**

A Medicare preventive visit conducted annually that includes a Health Risk Assessment, review of functional status, cognitive screening, preventive care review, and development of a personalized prevention plan. Billed as G0438 (initial) or G0439 (subsequent). No patient co-payment. Anchors RAF capture and attribution stability.

**Example:** *A PCP pairs a G0439 AWV with a 99214-25 E/M visit for a patient with COPD, hypertension, and obesity. The AWV closes HEDIS gaps; the E/M captures HCCs with MEAT documentation; the combined visit generates \$300–\$400 in revenue.*

### **Chronic Care Management (CCM)**

A monthly care management program for patients with two or more chronic conditions who require ongoing coordination of care between encounters. Requires at least 20 minutes of care management activities per month. Billed as 99490 / 99491 / 99487.

**Example:** *A care manager spends 25 minutes per month coordinating medications, scheduling follow-up labs, and communicating with specialists for a patient with heart failure, diabetes, and CKD. The practice bills CCM at \$42–60/month per enrolled patient.*

### **Transitional Care Management (TCM)**

Post-discharge coordination services following a hospital, skilled nursing facility, or other inpatient stay. Requires contact with the patient within 2 business days and a face-to-face visit within 7 days (99496) or 14 days (99495). Highest reimbursement rate in primary care.

**Example:** *A patient discharged from the hospital with a CHF exacerbation is contacted by the care coordinator within 24 hours. The PCP sees the patient within 7 days, bills 99496 at \$119, captures HCCs with updated MEAT documentation, and prevents a 30-day readmission.*

### **Remote Patient Monitoring (RPM)**

A technology-based program that collects physiologic data from patients between encounters using connected devices. Used for blood pressure, glucose, weight, and pulmonary function monitoring. Generates recurring monthly billing and supports RAF documentation.

**Example:** *A patient with uncontrolled hypertension receives a connected blood pressure cuff. Daily readings are reviewed by the clinical team. Monthly RPM billing generates \$55–75/month; trending data supports updated blood pressure and CKD documentation.*

### **Preventive Care Coordination**

Proactive outreach and scheduling to ensure patients complete age- and risk-appropriate preventive services: colonoscopy, mammogram, cervical cancer screening, lung cancer CT, diabetic eye exam, and immunizations.

**Example:** *A pre-visit preparation workflow identifies a 67-year-old patient overdue for colorectal screening. The navigator orders the FIT test and schedules a colonoscopy consult before the PCP visit so results are available at the appointment.*

### **Social Determinants of Health (SDOH)**

Non-medical factors that influence health outcomes: housing instability, food insecurity, transportation barriers, financial stress, social isolation, and educational attainment. SDOH screening is captured using Z-codes and affects both clinical care planning and anticipated CMS-HCC v29 RAF contribution.

**Example:** *A patient screens positive for food insecurity (Z59.41) and housing instability (Z59.01). The care coordinator connects the patient to community resources and documents both Z-codes, which are expected to carry HCC weight under v29.*

### **Nurse Navigator**

A registered nurse or LPN dedicated to population health functions: monitoring HCC recapture lists, conducting pre-visit chart preparation, scheduling priority visits for high-MLR / low-RAF patients, and conducting post-discharge TCM outreach.

**Example:** *A nurse navigator embedded in a PCP practice reviews the weekly HCC recapture list, identifies 22 patients with prior-year CHF documentation not yet recaptured, and schedules them for appointments within 30 days.*

### **Disease Registry**

A database of patients with a specific condition or risk factor, used to proactively manage care gaps, monitor outcomes, and ensure annual recapture of diagnoses.

**Example:** *A diabetes disease registry flags all patients with A1c drawn more than 90 days ago. The care coordinator generates a call list and initiates outreach to schedule lab orders before the next visit.*

### **Outmigration**

The process by which attributed patients receive care outside the primary network — through out-of-network specialists, independent imaging centers, external hospitals, or unaffiliated urgent care. Simultaneously reduces revenue, increases cost, and prevents RAF capture.

**Example:** *An attributed patient sees an out-of-network orthopedic surgeon after a delayed referral. The organization loses surgical revenue, loses care coordination, and loses the HCC documentation from the surgical encounter that would have contributed to RAF.*

## **V MEDICARE AND MEDICAID PROGRAMS**

### **Medicare Part A**

Hospital insurance covering inpatient hospital stays, skilled nursing facility care, hospice, and some home health. No premium for most beneficiaries. Subject to deductibles and co-insurance.

**Example:** *A Medicare patient admitted for COPD exacerbation is covered under Part A. The hospital receives a DRG payment; the attending physician bills under Part B separately.*

### **Medicare Part B**

Medical insurance covering physician services, outpatient care, preventive services, and durable medical equipment. Requires a monthly premium and covers 80% of allowed charges after the annual deductible.

**Example:** *A PCP bills 99214 under Part B. Medicare pays 80% of the allowed amount; the patient pays 20% as co-insurance unless they have a Medigap policy.*

### **Medicare Part D**

Prescription drug coverage provided through private plans. Administered separately from Parts A and B. Affects MLR analysis when specialty pharmacy spend is attributed to the population.

**Example:** *A patient's costly biologic medication is covered under Part D. The drug spend appears in MLR analysis only if the arrangement includes pharmacy risk.*

### Medicare Advantage (MA)

Privately administered Medicare plans offered by CMS-approved insurers. Members receive all Medicare benefits through the plan. Plans receive risk-adjusted PMPM payments from CMS based on demographics and RAF scores. Increasingly replacing traditional Medicare.

**Example:** *Approximately 54% of Medicare beneficiaries are enrolled in MA plans as of 2025. The plan receives higher payments for members with documented chronic conditions, creating financial incentive for complete RAF capture.*

### ACO REACH

Realizing Equity, Access, and Community Health. A CMS-administered Medicare ACO model that replaced the Global and Professional Direct Contracting model. Organizations accept financial accountability for attributed beneficiary populations with prospective payment and shared risk.

**Example:** *An ACO REACH organization receives monthly per-beneficiary payments and at year-end either earns shared savings (if costs fall below benchmark) or repays shared losses (if costs exceed benchmark).*

### Medicaid Managed Care

State-administered managed care programs for Medicaid beneficiaries, delivered through contracted managed care organizations (MCOs). States pay MCOs a PMPM capitation rate; MCOs manage utilization and quality.

**Example:** *A state Medicaid program contracts with three MCOs to manage its Medicaid population. Providers contract with each MCO separately and submit claims per that MCO's specific requirements.*

### MMAI (Medicare-Medicaid Alignment Initiative)

A federal-state program aligning Medicare and Medicaid services for dual-eligible beneficiaries. Designed to enhance access, reduce fragmentation, improve care coordination, and reduce duplicative services for the highest-cost, most complex patients.

**Example:** *A dual-eligible patient covered by both Medicare and Medicaid has all services coordinated through a single MMAI plan, eliminating COB complexity and improving care continuity.*

### Dual Eligible

Patients who qualify for both Medicare (typically by age or disability) and Medicaid (by income). Among the highest-cost, highest-complexity patients in any attributed population. Require careful attribution management and targeted care coordination.

**Example:** *A 72-year-old patient with Medicare as primary and Medicaid as secondary payer is dual eligible. Filing order, co-insurance, and care management requirements differ significantly from Medicare-only patients.*

### G0402 (Welcome to Medicare Visit)

The initial preventive physical examination covered by Medicare for beneficiaries within the first 12 months of Part B enrollment. Not an Annual Wellness Visit but establishes the baseline health history and initiates attribution and RAF capture.

**Example:** *A newly Medicare-eligible 65-year-old patient is scheduled for a G0402 Welcome to Medicare Visit. The PCP establishes the patient's baseline health status, initiates chronic condition documentation, and confirms attribution.*

### G0438 / G0439 (Annual Wellness Visit)

G0438 is the initial Annual Wellness Visit; G0439 is the subsequent AWW. Both include a Health Risk Assessment, personalized prevention plan, and functional status review. No patient co-payment. Must be at least 12 months after a prior AWW.

**Example:** *A patient who had a G0438 in March 2024 is eligible for a G0439 in April 2025 or later. The subsequent AWW is billed at a slightly lower rate but drives the same RAF capture and quality closure value.*

### CMS (Centers for Medicare and Medicaid Services)

The federal agency that administers Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and the Health Insurance Marketplace. Sets payment rates, quality standards, and program requirements.

**Example:** *CMS releases the annual Medicare Physician Fee Schedule each fall, updating wRVU values, conversion factors, and covered service policies effective January 1 of the following year.*

## VI QUALITY PERFORMANCE AND MEASUREMENT

### Quality Improvement Project (QIP)

A defined clinical initiative targeting improvement in a specific quality measure. Common in VBC contracts and MA plans. QIPs generate quality bonuses and improve Star Ratings.

**Example:** *A PCP practice launches a QIP to improve colorectal cancer screening rates from 52% to 70% by year-end by pre-ordering FIT tests for all eligible patients at their next scheduled visit.*

### CAHPS (Consumer Assessment of Healthcare Providers and Systems)

A standardized patient experience survey measuring how patients perceive access, communication, care coordination, and overall quality. Used in Star Ratings and value-based performance evaluations.

**Example:** *A PCP with consistently low CAHPS scores on access and communication affects the plan's 4-star rating. The PCP's practice is reviewed for scheduling improvements and provider communication training.*

### Gap Closure

The process of identifying and addressing missing preventive or chronic care services before the quality measurement period ends. Directly affects HEDIS scores, Star Ratings, and quality bonuses.

**Example:** *A care coordinator identifies 38 diabetic patients whose nephropathy screening (urine microalbumin) has not been ordered this year. Closing this gap before December 31 improves the diabetes composite HEDIS score.*

### CPT II Codes

Administrative CPT codes used to document that a quality measure was completed or excluded at a clinical encounter. Used to report HEDIS-eligible services without requiring claims data.

**Example:** *A PCP uses CPT II code 3074F to document blood pressure control was achieved at the visit, contributing to HEDIS blood pressure management performance without requiring a separate claims search.*

### NCQA

National Committee for Quality Assurance. The organization responsible for health plan accreditation and HEDIS measure maintenance. NCQA accreditation and HEDIS performance affect plan Star Ratings and commercial contract positioning.

**Example:** *A health plan achieves NCQA Excellent Accreditation based on its HEDIS scores and operational standards. This accreditation allows the plan to market its quality credentials to employers and Medicare beneficiaries.*

### Pay-for-Performance (P4P)

A payment model that supplements FFS reimbursement with quality-based bonuses tied to achievement of defined clinical quality metrics. An intermediate step between pure FFS and full risk.

**Example:** *A commercial payer offers a P4P bonus of \$8 per member per year for practices that achieve diabetes care bundled measure completion above 70%, generating up to \$40,000 annually for a practice with 5,000 commercial members.*

### Depression Screening (PHQ-9 / PHQ-2)

Standardized depression screening tools used to identify and quantify depressive symptoms. Required for HEDIS depression screening measures, AWV documentation, and behavioral health HCC capture under CMS-HCC v28/v29.

**Example:** A PCP administers the PHQ-9 during the AWW. A score of 12 triggers documentation of major depressive disorder, moderate severity (F32.1), enrollment in collaborative care, and a follow-up appointment within 30 days.

## VII REVENUE CYCLE MANAGEMENT

### Charge Capture

The process of recording and submitting all services rendered for billing. Gaps in charge capture are direct, preventable revenue losses. Should be reconciled daily across all places of service.

**Example:** A biologic injection administered in the office was not captured in the EMR charge system. The \$1,850 drug administration and NDC charge is missed. Daily charge reconciliation catches this before the claim window closes.

### Work RVU (wRVU)

The work relative value unit component of the Medicare Physician Fee Schedule, reflecting physician effort, time, technical skill, and mental effort. The basis for most physician compensation models. Should be reconciled against collectible, not billed, claims.

**Example:** A 99214 carries 1.92 wRVUs. A physician completing 20 such visits in a day generates 38.4 wRVUs. If 8% of claims are denied, only 35.3 wRVUs correspond to collectible revenue.

### Clean Claim Rate

The percentage of submitted claims accepted by the payer on first submission without edits, rejections, or requests for additional information. Target: greater than 95%. A proxy measure for front-end workflow quality.

**Example:** A practice with a 91% clean claim rate has 9% of claims requiring rework before payment. At \$180 average claim value and 400 daily encounters, this represents \$6,480 per day in accounts receivable delay.

### Denial Rate

The percentage of submitted claims denied by payers, categorized by root cause: authorization, eligibility, coding, timely filing, clinical documentation, or duplicate billing. HFMA benchmark: total denial rate below 8%.

**Example:** A specialty practice has a 14% authorization denial rate on biologic injections. Root cause: retroauthorization not obtained for add-on procedures identified during the procedure. Corrective action: same-day retroauth workflow.

### Net Collection Rate (NCR)

The percentage of collectible net revenue actually collected after contractual adjustments. Measures how effectively the organization captures available revenue. Target: greater than 95%.

**Example:** A practice collects \$4.8M against \$5.1M in net (post-contractual-adjustment) revenue. The NCR is 94.1%. Investigation reveals \$120K in avoidable bad debt and \$180K in unworked patient balances.

### Days in AR

The average number of days from date of service to payment receipt. A key measure of revenue cycle efficiency. MGMA benchmark: less than 35 days for physician practices. High DAR indicates work queue or payer issues.

**Example:** A practice with DAR of 52 has excess accounts receivable aging. Investigation reveals 18% of claims aging over 90 days are authorization denials never appealed.

### Accounts Receivable (A/R)

Outstanding balances owed to the organization from payers and patients. Categorized by age (0–30, 31–60, 61–90, 91–120, 120+ days). A/R over 90 days is typically at high risk of write-off.

**Example:** A practice's A/R aging shows 22% of outstanding balance in the 90+ day bucket. Of that, 60% is commercial payer denials never appealed and 40% is patient balances over 90 days with no collection activity.

**Contractual Adjustment**

The difference between the billed gross charge and the payer-allowed amount under the contract. Not collectible from the patient for participating providers. Must be validated against contracted rates to identify underpayments.

**Example:** *A physician bills \$320 for a 99214. The Medicare allowed amount is \$74. The \$246 difference is the contractual adjustment. If the practice is paid \$62 instead of \$74, the \$12 gap is an underpayment requiring recovery.*

**Prior Authorization (PA) Workflow**

The operational process for obtaining payer approval before services are rendered: identifying PA requirements, gathering clinical documentation, submitting the request, tracking the decision, and managing denials and appeals.

**Example:** *A PA workflow for biologics includes: confirming PA requirement in the payer portal, submitting diagnosis, failed therapies, and clinical notes, tracking the 3–5 day review timeline, and initiating retro-auth for same-day procedures identified intraoperatively.*

**Timely Filing**

The payer-mandated deadline for submitting claims after the date of service. Claims submitted after the filing limit are denied without appeal rights. Common limits: 90 days to 12 months depending on payer.

**Example:** *A claim for a January 15 date of service must be submitted by July 15 under a 180-day filing window. A claim submitted July 20 is denied for timely filing; the denial is not appealable.*

**VIII FINANCIAL AND CONTRACT METRICS****Per Member Per Month (PMPM)**

Monthly cost or revenue per attributed patient. Used to track population health investment, care management costs, and risk-adjusted revenue trends.

**Example:** *An ACO's total cost of care is \$9,800 PMPM across 12,000 attributed lives. The benchmark is \$10,200 PMPM. The organization has generated \$400 PMPM in savings — \$57.6M total — subject to the shared savings formula.*

**Medical Loss Ratio (MLR)**

The percentage of premium revenue spent on direct patient care versus administrative overhead and profit. In MA, CMS requires plans to maintain at least 85% MLR. For provider organizations in risk contracts, MLR measures care delivery efficiency.

**Example:** *A medical group's attributed MA population costs \$88M to manage, against \$100M in risk-adjusted premium revenue. The MLR is 88% — within target. Reducing avoidable admissions by 5% would lower MLR to 83%, generating \$5M in potential shared savings.*

**Actuarial Benchmark**

The projected cost target set by the payer or CMS for an attributed population, typically based on prior-year spending trended forward and adjusted for RAF changes. Shared savings and losses are measured against this benchmark.

**Example:** *CMS sets an ACO's per-capita benchmark at \$11,400 annually. If the ACO achieves \$10,800 actual cost per capita, the \$600 savings is shared per the contract formula.*

**Risk Corridor**

A defined range within which the organization bears full financial risk. Above the corridor ceiling, stop-loss protection engages; below the floor, the payer retains some savings.

**Example:** *A risk corridor from -5% to +5% of benchmark means the provider absorbs all losses or retains all savings within that range. Losses beyond 5% above benchmark are partially absorbed by the payer.*

**Contribution Margin**

Revenue minus variable costs. Measures the financial contribution of a service line or patient segment to fixed overhead and profitability.

**Example:** *An infusion center generates \$2.8M in revenue with \$1.4M in direct variable costs (drugs, nursing, supplies). Its contribution margin is \$1.4M, covering a portion of facility and administrative overhead.*

### **Operating Margin**

Net operating income divided by total revenue. Measures financial performance after all operating expenses are deducted.

**Example:** *A medical group with \$42M in revenue and \$39.5M in total operating expenses has an operating margin of 5.95%. Below 4% is financially unstable for most physician groups.*

### **EBITDA**

Earnings before interest, taxes, depreciation, and amortization. A measure of operational financial performance used in healthcare group valuations and PE transactions.

**Example:** *A physician practice with \$12M revenue, \$1.2M EBITDA, and a 3× EBITDA multiple has an enterprise valuation of approximately \$3.6M in a transaction context.*

### **Capitated Revenue**

Revenue received under risk contracts based on a fixed PMPM rate per attributed member. Predictable but places financial risk on the provider if utilization exceeds projections.

**Example:** *A primary care group receives \$38 PMPM for 6,000 attributed MA members. Monthly capitated revenue is \$228,000. If the group manages care efficiently, this revenue exceeds FFS equivalent; if utilization is high, it may fall short.*

### **Cost per RVU**

The organization's total expense divided by total work RVUs produced. Measures operational efficiency in physician practices. MGMA benchmark: varies by specialty and setting.

**Example:** *A practice produces 28,000 wRVUs annually with \$4.2M in total operating expense. Cost per wRVU is \$150. If the practice generates \$165 per wRVU in collections, the contribution margin is \$15 per wRVU.*

## **IX OPERATIONAL LEADERSHIP**

### **Network Integrity**

Ensuring that referrals, diagnostic orders, specialty consultations, and ancillary services are completed within the contracted provider network. Essential for leakage control, care coordination, and revenue retention in VBC.

**Example:** *A CIN measures network integrity by tracking the ratio of referrals placed to referrals completed in-network. An 87% in-network completion rate means 13% of referrals are leaking to outside providers.*

### **Leakage**

Referral or revenue leaving the network to external providers. In value-based care, leakage simultaneously reduces revenue, increases cost, prevents RAF capture, and fragments care coordination.

**Example:** *A cardiology referral placed without a scheduled in-network appointment results in the patient self-navigating to a competing cardiology practice. This is a leakage event with downstream consequences for imaging, procedure, and surgical revenue.*

### **Attribution Reconciliation**

The quarterly process of validating attributed patient panels against payer enrollment files to identify and correct errors: patients attributed to the wrong PCP, patients who have dis-enrolled, and newly eligible patients not yet attributed.

**Example:** *An attribution reconciliation identifies 340 patients attributed to a retired physician. These patients are re-attributed to active PCPs, generating AWV and E/M scheduling opportunities and restoring RAF capture credit.*

**Closed-Loop Referral**

A referral management standard in which the referral process is not complete until the appointment is scheduled, the patient attends, and the result is returned to the ordering provider. No referral is closed with only a request placed.

**Example:** *A closed-loop referral for nephrology: PCP places order → central navigation team schedules appointment within 24 hours → patient attends → nephrology note returns to PCP inbox → referral is marked complete. Any break in this chain triggers escalation.*

**Throughput**

The efficiency with which patients move through the care process from check-in through rooming, encounter, checkout, and referral scheduling. Measured by door-to-room time, cycle time, and schedule utilization rate.

**Example:** *A practice with 20-minute average door-to-room time and 82% schedule utilization has throughput inefficiencies reducing daily encounter volume. Standardizing rooming workflows to 12 minutes adds 2–3 additional patients per day.*

**Provider Compensation Model**

The framework linking physician and APP compensation to productivity, quality, and VBC performance metrics. Models range from pure wRVU-based salary to hybrid models with RAF accuracy, HEDIS closure, and MLR components.

**Example:** *A hybrid compensation model pays base salary for 4,200 wRVUs, a quality bonus for HEDIS above 75th percentile, and a VBC incentive for maintaining RAF above panel benchmark. This aligns compensation with financial and clinical performance goals.*

**Standard Work**

Documented, repeatable workflows that define the expected steps, owner, timing, and output for every operational process. Standard work enables consistent performance, training, and measurement.

**Example:** *Standard work for charge capture defines: rooming MA documents charges in real time (owner: MA, timing: during visit, output: charge submitted within 30 minutes of service). Without standard work, charge capture is inconsistent and unmeasurable.*

**Incentive Pool**

Funds allocated for quality and performance distribution among providers based on achievement of defined metrics including Star Ratings, HEDIS closure rates, RAF targets, and cost benchmarks.

**Example:** *An ACO distributes \$2.4M in shared savings through an incentive pool. PCPs with AWW completion above 80% and RAF above panel median receive a proportionally higher distribution than PCPs below those thresholds.*

**X ADVANCED REVENUE CYCLE MANAGEMENT****Gross Charges**

The full billed amount for a service before any contractual adjustments, write-offs, or payments are applied. Gross charges are rarely collected at face value; the difference between gross charges and net revenue is the contractual adjustment.

**Example:** *A physician bills \$420 for a 99215. Medicare's allowed amount is \$109. The gross charge is \$420; the contractual adjustment is \$311; the collectible revenue is \$109.*

**Net Revenue**

Revenue remaining after contractual adjustments are subtracted from gross charges. Net revenue represents what the organization expects to collect from payers and patients combined. Gross collections net of contractual adjustment is the most accurate measure of financial performance.

**Example:** *A practice bills \$8.4M gross in a month. Contractual adjustments are \$5.2M. Net revenue is \$3.2M. Actual collections of \$3.0M yield a net collection rate of 93.75%.*

**Claim Scrubbing**

The pre-submission review process that checks claims for errors — missing modifiers, incorrect diagnosis codes, bundling conflicts, and authorization mismatches — before they are sent to the payer. Reduces denial rates and accelerates payment.

**Example:** *A claims scrubber catches that a 99213 and a procedure code are being submitted without modifier 25. The edit stops the claim; the coder adds the modifier; the clean claim is submitted the same day.*

### **Remittance Advice (ERA/EOB)**

The electronic document sent by the payer explaining how a claim was processed: amount billed, amount allowed, amount paid, adjustments, and denial reason codes. Electronic Remittance Advice (ERA) is machine-readable; Explanation of Benefits (EOB) is patient-facing.

**Example:** *An ERA shows a 99214 was allowed at \$74 but paid at \$62. The \$12 underpayment is identified, flagged for appeal, and recovered through the underpayment recovery workflow.*

### **Denial Root Cause Analysis**

The systematic process of categorizing denied claims by cause — authorization, eligibility, coding, timely filing, or clinical documentation — and tracing denials upstream to identify the workflow failure that generated them.

**Example:** *A root cause analysis reveals 68% of authorization denials share a common pattern: CPT codes were authorized for outpatient but performed at the ASC. The corrective action is to confirm site-of-service authorization at scheduling.*

### **First Pass Resolution Rate (FPRR)**

The percentage of claims paid on the first submission without rework. High-performing practices target greater than 90%. Low FPRR indicates front-end failures in eligibility verification, authorization, or coding.

**Example:** *A specialty practice has a 78% FPRR. At 500 daily claims, 110 require rework each day. At \$42 average rework cost per claim, this represents \$4,620 in daily administrative waste.*

### **Underpayment Recovery**

The process of identifying and appealing claims where the payer paid less than the contracted allowed amount. Requires systematic comparison of payment received against contract fee schedule.

**Example:** *A contract audit identifies that a commercial payer has been paying \$68 instead of \$74 for 99214 over 18 months. The underpayment recovery process files retroactive appeals, recovering \$84,000 in under-collected revenue.*

### **Secondary Billing**

The process of billing a secondary payer for the remaining patient balance after the primary payer has adjudicated the claim. Common for dual-eligible patients, employees with multiple insurance plans, and Medicare supplement holders.

**Example:** *After Medicare pays \$74 for a 99214 and leaves a \$14.80 co-insurance balance, the practice files a secondary claim to the patient's Medigap plan, which pays the co-insurance and eliminates the patient balance.*

### **Charge Master (CDM)**

The comprehensive list of all services, procedures, supplies, and drugs a healthcare organization offers, with associated charges. The CDM is the basis for all billing and must be maintained for accuracy, compliance, and contract alignment.

**Example:** *A practice's CDM lists a biologic injection at \$2,400. If the NDC-to-charge mapping is incorrect or the line item is missing, the drug is administered but no charge is generated, creating direct revenue leakage.*

### **Credit Balance**

An overpayment on a patient or payer account resulting from duplicate payments, refunds, or misapplied payments. Must be identified, reviewed, and refunded within regulatory timeframes. Unresolved credit balances are a compliance risk.

**Example:** A patient pays \$150 at check-in for an estimated balance. The claim adjudicates at \$0 patient responsibility. The \$150 credit balance must be refunded within 60 days or it becomes a compliance liability.

### Bad Debt

Patient or payer balances that are unlikely to be collected after reasonable collection efforts have been exhausted. Reported separately from contractual adjustments. High bad debt rates indicate failures in pre-service financial counseling and point-of-service collections.

**Example:** A practice writes off \$220,000 in bad debt annually. Analysis shows 78% originated from patients never asked for payment at check-in. Implementing a pre-service collections workflow reduces bad debt by 40% within six months.

### Accounts Receivable (A/R) Aging

The categorization of outstanding balances by the number of days since the date of service: 0–30, 31–60, 61–90, 91–120, and 120+ days. The aging report is the primary tool for prioritizing collection activity and identifying systemic denial issues.

**Example:** An A/R aging report shows \$480,000 in the 91–120 day bucket. Director review reveals 70% are commercial payer denials for modifier errors on biologic administration claims — a root cause requiring immediate coding correction.

### Administrative Write-Off

A write-off of an otherwise potentially collectible balance due to a specific administrative decision: claim timely filing missed, incorrect payer billed, or patient hardship approved. Requires director-level approval and root-cause documentation.

**Example:** A \$340 claim is administratively written off because the practice submitted it to the wrong payer and the correct payer's timely filing window expired. The write-off requires director sign-off and triggers a workflow correction to prevent recurrence.

### Reconciliation

The daily, weekly, and monthly process of confirming that every service rendered has a corresponding charge, every charge has a corresponding claim, every claim has a corresponding payment, and every payment has been correctly posted. Reconciliation is the operational backbone of revenue integrity.

**Example:** End-of-day reconciliation confirms 48 patients were seen, 48 charges were submitted, and the cash drawer matches the co-pay log. A discrepancy of \$75 triggers review, revealing one co-pay was collected but not posted — corrected before the business day closes.

## XI PATIENT COLLECTIONS, OUT-OF-POCKET, AND FINANCIAL RESPONSIBILITY

### Patient Out-of-Pocket (OOP)

The total amount a patient is responsible for paying for covered healthcare services, including deductibles, co-pays, co-insurance, and any non-covered services. Excludes premiums. Federal law caps annual OOP maximums for most plans.

**Example:** A patient with a \$3,000 annual deductible, 20% co-insurance after the deductible, and a \$6,500 OOP maximum will pay \$3,000 for early-year services, then 20% co-insurance until they reach \$6,500, after which the plan pays 100%.

### Deductible

The amount a patient must pay for covered services each plan year before the insurance plan begins sharing cost. Does not apply to preventive services or co-pay-based visits in most plans. Resets annually on the plan anniversary date.

**Example:** A patient with a \$2,500 deductible has a knee MRI in January. The MRI costs \$1,200 allowed. The patient pays \$1,200, reducing their remaining deductible to \$1,300. The next service is applied to the remaining \$1,300 until the deductible is met.

**Co-payment (Co-pay)**

A fixed dollar amount a patient pays at each visit or for each prescription, defined in the plan benefits. Co-pays typically apply regardless of deductible status. Common amounts: \$20–30 for PCP visits, \$40–60 for specialist visits, \$100–300 for emergency department visits.

**Example:** *A patient's MA plan has a \$25 PCP co-pay and \$55 specialist co-pay. The patient owes \$25 at each primary care visit regardless of whether the deductible is met. The co-pay must be collected at check-in — deferral creates a collection problem.*

**Co-insurance**

The percentage of the allowed amount the patient is responsible for after the deductible is met. Typically 10–30% of the payer-allowed amount. Unlike a co-pay, co-insurance is a percentage and varies by service cost.

**Example:** *After meeting a \$1,500 deductible, a patient with 20% co-insurance has a specialist visit with an allowed amount of \$185. The patient owes \$37 (20% of \$185); the plan pays \$148 (80%).*

**Out-of-Pocket Maximum (OOP Max)**

The annual cap on total patient financial responsibility for covered services. Once the OOP max is reached, the plan pays 100% of covered services for the remainder of the plan year. For 2026, ACA-compliant plans cap OOP at approximately \$9,450 individual / \$18,900 family.

**Example:** *A patient hits their \$7,000 OOP maximum in September after a hospitalization and several specialist visits. All remaining covered services through December are paid at 100% by the plan. The practice still bills the payer; the patient's share is \$0.*

**Pre-service Patient Estimate**

A written estimate of the patient's expected financial responsibility provided before the service is rendered. Required under the No Surprises Act for scheduled services. Enables pre-service collection and reduces post-service collection failures.

**Example:** *A practice generates a patient estimate for a scheduled colonoscopy showing the patient owes \$420 based on current deductible status and 20% co-insurance. The patient is contacted 72 hours before the appointment to collect or establish a payment plan.*

**Point-of-Service (POS) Collection**

The collection of patient financial responsibility — co-pays, deductibles, and co-insurance — at the time of the clinical encounter before the patient leaves the building. The most financially effective collection timing, with an 88% collection rate versus 15% at 90+ days post-service.

**Example:** *A check-in workflow requires the front desk to confirm the patient's co-pay, check the deductible status in the eligibility tool, and collect the applicable balance before the patient is roomed. The CMA does not room the patient until co-pay is collected or a documented exception exists.*

**No Surprises Act**

Federal law effective January 1, 2022, prohibiting unexpected bills for out-of-network emergency services and certain non-emergency services at in-network facilities. Requires providers to give good-faith cost estimates to self-pay and uninsured patients.

**Example:** *Under the No Surprises Act, a patient seen at an in-network facility by an out-of-network anesthesiologist cannot be billed more than their in-network cost-sharing. The provider must bill the payer directly and cannot balance-bill the patient.*

**Balance Billing**

Billing a patient for the difference between a provider's billed charge and the payer-allowed amount. Prohibited for in-network providers under most contracts and for most services under the No Surprises Act. Allowed only for clearly disclosed non-covered services.

**Example:** *A participating provider bills Medicare \$320 for a 99215. Medicare allows \$109. The \$211 difference is a contractual adjustment — the provider cannot bill the patient the \$211. Doing so is a violation of the Medicare participation agreement.*

**Advance Beneficiary Notice (ABN)**

A written notice given to Medicare patients before a non-covered or potentially non-covered service is rendered, informing them they may be financially responsible for the cost. Required to bill the patient if Medicare denies the service.

**Example:** *Before administering a Vitamin D screening test that Medicare may deny for lack of documented deficiency, the practice has the patient sign an ABN. If Medicare denies the claim, the patient has acknowledged financial responsibility for the \$48 lab fee.*

### **Financial Counseling**

A patient-facing service that helps patients understand their insurance benefits, estimated financial responsibility, and payment options before or after service. Reduces bad debt, improves collections, and supports patient satisfaction.

**Example:** *A financial counselor meets with a patient scheduled for a \$4,200 procedure who has a \$3,000 remaining deductible. The counselor explains the cost, offers a payment plan, and enrolls the patient in a care credit program before the procedure date.*

### **Payment Plan**

A formal agreement between the practice and patient to pay an outstanding balance in installments over a defined period. Must be documented, monitored, and include a defined default process.

**Example:** *A patient owes \$1,800 after an orthopedic procedure. A payment plan is established at \$300 per month for six months. The EMR flags the account if a payment is missed at 30 days; the financial counselor initiates outreach at 45 days.*

### **Self-Pay Patient**

A patient without insurance coverage who is responsible for 100% of the cost of services. Self-pay patients require advance notice of charges, a financial screening for assistance programs, and application of the organization's self-pay discount policy before services are rendered.

**Example:** *A self-pay patient is scheduled for a joint injection. The practice provides a written cost estimate based on the charge master with the applicable self-pay discount (typically 30–66% of billed charge), collects payment in advance, and documents the patient's signed acknowledgment.*

### **High-Deductible Health Plan (HDHP)**

An insurance plan with a deductible above the IRS threshold (approximately \$1,650 individual / \$3,300 family for 2026) that qualifies the enrollee for a Health Savings Account (HSA). Shifts more upfront cost to patients and significantly increases collection complexity.

**Example:** *A commercially insured patient with a \$4,000 HDHP deductible owes the full allowed amount for every service until the deductible is met. At a 99214 allowed amount of \$185, the patient owes \$185 per visit until they have paid \$4,000 out of pocket. Pre-service estimate and collection are essential.*

### **Health Savings Account (HSA)**

A tax-advantaged savings account available to patients enrolled in an HDHP. Funds can be used for qualified medical expenses. Patients with HSAs often pay at the point of service using an HSA debit card.

**Example:** *A patient with an HSA balance of \$2,400 pays their \$185 specialist co-insurance using an HSA card at checkout. The practice collects immediately, the patient uses pre-tax dollars, and no post-service billing is needed.*

### **Eligibility Verification**

The real-time confirmation of a patient's current insurance coverage, plan type, deductible status, co-pay amount, and out-of-network benefits before the date of service. Should be performed at scheduling and again at check-in. Failures create claim denials and uncollected patient balances.

**Example:** *Eligibility verification at scheduling confirms a patient's BCBS plan has a \$1,200 remaining deductible, a 20% co-insurance, and requires a PCP referral for specialist visits. This information generates a patient estimate, triggers a referral request, and prepares the front desk for POS collection.*

## XII EPIC EMR TERMINOLOGY

### Hyperspace

The primary graphical user interface of the Epic EMR. The environment in which clinical, administrative, and billing staff perform their daily work. Contains multiple activity workspaces organized by role and workflow.

**Example:** *A front desk staff member logs into Hyperspace to check patients in, verify eligibility in the DAR, and update the appointment schedule. A physician logs in to review the in-basket, open charts, and complete documentation.*

### MyChart

Epic's patient-facing portal and mobile application. Allows patients to view medical records, schedule appointments, message providers, pay bills, and complete pre-visit health questionnaires. MyChart activation is essential for patient attribution, communication, and pre-service financial workflow.

**Example:** *A patient activated on MyChart completes a pre-visit health history form two days before the appointment. The form populates the chart, reducing rooming time and ensuring the HRA is complete before the AWW begins.*

### In Basket

Epic's internal messaging and task management system. Routes patient messages, lab results, refill requests, referral responses, and staff communications to the appropriate provider or team member. In Basket management is a key operational metric.

**Example:** *A nurse navigator receives an in-basket message flagging that a high-MLR patient's A1c result is 9.2%. The navigator contacts the patient, schedules a follow-up visit, and sends a message to the PCP for medication adjustment review.*

### Work Queue (WQ)

A prioritized list of tasks, claims, or patient records requiring action by a specific staff role. Used extensively in billing and coding workflows to manage denials, charge edits, authorization requests, and claim submissions. Unworked WQ items are a primary driver of claim denials and timely filing failures.

**Example:** *The Charge Review WQ shows 34 encounters from the prior day that have not had charges submitted. Each item over 24 hours old is flagged. The billing team works the queue to submit charges before the end of day.*

### SmartPhrase

A reusable text shortcut in Epic documentation that auto-expands into a pre-written phrase or paragraph when the shortcut is typed. Used to standardize clinical documentation language, improve efficiency, and embed MEAT documentation language.

**Example:** *A physician types ".htnmeat" in the assessment and plan. Epic expands the SmartPhrase to: "Hypertension — patient monitored for blood pressure control; medication response evaluated; current status stable; lisinopril 10mg continued." MEAT criteria are embedded in a single shortcut.*

### SmartSet

A pre-built collection of orders, documentation, and workflows grouped for a specific clinical scenario. Triggers a standardized set of actions when opened, reducing variability and supporting evidence-based care and HCC capture.

**Example:** *Opening the "Type 2 Diabetes Annual Visit" SmartSet automatically populates orders for A1c, urine microalbumin, dilated eye exam referral, and foot exam, and opens MEAT documentation prompts for all diabetes-related HCCs.*

### Best Practice Advisory (BPA)

A clinical decision support alert that appears in the Epic workflow to prompt a specific action: ordering a test, flagging a drug interaction, completing a quality measure, or documenting a required element. Designed to close care gaps at the point of care without requiring the physician to remember every protocol.

**Example:** When a physician opens a chart for a 68-year-old diabetic patient, a BPA fires: “Diabetic retinal exam overdue — last completed 14 months ago. Order referral?” The physician clicks “Order” and the referral is placed in 10 seconds.

### Problem List

The section of the Epic chart that lists a patient’s active, chronic, and resolved medical problems with associated ICD-10 codes and status flags. The problem list is the primary source of HCC documentation and must be reconciled at every encounter. Outdated or incorrectly coded problem list entries result in RAF errors.

**Example:** A patient’s problem list shows “Diabetes mellitus” coded as E11.9. The navigator updates it to E11.22 (diabetes with CKD) after reviewing the most recent labs. At the next visit, the physician confirms the updated code, and the HCC is correctly submitted.

### DAR (Daily Activity Report)

The Epic scheduling and billing tool that displays a day’s appointments, patient insurance information, co-pay amounts, outstanding balances, and authorization status for each patient on the schedule. The DAR is the primary front-desk tool for eligibility verification and POS collection.

**Example:** A front desk employee opens the DAR for the next day and reviews each patient’s co-pay amount, authorization status, and outstanding balance. Patients with balances over \$200 are flagged for financial counselor outreach before the appointment.

### Charge Router

The Epic workflow that routes completed charges from clinical documentation to the billing queue for coding review, charge edit resolution, and claim submission. Charge router configuration determines which charges require manual review and which auto-route to submission.

**Example:** A charge for a biologic injection routes through the Charge Router to a specialized billing queue for drug administration code review and NDC validation before submission. The charge reviewer confirms the correct J-code, units, and NDC are applied.

### Edit Work Queue (Edit WQ)

A claim-specific work queue containing charges or claims that have been flagged by Epic’s billing rules engine for correction before submission. Common edit types: missing authorization, duplicate code, modifier requirement, diagnosis mismatch. Edit WQ aging is a direct indicator of claim submission delays.

**Example:** An Edit WQ contains 28 claims flagged for “Missing modifier — E/M billed same day as procedure.” The biller reviews each claim, adds modifier 25 where documentation supports a separately identifiable E/M, and routes to submission. Claims without supporting documentation are escalated to the provider.

### Clarity

Epic’s operational reporting database. Stores data from Hyperspace in a format accessible for operational reporting, analytics dashboards, and population health queries. Used by analysts to build provider scorecards, A/R aging reports, and RAF performance dashboards.

**Example:** A population health analyst queries Clarity to generate a list of all attributed MA patients with no AWV in the current calendar year, a prior-year HCC for CHF, and no PCP visit in the last six months. The resulting list is the high-priority outreach schedule for the next 30 days.

### Caboodle

Epic’s enterprise data warehouse. Designed for complex, cross-system analytics that integrate clinical, financial, and operational data. Supports advanced population health reporting, predictive modeling, and value-based care performance dashboards.

**Example:** A VBC analyst builds a Caboodle dashboard tracking average panel RAF score by PCP, MLR by attributed population segment, and CCM enrollment rate — all updated weekly — to identify providers in the High MLR / Low RAF quadrant for navigator outreach.

### SlicerDicer

Epic's self-service reporting and analytics tool that allows clinical and operational users to filter, segment, and explore patient data without IT support. Used to identify care gaps, analyze utilization patterns, and build quality improvement reports.

**Example:** *A practice manager uses SlicerDicer to identify all diabetic patients who have not had an A1c drawn in the past 90 days, stratified by PCP. The resulting list is distributed to care coordinators for outreach scheduling.*

### **HAR (Hospital Account Record)**

The Epic record that tracks all financial transactions for a patient's encounter in the hospital billing module. Each HAR contains charges, payments, adjustments, and the claim history for an inpatient or outpatient hospital visit.

**Example:** *A revenue cycle analyst reviews the HAR for a complex inpatient case to confirm all procedure charges were captured, the DRG is correctly assigned, and secondary payer billing has been completed after Medicare adjudication.*

### **EAP (Epic Procedure Master)**

The Epic database of all billable procedures, services, and supplies with associated CPT codes, charge amounts, and order settings. The EAP is the source of truth for order-to-charge accuracy. Incorrect or missing EAP entries cause charge capture failures.

**Example:** *A new biologic injection is added to the formulary. The EAP entry must be created with the correct J-code, NDC, charge amount, and authorization requirement before the drug can be ordered and billed. A missing EAP entry means no charge is generated when the drug is administered.*

### **SER (Staff/Enterprise Record)**

The Epic master record for providers and staff, containing credentials, specialties, NPI numbers, and billing settings. SER accuracy directly affects claim submission — incorrect NPI, taxonomy code, or rendering provider information causes claim rejections.

**Example:** *A new NP's SER must be configured with the correct NPI, taxonomy code (363L00000X for NPs), supervising physician link, and billing settings before the NP's first patient encounter. Incorrect SER configuration causes Medicare claim rejections for incident-to billing.*

### **Order Transmittal**

The Epic function that routes orders — labs, imaging, referrals, and prescriptions — to the appropriate external or internal destination. Order transmittal tracking confirms whether orders have been received, scheduled, and completed, supporting closed-loop referral management.

**Example:** *A referral order transmitted to the cardiology scheduling pool generates a transmittal confirmation. If the cardiology office has not scheduled the appointment within 48 hours, an escalation alert fires in the referring provider's in-basket.*

### **Patient Estimate Tool**

The Epic functionality that calculates expected patient financial responsibility based on real-time eligibility, benefit structure, and the planned services. Generates a written estimate that can be printed or sent to the patient through MyChart before the date of service.

**Example:** *A scheduler uses the Patient Estimate Tool to generate a cost estimate for a scheduled colonoscopy. The tool queries the patient's current deductible status (\$1,100 remaining) and 20% co-insurance, producing a printed estimate of \$380 that is reviewed with the patient during scheduling.*

### **Authorization Management (Beacon/Order module)**

Epic's integrated workflow for tracking prior authorization requirements, submission status, approval decisions, and expiration dates for orders and scheduled services. Links authorizations directly to encounter charges to prevent submission of unauthorized claims.

**Example:** *The authorization management module flags that a scheduled infusion requires PA and the current authorization expires in 4 days. The pre-certification team receives an alert, submits a renewal request, and confirms the new authorization before the patient's next infusion date.*

## Closing Note

---

Fluency in this terminology is not an administrative exercise. It is the foundation of effective participation in value-based care — for physicians, care coordinators, practice administrators, and executive leaders alike.

The organizations that perform best in risk-based arrangements are those where every team member, from the front desk to the C-suite, understands the financial and clinical implications of the work they do every day. When a CMA understands why pre-visit chart preparation matters for RAF, when a scheduler understands why a closed referral loop prevents outmigration, and when a physician understands how MEAT documentation translates into accurate reimbursement — the entire organization performs differently.

This guide is designed to be used, referenced, and shared. It should be part of onboarding, performance conversations, and operational planning. The terminology is the common language of a high-performing VBC organization.

### **Kontiki Strategic Health Advisors**

Michele Kadlec | Strategic Advisor

[www.kontikish.com](http://www.kontikish.com) | 630-624-3024

*Copyright © 2026 Kontiki Strategic Health Advisors | Michele Kadlec*

*All Rights Reserved. Confidential and Proprietary Material. Do Not Copy, Reproduce, Share, Publish, or Distribute Without Written Permission.*