4.1 Glossary

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As used in this document, each of the following terms shall have the indicated meanings unless the context clearly requires otherwise:

ACCESS means a patient's ability to obtain medical care. The ease of access is determined by several components, including the availability of medical services and their acceptability to the patient, the location of facilities, transportation, hours of operation, and cost.

ADC-RELATED is a Medicaid eligibility group that includes families with a child under 21 with a deprivation, federally non participating parents, children under 21 and some pregnant women.

AGENCY means the New York Medicaid Agency.

AMBULATORY CARE is an umbrella term used to describe all the types of health services that are provided on an outpatient basis. While many inpatients may be ambulatory, the term "ambulatory care" generally implies that the patient has come to a location such as a clinic, health center, or physician's office to receive services and has departed the same day.

BEHAVIORAL HEALTH means **t**he assessment or treatment of mental and/or alcohol and/or psychoactive, substance abuse disorders.

BENEFICIARY means any person eligible to receive services agreed upon in a contract, normally used for participants in the Medicaid program.

BENEFIT PACKAGE refers to the services which health plans will offer members, as well as services available to members on a fee-for-service "wraparound" basis.

CAPACITY means the number of unduplicated eligibles which health plans have agreed to enroll and serve and for which the State has assessed the adequacy of the network and the MCOs financial and administrative capacity.

CAPITATED SERVICE means any Medicaid covered service for which a health plan receives a capitation payment.

CAPITATION is a contractual arrangement through which a health plan agrees to provide specified health care services to enrollees for a specified prospective payment per member, per month.

CAPITATION RATE is the amount paid per member, per month for services to be provided at risk.

CARE MANAGEMENT refers to the responsibilities of the Primary Care Provider (PCP) in directing most care and services received by Medicaid recipients.

CASE MANAGEMENT is a health care method in which medical, social, and other services are coordinated by one entity. The objective of case management is to provide medically necessary quality care and to assure access and continuity of care for a patient. In Medicaid case management, this responsibility includes diagnosis of health risk, identification of disease, development of a treatment plan, referral, consultation, ordering of therapy, admission to hospitals, follow-up care, prior approval of referred services, locating, coordinating, and monitoring all plan-covered and Medicaid-covered medical care on behalf of a Medicaid enrollee. It may also entail coordinating social services which the patient may be eligible for or require.

CASE MANAGER means the person responsible for coordinating the enrollee's health care in conjunction with the PCP.

COMPREHENSIVE PRIMARY CARE CENTER (CPCC) means an entity licensed pursuant to Article 28 of the Public Health Law as a diagnostic and treatment center which provides basic medical care to the general population without regard to patient category or characteristics such as health status, diagnosis, age or sex.

COMPUTER SCIENCES CORPORATION (CSC) means the New York State Medicaid fiscal agent.

CSC BILLING POLICIES & PROCEDURES means refers to those documents prepared by Medicaid's fiscal agent, CSC, for the purpose of instructing Medicaid providers in appropriate claims filing procedures.

CONTRACTING PROVIDERS are physicians, nurses, technicians, teachers, researchers, hospitals, home health agencies, nursing homes, or any other individuals or institutions with which an entity contracts for medical services.

COVERED SERVICES means the medical services and benefits packages described in this document.

DAYS means calendar days unless otherwise specified.

DISENROLLMENT means the process by which a member's entitlement to receive services from a health plan is terminated.

EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT) is a program which covers screening and diagnostic services to determine physical and mental defects in enrollees under the age of 2 1; and to ascertain health care treatment and

other measures to correct or ameliorate any defects and chronic conditions discovered. Also known in New York as "Child/Teen Health Plan" (C/THP).

EDUCATION AND OUTREACH means the activities that are designed to aid Medicaid beneficiaries and MCO enrollees in acquiring knowledge, skills, and abilities needed to improve and/or maintain their physical, and mental health, including the appropriate use of health care services.

ELECTRONIC MEDICAID ELIGIBILITY VERIFICATION SYSTEM (EMEVS) means the State's medical assistance automated eligibility verification system.

ELIGIBLE PERSON means a person whom the State determines to be entitled to receive services under the Medicaid program and who meets all other conditions for enrollment into a health plan under this program.

EMERGENCY DENTAL CONDITION means a dental condition requiring immediate treatment to control hemorrhage, relieve acute pain, eliminate acute infection, pulpal death or loss of teeth.

EMERGENCY MEDICAL CONDITION means a medical or behavioral -condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, who possesses an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in: 1) placing the person's health in serious jeopardy; or 2) serious impairment to bodily functions; or 3) serious dysfunction of any bodily organ or part, or 4) serious disfigurement.

EMERGENCY SERVICES means health care services and items, including psychiatric stabilization and medical detoxification from drugs or alcohol, furnished in the emergency department of **a** hospital, or **a** specialized psychiatric emergency room.

ENCOUNTER is a record of a medically related service (or visit) rendered by (a) provider(s) to a beneficiary who is enrolled in a participating health plan during the date of service. It includes (but is not limited to) all services for which Contractor incurred any financial responsibility.

ENROLLEE means a Medicaid recipient who has been certified by the State of New York as eligible to enroll with an MCO and who has signed an enrollment form to join an MCO or who has been assigned by Medicaid to the MCO. This term is interchangeable with member.

ENROLLMENT COUNSELING FIRM means the State-contracted entity that will provide enrollment and education and outreach services in accordance with the specifications outlined in Appendix 1.12. The Enrollment Counseling Firm is also referenced as the "Enrollment Broker" or the "Enrollment Counselor".

ENROLLMENT EFFECTIVE DATE means the date on which an enrollee can begin to receive services through his or health plan.

EXCLUSIONS OR OUT-OF-PLAN SERVICES means those Medicaid covered services that are not identified as capitated MCO services.

EXTENDED BENEFITS PACKAGE (EBP) means A county managed Medical fee-for-service alcohol and substance abuse program to become available in some counties when managed care enrollees exhaust their in-plan alcohol and substance abuse services. In counties where there are no EBPs, benefit exhaustees will access alcohol and substance abuse services on a fee-for-service basis.

FAMILY means a mother and child(ren), a father and child(ren) a father and mother and child(ren), or a husband and wife residing in the same household for purposes of family enrollment in mandatory counties.

FAMILY ASSISTANCE means New York's federally funded public assistance program.

FEE-FOR-SERVICE (FFS) is a method of reimbursement based on payment for specific services rendered to an enrollee. Fee-for-service is the traditional method of reimbursement used by physicians and almost always occurs retrospectively (i.e., after the service has been rendered).

GUARANTEED ELIGIBILITY means the period beginning on the enrollee's enrollment effective date and ending six months thereafter, during which enrollment and capitation payments on behalf of the enrollee continue even if a change in the enrollee's financial or other circumstances ordinarily would have rendered him or her ineligible to receive Medicaid services.

HCFA means the Health Care Financing Administration section of the United States Department of Health and Human Services. HCFA is the federal agency responsible for administering Medicare and overseeing the states' administration of Medicaid.

HEALTH MAINTENANCE ORGANIZATION (HMO) or " Health Plan" means any organization that is licensed as a Health Maintenance Organization or Prepaid Health Services Plan by the State of New York, or that otherwise meets the definition of an HMO as delineated in the New York State Medicaid Plan.

IBNR (Incurred But Not Reported) means liability for services rendered for which claims have not been received.

LOCK-IN period means the period during which the enrollee may not disenroll from his or her health plan except for reasons specified in this document.

In mandatory counties enrollees may disenroll for any reason during the first (30) days after the enrollment effective date (60 days for auto-assigned persons) and continuing for eleven months (or 10 as applicable) thereafter, during which the enrollee may not disenroll from his/her health plan except for good cause as defined in regulations.

In voluntary counties that have opted to implement a lock-in, enrollees may disenroll for any reason during the first (90) days after the enrollment effective data, thereafter (nine months) the enrollee may not disenroll except for good cause as defined by the Commissioner.

In New York City, prior to the full implementation of the 1115(a) waiver, all new enrollees, in either a voluntary or mandatory area, will have a 90 day period after the effective date of enrollment to change MCOs. Upon full implementation of the waiver, the opt-out period may be changed to 30 days for those new enrollees who chose their MCO and 60 days for those enrollees who were auto-assigned. The lock-in will remain in effect for the remainder of the first twelve months of enrollment. Until full implementation of the waiver, nine months, after implementation, eleven months if the MCO was chosen and ten months if the enrollee was auto-assigned.

LOW INCOME FAMILIES MEDICAID ELIGIBILITY GROUP includes families with children under age 21, children under age 21 who are not living with caretaker relatives, and some pregnant women. This group includes children who receive foster care but who are not eligible under Title IV-E.

MANAGED CARE is a comprehensive approach to the provision of health care that combines clinical services and administrative procedures within an integrated, coordinated system to provide timely access to cost effective primary care and other medically necessary services. Managed care's emphasis on access to primary care is intended to increase utilization of clinical preventive and primary care services, and thus reduce the unnecessary use of emergency rooms for ambulatory care and possibly eliminate hospitalizations.

MANAGED CARE ORGANIZATION (MCO) means an appropriately licensed HMO, PHSP or IDS in the State of New York.

MANAGEMENT INFORMATION SYSTEM (MIS), in the context of Medicaid managed care, includes all data information collection processes and the utilization of collected data elements by the State.

MARKETING means any activity of a health plan by which information about the health plan is made known to eligible persons for purposes of persuading them to enroll with the plan.

MEDICAID (TITLE XIX) is the medical assistance program authorized by Title XIX of the Social Security Act. The program provides medical benefits for certain low income persons. It is jointly administered by the federal and state governments.

MEDICAL HOME means the primary care provider and provider site where the delivery and coordination of services necessary to meet each enrolled individual's health care needs occurs.

MEDICALLY NECESSARY SERVICE means health care and services that are necessary to prevent, diagnose, manage or treat conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity or threaten some significant handicap.

MEDICAL RECORD means a complete record, kept at the site of the enrollee's participating primary care provider, that documents care received under the benefit package by the enrollee, in accordance with all applicable laws, rules, and regulations, and is signed by the medical professional rendering the service.

MEDICARE (TITLE XVIII) of the Social Security Act of 1965, which provides payment for medical and health services to the population age 65 and over, and other qualified disabled individuals under age 65. Medicare has two basic coverages: Part A, which pays for hospitalization costs; and Part B, which pays for physician services, lab and x-ray services, durable medical equipment, and outpatient and other services. Dual eligibles are individuals who are entitled to Medicare Part A and/or Part B, and are eligible for some form of Medicaid benefit.

MEMBER, as the term is used herein, means an eligible person who is enrolled with a health plan. This term is interchangeable with enrollee Medicaid recipient who has been certified by the State as eligible to enroll in an MCO and who has signed an enrollment form to join the plan offered by the Contractor, or who has been assigned by Medicaid to a Contractor's plan.

MEMBER SERVICES REPRESENTATIVE means an individual employed by the MCO who is responsible for assisting enrollees with all HMO policies, procedures, and benefits. These individuals may also be responsible for receiving any enrollee complaints and assisting enrollees in initiating grievance procedures.

NON-PARTICIPATING PROVIDER means a physician or other provider who has not contracted with, or is not employed by, the health plan to deliver services to its members. Used interchangeably with non-network or out-of-network provider.

NON-PHYSICIAN PROVIDERS means medical practitioners other than Medical Doctors and Doctors of Osteopathy - including physician assistants, certified nurse practitioners, and certified midwives - who are able to furnish primary and pregnancy-related services to Title XIX enrollees as part of their scope of practice.

OUT-OF-NETWORK PROVIDER means a provider that does not have an agreement with the Contractor to provide services to Medicaid recipients through participation in the MCO's

network.

OUTPATIENT CARE means the treatment provided to an enrollee who is not confined in **a** health care facility. Outpatient care is often associated with treatment in **a** hospital that does not necessitate an overnight stay, e.g., emergency treatment.

PARTICIPATING PROVIDER means any individual provider, institution, or other entity who participates in the Medicaid fee-for-service program.

PER MEMBER PER MONTH (PMPM) is the unit of measure for each member for each month the member was enrolled in a participating Health Plan.

PLAN means an MCO participating in The Partnership Plan. Also referred to as a Health Plan.

PLAN PHYSICIAN means a physician licensed to practice in New York and who has contracted with or is employed by a participating health plan to furnish services.

PREPAID BENEFIT PACKAGE means the set of health care related services which Contractor will be responsible to provide and for which Contractor will receive reimbursement through a per member per month predetermined capitation rate.

PREVENTIVE CARE means the treatment to avert disease/illness and/or its consequences. There are three levels of preventive care: primary, such as immunizations, aimed at preventing disease; secondary, such as disease screening programs aimed at early detection of disease; and tertiary, such as physical therapy, aimed at restoring function after the disease has occurred. Commonly, the term "preventive care" is used to designate prevention and early detection programs rather than restorative programs.

PRIMARY CARE means the basic level of health care usually rendered by general and family practitioners, internists, obstetricians, pediatricians, and non-physician providers. This type of care emphasizes caring for the enrollee's general health needs as opposed to a more specialized or fragmented approach to medical care. Primary care is usually rendered in ambulatory settings.

PRIMARY CARE PROVIDER (PCP) means the individual practitioner selected by, or assigned to the enrollee to provide and coordinate all of the enrollee's health care needs and to initiate and monitor referrals for specialized services when required. Primary Care Providers generally shall be Medical Doctors, Doctors of Osteopathy, Physician Assistants, and Nurse Practitioners in the following specialties: family and general practice, pediatrics, and internal medicine. Obstetricians may elect to participate as a PCP. Primary Care Providers also shall meet the credentialling criteria established by the plan and approved by the State. PCPs may also be referred to as a client's "personal doctor" or "personal provider".

QUALITY ASSURANCE is the formal set of activities to assure a standard of quality of services provided. Quality assurance includes quality assessment and corrective actions taken to remedy any deficiencies identified through the assessment process. Comprehensive quality assurance includes mechanisms to ensure the quality of both enrollee services and administrative and support services. Term used interchangeably with Quality Improvement.

QUALITY ASSURANCE REPORTING REQUIREMENTS (QARR) defines the quality measures for MCOs and the related reporting standards.

QUALITY OF CARE is the degree or grade of excellence with respect to medical services received by enrollees, administered by providers or programs, in terms of technical competence, need, appropriateness, acceptability, humanity, structure, etc.

RATE CATEGORY refers to the specific age/sex cell, or cohorts, that together make-up the total eligible population for this program. Capitation payments to health plans are made on a rate category-specific basis.

REINSURANCE refers to the program operated by the State of New York Department of Health through which MCOs may protect against part of the cost of providing inpatient hospital services to its members when such costs exceed pre-determined thresholds. Also referred to as "stop-loss".

RESOURCE CENTER is a site located in New York City and operated by the contracted Enrollment Counseling Firm that is designed to disseminate managed care information to Medicaid beneficiaries who are potential enrollees. The resource center may house some enrollment counseling staff, and may also provide health education and living skills programs and services to members on an ongoing basis.

RESTRICTED RECIPIENT PROGRAM (RRP) is an administrative mechanism whereby selected fee-for-service Medicaid recipients with a demonstrated pattern of abusive utilization of services must access medical care and services through one or more designated primary providers. A recipient is restricted if, upon review by the Office of Medicaid Management (OMM), it is found that the recipient has displayed a pattern of receiving excessive, duplicative, contraindicated or conflicting health care services or supplies, or if it is determined that the recipient has engaged in card loaning, using forged or altered prescriptions/fiscal orders, using multiple Medicaid identification cards or selling drugs obtained through the Medicaid program.

SAFETY NET means New York's state funded public assistance program.

SINGLES/CHILDLESS COUPLES (S/CC) MEDICAID ELIGIBILITY GROUP includes single individuals and childless couples who are not certified blind or certified disabled and who are between the ages of 21 and 65.

SERIOUSLY AND PERSISTENTLY MENTALLY ILL (SPMI) OR SERIOUSLY EMOTIONALLY DISTURBED (SED) Individuals who utilize mental health services during a 12 month period, as follows, are identified as SPMI or SED: Ten or more service encounters, including inpatient hospital days related to a psychiatric diagnosis and/or visits to a mental health clinic, psychiatrist or psychologist; or one or more specialty mental health visits (e.g., psychiatric rehabilitation treatment program; day treatment; continuing day treatment; comprehensive case management; partial hospitalization; rehabilitation services provided to residents of OMH licensed community residences and family based treatment and mental health clinics for seriously emotionally disturbed children).

SPECIAL NEEDS PLANS refers to managed care networks established specifically to serve individuals who are HIV+ and individuals who are Seriously and Persistently Mentally Ill or Seriously Emotionally Disturbed. The State would contract with such networks under the authority of its Section 1115(a) waiver following the waiver's approval by HCFA.

STATE means New York State Department of Health, the single State agency for Medicaid.

STATE PLAN means the comprehensive written statement submitted to HCFA by each state Medicaid agency describing the nature and scope of its Medicaid program. Also referred to as State Medicaid Plan.

STOP-LOSS means a provision used to limit a Contractor's financial liability for an enrollee whose need for certain services from the Contractor exceeds a pre-established level on an annual basis. Also known as reinsurance.

SUB-CONTRACT means any agreement entered into by a plan for any services necessary to meet the requirements of their original contract. A "subcontractor" is one who agrees to perform part of a contract for the principal contractor or another subcontractor.

SUBSPECIALIST means a physician qualified in a particular branch of medicine or surgery, including one who, by virtue of advanced training, is certified by a specialty board as being qualified to so practice.

TANF means the Temporary Assistance for Needy Families the federal public assistance program.

URGENT MEDICAL CONDITION means a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that **a** prudent layperson, who possesses an average knowledge of medicine and health, could reasonably expect the absence of medical attention within twenty-four (24) hours to result in: 1) placing the person's health in serious jeopardy; or 2) serious impairment to bodily functions; or 3) serious dysfunction of any bodily organ or part.

UTILIZATION means the rate patterns of service usage or types of service occurring within a specified time. Utilization is generally expressed in rates per unit of population-at-risk for a given period; e.g., the number of admissions to a hospital per 1,000 persons enrolled in an HMO per year.

UTILIZATION REVIEW is the process of evaluating the necessity, appropriateness, and efficiency of the use of medical services, procedures, and facilities.

WELFARE MANAGEMENT SYSTEM (WMS) is the statewide automated file system used by the local districts to track eligibility and demographic information for public and medical assistance clients.

WRAPAROUND BENEFITS refers to the portion of the benefit package that is not included in health plan's capitation, but instead will be funded by the State on a fee-for-service basis.

ACRONYMS

1. **ADA** – Americans with Disabilities Act
2. **CLIA** – Clinical Laboratory Improvement Act
3. **CRCS** – Capitation Rate Calculation Sheet
4. **CSC** – Computer Sciences Corporation
5. **C/THP** – Child/Teen Health Plan
6. **CY** – Calendar Year
7. **D&TC** – Diagnostic & Treatment Center
8. **DUR** – Drug Utilization Review
9. **EMEVS** – Electronic Medicaid Eligibility Verification System
10. **EOP** – Explanation Of Payment
11. **EPSDT** – Early, Periodic, Screening, Diagnosis and Treatment
12. **EQRO** – External Quality Review Organization
13. **FA** – Fiscal Agent
14. **FDA** – Food and Drug Administration
15. **FFS** – Fee-For-Service
16. **FFY** – Federal Fiscal Year (October 1st – September 30th)
17. **FPL** – Federal Poverty Level
18. **FQHC** – Federally Qualified Health Center
19. **HCFA** – Health Care Financing Administration
20. **HEDIS** – Health Plan Employer Data and Information Set

21. **HHC** – Health and Hospitals Corporation

22. **HHS** – Health and Human Services

23. **HMO** – Health Maintenance Organization

24. **HRA -** Human Resources Administration (New York City Medical Assistance program local agency)

25. **IBNR** – Incurred But Not Reported

26. **IEP** – Individualized Education Plan

27. **IFSP** – Individualized Family Service Plan

28. **IPRO** – Island Peer Review Organization

29. **JCAHO** – Joint Commission on Accreditation of Healthcare Organization

30. **LDSS** – Local Department of Social Services

31. **MAO** – Medical Assistance Only

32. **MCO** – Managed Care Organization (HMOs and PHSPs)

33. **MEDS** – Medicaid Encounter Data System

34. **MMIS** – Medicaid Management Information System

35. **MOU** – Memorandum Of Understanding

36. **NCQA** – National Committee on Quality Assurance

37. **NPDB** – National Practitioner Data Bank

38. **OASAS** – Office of Alcohol and Substance Abuse Services

39. **OMC** – Office of Managed Care (New York State Department of Health)

40. **OMH** – Office of Mental Health

41 **OMMC** – Office of Medicaid Managed Care (New York City Mayor's office)

42. **OMRDD** – Office of Mental Retardation and Developmental Disabilities

43. **OPD** – Outpatient Department

44. **OTC** – Over The Counter

45. **PCCM** – Primary Care Case Management

46. **PCP** – Primary Care Provider

47. **PHSP** – Prepaid Health Service Plan

48. **PMPM** – Per Member, Per Month

49. **QARR** – Quality Assurance Reporting Requirements

50. **RBUC** – Received But Unpaid Claims

51. **RFI** – Request For Information

52. **RFP** – Request For Proposals

53. **RHC** – Rural Health Clinic

54. **SDOH** – State Department Of Health

55. **SED** – Seriously Emotionally Disturbed

56 **SFY** – State Fiscal Year (in New York the fiscal year is April 1st – March 31st)

57 **SNP** – Special Needs Plan

58. **SOBRA** – Sixth Omnibus Budget Reconciliation Act (Poverty Level Eligibility)

59. **SPMI** – Seriously and Persistently Mentally Ill

60. **TPL** – Third-Party Liability

61. **UPL** – Upper Payment Limit

62. **WIC** – Women, Infants and Children Food Program (Special Supplemental Food Program)

63. **WMS** – Welfare Management System