

## DEFINITIONS AND ACRONYMS

*In order to ensure a clear understanding of the terms used through all documents pertaining to The Partnership Plan, the following definitions are offered:*

1. **Access** - a patient's ability to obtain medical care.
2. **Agency** - the New York Medicaid Agency.
3. **Ambulatory Care** - 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.
4. **Base Year** - the period of time from which data is extracted for purposes of calculating the PMPM cost for each Medicaid Eligibility Group (MEG).
5. **Benefit Package (Medicaid)** - refers to the services that MCOs will offer members, as well as services available to members on a fee-for-service "wrap-around" basis. The FHPlus benefit package consists solely of those services in the Contractor's approved benefit package - there are no services available outside the prepaid benefit package on a fee-for-service basis.
6. **Behavioral Health** - the assessment or treatment of mental and/or chemical dependency disorders.
7. **Capacity** - 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 MCO's financial and administrative capacity.
8. **Capitated Services** - those services that are covered by the MCO and for which the plan is at financial risk.
9. **Capitation Rate** - a fixed, per capita amount that an MCO is paid monthly without regard to the actual number or nature of services provided to each enrollee.
10. **Care Management** - refers to the responsibilities of the Primary Care Provider (PCP) in directing most care and services received by Medicaid/FHPlus enrollees.
11. **Case Management** - a model through 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. This responsibility includes identification of a health risk, diagnosis of disease and development of a treatment plan.
12. **Case Manager** - the person responsible for coordinating the enrollee's health care in conjunction with the PCP.

13. **Centers for Medicare and Medicaid Services (CMS)** - Medicaid's federal oversight agency, formerly the Health Care Financing Administration (HCFA).
14. **Clean Claim** - a claim that can be processed without obtaining additional information from the provider of the service or a third party.
15. **Comprehensive Primary Care Center (CPCC)** - 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.
16. **Computer Sciences Corporation (CSC)** - the New York State Medicaid fiscal agent.
17. **CSC Billing Policies & Procedures** - refers to those documents prepared by Medicaid's fiscal agent, CSC, for the purpose of instructing providers in appropriate claims filing procedures.
18. **Contracting Providers** - physicians, nurses, technicians, health centers, clinics, hospitals, home health agencies, nursing homes or any other individuals or institutions with which an MCO contracts for medical services.
19. **Contractor** - the Managed Care Organization (HMO, SNP or PHSP) or the Partial Capitation plan with which a local district or the State of New York has executed a contract to provide services to Medicaid and/or FHPlus beneficiaries.
20. **Court-Ordered Services** - those services that the contractor is required to provide to enrollees pursuant to orders of courts of competent jurisdiction, provided however, that such ordered services are within the contractor's benefit package and reimbursable under Title XIX of the Federal Social Security Act (SSA), SSL 364-j(4)(r).
21. **Days** - calendar days unless otherwise specified.
22. **Designated Third Party Contractor** - the provider who contracts with the SDOH to provide family planning and reproductive health services for FHPlus enrollees in plans whose benefit package excludes such services.
23. **Disenrollment** - a Medicaid Agency approved or sanctioned discontinuance of an enrollee's participation in a managed care plan.
24. **Early, Periodic, Screening, Diagnosis and Treatment (EPSDT)** - a specific program for Medicaid children. This program is known as the Child/Teen Health Plan (C/THP) in New York.
25. **Education and Outreach** - the activities that are designed to aid Medicaid/FHPlus 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.
26. **Effective Date of Disenrollment** means the date on which an Enrollee may no longer receive services from the Contractor's Plan.

27. ***EMedNY*** – the electronic Medicaid system of New York (eMedNY) is the name of the New York State Medicaid program’s claim processing system. The system allows New York Medicaid providers to submit claims and receive payments for Medicaid-covered services provided to eligible clients. eMedNY offers several innovative technical and architectural features, facilitating the adjudication and payment of claims and providing extensive support and convenience for its users. Computer Sciences Corporation (CSC) is the eMedNY contractor and is responsible for its operation.
28. ***Emergency Dental Condition*** - a dental condition requiring immediate treatment to control hemorrhage, relieve acute pain, eliminate acute infection, or avoid pulpal death or loss of teeth.
29. ***Emergency Medical Condition*** - 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 in the case of a pregnant woman, the health of the woman or her unborn child or, in the case of a behavioral condition, placing the health of such person or others in serious jeopardy; or 2) serious impairment to bodily functions; or 3) serious dysfunction of any bodily organ or part; or 4) serious disfigurement.
30. ***Emergency Services*** - means covered medical services that are required to treat an Emergency Medical Condition and include health care procedures, treatments or services, needed to evaluate or stabilize an Emergency Medical Condition including psychiatric stabilization and medical detoxification from drugs or alcohol.
31. ***Encounter*** - a record of a medically related service (or visit) rendered by a provider(s) to a beneficiary who is enrolled in a participating MCO during the period of coverage. It includes (but is not limited to) all services for which a Contractor has financial responsibility.
32. ***Enrollee*** - a Medicaid/FHPlus recipient who has been certified by the State as eligible to enroll with an MCO and who has signed an enrollment form to join the Managed Care plan offered by the Contractor, or who has been assigned by Medicaid to the Contractor’s Plan. May also be referred to as a member.
33. ***Enrollment and Benefits Counseling Firm*** - the State-contracted entity that provides enrollment and education and outreach services to eligible persons; effectuates enrollments and disenrollments in MMC and FHPlus; and provides other contracted services on behalf of the SDOH and the LDSS in accordance with the specifications outlined in Appendix 1.10. The Enrollment Counseling firm is also referenced as the “Enrollment Broker” or the “Enrollment Counselor”.
34. ***Enrollment Date*** - the date that an eligible’s coverage through a Contractor becomes effective. At the outset of The Partnership Plan, this date will always be the first day of a month.
35. ***Enrollment Facilitator*** - an entity (and its agents) under contract with SDOH that assists children and adults in the Medicaid, Family Health Plus, Child Health Plus, Prenatal Care Assistance Program (PCAP) and/or WIC application and enrollment process. This includes assisting potentially eligible family members and adults in completing the required application and renewal form, conducting

the face-to-face interview, assisting in the collection of required documentation, assisting in the health plan selection process and referring individuals to other appropriate services (e.g., PCAP and/or WIC).

36. ***Exclusions or Out-of-Plan Services*** - those Medicaid covered services that are not identified as capitated MCO services.
37. ***Facilitated Enrollment*** - the enrollment infrastructure established by SDOH to assist children and adults in applying for or renewing the Medicaid, Family Health Plus or Child Health Plus programs, the Prenatal Care Assistance Program and/or the Special Supplemental Food Program for Women, Infants and Children (WIC), using a joint application.
38. ***Family*** - refers to a mother and child(ren), a father and child(ren), a father and mother and child(ren), a husband and wife residing in the same household or persons included in the same case.
39. ***Family Health Plus or FHPlus*** - the program established under Title 11-D, ' 369-ee of the Social Services Law to expand medical assistance to low income adults age 19 - 64.
40. ***Fee-for-Service*** - a method of Medicaid reimbursement that is payment to providers for services rendered to Medicaid recipients subsequent to, and specifically for, the rendering of those services.
41. ***Guaranteed Eligibility Period*** - 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/FHPlus services.
42. ***Health Care Financing Administration (HCFA)*** - Medicaid's federal oversight agency, now CMS (Centers for Medicare and Medicaid Services).
43. ***Health Maintenance Organization (HMO)*** - any organization or entity that is licensed as a health maintenance organization by the State of New York's Department of Health or a corporation licensed pursuant to the State Insurance Law.
44. ***Implementation Date*** - the 1<sup>st</sup> of the month in which the first Medicaid beneficiary is enrolled in a managed care plan on a mandatory basis in a specific local district under The Partnership Plan.
45. ***Initial Enrollment Period*** – the one year period of time during which the Enrollee may not disenroll from the Contractor's MCO and enroll in a different FHPlus MCO, except during the initial 90 days, or unless the Enrollee can demonstrate good cause as defined by the State Department of Health.
46. ***Inpatient Stay Pending Alternate Level of Medical Care*** – continued care in a hospital pending placement in an alternate lower medical level of care, consistent with the provisions of 18 NYCRR § 505.20 and 10 NYCRR Part 85.
47. ***Institution for Mental Disease*** - this term, as used, is in accordance with the federal definition which is as follows: a hospital, nursing facility or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services.

48. ***Integrated Delivery System (IDS)*** - a not-for-profit corporation or a business corporation, other than a corporation established pursuant to Article 28 of the Public Health Law, which contracts with physicians and other providers of medical or medically related services in order that it may then contract with one or more managed care organizations to make the services of such providers available to the enrollees of the managed care organization. As of April 1, 2002, IDSs are no longer allowed under State law.
49. ***Lead Agency*** - an entity and its agents, under contract with the SDOH, which provides training, support and technical assistance to community-based enrollment facilitators. The lead agency provides supervision and quality control by reviewing applications for Medicaid, FHPlus, CHPlus, Prenatal Care Assistance Program (PCAP) and/or WIC prior to submission to health plans or the local social services districts (LDSSs), and acts as the interface between the community-based enrollment facilitators and the health plan or the LDSSs.
50. ***Lock-in Period*** - the period following the ninety (90) day grace period after the enrollment effective date and continuing for nine (9) months thereafter, during which the enrollee may not disenroll from his/her health plan unless the Enrollee becomes eligible for an exclusion or an exemption or can demonstrate good cause as established in State law and in 18 NYCRR §360-10.13.
51. ***Managed Care Organization (MCO)*** - an appropriately certified and/or licensed HMO, Special Needs Plan (SNP), partial capitation plan or Prepaid Health Services Plan (PHSP) in the State of New York or a corporation licensed pursuant to the State Insurance Law.
52. ***Marketing*** - any activity of an MCO by which information about the health plan is made known to eligible persons for purposes of persuading them to enroll with the plan.
53. ***Medicaid (Title XIX)*** - the medical assistance program authorized by Title XIX of the Social Security Act, which is jointly administered by the federal government and New York State.
54. ***Medicaid Advantage*** – means the program that New York State developed to enroll those persons who are Dually Eligible (Medicare/Medicaid eligible) and meet eligibility criteria in a Medicaid Advantage MCO.
55. ***Medicaid Beneficiary*** - any individual in receipt of benefits under the approved New York State Plan for Medical Assistance (hereinafter referred to as the State Plan) and may also be referred to as an “eligible” or a “recipient”.
56. ***Medicaid Eligibility Verification System (MEVS)*** - the State’s medical assistance automated eligibility verification system, formerly EMEVS (Electronic Medicaid Eligibility Verification System)
57. ***Medically Necessary*** – 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.
58. ***Medical Home*** - 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.

59. **Medical Record** - a single complete record kept at the site of the enrollee's primary care provider that documents all of the treatment plans developed and medical services received by the enrollee.
60. **Member** - a Medicaid/FHPlus 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. May also be referred to as an "enrollee".
61. **Member Services Representative** - 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.
62. **Non-consensual Enrollment** - enrollment of an eligible person, other than through auto-assignment, newborn enrollment or case addition, in a managed care plan without the consent of the eligible person or a person with the legal authority to act on behalf of the eligible person at the time of enrollment.
63. **Non-participating Provider** - a physician or other provider who has not contracted with or is not employed by the MCO to deliver services to its members. Used interchangeably with "non-network" or "out-of-network" provider.
64. **Non-physician Provider** - medical practitioners other than Medical Doctors and Doctors of Osteopathy - including physician assistants, certified nurse practitioners and certified midwives - who are able to furnish services to Title XIX enrollees as part of their scope of practice.
65. **Out-of-Network Provider** - a provider that does not have an agreement with the Contractor to provide services to Medicaid enrollees through participation in the MCO's network.
66. **Outpatient Care** - 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).
67. **Partial Capitation Plan** - a plan authorized by the State of New York's Department of Health to enroll and serve Medicaid beneficiaries on a fee-for-service or limited risk basis, and assume responsibility for the care of the individuals, including making referrals for specialty care.
68. **Participating Provider** - any individual provider, institution or other entity who participates in a managed care plan or who has a contract with the managed care plan.
69. **Permanent Placement Status** - means the status of an individual in a Residential Health Care Facility (RHCF) when the LDSS determines that the individual is not expected to return home based on medical evidence affirming the individual's need for permanent RHCF placement.
70. **Per Member Per Month (PMPM)** - the unit of measure for each member for each month the member was enrolled in a participating health plan.

71. **Post-Stabilization Care Services** – covered services, related to an Emergency Medical Condition, which are provided after an enrollee is stabilized in order to maintain the stabilized condition, or to improve or resolve the enrollee’s condition.
72. **Plan** - an MCO participating in The Partnership Plan. Also referred to as a Health Plan.
73. **Plan Benefits** - those services described in Chapter 4 of this Protocol which, through the execution of a contract with a local district or the State, the Contractor has agreed to provide to Medicaid enrollees.
74. **Prepaid Health Services Plan (PHSP)** - any organization or entity licensed by the State of New York’s Health Department to provide comprehensive services to Medicaid beneficiaries on an at-risk, capitated basis.
75. **Preventive Care** - the treatment to avert disease/illness and/or its consequences. Three levels of preventive care are specified:
- 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.
76. **Primary Care** - the basic level of health care usually rendered by general and family practitioners, internists, obstetricians, pediatricians and certain non-physician providers. This type of care emphasizes providing 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.
77. **Primary Care Provider (PCP)** - the provider selected by or assigned to the MCO enrollee from the Contractor’s list of participating PCPs to provide and coordinate all of the enrollee’s health care needs and to initiate referrals for specialized services when required. PCPs are generally Family Practitioners, General Practitioners, Pediatricians, Internists and Nurse Practitioners. MCOs, at their option, may permit OB/GYN providers to serve as PCPs, subject to SDOH qualifications. PCPs may also be referred to as a client’s “personal doctor” or “personal provider”.
78. **Quality Assurance** - refers to the process of assuring that the delivery of health care is appropriate, timely, accessible, available and medically necessary.
79. **Quality Assurance Reporting Requirements (QARR)** - defines the quality measures for MCOs and the related reporting standards (see Appendix 20.3).
80. **Quality of Care** - the degree or grade of excellence with respect to medical services received by enrollees or administered by providers or programs, in terms of technical competence, need, appropriateness, acceptability, humanity and structure.

81. **Rate Category** - refers to the specific age/sex cells or cohorts that together make up the total eligible population for this program. Capitation payments to MCOs are made on a rate category-specific basis.
82. **Reinsurance** - 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, except that there is no SDOH-operated program for FHPlus plans. FHPlus plans must purchase reinsurance coverage from a private reinsurer unless they can demonstrate that they are able to self-insure or they have comparable and satisfactory (in the State's judgment) coverage from another source.
83. **Residential Health Care Facility (RHCF) Services** –means a full range of inpatient Medicaid Residential Health Care Facility (RHCF) Services, provided by facilities licensed under New York State Public Health Law, including AIDS nursing facilities, which a Medicaid managed care organization (MCO) is required to provide, except for individuals in permanent placement, including the following health care services: medical supervision, 24-hour per day nursing care, assistance with the activities of daily living, physical therapy, occupational therapy, speech-language pathology services and other services such as MCO-authorized respite days and bed hold days. There is no limit to the number of medically necessary days that an MCO may authorize and provide as long as the recipient's stay is classified as a rehabilitative stay and meets the requirements for covered RHCF services as defined in Appendix K of the MMC/FHPlus Model Contract. Available at [http://www.nyhealth.gov/health\\_care/managed\\_care\\_and\\_family\\_health\\_plus\\_model\\_contract.pdf](http://www.nyhealth.gov/health_care/managed_care_and_family_health_plus_model_contract.pdf). However, the MCO's financial liability is limited by a 60-day calendar year stop loss.
84. **Resource Center** - 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.
85. **Restricted Recipient Program (RRP)** - 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 Health Insurance Programs (OHIP), 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.
86. **Special Needs Plans (SNPs)** - refers to Medicaid managed care networks established specifically to serve individuals who are HIV+. The State contracts with such networks under the authority of its Section 1115 waiver with the approval of CMS.
87. **Specialist** - 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.
88. **State** - Generally, New York State Department of Health, the single State agency for Medicaid.

89. **Stop-loss** - a provision used to limit a Medicaid managed care contractor's financial liability for an enrollee whose need for certain services from the contractor exceeds a pre-established level on an annual basis. Stop-loss does not apply to FHPlus.
90. **“Supplemental Maternity Capitation Payment”** - means the fixed amount paid to the Contractor for the prenatal and postpartum physician care and hospital or birthing center delivery costs, limited to those cases in which the plan has paid the hospital or birthing center for the maternity stay, and can produce evidence of such payment.
91. **“Supplemental Newborn Capitation Payment”** - means the fixed amount paid to the Contractor for the inpatient birthing costs for a newborn enrolled in the plan, limited to those cases in which the plan has paid the hospital or birthing center for the newborn stay, and can produce evidence of such payment.
92. **Transitional Home Health Services Pending Placement of Personal Care (Home Attendant) Services -- in NYC Only - New Benefit as of 10/01/05** – Home health services provided by a certified home health agency to a Medicaid managed care enrollee for up to a thirty (30) day period while the NYC Human Resources Administration (HRA) completes the assessment and placement process for a personal care services aide (home attendant). Authorization and approval of the Medicaid managed care plan are required, and these services may be limited to plan network providers. Other criteria may apply. (See NYC Medicaid managed care contract amendment of 10/01/05 for details.)
93. **Urgently Needed Services** - means covered services that are not Emergency Services as defined in this section, provided when an Enrollee is temporarily absent from the Contractor's service area, when the services are medically necessary and immediately required: (1) as a result of an unforeseen illness, injury or condition; and (2) it was not reasonable given the circumstances to obtain the services through the Contractor's plan.
94. **Utilization Review** - the process of evaluating the medical necessity, appropriateness and efficiency of health care services.
95. **Welfare Management System (WMS)** - the statewide automated file system used by the local districts to track eligibility and demographic information for public and medical assistance clients.
96. **Wrap-around Benefits** - the portion of the Medicaid benefit package that is not included in the MCO's capitated services package, but instead are funded by the State through the fee-for-service program.

## ACRONYMS

1. **ADA** - Americans with Disabilities Act
2. **CLIA** - Clinical Laboratory Improvement Act
3. **CMS** - Centers for Medicare and Medicaid Services
4. **CRCS** - Capitation Rate Calculation Sheet
5. **CSC** - Computer Sciences Corporation
6. **C/THP** - Child/Teen Health Plan
7. **CY** - Calendar Year
8. **D&TC** - Diagnostic and Treatment Center
9. **DHCA** - Division of Health Care Access (New York City Mayor's Office)
10. **DUR** - Drug Utilization Review
11. **EMedNY** – Electronic Medicaid New York
12. **EOP** - Explanation of Payment
13. **EPSDT** - Early, Periodic Screening, Diagnosis and Treatment
14. **EQRO** - External Quality Review Organization
15. **FA** - Fiscal Agent
16. **FDA** - Food and Drug Administration
17. **FE** - Facilitated Enrollment
18. **FHP or FHPlus** - Family Health Plus
19. **FFS** - Fee-for-service
20. **FFY** - Federal Fiscal Year
21. **FPL** - Federal Poverty Level

22. **FQHC** - Federally Qualified Health Center
23. **F-SHRP** - Federal-State Health Reform Partnership
24. **HCFA** - Health Care Financing Administration, now CMS, Centers for Medicare and Medicaid Services
25. **HEDIS** - Health Plan Employer Data and Information Set
26. **HHC** - Health and Hospitals Corporation
27. **HHS** - Health and Human Services
28. **HMO** - Health Maintenance Organization
29. **HRA** - Human Resources Administration (New York City Medical Assistance program local agency)
30. **IBNR** - Incurred But Not Reported
31. **IDS** - Integrated Delivery System – as of April 1, 2002, IDSs are no longer allowed under State law
32. **IEP** - Individualized Education Plan
33. **IFSP** - Individualized Family Service Plan
34. **IMD – Institution for Mental Disease**
35. **IPRO** - Island Peer Review Organization
36. **JCAHO** - Joint Commission on Accreditation of Healthcare Organizations
37. **LDSS** - Local Department of Social Services
38. **MAO** - Medical Assistance Only
39. **MCO** - Managed Care Organization
40. **MEDS** - Medicaid Encounter Data System
41. **MEVS** – Medicaid Eligibility Verification System, formerly **EMEVS** - Electronic Medicaid Eligibility Verification System
42. **MMIS** - Medicaid Management Information System

43. **MOU** - Memorandum of Understanding
44. **NCQA** - National Committee on Quality Assurance
45. **NPDB** - National Practitioner Data Bank
46. **OASAS** - Office of Alcohol and Substance Abuse Services
47. **OMC** - Office of Managed Care, now Division of Managed Care and Program Evaluation (New York State Department of Health)
48. **OMH** - Office of Mental Health
49. **OMMC** - Office of Medicaid Managed Care (New York City Mayor' s Office)
50. **OMRDD** - Office of Mental Retardation and Developmental Disabilities
51. **OPD** - Outpatient Department
52. **OTC** - Over the Counter
53. **PCCM** - Primary Care Case Management
54. **PCP** - Primary Care Provider
55. **PHSP** - Prepaid Health Services Plan
56. **PMPM** - Per Member Per Month
57. **QARR** - Quality Assurance Reporting Requirements
58. **RBUC** - Received But Unpaid Claims
59. **RFI** - Request for Information
60. **RFP** - Request for Proposals
61. **RHC** - Rural Health Clinic
62. **RHCF** – Residential Health Care Facility
63. **SDOH** - State Department of Health
64. **SDSS** - State Department of Social Services
65. **SED** - Seriously Emotionally Disturbed

66. **SFY** - State Fiscal Year
67. **SNP** - Special Needs Plan
68. **SOBRA** - Sixth Omnibus Budget Reconciliation Act (Poverty Level Eligibility)
69. **SPMI** - Seriously and Persistently Mentally Ill
70. **TPL** - Third-Party Liability
71. **UPL** - Upper Payment Limit
72. **WIC** - Women, Infants and Children's Food Program (Special Supplemental Food Program)
73. **WMS** - Welfare Management System