

Virginia Healthcare Resource Guide

2026-2027

Prepared by the Virginia Center for Health Innovation

Welcome

Greetings, Virginia legislators and state health policymakers! As leaders in health policy, the Virginia Center for Health Innovation has developed this resource guide to help you as you sort through the increasing complexity and sea of acronyms currently in use in health care in Virginia. We have tried to limit key terms to those most likely to be discussed during the legislative session, while acknowledging that we could have doubled or tripled the size of this document. We are also providing you with the contact information for organizations that we work with in health policymaking, so that you can easily reach out to them with any questions you may have! We are here to help you!



Beth A. Bortz, MPP
President & CEO
Virginia Center for Health Innovation

Contents

About the Virginia Center for Health Innovation (VCHI)..... 2

About the Virginia Task Force on Primary Care 4

About the Research Consortium @ VCHI..... 6

Health Care Glossary 8

Rural Health Transformation Key Terms and Acronyms 40

Works Cited..... 44

Our Partners 46

Contact Us..... 49

About the Virginia Center for Health Innovation (VCHI)

Who We Are

The Virginia Center for Health Innovation (VCHI) is a **nonprofit, non-partisan, multi-stakeholder public-private partnership** established in 2012, as the result of a recommendation from the Governor's Virginia Health Reform Initiative (VHRI). Since the organization's inception, VCHI has cultivated trusted relationships with key stakeholders and helped turn competition into collaboration to design a health care system in Virginia that delivers **better health for patients, better satisfaction for providers, and better value for purchasers**.

What We Do

VCHI is the principal trusted convener in the Commonwealth of Virginia leading cross-sector improvement in health care value.

VCHI provides transparent and equitable access to research on and the monitoring of indicators tracking the performance of Virginia's health and health care delivery system.

VCHI champions policy changes and improvements in Virginia's health care data infrastructure so that those who provide, receive, and purchase health care can make better informed decisions.

VCHI Board of Directors

Meredith Touchstone
Chair
CarMax

L. Gordon Moore, MD
Vice Chair
AsyncHealth

Sweeny Bansal, MBA, MEng
Treasurer
Molina Healthcare

Aneesh Chopra
Secretary
Arcadia

Jeff Ricketts
Immediate Past Chair
Retired, Anthem Virginia

Jeff Dobro
Eudaimonia Concepts

Secretary Marvin B. Figueroa
Commonwealth of Virginia

Charles O. Frazier, MD
Riverside Health System

Nick Frenzer
Veeva

Sheryl Garland
VCU Health

Linda Hines, RN, MSN, MBA
Humana

Aryana Khalid
Finsbury Glover Hering

Michele Nedelka, MD
Bon Secours

Andrey Ostrovksy, MD
Social Innovation Ventures

Shelly Smith, DNP
Synergy Center, UVA

Amit Vashist, MD, FACHE
Ballad Health

Our Core Services

1. Build collaborations to advance health care value and delivery in Virginia.
2. Produce and mobilize data, research, and evidence to inform decision-making.
3. Identify, test, evaluate, and advance innovative models of health care payment and delivery.
4. Measure and communicate Virginia's progress toward a value-driven healthcare system to support informed decision-making.

Key Initiatives

Virginia Task Force on Primary Care

VCHI staffs the Virginia Task Force on Primary Care (VTFPC). Primary care faced serious challenges before COVID, but the pandemic brought these issues to light and, in fact, made them much worse. The multi-stakeholder task force was launched to address real concerns about primary care sustainability.

See pages 4-5 for more information on the VTFPC.

Research Consortium @ VCHI

The Research Consortium is a public-private partnership to drive timely, actionable research and evaluation to inform state decision-makers and promote evidence-based health policy.

See pages 6- 7 for more information on the Research Consortium.

Smarter Care Virginia

VCHI served as the principal investigator for Smarter Care Virginia (SCV), a first-in-the-nation learning collaborative tackling the reduction of low-value health services with the help of 7,000 clinicians and a robust Employer Task Force. Please visit www.vahealthinnovation.org/scv for more information on Smarter Care Virginia.

VIRGINIA CENTER FOR HEALTH INNOVATION

About the Virginia Task Force on Primary Care

Background

A robust primary care infrastructure is associated with increased life expectancy, fewer avoidable emergency department visits, fewer preventable inpatient admissions, higher vaccination rates, and overall better health of the population.

The Virginia Task Force on Primary Care (VTFPC) was launched by VCHI in August 2020 in response to the critical needs of front-line primary care providers exacerbated by the COVID-19 pandemic and continuing to challenge the profession, including:

- Record levels of burnout and workforce shortages,
- Inadequate and ineffective resource allocation,
- Burdensome and confusing quality reporting requirements, and
- Insufficient data infrastructure to support timely, high-quality care for Virginians.

Membership

The Task Force is funded by the Virginia Department of Health and currently has 28 members and 5 additional committee members, representing front-line providers, health system administration, health plans, employers, patient representatives, state officials, and General Assembly members. Committees vary by year based on the priorities set by the Task Force. Current committees include:

- Primary Care Payment Committee
- Rural Health Transformation for Primary Care Committee

Pilots

Primary Pathways

Primary Pathways is a multi-payer alignment pilot to expand and support pediatric practices in caring for the behavioral health needs of their patients. Participating health plans include Anthem and Sentara Medicaid managed care organizations (MCOs). The pilot includes 34 practice sites with 202 primary care providers, 16 behavioral health providers, and 16,000 Medicaid members.

Person-Centered Primary Care Measure

The Person-Centered Primary Care Measure (PCPCM) is an 11-item patient-reported measure that assesses primary care aspects rarely captured, yet thought responsible for, primary care effects on population health, equity, quality, and sustainable expenditures. Before Virginia health plans will consider using this measure as part of value-based payment contracting, they requested an implementation pilot and evaluation.

Joy in Healthcare

Virginia Joy in Healthcare is a statewide, first-in-the-nation, multi-organization partnership to better understand and address the causes of clinician burnout and impediments to well-being, particularly as they relate to the provision of primary care. Large health care entities participate in the American Medical Association's Joy in Medicine Program and implement programs and policies that actively support well-being so clinicians and their patients can thrive. Instead of seeing retention as a solo enterprise or even a competition across organizations, the Virginia-supported participants conduct organizational surveys with the same set of standard questions so that each organization can understand where it stands in terms of provider well-being and the state can see and respond to data from across the Commonwealth.

Reports

Primary Care Investment Report

The VTFPC publishes an annual report on primary care investment trends in the Commonwealth. The 2026 edition expands upon prior reports to provide a more comprehensive assessment. Drawing on Virginia All Payer Claims Database data from 2019 - 2024, the report examines trends in primary care spending, utilization and continuity of care, workforce composition, and geographic variation across domains. Read the 2026 report at www.vahealthinnovation.org/virginia-primary-care-investment-report-2026/.

Primary Care Scorecard

The Virginia Primary Care Scorecard monitors key indicators of primary care investment, utilization, workforce, outcomes, and access across the Commonwealth. Together with the Investment Report, the scorecard aims to provide an annual tracking tool to monitor the health and wellbeing of primary care in Virginia through an interactive exploration of data. Explore the dashboard at www.vahealthinnovation.org/primary-care-scorecard-dashboard-2026/.

Learn More

Visit www.vahealthinnovation.org/virginia-task-force-on-primary-care/ for more information on the Task Force, its 2027 workplan and recommendations, reports, pilots, tools, events, and more.

VIRGINIA TASK FORCE ON PRIMARY CARE

About the Research Consortium @ VCHI

Background

The Research Consortium @ VCHI is a public-private partnership to drive timely and actionable research to inform state decision-makers and promote evidence-based health policy. It officially launched on October 7th, 2025, with over 100 representatives from industry, academia, state government, healthcare, and data organizations gathering for this milestone for Virginia. The Consortium launched with $500,000 in seed funding from the Virginia General Assembly.

Selected Projects

Rural Health Transformation Program Lead Evaluator

The Virginia Center for Health Innovation is named in Virginia's RHT proposal to CMS as a partner "to conduct an evaluation of the program's impact and lessons learned," including:

- **Virtual RHT Hub:** acts as an extranet and technical assistance platform, offering an accessible space for partners to engage with program materials and submit required data; also serves as a knowledge base providing insight into ongoing work for key stakeholders.
- **Metrics Reporting:** VCHI supports statewide reporting of all initiative-specific metrics to CMS as part of the annual reporting requirements. This role includes strategic metric design, technical assistance with data acquisition and integration, and data analysis. In partnership with the RHTP team and Key Implementation Partners, VCHI also supports refinement of metric specifications and facilitates the establishment of baseline and target values for all required metrics.
- **Rural Health Scorecard:** integrates multiple types of metrics from a variety of data sources to monitor RHTP implementation, performance, and impact. It includes an annual report, interactive dashboards, a centralized data repository, and other reporting tools. It will be used by Virginia RHTP leaders, managers, and key implementation partners to support monitoring, continuous improvement, and informed decision-making.
- **Evaluation Studies:** For a subset of initiatives, VCHI will conduct detailed academic evaluations of effectiveness, outcomes, and impact. These evaluations will generate evidence on what works, guide improvements, and inform future funding.

Data collected and insights from VCHI's program-wide evaluation will be leveraged in "Initiative Learning and Accountability Consortiums," part of Virginia's ongoing stakeholder engagement plan to engage subrecipients, share insights, and drive program improvements.

See pages 40-43 for RHTP key terms and acronyms.

Enhancing Primary Care Capacity for High-Quality Osteoporosis Management

The Research Consortium @ VCHI is partnering with Carilion Clinic to leverage implementation science to expand capacity for improved osteoporosis treatment in the primary care setting. The two-year $300,000 award from Academy Health includes advanced implementation science training for Dr. Michelle Rockwell, the Research Consortium's Executive Director.

Identifying Care Gaps for Patients with Type 2 Diabetes

In partnership with the Virginia Department of Medical Assistance Services (DMAS), the Research Consortium is conducting a statewide analysis of care for Virginia Medicaid members with type 2 diabetes. The project will identify gaps in guideline-recommended care, including laboratory testing, nutrition and mental health services, monitoring, and medications. Findings will examine relationships between care gaps, diabetes-related complications, and costs, highlighting geographic variation and opportunities to improve diabetes care across Virginia.

Examining Negotiated Rates for Behavioral Health and Primary Care

The Robert Wood Johnson Foundation awarded the Research Consortium @ VCHI a $100,000 Health Data for Action Grant to address information gaps policymakers confront regarding Medicaid and commercial reimbursement rates, resulting in a JAMA Health Forum publication "Benchmarking Preventive Care Medicaid Rates to Private Payers" (September 2026).

Research Executive Committee

Jeff Ricketts
Co-Chair

Delegate Rodney Willett
Co-Chair

Aneesh Chopra, MPP
Arcadia

Jeff Dobro, MD
Eudaimonia Concepts

Christopher Koller
Ariadne Labs

Andrew Mitchell
Virginia DMAS

Shelly Smith, DNP
Synergy Center, UVA

Learn More

Visit www.vahealthinnovation.org/research-consortium/ to learn more.

Research Consortium
at Virginia Center for Health Innovation

Health Care Glossary

340B Drug Pricing Program

Section 340B of the Public Health Service Act requires pharmaceutical manufacturers participating in Medicaid to sell outpatient drugs at discounted prices to health care organizations that care for many uninsured and low-income patients. These organizations include federal grantee organizations, critical access hospitals, sole community hospitals, rural referral centers, and public and disproportionate share hospitals.[1]

Accountable Care Organization (ACO)

A group of health care professionals who coordinate patient care and provide chronic disease management, with an aim of improving the quality of care patients receive. The organization's payment is tied to achieving health care quality goals and outcomes that result in cost savings.[2]

Advanced Alternative Payment Model (AAPM)

An Alternative Payment Model that meets specific criteria established by the Medicare Access and CHIP Reauthorization Act and CMS regulations.[3]

Advanced Primary Care Management (APCM)

APCM services combine elements of several existing care management and communication technology-based services that clinicians may have already been billing, in order to simplify billing and documentation requirements, while ensuring patients receive quality primary care.[4]

Adverse Selection

A situation in which the buyers and sellers of a product do not have the same information available. In health insurance, people with a high risk of illness or pre-existing conditions are much more likely to buy comprehensive insurance. This was not an option in the medically underwritten model of individual health insurance (i.e., pre-2014 in most states), because pre-existing conditions were a factor in determining eligibility and price. Healthy people opting not to purchase health insurance until they needed coverage could sharply increase premiums.[5]

Affordable Care Act (ACA)

The comprehensive health care reform law enacted in March 2010 (sometimes known as ACA or "Obamacare"). The law has 3 primary goals: 1) Make affordable health insurance available to more people by providing consumers with subsidies ("premium tax credits") that lower costs for households with incomes between 100-400% of the federal poverty level (FPL); 2) Expand the Medicaid program to cover all adults with income below 138% of the FPL (not all states have expanded their Medicaid programs, but Virginia expanded in 2019); and 3) Support innovative medical care delivery methods designed to lower the costs of health care generally.[2]

Agency for Healthcare Research and Quality (AHRQ)

A federal entity whose mission is to produce evidence to make health care safer, higher quality, more accessible, equitable, and affordable, and to work with the U.S. Department of Health and Human Services and other partners to make sure that evidence is understood and used.[6]

All-Payer Claims Database (APCD)

Database of information from the claims received or paid by all or most of the third-party payers who pay for services rendered to patients living in a geographic area, such as a state or metropolitan area. Several state governments have established APCDs and require health insurance plans to submit information from the claims they pay for residents of the state. Virginia's APCD is administered by Virginia Health Information (VHI).[3]

Allowed Amount

Total payment that a payer such as a health plan determines a provider is eligible to receive when a service is delivered to a patient insured by that payer. Since the provider is generally responsible for collecting whatever cost-sharing amount the payer requires the patient to pay, the amount the payer actually pays the provider is equal to the allowed amount minus the required patient cost-sharing.[3]

Alternative Payment Model (APM)

A term commonly used to mean any method of paying providers that is different from the standard fee-for-service method of payment.[3]

Ancillary Services

A service delivered by a provider that is not considered one of the primary activities of the provider but instead complements or supports a primary activity in some way. For example, laboratory tests and imaging that support accurate diagnosis of patients, but do not have a direct therapeutic value in addressing a patient's health condition, are generally considered to be ancillary services when they are delivered by a hospital or physician practice.[3]

Area Agency on Aging (AAA)

A public or private nonprofit agency designated by a state to address the needs and concerns of all older persons at the regional and local levels.[7]

Attribution

A process for determining which healthcare provider or providers should be held responsible for one or more specific aspects of the cost or quality of a patient's care in the absence of an explicit signal from the patient or a particular provider that the provider will be responsible. For example, when one of a health plan's members is admitted to the hospital, the health plan may

"attribute" responsibility for that admission to a primary care physician that the member had seen during the prior year, even if the physician did not order the admission, did not provide any services during the admission, was not aware that the admission occurred, and did not explicitly accept responsibility for providing services to the patient that could have avoided the admission.[3]

Avoidable ER / Potentially Preventable ER / Unnecessary ER

Refers to an emergency room visit for a health condition that could have been treated in a non-emergency setting or prevented by access to routine primary care.[8]

Balance Billing / Surprise Billing

These terms are often used interchangeably and refer to when a provider bills a patient for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider could balance bill or surprise bill the patient for the remaining $30. A preferred provider may not balance bill or surprise bill for covered services. Virginia's legislation (HB 1251/SB 172) covers emergency care and out-of-network services at in-network facilities, not all balance billing; self-funded plans are excluded unless they opt in. [2]

Behavioral Health

Assessment and treatment of mental health or substance use disorders.[3]

Benefit Design

In a health insurance plan, the benefit design is a set of rules that describe the types of healthcare services that will be covered by the plan, the providers from which a member of the plan can receive a covered service, the cost-sharing amounts that a member of the plan will be responsible for paying when receiving a service, and any other requirements or restrictions on how or when the plan member can receive covered health care services.[3]

Billed Amount

Total charge a healthcare provider sends to an insurance company for a service, procedure, or visit; the standard fee before any insurance negotiations or discounts happen.[9]

Biologic

Biologic medicines contain substances that have been created by using living cells or organisms. Examples of biologic medicines include gene therapies, transplant tissue, recombinant proteins, stem cell therapies, and monoclonal antibodies. They are often used to treat severe and life-threatening diseases. Biologics differ from traditional drugs in terms of material sources, structural complexities, manufacturing process, and regulatory requirements.

As a result, biologics can sometimes have a higher price, creating barriers to access for some patients.[10]

Biosimilar

A class of drugs designed to increase access for patients who need treatment with a biologic medicine. The U.S. Food and Drug Administration (FDA) defines a biosimilar as a biological product that is highly similar to and has no clinically meaningful differences from an existing FDA-approved reference product in terms of safety, purity, and potency.[10]

Brand Drug

A drug sold by a drug company under a specific name or trademark and that is protected by a patent. Brand name drugs may be available by prescription or over the counter.[3]

Bundled Payment

A payment is described as "bundled" when it covers multiple health care services, particularly if those services had previously been paid separately.[3]

Capacity Building Funds

Start-up funds offered to providers or health care entities to support upfront implementation costs for a specific program or new model of care. Funds are typically time-limited and may include payment for costs that are not typically billable services, such as costs associated with hiring staff or acquiring data infrastructure.[11,12]

Capitation

A payment arrangement in which a physician or group of physicians receives a predetermined, risk-adjusted amount of money for each individual (per patient or "head") attributed to them over a specific period. This payment is made irrespective of the volume or type of services the patient uses.[3]

Cardinal Care

A unifying brand encompassing all managed care health coverage programs for Virginia Medicaid members. Cardinal Care combined Virginia's two previously existing managed care programs - Medallion 4.0 and Commonwealth Coordinated Care Plus (CCC Plus) - on October 1, 2023, to create a single identity for all members receiving services through Medicaid health plan partners.[13]

Care Coordination

The organization of treatment across several health care providers. Medical homes and Accountable Care Organizations are two common ways to coordinate care.[2]

Carve-Out

A set of services that is paid for in a way that differs from the way payment is made for other services. For example, a single global payment might be paid to a provider for all services, except for a list of specific services or conditions that would still be paid on a traditional fee-for-service basis or through individual bundled payments. A carve-out may apply to the delivery of services as well as to payment. For example, many purchasers and payers have "carved out" behavioral health services and require that patients receive them from a different set of providers than the providers who deliver physical health services to the patients; the behavioral health providers are paid separately and in different ways than the providers who deliver physical health services.[3]

Case Mix

A general term used to describe the types of patients cared for by a provider during a period of time. A case mix index may be calculated to assess whether a particular provider is caring for patients who have more complex needs or who need more expensive services.[3]

Center for Medicare and Medicaid Innovation (CMMI)

A division of the Centers for Medicare and Medicaid Services (CMS) that was created by the Affordable Care Act to test payment models "where there is evidence that the model addresses a defined population for which there are deficits in care leading to poor clinical outcomes or potentially avoidable expenditures", with a focus on "models expected to reduce program costs while preserving or enhancing the quality of care received by individuals."[3]

Center of Excellence

A particular service line of a specific provider that has been determined in some way to provide higher quality services at the same or lower cost than other providers.[3]

Centers for Disease Control and Prevention (CDC)

A U.S. federal government agency whose mission is to protect public health by preventing and controlling disease, injury, and disability. The Centers for Disease Control and Prevention promotes healthy behaviors and safe, healthy environments. It keeps track of health trends, tries to find the cause of health problems and outbreaks of disease, and responds to new public health threats. The Centers for Disease Control and Prevention works with state health departments and other organizations throughout the country and the world to help prevent and control disease. The Centers for Disease Control and Prevention is part of the U.S. Public Health Service of the Department of Health and Human Services (DHHS). Also called CDC.[14]

Centers for Medicare and Medicaid Services (CMS)

The federal agency that runs Medicare and the federally facilitated Marketplace and supervises states' administration of Medicaid and the Children's Health Insurance Program.[2]

Certificate of Public Need (COPN)

Virginia's Certificate of Public Need (COPN), sometimes referred to as CON (Certificate of Need), program was created in 1973, and a 1974 federal law soon required states to have such programs. COPN requires health care providers seeking to open or expand a health care facility or provide certain services like imaging to receive approval from a regulatory body and prove that a community needs the services the facility would deliver. Its purpose was to control cost and increase access to care. The federal mandate was repealed in 1986, but Virginia's program remains.[15]

Children's Health Insurance Program (CHIP)

In Virginia, this program is known as FAMIS and is run by the state Medicaid agency (DMAS). It covers about 7.2 million children and pregnant women nationwide and about 186,000 in Virginia (June 2026). Eligibility for the program is based on family income and is federally required to provide primary care, dental care, behavioral health services, and vaccinations for children from birth to age 19.[2]

Chronic Disease Management

An integrated care approach to managing illness which includes screenings, check-ups, monitoring and coordinating treatment, and patient education. It can improve quality of life while reducing health care costs by preventing or minimizing the effects of a disease.[2]

Claim

A request for payment that a patient or health care provider submits to a health insurer after covered services are provided.[2]

Claims Data

Information that is recorded on the forms used to submit claims for payment. Two key types of information recorded on claims forms are (1) one or more procedure codes describing specific services the patient received, and (2) one or more diagnosis codes describing the problem that was being treated. The primary goal of a claim form is to document that a specific service is eligible for payment from the payer.[3]

Clinically Integrated Network (CIN)

A collection of providers from different specialties who create processes and systems for managing and coordinating the care they deliver to individual patients. If a clinically integrated

network meets specific standards established by the Federal Trade Commission (FTC), the providers in the network can jointly negotiate with payers in ways that could otherwise be deemed to be a violation of antitrust laws, even if they are not taking financial risk.[3]

Code of Federal Regulations (CFR)

Medicaid federal regulations are located at 42 CFR 430 through 42 CFR 505.[16]

Co-Insurance

The percentage of costs of a covered health care service the patient pays after paying any required deductible.[3]

Co-Payment/ Co-Pay

A fixed amount patients pay for a covered health care service after paying their deductible. If the patient has not met their deductible, they pay the full allowable amount for the service.[3]

Commonwealth Coordinated Care Plus (CCC Plus)

A former Virginia Medicaid managed long-term services and supports program. It was combined with Medallion 4.0 into Cardinal Care Managed Care on October 1, 2023. CCC Plus uses an integrated delivery model across a comprehensive range of health services to assist members with complex care needs. Enrollment in the program is required for qualifying individuals, who benefit from the person-centered care management program. CCC Plus includes Medicaid members who: are 65 or older; are children or adults with disabilities; receive Medicare benefits and full Medicaid benefits (dual eligible); receive Medicaid long-term services and supports (LTSS) in a facility or through one of the home and community-based (HCBS) waivers; or are medically complex (have a medical or behavioral health condition and a functional impairment).[17]

Community Care Hub (CCH)

A community-centered entity that organizes and supports a network of community-based organizations providing services to address health-related social needs.[18]

Community Health Needs Assessment (CHNA)

A state, tribal, local, or territorial health assessment that identifies key health needs and issues through systematic, comprehensive data collection and analysis. Many health care entities may conduct these, including non-profit hospitals.[19]

Community Health Worker (CHW)

A frontline public health worker who is a trusted member of and/ or has an unusually close understanding of the community served. This trusting relationship enables the worker to serve

as a liaison/ link/ intermediary between health/ social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery.[20]

Community Services Board (CSB)

CSBs provide an array of emergency, local inpatient, outpatient, case management, day support, employment, residential, and wellness and prevention services to adults with serious mental illnesses, children who have or are at risk of serious emotional disturbance, individuals with an intellectual disability or who are receiving Medicaid developmental disability waiver services, or individuals with substance use disorders.[21]

Concierge Medicine

A mode of care delivery by a physician practice that provides more time with patients and more rapid response to requests for assistance than is possible under typical physician payment schedules, including longer office visits, phone calls, 24-hour access, etc. Typically, a patient pays a monthly, quarterly, or annual fee for concierge care in addition to fees for individual services, or the concierge fee may cover some services (such as office visits) but not other services.[3]

Conditions of Participation (CoPs)/ Conditions for Coverage (CfCs)

Health and safety standards that health care organizations must meet to begin and continue participating in the Medicare and Medicaid programs.[22]

Continuity of Care

The process by which the patient and their care team are cooperatively involved in ongoing health care management toward the shared goal of safe, quality, cost-effective medical care.[23]

Corporate Practice of Medicine (CPOM)

CPOM laws are regulations that prohibit standard corporations (or other non-physician entities) from practicing medicine or employing practicing physicians. The primary goal of these laws is to ensure that medical decisions are made solely based on patient care and not influenced by corporate interests. These laws vary by state.[24]

Cost-Based Reimbursement

In a cost-based reimbursement system, a provider calculates the total amount it spent to deliver one or more health care services for a patient, and the payer reimburses the provider for those costs. If costs cannot be specifically associated with an individual patient, the provider would calculate the total costs for delivering those services to all patients, and then the payer would pay a percentage of those costs based on the percentage of the provider's total patients who are insured by that payer. For example, Medicare payments to Critical Access Hospitals

are calculated as 101% of the portion of the hospital's costs attributable to Medicare beneficiaries who received services from the hospital.[3]

Cost-Sharing

The amount that a patient pays out-of-pocket to a health care provider in return for a service, with no reimbursement from a third-party payer. The four principal approaches to cost-sharing are co-payments, co-insurance, deductibles, and balance billing.[3]

Current Procedural Terminology (CPT)

A listing of definitions and alphanumeric codes for reporting medical services and procedures performed by physicians. It is maintained by the American Medical Association under the supervision of the CPT Editorial Panel.[3]

Deductible

The amount paid for covered health care services before an insurance plan starts to pay. With a $2,000 deductible, for example, a patient will pay the first $2,000 of covered services.[2]

Delivery System Reform Incentive Payment (DSRIP) Program

A special pool of funds that can be used by a state Medicaid program to encourage or support changes in care to Medicaid beneficiaries and other low-income individuals by hospitals and other providers. The programs are created on a state-by-state basis through Section 1115 Medicaid waivers approved by CMS. A DSRIP waiver was prepared for Virginia by the Virginia Center for Health Innovation but not completed by Virginia Medicaid in 2016.[3]

Department for Aging and Rehabilitative Services (DARS)

A Virginia state agency charged with improving the employment, quality of life, security, and independence of older Virginians, Virginians with disabilities, and their families.[25]

Department of Behavioral Health and Developmental Services (DBHDS)

State agency that manages all aspects of behavioral and developmental health care.[26]

Department of Health Professions (DHP)

State agency composed of Virginia's 13 health regulatory boards, the Board of Health Professions, the Prescription Monitoring Program and the Health Practitioners' Monitoring Program. DHP licenses and regulates over 500,000 healthcare practitioners across more than 65 professions.[27]

Department of Medical Assistance Services (DMAS)

The agency that administers the FAMIS and Medicaid programs in Virginia.[28]

Department of Social Services (DSS)

The agency responsible for determining eligibility for medical assistance and the provision of related social services. This includes the local departments of social services administered by cities and counties.[16]

Designated State Health Program

A program approved in some states under Section 1115 Waivers to allow Federal Medicaid funding to be used for services that are not typically eligible for such funding.[3]

Direct Contracting

An arrangement between a purchaser and a provider to deliver health care services for the purchaser's members in return for a payment specified in a contract with the purchaser rather than in a contract with a separate health insurance company. A direct contract may be focused on particular types of services, e.g., the purchaser may agree to pay a provider for knee replacement surgeries performed on the purchaser's members, or a direct contract may involve an agreement by the provider to deliver or arrange for all or most types of health services for the purchaser's members. In general, in order to have direct contracting for a broad range of services, either the provider will need to have a provider-owned health plan that can manage the benefits and payments, or the purchaser and provider will need to jointly agree to use a third-party administrator to manage the terms of the contract.[3]

Direct Primary Care (DPC)

A payment model in which a primary care practice charges a monthly, quarterly, or annual fee to a patient to cover all or most of the services the primary care practice provides to the patient, including visits, laboratory testing, care management, etc., with no separate fees charged for individual services. Direct primary care is a capitation payment, but with the payment coming from the patient rather than a health insurance plan. In contrast, "concierge medicine" is typically a structure where a patient pays a fee of some kind in addition to fee payment from the health insurance plan for individual services, with the additional patient-paid fee assuring that the patient will receive services that would not otherwise be possible under current fee schedules, including longer visits, phone calls, 24-hour access, etc.[3]

Disproportionate Share Hospital (DSH)

Hospitals that serve a significantly disproportionate number of low-income patients and receive payments from the Centers for Medicare & Medicaid Services to cover the costs of providing care to uninsured patients. Section 1886(d)(1)(B) of the Social Security Act defines DSHs. [29]

Downside Risk

The term "downside risk" has been used to describe two different types of situations: the provider could receive less in payments than the costs it incurs in delivering services, or the provider could receive less in payments than it would have otherwise received (regardless of whether costs have decreased by more than the payments).[3]

Dual Eligibility

An individual's eligibility to enroll in both Medicaid and Medicare programs. Individuals who are eligible for both programs are commonly referred to as duals or dual eligibles.[3]

Electronic Health Record (EHR)

A digital version of a patient's paper chart. It contains health information collected and maintained by healthcare providers over time. It is a comprehensive, longitudinal record of a patient's health history, including diagnoses, lab results, medications, physician notes, and more, accessible to authorized healthcare professionals. One of the key features of an EHR is that it can be created, managed, and consulted by authorized providers and staff across more than one healthcare organization.[30]

Essential Health Benefits

A set of 10 categories of services that individual and small-group health plans, including Marketplace plans, must cover under the Affordable Care Act. These include doctors' services, inpatient and outpatient hospital care, prescription drug coverage, pregnancy and childbirth, mental health services, and more. Some plans cover more services. Plans must offer dental coverage for children. Dental benefits for adults are optional.[2]

Exchange

Another term for the Health Insurance Marketplace®, a service available in every state that helps individuals, families, and small businesses shop for and enroll in affordable medical insurance.[2]

Family Assistance to Medical Insurance Security (FAMIS)

Virginia's CHIP program operates under Title XXI of the Social Security Act and provides comprehensive health benefits to children until the age of 19, in families with incomes at or below 205 percent of the federal poverty level who do not have any health insurance coverage and are not eligible for Medicaid. Certain pregnant women may also be covered under FAMIS.[16]

Federal Medical Assistance Percentage (FMAP)

The percentage of a state's Medicaid spending that the Federal government will cover. For federal fiscal year 2027 (beginning October 1, 2026), Virginia's percentage is 50.02%.[3]

Federal Poverty Level (FPL)

A measure of income issued every year by the Department of Health and Human Services. Federal poverty levels are used to determine patient eligibility for certain programs and benefits, including savings on Marketplace health insurance, and Medicaid and CHIP coverage. The 2026 federal poverty guideline is $15,960 for one person and $33,000 for a family of four.[2]

Federally Qualified Health Center (FQHC)

Federally funded nonprofit health centers or clinics that serve medically underserved areas and populations. Federally qualified health centers provide primary care services regardless of ability to pay. Services are provided on a sliding-scale fee.[2]

Fee-For-Service (FFS)

A method in which doctors and other health care providers are paid for each service performed. Payment can be through insurance or self-pay by the patient. Examples of services include tests and office visits.[2]

First Dollar Shared Savings

In a shared savings payment model, if the provider's share of savings is calculated based on the total amount of savings generated, it is said to receive "first dollar shared savings". This is in contrast to a structure where the payer keeps all of the initial savings until a certain threshold is reached and only then shares additional savings with the provider. This does not guarantee a provider will receive a share of savings no matter how small the savings are. For example, in the Medicare Shared Savings Program, the savings must exceed the Minimum Savings Rate in order for an Accountable Care Organization to be eligible for any shared savings payment, but if the Minimum Savings Rate is achieved, then the share of savings is calculated based on the total savings achieved.[3]

Food and Drug Administration (FDA)

The federal agency of the U.S. Department of Health and Human Services responsible for protecting the health of the public by ensuring the safety, efficacy, and security of human and veterinary drugs, biological products, and medical devices; and by ensuring the safety of the nation's food supply, cosmetics, and products that emit radiation. FDA also has responsibility for regulating the manufacturing, marketing, and distribution of tobacco products.[31]

Food Desert

Communities that meet low-income and low-access thresholds lacking stores that sell healthy, affordable food, which may contribute to poor diet, obesity, and other diet-related illness.[32]

Formulary/ Drug List

A list of prescription drugs covered by a prescription drug plan or another insurance plan offering prescription drug benefits.[2]

Freestanding Emergency Department (FSED)

A licensed facility that is structurally separate and distinct from a hospital and provides emergency care. There are two distinct types of FSEDs: a hospital outpatient department (HOPD), also referred to as an off-site hospital-based or satellite emergency department (ED), and independent freestanding emergency centers (IFECs). The number of FSEDs has increased in an ever-changing regulatory and health care environment.[33]

Fully Insured

An employer or other purchaser is said to be fully insured if they purchase a health insurance policy for each of their employees or members and pay premiums to a health insurance company to cover the costs of claims for health care services.[3]

Generic Drug

A medication created to be the same as an already marketed brand-name drug in dosage form, safety, strength, route of administration, quality, performance characteristics, and intended use. These similarities help to demonstrate bioequivalence, which means that a generic medicine works in the same way and provides the same clinical benefit as the brand-name medicine.[34]

Global Payment

A payment that covers all or most of the services that a patient needs from all providers during a particular period of time. The term "global payment" is generally used in reference to a payment that covers multiple episodes of care for multiple types of conditions, whereas the term "episode payment" is used for a payment that is limited to a particular time period or to care associated with a particular procedure.[3]

Graduate Medical Education (GME)

Any type of formal medical education, usually hospital-sponsored or hospital-based training, pursued after receipt of the M.D. or D.O. degree in the United States. This education includes internship, residency, subspecialty and fellowship programs, and leads to state licensure and board certification.[35]

HCAHPS

An abbreviation for Hospital Consumer Assessment of Healthcare Providers and Systems, which is one of a family of CAHPS surveys that ask consumers and patients to rate their experiences receiving care in a variety of health care settings. The HCAHPS survey is specifically designed for services delivered in hospitals. The results of CAHPS surveys are used as a performance measure in some payment models.[3]

Health and Human Services, U.S. Department of (HHS)

Federal cabinet-level government department that provides health and human services and promotes research in social services, medicine, and public health. It achieves this through 11 agencies that manage more than 100 programs. The agencies include the Centers for Disease Control and Prevention (CDC), the Food and Drug Administration (FDA), the Administration for Children and Families (ACF), and the Centers for Medicare and Medicaid Services (CMS).[36]

Healthcare Common Procedure Coding System (HCPCS)

A comprehensive set of billing codes maintained by the Centers for Medicare and Medicaid Services in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).[3]

Health Coordination Network (HCN)

The HCN was formerly known as the Emergency Department Care Coordination (EDCC) program and equips providers, care teams, and policymakers with near real-time health information, improving patient transitions, guiding smarter decisions, and advancing statewide health outcomes. A single, statewide, real-time communication and collaboration program among healthcare providers and care management personnel in Virginia. Established by the Virginia General Assembly as a response to the overutilization of emergency departments, this system provides clinicians with alerts when their patients seek emergency care.[37]

Health Information Exchange (HIE)

Electronic health information exchange (HIE) allows doctors, nurses, pharmacists, other health care providers, and patients to appropriately access and securely share a patient's vital medical information electronically, improving the speed, quality, safety, and cost of patient care. In Virginia, the HIE is administered by Virginia Health Information.[38]

Health Insurance Marketplace®

A service that helps people shop for and enroll in health insurance. The federal government operates the Health Insurance Marketplace®, available at HealthCare.gov, for most states. Some states run their own Marketplaces. Since the 2024 plan year, Virginia has run its own state-based Marketplace, Virginia's Insurance Marketplace.[2]

Health Insurance Portability and Accountability Act (HIPAA)

A federal law intended to improve the availability and stability of health insurance coverage. Title II of HIPAA protects the confidentiality and integrity of individually identifiable health information past, present, or future.[2]

Health Maintenance Organization (HMO)

A type of health insurance plan that usually limits coverage to care from doctors who work for or contract with the HMO. It generally will not cover out-of-network care except in an emergency. An HMO may require a patient to live or work in its service area to be eligible for coverage. HMOs often provide integrated care and focus on prevention and wellness.[2]

Health Professional Shortage Area (HPSA)

HPSAs can be geographic areas, populations, or facilities. These areas have a shortage of primary, dental, or mental health care providers.[39]

Health-Related Social Needs (HRSN)

An individual's unmet, adverse social conditions (e.g., housing instability, homelessness, nutrition insecurity) that contribute to poor health and are a result of underlying social determinants of health (conditions in which people are born, grow, work, and age).[40]

Health Resources and Services Administration (HRSA)

An agency of the U.S. Department of Health and Human Services. It is the primary federal agency for improving access to health care services for people who are uninsured, isolated, or medically vulnerable. HRSA also identifies workforce shortage areas.[41]

High-Deductible Health Plan (HDHP)

A plan with a higher deductible than a traditional insurance plan. The monthly premium is usually lower, but the patient pays more health care costs before the insurance company starts to pay its share. A high-deductible plan (HDHP) can be combined with a health savings account (HSA), allowing a patient to pay for certain medical expenses with money free from federal taxes.[2]

Home and Community Based Services (HCBS)

HCBS programs address the needs of people with functional limitations who need assistance with everyday activities, like getting dressed or bathing. HCBS are often designed to enable people to stay in their homes, rather than moving to a facility for care. HCBS programs generally fall into two categories: health services and human services. HCBS programs may offer a combination of both types of services and do not necessarily offer all services from either category.[42]

Hospital Readmissions

A situation where a patient was discharged from the hospital and winds up going back in for the same or related care within 30, 60, or 90 days. The number of hospital readmissions is often used in part to measure the quality of hospital care, since it can mean that follow-up care was not properly organized, or that a patient wasn't fully treated before discharge.[2]

Improvement Threshold

A level of improvement in a clinician, medical practice, or health system performance that must be reached to qualify for a payment or a payment adjustment.[3]

In Lieu of Services (ILOS)

States and Medicaid managed care plans have the ability to cover health services or settings that are substitutes for services or settings covered under the state plan as "in lieu of services and settings" in accordance with 42 CFR §§ 438.3(e)(2) and 438.16.[43]

Independent Dispute Resolution (IDR)

The No Surprises Act created new protections against out-of-network balance billing and established a new process called independent dispute resolution (IDR), which is managed by the Department of Health and Human Services, the Department of Labor, and the Department of the Treasury (the Departments). Providers (including air ambulance providers), facilities, and health plans can use the process to determine the payment rates for certain out-of-network charges. When a provider or facility gets a payment denial notice or an initial payment from a health plan for certain out-of-network services, the health plan, provider, or facility must start an open negotiation period that lasts 30 business days. At the end of the negotiation period, if the health plan and provider or facility have not agreed on a payment amount, either party can begin the IDR process.[44]

Independent Practice Association (IPA)

An organization consisting of two or more independent physician practices that work jointly in some way. Some IPAs accept payment contracts on behalf of their members; others provide mechanisms for multiple practices to share infrastructure costs or staff that would otherwise not be affordable for small practices.[3]

Infrastructure Payment

In health care, this is a payment that is specifically designed to support the costs of "infrastructure" that a provider uses to deliver or manage care. In some cases, payers have required that the payment only be used for specific kinds of "infrastructure," whereas in others, the payment is made because of a recognition that a provider needs adequate payment to

support what is required to deliver high-quality care, but no restrictions are placed on how the provider can spend the payment.[3]

Inpatient

An individual who has been admitted to a hospital as a registered bed patient, generally for at least 24 hours, and is receiving services under the direction of a physician.[3]

Institutional Review Board (IRB)

An institutional review board (IRB) is the institutional entity charged with providing ethical and regulatory oversight of research involving human subjects, typically at the site of the research study.[45]

Intermediate Outcome Measure

A form of quality measure that determines whether specific kinds of results were achieved from health care services that are viewed as valuable solely or primarily because they have been shown to lead to other desirable outcomes. For example, a low hemoglobin A1c (HbA1c) level for a patient is an intermediate outcome measure that is viewed as desirable because it reduces the risk of other complications of diabetes, such as blindness and amputations.[3]

Interoperability

In health care, interoperability refers to the ability of different information systems, devices and applications (systems) to access, exchange, integrate and cooperatively use data in a coordinated manner, within and across organizational, regional and national boundaries, to provide timely and seamless portability of information and optimize the health of individuals and populations globally.[46]

Joint Commission on Health Care (JCHC)

The Joint Commission on Health Care (JCHC) is a standing commission of the Virginia General Assembly established in 1992. The Code of Virginia, Title 30, Chapter 18, states in part: "The purpose of the Commission is to study, report and make recommendations on all areas of health care provision, regulation, insurance, liability, licensing, and delivery of services." The JCHC is composed of 18 legislative members (8 Senate, 10 House of Delegates).[47]

Leakage

"Leakage" is said to occur when a patient receives a service from a provider other than the provider that anticipated delivering that service to the patient. When leakage occurs, the payment for the service will go to the other provider, which means the provider who expected to deliver the service will receive less revenue than they would have otherwise expected. For example, if an individual living near a hospital travels to a more distant hospital to receive a

service, the nearby hospital would consider that to be "leakage" from the patient population they expect to serve. In a payment model in which an entity is being held accountable for total spending on services for a group of patients, leakage of services to providers that are not part of the accountable entity could increase spending for the group of patients sufficiently to result in a financial penalty for the accountable provider.[3]

Length of Stay (LOS)

The amount of time that a patient spends in a hospital or other facility in order to receive a particular service or group of services.[3]

Low-Volume Threshold

A minimum number of patients or services required for a provider to be subject to a performance-based payment. In the Medicare Merit-based Incentive Payment System (MIPS), physicians who treat fewer patients or deliver fewer services than the Low-Volume Threshold established by CMS are not eligible for bonus or penalty payments under MIPS.[3]

MACRA

The Medicare Access and CHIP Reauthorization Act of 2015. This established a merit-based incentive program for outpatient physician payment.[3]

Managed Care Organization (MCO)

An organization that contracts with Virginia Medicaid to provide, arrange for, deliver, pay for, or reimburse any of the costs of health care services for Medicaid enrollees.[16]

Maximum Out-Of-Pocket Costs

The limit on total member copayments, deductibles, and coinsurance under a benefit contract.[3]

Medallion 4.0

Medallion 4.0 was Virginia's Medicaid managed care program for infants, children, pregnant women, and adults in low-income families with children. It provided acute and primary health care services, prescription drug coverage, and behavioral health services. Medallion 4.0 and CCC Plus were combined into Cardinal Care Managed Care on October 1, 2023.[48]

Medicaid

Insurance program that provides free or low-cost health coverage to some low-income people, families and children, pregnant women, the elderly, and people with disabilities. In Virginia, Medicaid is run by the Department of Medical Assistance Services (DMAS).[2]

Medical Home Payment

A wide range of different approaches to "medical home payment" have been created by payers to assist or encourage primary care practices, and in some cases specialty physician practices, to deliver care consistent with one or more of the principles of the Patient-Centered Medical Home. These payment models have generally been structured in one of the following ways: 1) additional or increased payment based on accreditation or certification; 2) payment for infrastructure; 3) new payments for specific services; 4) flexible payments; 5) pay-for-performance payments; 6) shared savings payments; or 7) combination payments.[3]

Medical Loss Ratio

The "medical loss ratio" means the total amount a health plan spends on payments for health care services divided by the total premium revenues received to cover those payments. The medical loss ratio is typically described as a percentage; the ratio must be lower than 100% in order for the insurance plan to remain solvent, since administrative expenses and profits are not included in the "medical loss," and a health plan must also retain some portion of premiums as a reserve against variations in the medical loss ratio. The Affordable Care Act set minimum medical loss ratios of 80% for individual and small-group plans and 85% for large-group plans; federal Medicaid managed care rules use an 85% standard.[3]

Medically Underserved Area (MUA)

A region of the U.S. that has a relative or absolute deficiency of health care resources, including hospital beds, equipment, and/ or medical personnel. An MUA is defined by an Index of Medical Underservice (IMU) score of 62.0 or less, which is based on four variables: ratio of primary medical care physicians per 1,000 population; infant mortality rate; percentage of the population with incomes below the poverty level; and percentage of the population age 65 or over.[39]

Medically Underserved Population (MUP)

MUPs refer to a specific population in a geographic region that has a shortage of primary care health services available to them. They may face economic, cultural, or language barriers to health care.[39]

Medicare

A federal health insurance program for people 65 and older and certain younger people with disabilities. It also covers people with End-Stage Renal Disease. Medicare has 4 major components: 1) Part A - inpatient hospital coverage, 2) Part B - outpatient and physician coverage, 3) Part C - full health care coverage offered through a private insurer (substitute for Part A, B, and often D), and 4) Part D - prescription drug coverage.[2]

Medicare Advantage (Medicare Part C)

A type of Medicare health plan offered by a private company that contracts with Medicare to provide a patient with all Part A and Part B benefits, and typically Part D benefits as well. Medicare Advantage Plans include Health Maintenance Organizations, Preferred Provider Organizations, Private Fee-for-Service Plans, Special Needs Plans, and Medicare Medical Savings Account Plans. If a patient is enrolled in a Medicare Advantage Plan, most Medicare services are covered through the plan and aren't paid for under Original Medicare. Most Medicare Advantage Plans offer prescription drug coverage.[2]

Medicare Part D

A program that helps pay for prescription drugs for people with Medicare. There are two ways to get Medicare prescription drug coverage: through a Medicare Prescription Drug Plan or a Medicare Advantage Plan that includes drug coverage. These plans are offered by insurance companies and other private companies approved by Medicare.[2]

Medicare Physician Fee Schedule

A fee schedule is a complete listing of fees used by Medicare to pay doctors or other providers/ suppliers.[3]

Medicare Shared Savings Program (MSSP)

The Medicare Shared Savings Program is a payment program established by the Affordable Care Act that providers can voluntarily choose to participate in if they meet the qualifications for an Accountable Care Organization (ACO) established in the statute and in regulations promulgated by CMS.[3]

Medigap Insurance

A Medigap policy is health insurance sold by private insurance companies to fill the "gaps" in general Medicare coverage (Part A and B). Medigap policies help pay some of the health care costs that the general Medicare coverage doesn't cover. If a patient is in Part A and B and has a Medigap policy, then Medicare and their Medigap policy will each pay their share of covered health care costs. Generally, when a patient buys a Medigap policy, they must have Medicare Part A and Part B. The patient will have to pay the monthly Medicare Part B premium. In addition, enrollees will have to pay a premium to the Medigap insurance company. As long as patients pay their premium, their Medigap policy is guaranteed renewable.[49]

Merit-based Incentive Payment System (MIPS)

A Medicare pay-for-performance system for physicians created by the Medicare Access and CHIP Reauthorization Act (MACRA). It consolidates several previous Medicare pay-for-performance programs - the EHR Incentive Program, the Physician Quality Reporting System,

and the Value-Based Payment Modifier - into a single pay-for-performance program based on four performance categories: quality, cost, improvement activities, and promoting interoperability. Physicians receive either increases or decreases in their payments under the Physician Fee Schedule based on their performance in the MIPS program; because the program is supposed to be budget-neutral, the magnitude of any increases received by physicians who qualify for increases will depend on the number of physicians receiving decreases in payments and the magnitude of those reductions.[3]

Narrow Network

A network of providers used by a health insurance plan or a purchaser that excludes some providers the patients would otherwise be likely to use. The choice of which providers are in the narrow network may be based on their willingness to accept lower payments, their scores on measures of quality or cost, their willingness or ability to coordinate care, or other factors.[3]

National Provider Identifier (NPI)

A unique identification number assigned to each physician or other provider that bills for health care services.[3]

Network

The facilities, providers, and suppliers a health insurer or plan has contracted with to provide health care services.[2]

Network Adequacy

The ability of the providers in the network to provide sufficient access to health care services for the patients who are being required or encouraged to use the network. The most basic standard of adequacy is to have at least one provider in the network who can deliver each service that a patient could potentially need under the insurance plan or payment. However, adequacy requirements can also include the maximum distance a patient must travel to receive care from a provider who can deliver the service the patient needs, the quality of care the providers in the network deliver, etc.[3]

No Surprises Act (NSA)

A federal law enacted on December 27, 2020, and effective January 1, 2022, to protect patients from unexpected out-of-network medical bills and balance billing when they receive certain types of out-of-network care, including emergency services, items and services provided at in-network facilities, and air ambulance services. [50]

Office-Based Opioid Treatment (OBOT)

In the office-based opioid treatment (OBOT) model, a primary care provider prescribes medication for opioid use disorder within their own clinical setting. In Virginia, OBOTs may be credentialed through a Medicaid MCO and be eligible for enhanced payments.[51]

Open Enrollment

The timeframe in which members are allowed to change from one Managed Care Organization (MCO) to another, without cause, which occurs at least once every 12 months.[16]

Operating Margin

The difference between total revenues and expenses for an organization or service line. A "positive margin" on a service means the organization made a profit delivering that service, and a "negative margin" means there was a financial loss in delivering the service. [3]

Opioid Treatment Program (OTP)

Opioid treatment programs (OTPs) use medication to treat patients with opioid use disorder (OUD). OTPs typically only dispense methadone, though some also offer buprenorphine and naltrexone. OTPs are the only setting where methadone can be dispensed to treat OUD. OTPs can be established in several different settings, including intensive outpatient programs, residential programs, and hospital locations.[51]

Opioid Use Disorder (OUD)

Opioid use disorder is a chronic disease of the brain, sometimes called an addiction, characterized by the persistent use of opioids despite harmful consequences. Patients typically have both physical dependence and loss of control over their opioid use and may experience serious consequences related to their use. It is a relapsing disorder, meaning people with OUD are at increased risk of reverting to opioid use, even after years of abstinence.[52]

Out-Of-Pocket Costs

Expenses for medical care that aren't reimbursed by insurance. Out-of-pocket costs include deductibles, coinsurance, and copayments for covered services plus all costs for services that aren't covered.[2]

Out-of-Pocket Maximum/ Limit

The most a patient has to pay for covered services in a plan year. After a patient spends this amount on deductibles, copayments, and coinsurance for in-network care and services, the health plan pays 100% of the costs of covered benefits.[2]

Outcome Measure

A form of quality measure that assesses the result of health care services in terms of patient health, quality of life, or functionality.[3]

Over the Counter (OTC)

Over-the-counter medicine is also known as OTC or nonprescription medicine. All these terms refer to medicine that you can buy without a prescription.[53]

Paid Amount

The actual dollar amount paid by an insurance plan or payer to a healthcare provider for a specific medical claim or line item.[9]

Patient Assistance Program (PAP)

PAPs help people with no health insurance and those who are underinsured afford medications. These programs are managed by pharmaceutical companies, nonprofits, and government agencies. PAPs may cover the full cost of medications or provide a discount.[54]

Patient Centered Medical Home (PCMH)

A primary care practice that is structured and operated consistent with a set of principles jointly developed by the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP), the American College of Physicians (ACP), and the American Osteopathic Association (AOA). Practices apply for PCMH recognition by demonstrating they meet standards of team-based care, proactive care management, coordinated care, patient engagement, and population health management. PCMH-recognized practices operate within the existing insurance infrastructure.[3]

Pay-for-Performance

A payment structure in which the amount that a provider is paid for services changes in some way based on one or more aspects of the provider's quality and/or financial performance.[3]

Payer

An organization that pays for health care expense coverage.[3]

Payment Bundling

A payment structure in which different health care providers who are treating a patient for the same or related conditions are paid an overall sum for taking care of the condition rather than being paid for each individual treatment, test, or procedure. In doing so, providers are rewarded for coordinating care, preventing complications and errors, and reducing unnecessary or duplicative tests and treatments.[2]

Payment Model

A description of a method for paying providers for health care services. A payment model may define a methodology for determining the relative amounts that will be paid for different services or patients, rather than the exact dollar amounts that will be paid to a specific provider. A payment model is typically implemented through a contract between a payer and a provider that may include additional specifications regarding the patients who will receive services covered by the payment model, the parameters that will be used to convert the methodologies of the payment model into actual payment amounts, etc.[3]

Per-Member-Per-Month Payment (PMPM)

A form of capitation payment that is made to a health care provider each month for each of the members of a health insurance plan who are assigned or attributed to that provider. The key characteristic of the PMPM payment is that it does not vary based on how many services a particular patient receives. The size and purpose of the payment can vary dramatically, and the payment can be made in addition to service-based payments, or it can be paid in place of service-based payments (i.e., a provider would receive a PMPM payment and no longer be able to bill for one or more other types of services). Payments are generally made monthly because the membership of a particular health plan can change frequently and to also allow individuals to change providers.[3]

Pharmacy Benefit Manager (PBM)

A company that administers pharmacy benefits for patients with drug insurance; i.e., the PBM determines which drugs will be covered and how much pharmacies will be paid for dispensing the drugs the patient is prescribed.[3]

Physician Fee Schedule (PFS)

The system that fee-for-service Medicare and Medicaid use to pay physicians.[3]

Plan First

A limited benefit Medicaid family planning program. Men and women who have income less than or equal to 205 percent of the federal poverty level may be eligible for Plan First if they are not eligible for a full benefit medical assistance program. This program only covers family planning services.[16]

Population Health Management

An approach to care delivery designed to help the individuals in a defined population avoid illness as well as treat their illnesses when they occur. Population health management services include proactive efforts to ensure individuals receive preventive screenings, to help them improve their health, and help them manage chronic conditions effectively.[3]

Population-Based Payment

A capitation payment that is paid for each individual in a group or "population", and that is not tied directly to the number or types of health care services those individuals receive. A population-based payment may be paid in addition to fees for individual services, or it may replace some or all fees.[3]

Preferred Drug List (PDL)

A list of outpatient drugs that is used to encourage providers to prescribe some medications over others, typically as a mechanism to negotiate higher supplemental rebates or encourage use of generic medications. The PDL may attach a higher copay or require prior authorization for some drugs.[55]

Preferred Provider

A provider that a patient is encouraged to use because the services delivered by the provider are of higher quality or lower cost than other providers.[3]

Preferred Provider Organization

A type of health plan that contracts with medical providers, such as hospitals and doctors, to create a network of participating providers. A patient pays less if he or she uses providers that belong to the plan's network. The patient can use doctors, hospitals, and providers outside of the network for an additional cost.[3]

Premium

The amount a patient pays for health insurance every month. In addition to the premium, a patient usually has to pay other costs for health care, including a deductible, copayments, and coinsurance.[2]

Prescription Monitoring Program (PMP)

Virginia's Prescription Monitoring Program (PMP) is a near "real-time" central database containing information used primarily by health care providers to better inform treatment and dispensing decisions. The database contains information on dispensed controlled substances as well as naloxone and registered cannabis products. PMP data is used to track trends in drug utilization, measure the impact of policy (legislative) actions, and support activities related to the opioid crisis response in the Commonwealth. The PMP also provides information to authorized law enforcement agents and regulatory personnel to assist with criminal or licensee investigations.[56]

Primary Care

Health services that cover a range of prevention, wellness, and treatment for common illnesses. Primary care providers include doctors, nurses, nurse practitioners, and physician assistants. They often maintain long-term relationships with a patient and advise and treat on a range of health-related issues. They may also coordinate care with specialists.[2]

Primary Care Provider

The physician, nurse practitioner, physician assistant [associate], or clinic that provides most of a patient's health care needs, provides referrals to other health care providers when needed, and monitors health.[16]

Prior Authorization (PA)

A process whereby a provider must seek explicit approval from a payer before delivering a particular service to a patient in order to receive payment for delivering that service.[3]

Process Measure

A type of quality measure based on whether a provider delivered a particular service or followed a particular process in delivering a service. A process measure indicates whether something was done, not what the outcome was.[3]

Prospective Payment

A generic term for a payment model in which the amount of payment for delivery of a particular service or care of a particular condition is defined prior to the delivery of the service or care of the condition, and the amount of payment does not change depending on the actual cost of delivering the service or caring for the condition.[3]

Protected Health Information (PHI)

Individually identifiable patient information, including demographics, which relates to a person's health, healthcare, or payment for healthcare.[16]

Qualified Entity (QE)

An organization that is authorized by federal law to receive Medicare claims data and to use it for public reporting of performance measures about health care providers and for analysis of opportunities to improve health care quality and affordability. Virginia Health Information (VHI) is a QE.[3]

Qualified Medicare Beneficiary (QMB)

A person whose income falls below 100% of federal poverty guidelines, for whom the state Medicaid program pays Medicare Part A and Part B premiums, deductibles, coinsurance, and copayments. Asset limits also apply.[3]

Rebates

Payments from drug manufacturers to pharmacy benefit managers (PBMs) in relation to prescription drugs dispensed to plan members. Drug rebate payments frequently serve as a tool of negotiation to promote the use of expensive brand drugs. Manufacturers get a prominent placement on payers' drug lists to increase market share, and in turn, PBMs and health plans receive a lower cost for the brand drug.[5]

Redetermination

A periodic review process used by government agencies to verify whether a person still meets the financial, household, or non-medical requirements to keep receiving public benefits.[57]

Reinsurance

A reimbursement system that protects insurers from very high claims. It usually involves a third-party paying part of an insurance company's claims once they pass a certain amount. Reinsurance is a way to stabilize an insurance market and make coverage more available and affordable.[2]

Relative Value Unit (RVU)

The unit of measurement in the Resource Based Relative Value Scale (RBRVS) that is used to assess the relative magnitude of the resources associated with delivering a specific healthcare service compared to other services. In the Medicare Physician Fee Schedule, the number of RVUs assigned to a service is multiplied by a conversion factor to determine the actual payment amount for the service.[3]

Risk Adjustment

A statistical process that accounts for the underlying health status and health spending of the enrollees in an insurance plan when looking at their health care outcomes or healthcare costs.[2]

Rural Health Clinic

A medical clinic specifically designated as such based on its location in a rural area and the fact that it has a shortage of health professionals. Medicare pays RHCs an "all-inclusive rate" (AIR) based on their costs, but there is a maximum payment per visit for RHCs, with higher maximums for RHCs that are part of a small hospital.[3]

Section 1115 Waiver

A waiver granted by CMS to a state under Section 1115 of the Social Security Act to allow it to spend Medicaid funds in different ways than what would otherwise be required.[3]

Self-Insured Plan

Type of plan usually present in larger companies where the employer itself collects premiums from enrollees and takes on the responsibility of paying employees - and dependents - medical claims. These employers can contract for insurance services such as enrollment, claims processing, and provider networks with a third-party administrator, or they can be self-administered. In a self-insured plan, the employer bears the financial risk for health care costs, not a separate insurer. [2]

Self-Pay

A self-pay patient pays a provider for its entire charge for a service from the patient's own funds, rather than relying on an insurance company or other third-party payer to pay for all or part of the provider's charge for the service.[3]

Skilled Nursing Facility (SNF)

A facility that accepts patients in need of rehabilitation and medical care.[3]

Small Business Health Options Program (SHOP)

SHOP helps small business owners provide medical and/ or dental insurance to their employees. Some smaller employers qualify for tax credits if they enroll in SHOP insurance. In Virginia, the state Chamber of Commerce operates the WiseChoice Healthcare Alliance.[2]

Social Determinants of Health (SDOH)

Conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.[39]

Specialty Drug

High-cost prescription medications used to treat complex, chronic conditions like cancer, rheumatoid arthritis, and multiple sclerosis. Specialty drugs sometimes require special handling and administration (typically injection or infusion), and patients using a specialty drug may need careful oversight from a healthcare provider who can watch for side effects and ensure that the medication is working as intended.[58]

Substance Abuse and Mental Health Services Administration (SAMHSA)

A branch of the U.S. Department of Health and Human Services that is charged with improving the quality and availability of treatment and rehabilitative services in order to reduce illness, death, disability, and the cost to society resulting from substance abuse and mental illnesses.[59]

Substance Use Disorder (SUD)

A treatable mental health disorder that affects a person's brain and behavior, leading to their inability to control their use of substances like legal or illegal drugs, alcohol, or medications. Symptoms can be moderate to severe, with addiction being the most severe form of SUD.[51]

Supplemental Nutrition Assistance Program (SNAP)

A federally funded program operated at the state level that provides monthly benefits to help lower-income individuals and families buy healthy food. Benefits are issued to a SNAP account and accessed with an Electronic Benefit Transfer (EBT) card.[60]

Supplemental Payments

Medicaid payments to providers that are separate from and in addition to the payments for services rendered to Medicaid enrollees. For example, states may provide supplemental payments to providers to support quality initiatives, graduate medical education (GME), and certain types of facilities (e.g., rural or safety-net providers), among other reasons. Often, providers receive supplemental payments in a lump sum. Most states make supplemental payments under fee-for-service (FFS), but the mechanism for making these payments differs according to the service delivery system. Some of these payments are federally required, whereas others are optional for states. States make supplemental payments to many different Medicaid providers, such as hospitals, nursing facilities, physicians, and mental health facilities. Medicaid disproportionate share hospital (DSH) payments are the only type of FFS supplemental payment that states are required to make. States also are permitted, but not required, to make other non-DSH FFS supplemental payments, which typically are limited by upper payment limits (UPLs) for certain institutional providers. These UPLs are what Medicare would pay for the same or comparable services.[61]

Team-Based Care

In a team-based care approach to care, a multidisciplinary group of providers communicate with each other and coordinate care to best address a patient's health needs.[62]

Temporary Detention Order (TDO)

In Virginia, a TDO is an order issued by a Magistrate that requires an individual to be held in a psychiatric facility for a period of 1 to 5 days until a commitment hearing is held.[63]

Therapeutic Equivalent

Drug products are considered to be therapeutic equivalents only if they are pharmaceutical equivalents and if they can be expected to have the same clinical effect and safety profile when administered to patients under the conditions specified in the labeling.[64]

Third-Party Administrator (TPA)

An organization that receives and pays claims on behalf of a self-funded employer or other self-insured purchaser but does not take any direct risk related to the cost of those claims. The claims processing and other services are delivered by the TPA under an Administrative Services Only (ASO) contract with the purchaser.[3]

Tiered Network

A network of providers in which the providers are divided into two or more tiers based on measures of cost or quality, and different cost-sharing requirements or other rules apply depending on which tier a provider is in. In a tiered network, all providers are generally considered to be "in-network" but with different cost-sharing requirements.[3]

Total Cost of Care (TCOC)

The total amount that is spent by one or more payers on all health care services received by a group of individuals. It is technically a measure of payer spending, not cost, since the amounts payers pay for services may be more or less than the actual costs incurred by the providers who deliver those services. If TCOC is calculated for patients who have a particular health problem or are receiving a particular procedure, it includes not only spending related to that problem or procedure, but spending for services related to all other health problems and procedures. Total cost of care may be impacted by payment rate and service utilization.[3]

Trigger Clause

A contractual provision that specifies a condition or event which, when met, automatically activates, alters, or terminates rights, obligations, or payments between the parties. Thirteen of the states that have expanded Medicaid under the Affordable Care Act, including Virginia, have "trigger laws" in place that would quickly end or potentially scale back Medicaid expansion if the share of federal funding for Medicaid expansion drops.[65]

Uncompensated Care

Health care or services provided by hospitals or health care providers that do not get reimbursed. Often uncompensated care arises when people do not have insurance and cannot afford to pay the cost of care.[2]

Underinsured

Individuals are frequently being described as "underinsured" if they have health insurance but either (a) the health insurance plan does not pay for one or more services the patient needs, or (b) the cost-sharing requirements in the benefit design are such that the patient cannot afford to pay the cost-sharing for the needed services.[3]

Upside Risk

A payment model in which a provider could receive higher payments for services than it would otherwise have received. The "risk" is simply the uncertainty the provider has regarding whether its payments will increase and by how much. However, many payment models that are described as only having "upside risk" actually involve downside risk in the sense that the higher payments may be less than the increase in costs incurred by the provider to qualify for those payments, thereby resulting in a reduction in the provider's margin.[2]

Urgent Care

A location distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.[3]

VAAACares

A Virginia statewide Community Care Hub, developing and maintaining a network of community-based organizations (CBOs) with centralized administrative and operational infrastructure.[66]

Value-Based Insurance Design (VBID)

Provisions of a health insurance plan's benefit design that are explicitly structured to encourage plan members to use higher quality services, lower cost services, or both, or to encourage patient or provider behaviors that lead to better clinical and financial outcomes. This may include elements such as reducing patient cost-sharing for services deemed to be of high value, eliminating coverage for services deemed to be of low value, or encouraging or requiring patients to use a narrow network or providers designated as Centers of Excellence for specific types of services.[3]

Value-Based Purchasing/ Payment (VBP)

VBP works by linking provider payments to improved performance by health care providers. This form of payment holds health care providers accountable for both the cost and quality of care they provide. It attempts to reduce inappropriate care and to identify and reward the best-performing provider.[3]

Virginia Department of Health (VDH)

A Virginia state agency dedicated to protecting and promoting the health of Virginians. The VDH is made up of a statewide Central Office in Richmond and 35 local health districts. These entities work together to promote healthy lifestyle choices that can combat chronic disease, educate the public about emergency preparedness and threats to their health, and track disease outbreaks in Virginia.[67]

Virginia Health Workforce Development Authority (VHWDA)

A state government office established by the General Assembly to identify and address health workforce issues in Virginia. The VHWDA assesses health workforce needs; sets priorities for the Area Health Education Center (AHEC) program; informs workforce policy; promotes strategies for workforce pipeline development; supports collaborations between communities, businesses, and social organizations to facilitate recruitment and retention efforts; advocates reducing the student debt load of health professionals; identifies High Priority Target Areas (HPTAs); and aims to create innovative health workforce development models.[68]

Virginia Rural Health Association (VRHA)

A nonprofit organization whose mission is to improve the health of rural Virginians through education, advocacy, and fostering cooperative partnerships.[69]

Withhold

In a payment model that includes penalties for poor performance, a payer may reduce payments to the provider during the performance period below what the provider would otherwise expect to receive (the reduction is the "withhold" amount); the payer then pays the withhold amount at the end of the performance period if the provider's performance met the threshold for avoiding a penalty. The use of a withhold avoids requiring the provider to send funds to the payer if the provider's performance is poor; instead, the provider has already received less money because it forfeits all or part of the withhold amount.[3]

Work Requirements

A policy in public assistance programs that mandates adult recipients to maintain a minimum level of employment, job training, education, or community service to keep their benefits. H.R. 1 (the One Big Beautiful Bill Act), the 2025 federal budget reconciliation law, introduced new work requirements, also referred to as community engagement requirements, for Medicaid members aged 19-64 who are covered through Medicaid expansion or an 1115 demonstration waiver that provides minimum essential coverage. States must implement them by January 1, 2027 (extensions possible through 2028), and members must show 80 hours per month of qualifying activity.[70]

Rural Health Transformation Key Terms and Acronyms

Terms

as used in RHTP reporting.

Clinician

A person delivering healthcare services.

Initiative

The four primary components of Virginia's RHTP.

1. Care IQ,
2. Connected Care, Closer to Home,
3. Homegrown Health Heroes, and
4. Live Well, Together.

Participant

An individual who is enrolled in, receives services from, or engages with a specific RHTP-funded sub-initiative. Participants may include patients, community members, caregivers, providers, students, trainees, or other individuals depending on the initiative.

Provider

An organization delivering healthcare services (e.g., hospital or clinic).

Resident

An individual living in a defined geographic area.

Rural localities

Of Virginia's 133 primary local governing entities (i.e., counties and independent cities), 76 are rural as defined by the Federal Office of Rural Health Policy (FORHP). For a map and current list, visit www.ruralhealthtransformationva.virginia.gov/virginias-rural-communities/.

Rural regions

Virginia has six rural regions as defined in Virginia's Rural Health Transformation proposal and the Virginia Rural Health Plan (2022-2026). These regions are the Eastern Shore and Northern Neck, Northern Piedmont, Roanoke/Alleghany, Shenandoah Valley, Southside, and Southwest. For a map and current list, visit www.ruralhealthtransformationva.virginia.gov/virginias-rural-communities/.

Sub-initiative

The 15 distinct programmatic components in Virginia's RHTP.

1. Active Kids
2. Allied Health Degrees
3. Attract & Retain Physicians
4. Build Career Programs
5. Community Paramedicine
6. Consumer Tech
7. Earn to Learn Programs
8. Food is Medicine
9. Innovative Maternal Care
10. Integrated Care for Duals
11. Mobile & Hybrid Care
12. Provider Interoperability
13. Provider Productivity
14. Remote Patient Monitoring
15. Tech Innovation Fund

Subrecipients (i.e., KIPs)

Organizations partnering with Virginia's central RHTP team to administer and implement the four initiatives/15 sub-initiatives. Responsible for carrying out program activities and reporting required evaluation data. Referred to as Key Implementation Partners or 'KIPs' internally.

Acronyms

ACGME

Accreditation Council for Graduate Medical Education

APRN

Advanced Practice Registered Nurse

BEAD

Broadband Equity, Access, and Deployment

BRFSS

Behavioral Risk Factor Surveillance System (CDC/VDH)

CBO

Community-Based Organization

CCBHC

Certified Community Behavioral Health Clinic

CEHRT
Certified Electronic Health Record Technology

CTE
Career and Technical Education

D-SNP
Dual Eligible Special Needs Plan

ETL
Earn to Learn

EPTC
Enhanced Premium Tax Credits

FIDE-SNP
Fully Integrated Dual Eligible Special Needs Plan

FORHP
Federal Office of Rural Health Policy

IMLC
Interstate Medical Licensure Compact

KPO
Key Performance Objective

MCHW
Maternal and Child Health Workforce

NAS
Neonatal Abstinence Syndrome

NCC
Non-Competing Continuation

NLC
Nurse Licensure Compact

ONC
Office of the National Coordinator for Health Information Technology (renamed ASTP/ONC in 2024)

PDC

Planning District Commissions

PLACES

CDC-Population Level Analysis and Community Estimates

PRISM

Practical, Robust Implementation and Sustainability Model; RE-AIM framework expansion

PSYPACT

Psychology Interjurisdictional Compact

RE-AIM

Reach, Effectiveness, Adoption, Implementation, and Maintenance

RFA

Requests for Applications

RHT

Rural Health Transformation, also sometimes used to refer to the Rural Health Core Team

RHTP

Rural Health Transformation Program, *originally Rural Vitality*

RPM

Remote Patient Monitoring

SPAI

Spatial Provider Access Index

STEP-VA

System Transformation Excellence and Performance Virginia

STLDI

Short-Term, Limited-Duration Insurance

VATI

Virginia Telecommunication Initiative

Virginia Works

Department of Workforce Development and Advancement

Works Cited

[1] hrsa.gov/opa

[2] healthcare.gov/glossary/

[3] glossary.chqpr.org/

[4]cms.gov/medicare/payment/fee-schedules/physician-fee-schedule/advanced-primary-care-management-services

[5] healthinsurance.org/glossary

[6] ahrq.gov/cpi/about/index.html

[7] acl.gov/programs/aging-and-disability-networks/area-agencies-aging

[8] vhi.org/report/potentially-avoidable-emergency-department-visits/

[9] p3care.com/blog/allowed-amount-vs-billed-amount/

[10] pfizer.com/news/articles/biologics_vs_biosimilars_understanding_the_differences

[11] mass.gov/info-details/capacity-building-for-accountable-care-organizations-community-partners-and-providers

[12] medicaid.ncdhhs.gov/blog/2023/02/06/tailored-care-management-capacity-building-funds-guidance-released

[13] dmas.virginia.gov/for-members/cardinal-care-members/

[14] cancer.gov/publications/dictionaries/cancer-terms/def/centers-for-disease-control-and-prevention

[15] msv.org/advocacy/issues/certificate-public-need-copn/

[16] vamedicaid.dmas.virginia.gov/node/286

[17] dmas.virginia.gov/for-members/cardinal-care-members/cardinal-care-managed-care/archived-information/ccc-plus/

[18] coe.aginganddisabilitybusinessinstitute.org/what-is-a-community-care-hub/

[19] cdc.gov/infrastructure/public-health-systems-emerging-practices/community-health-assessment-and-improvement-planning.html

[20] apha.org/apha-communities/member-sections/community-health-workers

[21] virginianavigator.org/article/64190/community-services-boards-and-behavioral-health-authorities

[22]cms.gov/medicare/health-safety-standards/conditions-coverage-participation

[23] aafp.org/about/policies/continuity-of-care

[24] permithealth.com/post/the-corporate-practice-of-medicine-50-state-guide

[25] dars.virginia.gov/

[26] dbhds.virginia.gov/

[27] dhp.virginia.gov/

[28] dmas.virginia.gov/

[29] hrsa.gov/opa/eligibility-and-registration/hospitals/disproportionate-share-hospitals

[30] healthit.gov/health-it-basics/benefits-ehrs/

[31] fda.gov/

[32] ers.usda.gov/amber-waves/2011/december/data-feature-mapping-food-deserts-in-the-u-s

[33] acep.org/siteassets/uploads/uploaded-files/acep/clinical-and-practice-management/resources/administration/fsed-and-ucs_info-paper_final_110215.pdf

[34] fda.gov/drugs/generic-drugs/generic-drugs-questions-answers

[35] acgme.org/about/overview/

[36] hhs.gov/

[37] vhi.org/hie/health-coordination-network/

[38] healthit.gov/health-it-basics/hie/

[39] bhw.hrsa.gov/workforce-shortage-areas/shortage-designation

[40] cms.gov/priorities-innovation-key-concepts-social-drivers-health-health-related-social-needs

[41] hrsa.gov/

[42] cms.gov/training-education/partner-outreach-resources/american-indian-alaska-native/ltss-ta-center/information/ltss-models/home-and-community-based-services

[43] medicaid.gov/medicaid/managed-care/guidance/lieu-of-services-and-settings

[44] cms.gov/initiatives/no-surprise-billing/overview/engaging-idr/about-independent-dispute-resolution

[45] orwh.od.nih.gov/toolkit/human-subjects-protections/institutional-review-board

[46] nationalcapitalarea.himss.org/resources/interoperability-healthcare

[47] jchc.virginia.gov/

[48] dmas.virginia.gov/for-members/cardinal-care-members/cardinal-care-managed-care/archived-information/medallion-40/

[49] cms.gov/medicare/health-drug-plans/

[50] beta.dol.gov/policy-regulations/pay-benefits/health-plans/surprise-billing-and-price-transparency

[51] ruralhealthinfo.org/toolkits/substance-use/2/treatment/medication-assisted-treatment

[52] yalemedicine.org/conditions/opioid-use-disorder

[53] fda.gov/drugs/buying-using-medicine-safely/understanding-over-counter-medicines

[54] cms.gov/medicare/coverage/prescription-drug-coverage/patient-assistance-program

[55] kff.org/state-health-policy-data/state-indicator/medicaid-preferred-drug-lists/

[56]dhp.virginia.gov/PractitionerResources/PrescriptionMonitoringProgram/

[57] ssa.gov/ssi/text-redets-ussi.htm

[58] healthinsurance.org/glossary/

[59] samhsa.gov/

[60] dss.virginia.gov/relief/food-assistance/snap/

[61] sgp.fas.org/crs/misc/R45432.pdf

[62] cms.gov/priorities/innovation-center/value-based-care-spotlight/providers

[63] arlingtonva.us/Government/Departments/DHS/Behavioral-Healthcare/ECO-TDO-and-Involuntary-Commitment

[64] sciencedirect.com/topics/pharmacology-toxicology-and-pharmaceutical-science/therapeutic-equivalence

[65] healthinsurance.org/faqs/which-states-have-trigger-laws-to-automatically-end-medicaid-expansion-if-federal-funding-drops/

[66] vaaacares.com/

[67] vdh.virginia.gov/

[68] vhwda.org/

[69] vrha.org/

[70]chcs.org/resource/a-summary-of-national-medicaid-work-requirements/

Our Partners

Ballad Health | *BalladHealth.org*
Contact: John Goetz | Vice President, Community & Govt Relations
Phone Number: (615) 448-8313 **Email Address:** John.Goetz@BalladHealth.org

Carilion Clinic | *CarilionClinic.org*
Contact: Chris Turnbull | Chief of Staff
Phone Number: (540) 266-6598 **Email Address:** CRTurnbull@CarilionClinic.org

Elevance Health | *ElevanceHealth.com*
Contact: Louis Thompson | Director of Medical Operations, Commercial Business
Phone Number: (804) 298-4089 **Email Address:** Louis.Thompson@Anthem.com

Epic Systems Corporation | *Epic.com*
Contact: Prerana Laddha | VP of R&D, Population Health & Post-Acute Care
Phone Number: (516) 815-6160 **Email Address:** Prerana@Epic.com

Equality Health | *EqualityHealth.com*
Contact: Lisa Stevens Anderson | National Market President
Phone Number: (602) 319-2545 **Email Address:** LSAnderson@EqualityHealth.com

Family Insight | *FamilyInsight.net*
Contact: Jennifer Switzer | CEO
Phone Number: (201) 213-7476 **Email Address:** Jennifer.Switzer@FamilyInsight.net

Federation of Virginia Food Banks | *VAFoodBanks.org*
Contact: Eddie Oliver | Executive Director
Phone Number: (804) 549-5675 **Email Address:** EOliver@VAFoodBanks.org

HCA Virginia Care Partners | *VirginiaCarePartners.com*
Contact: Gerard Filicko | Regional VP, Value Based Care
Phone Number: (804) 887-2151 **Email Address:** Gerard.Filicko@HCAHealthcare.com

Humana | *Humana.com/Medicaid/Virginia*
Contact: Linda Hines | Medicaid Regional President/ CEO
Phone Number: (804) 938-3276 **Email Address:** LHines5@Humana.com

Inova Health System | *Inova.org*
Contact: Craig Cheifetz | President, Primary Care
Phone Number: (703) 955-1261 **Email Address:** Craig.Cheifetz@inova.org

Marsh, People and Investments (Previously Mercer) | *Marsh.com*
Contact: Kristin Henshaw | Senior Principal & Market Leader, Virginia & Carolinas
Phone Number: (804) 239-7736 **Email Address:** Kristin.Henshaw@Mercer.com

Mary Washington Healthcare | *MWHC.com*
Contact: Stephanie Goldberg | Chief Academic Officer
Phone Number: (804) 519-2346 **Email Address:** Stephanie.Goldberg@MWHC.com

Merck & Co., Inc. | *Merck.com*
Contact: Tami Alvarado | Director, State Government Affairs & Policy
Phone Number: (202) 997-7118 **Email Address:** Tami.Alvarado@Merck.com

Patient First | *PatientFirst.com*
Contact: Chris Barker | VP, Payer Relations & Value-Based Care
Phone Number: (804) 356-6488 **Email Address:** Chris.Barker@PatientFirst.com

PhRMA | *PhRMA.com*
Contact: Nicole Wood | Senior Director, State Advocacy
Phone Number: (703) 244-9553 **Email Address:** NPalyaWood@PhRMA.org

Sellers Dorsey | *SellersDorsey.com*
Contact: Rusty Walker | Senior Director
Phone Number: (267) 683-4834 **Email Address:** JWalker@SellersDorsey.com

Sentara | *Sentara.com*
Contact: Dan Dickinson | VP, Complex Care, Executive Director, Sentara Quality Care Network
Phone Number: (757) 252-3143 **Email Address:** DJDickin@Sentara.com

Social Innovation Ventures | *SocialinnovationVentures.co*
Contact: Andrey Ostrovsky | Managing Partner
Phone Number: (443) 857-8199 **Email Address:** AndreyOstrovskyMD@gmail.com

The Medical Society of Virginia | *MSV.org*
Contact: Melina Davis | CEO & EVP
Phone Number: (804) 377-1061 **Email Address:** MDavis@MSV.org

UnitedHealthcare | *UHC.com*
Contact: Marianne Randazzo | VP Account Management
Phone Number: (804) 334-9094 **Email Address:** Marianne_Randazzo@UHC.com

UVA Medical Center | *UVAHealth.com*
Contact: Mary Coffey | Director of Professional Development
Phone Number: (804) 721-7099 **Email Address:** WSC7au@uvahealth.org

UVA Physicians Group | *UVAHealth.com/About/UVA-UPG*
Contact: Rebekah Compton | Chief Operating Officer
Phone Number: (434) 466-5166 **Email Address:** RC8b@UVAHealth.org

UVA School of Nursing | *Virginia.edu*
Contact: Shelly Smith | Professor of Nursing, General Faculty | NR-Research
Phone Number: (804) 955-9064 **Email Address:** SRP5k@virginia.edu

VCU Health | *VCUHealth.org*
Contact: Karah Gunther | VP External Affairs and Health Policy
Phone Number: (804) 828-6879 **Email Address:** KLGunther@VCU.edu

Veeva Systems | *Veeva.com*
Contact: Anthony Corso | Vice President, Public Policy
Phone Number: (614) 401-2914 **Email Address:** Anthony.Corso@Veeva.com

Virginia Academy of Family Physicians | *VAFP.org*
Contact: Mary Lindsay White | Executive Vice President
Phone Number: (804) 968-5200 **Email Address:** MLWhite@VAFP.org

Virginia Biotechnology Association | *VABio.org*
Contact: John Newby | Chief Executive Officer
Phone Number: (804) 643-6360 **Email Address:** John.Newby@VABio.org

Virginia Council of Nurse Practitioners | *VCNP.net*
Contact: Amy Johnson | Lynchburg Regional President, State Board Member
Phone Number: (540) 798-8336 **Email Address:** Amy.Johnson@CentraHealth.com

Virginia Health Catalyst | *VAHealthCatalyst.org*
Contact: Victor McKenzie | Chief Executive Officer
Phone Number: (804) 269-8720 **Email Address:** VMcKenzie@VAHealthCatalyst.org

Virginia Public Health Association | *VirginiaPublicHealth.org*
Contact: Syril Pettit | President, Board of Directors
Email Address: SPettit@HesiGlobal.org

Contact Us



Beth Bortz, MPP

President & CEO

Phone Number: (804) 929-5844

Email Address: BBortz@VAHealthInnovation.org



Michelle Rockwell, PhD, RD

Executive Director, Research Consortium

Phone Number: (919) 943-0045

Email Address: MRockwell@VAHealthInnovation.org



Meredith Young, MNSP

Senior Researcher

Phone Number: (540) 597-3316

Email Address: Meredith@VAHealthInnovation.org



Chelsey Oppan, MPH

Lead Data Analyst

Phone Number: (571) 299-0510

Email Address: Chelsey@VAHealthInnovation.org



Zelda Hinkle, MNM

Director of Operations & Communications

Phone Number: (804) 972-5270

Email Address: Zelda@VAHealthInnovation.org

Mailing Address: P.O. Box 1248, Midlothian, VA 23113

.