50 - Definitions

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Unless otherwise stated in this chapter, the following definitions apply:

Accreditation

An evaluative process (usually involving both on and off site surveys) in which a health care organization chooses to undergo an examination of its policies, procedures and performance by an external organization ("accrediting body").

Accreditation Cycle for Medicare Advantage (MA) Deeming

The duration of CMS's recognition of the validity of an accrediting organization's determination that a MAO is "fully accredited."

Accrediting Organization (AO)
A private, national accreditation organization that has been approved and authorized by CMS to deem that a MAO is in compliance with certain Medicare requirements.

Annual Update
The Annual Update is comprised of the information required in the components of the Do, Study, and Act sections of the Plan-Do-Study-Act quality improvement model specific to the CCIP and QIP initiatives.

Benchmarking
The process of measuring products, services, strategies, processes, and practices against known leaders/best-in-class companies/entities.

Chronic Care Improvement Program (CCIP)
An initiative with a clinical focus that includes interventions designed to improve the health of individuals who live with multiple or sufficiently severe chronic conditions, and includes patient identification and monitoring. Other programmatic elements may include the use of evidence-based practice guidelines, collaborative practice models involving physicians as well as support-services providers, and patient self-management techniques.

Consumer Assessment of Healthcare Providers and Systems (CAHPS®)
A patient's perspective of care survey, administered annually, in which a sample of members from provider organizations (e.g., MAOs, PDPs, PFFS) are asked for their perspectives of care that allow meaningful and objective comparisons between providers on domains that are important to consumers; create incentives for providers to improve their quality of care through public reporting of survey results; and enhance public accountability in health care by increasing the transparency of the quality of the care provided in return for the public investment.

Corrective Action Plan (CAP)
A formal process where CMS informs an MAO that it is out of compliance with one or more CMS requirements. The CAP may result from an audit or result from other ad-hoc compliance events unrelated to an audit.

Deemed Status
A designation granted to an MAO which concludes that the MAO has been reviewed by an AO for those standards within the categories that the AO has the authority to deem on behalf of CMS.

Deeming Authority
The authority granted by CMS to AOs to determine, on CMS' behalf, whether a MAO evaluated by the accrediting organization is in compliance with certain Medicare requirements.

Equivalency Review
The process CMS employs to compare an AO's standards, processes and enforcement

activities to the comparable CMS standards, processes and enforcement activities.

Fully Accredited
Fully accredited is a designation that all the elements within the accreditation standards have been surveyed and fully met or have otherwise been determined to be acceptable without significant adverse findings, recommendations, required actions or corrective actions.

Goal
The measurable outcome of the process under study in QIPs and CCIPs.

Healthcare Effectiveness Data and Information Set (HEDIS®)
A widely used set of health plan performance measures utilized by both private and public health care purchasers to promote accountability and assess the quality of care provided by managed care organizations.

Health Outcomes Survey (HOS)
The first outcomes measure used in the Medicare program. It is a longitudinal, self-administered survey that uses a health status measure, the VR-12, to assess both physical and mental functioning. A sample of members from each MAO health plan is surveyed. Two years later these same members are surveyed again in order to evaluate changes in health status.

Health Outcomes Survey - Modified (HOS-M)
The HOS-M is a modified version of the Medicare HOS. The HOS-M is administered to Medicare beneficiaries enrolled in Programs of All Inclusive Care for the Elderly (PACE). The instrument assesses the physical and mental health frailty level of the Program members to generate information for payment adjustment.

National Committee for Quality Assurance (NCQA)
A private, 501(c)(3) not-for-profit organization that has contracted with CMS to develop a set of measures to evaluate the structure, processes, and performance of SNPs.

Quality
The Institute of Medicine (IOM) defines quality as “the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.”

Quality Improvement Organization (QIO)
Formerly known as Peer Review Organization, this is an entity that CMS contracts with in each state to fulfill provisions in Title XI of the Act as amended by the Peer Review Improvement Act of 1982. These provisions relate to improving the quality of care for Medicare beneficiaries, protecting the integrity of the Medicare Trust Fund by ensuring that payments for services are reasonable and medically necessary and protecting beneficiaries by addressing care related complaints and other beneficiary issues.

Quality Improvement Project (QIP)
An initiative that focuses on specified clinical and/or non-clinical areas.

Sample
A subgroup of units chosen from a diffuse and statistically representative group of units or population.

Unit of Analysis for Deeming
For deeming, CMS will recognize the deemed status of MAOs if they are accredited at the same jurisdictional level (whether contract, state, or multi-state) that CMS would have used it, rather than the AO, had conducted the survey.