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A Glossary of Commonly Used Acronyms in Florida Managed Care

December 10, 2020

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Anyone who interacts with third party payors encounter acronyms on a regular basis. While acronyms are intended to facilitate efficient communication, their use often instead leads to confusion. This blog is intended to provide a brief overview of some commonly used acronyms in managed care. Please note that, although some of the acronyms are specifically applicable to Florida, most are used throughout the country. Also note that the following are general descriptions intended to provide a high-level understanding of the acronyms. Please refer to your specific jurisdiction for more detailed definitions. For ease of reference, we have included links to the 2020 Florida statutory definitions where applicable.

Types of Entities & Types of Coverage

ACO – Accountable Care Organization

An organization of physicians, which may also include hospitals and other healthcare providers, that provides coordinated care to Medicare recipients and is paid by the Centers for Medicare and Medicaid Services based upon their patients' quality metrics and reductions to the cost of their patients' care.

DMPO – Discount Plan Organization (formerly known as Discount Medical Plan Organization)

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A company that provides access to medical providers at a discount from the providers' usual rates.

See Section 636.202(2), F.S.

EPO – Exclusive Provider Organization

A product offered by a health insurance company that, like an HMO, controls cost in part by generally restricting access only to healthcare providers who have contracts with the health insurance company (contracted providers are also referred to as in-network providers).

See Section 627.6472, F.S. for definitions of exclusive provider and exclusive provider provision.

FISO – Fiscal Intermediary Services Organization

A company that contracts with an HMO's in-network providers and that collects payments on behalf of the providers from the HMOs.

See Section 641.316(2)(b), F.S.

HMO – Health Maintenance Organization

An MCO that provides comprehensive health coverage and that controls cost in part by generally restricting access only to healthcare providers who have contracts with the HMO.

See Sections 110.123(2)(d), 641.19(11), and 766.105(1)(e), F.S.

MCO – Managed Care Organization

A company (usually a health insurer or HMO) that provides health coverage with mechanisms to control costs and reduce excessive or inappropriate care.

See Sections 409.901(13), 409.920(1)(e), and 409.962(10). F.S. for definitions of managed care plan(s).

PBM – Pharmacy Benefits Manager

A company that negotiates with drug manufacturers on behalf of MCOs or similar entities to help control prescription drug costs and provide prescription drug benefits.

See Sections 624.490(1), 627.64741(1)(b), 627.6572(1)(b), and 641.314(1)(b), F.S.

PHC – Prepaid Health Clinics

An MCO that provides comprehensive health coverage, except that it does not cover inpatient hospital expenses, and that controls cost in part by generally restricting access only to healthcare providers who have contracts with the PHC.

See Section 641.402(4), F.S.

PHO – Physician (or Provider) Hospital Organization

A company that contracts with physicians and hospitals to form a single organization for the purpose of contracting with MCOs and similar entities.

PLHSO – Prepaid Limited Health Services Organization

An MCO that is limited to providing only certain types of coverages (i.e., dental, vision, etc.) and that controls cost in part by generally restricting access only to healthcare providers who have contracts with the PLHSO.

See Section 636.003(7), F.S.

POS – Point of Service (type of HMO product)

An MCO product offered by an HMO that allows a member the ability to access out-of-network providers, but at a greater cost than in-network providers (this is similar to an insurance company PPO product).

See Section 641.31(38), F.S. for point of service requirements.

PPO – Preferred Provider Organization

A product offered by a health insurance company that provides financial incentives to use healthcare providers that are contracted with the insurance company but also allows access to non-contracted providers (also referred to as out-of-network providers) at a greater cost.

See Section 627.6471, F.S. for definitions of preferred provider network and preferred provider.

PSN – Provider Service Network

In Florida, an MCO that is majority-owned and -controlled by Medicaid providers and that contracts with the Florida Agency for Healthcare Administration to provide comprehensive health coverage to Medicaid recipients.

See Sections 409.912(1)(b), 409.962(14), and 641.19(22), F.S.

TPA – Third Party Administrator (also known as Insurance Administrator)

A company that contracts with health insurers or similar entities such as HMOs, usually to provide claims processing services, but in Florida, a TPA may also solicit coverage and collect premiums.

See Section 626.88(1), F.S.

In addition, following are some commonly used state and federal acronyms and their meanings:

Federal Regulators & State Insurance Commission Associations

CMS – Centers for Medicare and Medicaid Services

HHS – U.S. Department of Health and Human Services

NAIC – National Association of Insurance Commissioners

Laws

ACA/PPACA – Patient Protection and Affordable Care Act (ObamaCare)

ERISA – Employee Retirement Income Security Act

HIPAA – Health Insurance Portability and Accountability Act

Florida Regulators

AHCA – Florida Agency for Healthcare Administration

DFS – Florida Department of Financial Services

OIR – Florida Office of Insurance Regulation
