

Definitions Used in Managed Care

Adult Day Health Care (ADHC) means an organized day program of therapeutic, social and health activities and services provided to persons 55 years or older or other adults with functional impairments, either physical or mental, for the purpose of restoring or maintaining optimal capacity for self-care as set forth in Title 22, Section 78007 of the California Code of Regulations.

Adult Day Health Care (ADHC) Center means a facility licensed to provide adult day health care, or a distinct portion of a licensed health facility in which such care is provided in a specialized unit, under a special permit issued by the Department pursuant to Title 22, Section 54105 of the California Code of Regulations.

Adult Expansion Member means a Member enrolled in aid codes L1, M1, and 7U as newly eligible and who meets the eligibility requirements in Title XIX of the federal Social Security Act, Section 1902(a)(10)(A)(i)(VIII), and the conditions as described in the federal Social Security Act, Section 1905(y). Expenditures for services provided to Adult Expansion Members qualify for the enhanced federal medical assistance percentage described in that section.

Advance Directives means a written instruction, such as a living will or durable power of attorney for health care, recognized under State law.

Affiliate means an organization or person that directly or indirectly through one or more intermediaries' controls, or is controlled by, or is under control with the Contractor and that provides services to, or receives services from, the Contractor.

Allied Health Personnel means specially trained, licensed, or credentialed health workers other than Physicians, podiatrists and Nurses.

Ambulatory Care means the type of health services that are provided on an outpatient basis.

Appeal means a request for review of one of the following actions:

- A. A denial or limited authorization of a requested service, including the type or level of service;
- B. A reduction, suspension, or termination of a previously authorized service;
- C. A denial, in whole or in part, of payment for a service;
- D. Failure to provide services in a timely manner; or
- E. Failure to act within the timeframes provided in 42 CFR 438.408(b)

Basic Case Management means a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs. Services are provided by the Primary Care Physician (PCP) or by a PCP-supervised.

Beneficiary Assignment means the act of Department of Health Care Services (DHCS) or DHCS' enrollment contractor of notifying a beneficiary in writing of the health plan in which the beneficiary shall be enrolled if the beneficiary fails to timely choose a health plan. If, at any time, the beneficiary notifies DHCS or DHCS' enrollment contractor of the beneficiary's health plan choice, such choice shall override the beneficiary assignment.

Beneficiary Identification Card (BIC) means a permanent plastic card issued by the State to Medi-Cal recipients that is used by Contractors and providers to verify Medi-Cal eligibility and health plan enrollment.

Definitions Used in Managed Care

California Children Services (CCS) means those services authorized by the CCS program for the diagnosis and treatment of the CCS eligible conditions of a specific Member.

California Children Services (CCS) Program means the public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of 21 years who have CCS eligible conditions.

Care Coordination means services which are included in Basic Case Management, Complex Case Management, Comprehensive Medical Case Management Services, Person Centered Planning and Discharge Planning, and are included as part of a functioning Medical Home.

Children with Special Health Care Needs (CSHCN) are defined as children who have or are at increased risk for chronic physical, behavioral, developmental, or emotional conditions, and who also require health care or related services of a type or amount beyond that required by children generally.

Claims and Eligibility Real-Time System (CERTS) means the mechanism for verifying a recipient's Medi-Cal or County Medical Services Program (CMSP) eligibility by computer.

Clean Claim means a claim that can be processed without obtaining additional information from the provider of the service or from a third party.

Community Based Adult Services (CBAS) means an outpatient, facility based service program that delivers skilled nursing care, social services, therapies, personal care, family/caregiver training and support, nutrition services, transportation, and other services.

Complex Case Management means the systematic coordination and assessment of care and services provided to Members who have experienced a critical event or diagnosis that requires the extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services. Complex Case Management includes Basic Case Management.

Comprehensive Medical Case Management Services means services provided by a Primary Care Provider, in collaboration with the Contractor, to ensure the coordination of Medically Necessary health care services, the provision of preventive services in accordance with established standards and periodicity schedules and the continuity of care for Medi-Cal enrollees. It includes health risk assessment, treatment planning, coordination, referral, follow-up, and monitoring of appropriate services and resources required to meet an individual's health care needs.

County Organized Health System (COHS) means a Medi-Cal Managed Care plan serving either a single or multiple-county area.

Covered Services means Medical Case Management and those services set forth in Title 22 CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301, and Title 17 CCR, Chapter 4, Subchapter 13, Article 4, beginning with Section 6840.

Credentialing means the recognition of professional or technical competence. The process involved may include registration, certification, licensure and professional association membership.

Department of Health Care Services (DHCS) means the single State Department responsible for administration of the federal Medicaid (referred to as Medi-Cal in California)

Definitions Used in Managed Care

Program, California Children Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP), and other health related programs.

Department of Managed Health Care (DMHC) means the State agency responsible for administering the Knox-Keene Health Care Service Plan Act of 1975.

Dietitian/Nutritionist means a person who is registered or eligible for registration as a Registered Dietitian by the Commission on Dietetic Registration (Business and Professions Code, Chapter 5.65, Sections 2585 and 2586).

Discharge Planning means planning that begins at the time of admission to a hospital or institution to ensure that necessary care, services and supports are in place in the community before individuals leave the hospital or institution in order to reduce readmission rates, improve Member and family preparation, enhance Member satisfaction, assure post-discharge follow-up, increase medication safety, and support safe transitions.

Eligible Beneficiary means any Medi-Cal beneficiary who is residing in the Contractor's Service Area with one of the following aid codes:

Aid Group	Mandatory Aid Codes	Non-Mandatory Aid Codes
Family	01, 02, 08, 30, 32, 33, 34, 35, 38, 39, 47, 54, 59, 72, 82, 0A, 3A, 3C, 3E, 3F, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 3W, 7A, 7W, 7X, 8P, 8R, E2, E5, K1, M3, M7, P5, P7, P9	03, 04, 06, 07, 40, 42, 43, 45, 46, 49, 4A, 4F, 4G, 4H, 4K, 4L, 4M, 4N, 4S, 4T, 4W, 5K, 7J
Disabled/Medi-Cal Only	20, 24, 26, 2E, 2H, 36, 60, 64, 66, 6A, 6C, 6E, 6G, 6H,	
Adult Expansion	L1, M1, 7U	
Aged/Medi-Cal Only	10, 14, 16, 1E, 1H	
Optional Targeted Low- Income Child	5C, 5D, H1, H2, H3, H4, H5, E7, M5, T1, T2, T3, T4, T5	
Adult		86
AIDS Beneficiary		
Breast and Cervical Cancer Treatment Program (BCCTP)		0N,0P, 0W
Disabled/Dual Eligible		20, 24, 26, 2E, 36, 60, 64, 66, 6A, 6C, 6E, 6G, 6H, 6J, 6N, 6P, 6V
Aged/Dual Eligible		10, 14, 16, 1E, 1H, 2H

Definitions Used in Managed Care

An Eligible Beneficiary may continue to be a Member following any redetermination of Medi-Cal eligibility that determines that the individual is eligible for, and the individual thereafter enrolls in, the BCCTP.

The following exclusions apply to all the above:

- A. Individuals who have been approved by the Medi-Cal Field Office or the California Children Services Program for any major organ transplant that is a Medi-Cal FFS benefit except kidney transplants.
- B. Individuals determined by the Medi-Cal Field Office to be in need of long term care and residing in a Skilled Nursing Facility for 30 calendar days past the month of admission.
- C. Individuals who have commercial or Medicare HMO coverage, unless the Medicare HMO is a provider under this Contract and DHCS has agreed, as a term of the HMO's contract, that these individuals may be enrolled. Individuals with Medicare FFS coverage are not excluded from enrolling under this Contract.

Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention could reasonably be expected to result in any of the following:

- A. Placing the patient's health (or in the case of pregnant woman, the health of the woman or unborn child) in serious jeopardy.
- B. Serious impairment to bodily function.
- C. Serious dysfunction of any bodily organ or part.

Emergency Services means inpatient and outpatient covered services that are furnished by a provider that is qualified to furnish those health services needed to evaluate or stabilize an Emergency Medical Condition.

Encounter means any single medically related service rendered by a medical provider(s) to a Member enrolled in the health plan during the date of service. It includes, but is not limited to, all services for which the Contractor incurred any financial liability.

Encounter Data means the administrative information that describes health care interactions between patients and providers.

Enhanced Case Management (ECM) means a service for Members who received ADHC services from July 1, 2011 through February 29, 2012 but were deemed ineligible for CBAS, consisting of Complex Case Management and Person-Centered Planning services including the coordination of eligible Medi-Cal beneficiaries' individual needs for the full array of necessary long-term services and supports including medical, social, educational, and other services, whether covered or not under the Medicaid program, and periodic in-person consultation with the Member and/or the Member's designees.

Enrollment means the process by which an Eligible Beneficiary becomes a Member of the Contractor's plan.

Definitions Used in Managed Care

External Accountability Set (EAS) means a set of HEDIS® and DHCS-developed performance measures selected by DHCS for evaluation of health plan performance.

External Quality Review Organization (EQRO) means a Peer Review Organization (PRO), PRO-like entity, or accrediting body that is an expert in the scientific review of the quality of health care provided to Medicaid beneficiaries in a State's Medicaid managed care plans.

Federal Financial Participation (FFP) means federal expenditures provided to match proper State expenditures made under approved State Medicaid plans.

Federally Qualified Health Center (FQHC) means an entity defined in Section 1905 of the Social Security Act. (42 USC 1396d (l)(2)(B).)

Fee-For-Service (FFS) means a method of payment based upon per unit or per procedure billing for services rendered to an Eligible Beneficiary.

Fee-For-Service Medi-Cal means the component of the Medi-Cal Program which Medi-Cal providers are paid directly by the State for services not covered under this Contract.

Fee-For-Service Medi-Cal Mental Health Services (FFS/MC) means the services covered through Fee-For-Service Medi-Cal which includes mental health outpatient services and acute care inpatient services.

Grievance means an oral or written expression of dissatisfaction, including any complaint, dispute, request for reconsideration, or appeal made by a Member. In the case of a Grievance that constitutes an "appeal" under 42 CFR 438.400(b), the provider must have the Member's written consent before filing the Grievance on behalf of the Member.

Health Maintenance Organization (HMO) means an organization that, through a coordinated system of health care, provides or assures the delivery of an agreed upon set of comprehensive health maintenance and treatment services for an enrolled group of persons through a predetermined periodic fixed prepayment.

Health Plan Employer Data and Information Set (HEDIS®) means the set of standardized performance measures sponsored and maintained by the National Committee for Quality Assurance.

Individualized Plan of Care (IPC) means a written plan designed to provide the Member determined to be eligible for CBAS with appropriate treatment in accordance with the assessed needs of the Member.

Intermediate Care Facility (ICF) means a Facility which is licensed as an ICF by DHCS or a hospital or Skilled Nursing Facility which meets the standards specified in 22 CCR 51212 and has been certified by DHCS for participation in the Medi-Cal program.

Independent Provider Association or Independent Practice Association (IPA) means a network of physicians in a region or community—solo practitioners and groups of physicians—who agree to participate in an association to contract with health maintenance organizations, other managed care plans, and also vendors for the benefit of the each of the physicians in the IPA. The IPA physicians do not combine their individual practices. Instead, the IPA physicians retain their practices and work out of their own offices. Participating Provider Group (PPG) is a term used interchangeably with IPA.

Knox-Keene Health Care Service Plan Act of 1975 means the law that regulates HMOs and is administrated by the DMHC, commencing with Section 1340, Health and Safety Code.

Definitions Used in Managed Care

Laboratory Testing Site means any laboratory and any provider site, such as a PCP or specialist office or clinic, that performs tests or examinations on human biological specimens derived from the human body.

Medi-Cal Eligibility Data System (MEDS) means the automated eligibility information processing system operated by the State which provides on-line access for recipient information, update of recipient eligibility data and on-line printing of immediate need beneficiary identification cards.

Medical Home means a place where a Member's medical information is maintained and care is accessible, continuous, comprehensive and culturally competent. A Medical Home shall include at a minimum: a Primary Care Physician (PCP) who provides continuous and comprehensive care; a physician-directed medical practice where the PCP leads a team of individuals who collectively take responsibility for the ongoing care of a Member; whole person orientation where the PCP is responsible for providing all of the Member's health care needs or appropriately coordinating care; optimization and accountability for quality and safety by the use of evidence-based medicine, decision support tools, and continuous quality improvement; ready access to assure timely preventive, acute and chronic illness treatment in the appropriate setting; and payment which is structured based on the value of the patient-centered medical home and to support case management, coordination of care, enhanced communication, access and quality measurement services. This definition can change to include all standards as set forth in W&I 14182(c) (13)(B).

Medically Necessary or **Medical Necessity** means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury.

When determining the Medical Necessity of Covered Services for a Medi-Cal beneficiary under the age of 21, "Medical Necessity" is expanded to include the standards set forth in 22 CCR 51340 and 51340.1.

Member means any Eligible Beneficiary who is enrolled with Contractor. For the purposes of this Contract, "Enrollee" shall have the same meaning as "Member".

Member Evaluation Tool (MET) means the information collected from a health information form completed by beneficiaries at the time of enrollment by which they may self-identify disabilities, acute and chronic health conditions, and transitional service needs. Contractor shall receive the MET from the enrollment broker with the enrollment file and shall use the MET for early identification of members' healthcare needs. For newly enrolled SPD beneficiaries Contractor must use the MET as part of the health risk assessment process.

Minimum Performance Level refers to a minimum requirement of performance of Contractor on each of the External Accountability Set measures.

Minor Consent Services means those Covered Services of a sensitive nature which minors do not need parental consent to access, related to:

- A. Sexual assault, including rape.
- B. Drug or alcohol abuse for children 12 years of age or older.
- C. Pregnancy.
- D. Family planning.

Definitions Used in Managed Care

- E. Sexually transmitted diseases (STDs), designated by the Director, in children 12 years of age or older.
- F. Outpatient mental health care for children 12 years of age or older who are mature enough to participate intelligently and where either (1) there is a danger of serious physical or mental harm to the minor or others or (2) the children are the alleged victims of incest or child abuse.

Non-Emergency Medical Transportation means ambulance, litter van and wheelchair van medical transportation services when the Member's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated, and transportation is required for the purpose of obtaining needed medical care, per Title 22 CCR Sections 51323, 51231.1, and 51231.2, rendered by licensed providers.

Non-Medical Transportation means transportation of Members to medical services by passenger car, taxicabs, or other forms of public or private conveyances provided by persons **not** registered as Medi-Cal providers. Does not include the transportation of sick, injured, invalid, convalescent, infirm, or otherwise incapacitated Members by ambulances, litter vans, or wheelchair vans licensed, operated and equipped in accordance with State and local statutes, ordinances or regulations.

Non-Physician Medical Practitioners (Mid-Level Practitioner) means a nurse practitioner, certified nurse midwife, or physician assistant authorized to provide Primary Care under Physician supervision.

Nurse means a person licensed by the California Board of Nursing as, at least, a Registered Nurse (RN).

Optional Targeted Low-Income Child (OTLIC) means a Member whose eligibility determination for Medi-Cal places them in aid codes 5C or 5D, or whose Medi-Cal eligibility places them in aid codes H1, H2, H3, H4, H5, E7, M5, T1, T2, T3, T4, T5, in accordance with Welfare and Institutions Code Sections 14005.26 and 14005.27.

Other Healthcare Coverage (OHC) means coverage for health related services or entitlements for which an Eligible Beneficiary is eligible under private health plan, any indemnification insurance program, any other State or federal medical care program, or under other contractual or legal entitlement. The responsibility of an individual or entity, other than Contractor or the Member, for the payment of the reasonable value of all or part of the healthcare benefits provided to a Member. This responsibility may result from a health insurance policy or other contractual agreement or legal obligation, excluding tort liability.

Outpatient Care means treatment provided to a Member who is not confined in a health care Facility.

Outpatient Mental Health Services means outpatient services that Contractor will provide for Members with mild to moderate mental health conditions including: individual or group mental health evaluation and treatment (psychotherapy); psychological testing when clinically indicated to evaluate a mental health condition; psychiatric consultation for medication management; and outpatient laboratory, supplies, and supplements.

Person Centered Planning means an ongoing process designed to develop an individualized care plan specific to each person's abilities and preferences. Person centered planning is an integral part of Basic and Complex Care Management and Discharge Planning

Definitions Used in Managed Care

Physician means a person duly licensed as a Physician by the Medical Board of California.

Post-stabilization Services means Covered Services that are provided after a Member is stabilized following an Emergency Medical Condition in order to maintain the stabilized condition or, under the circumstances described in 42 CFR 438.114(e) to improve or resolve the Member's condition.

Preventive Care means health care designed to prevent disease and/or its consequences.

Primary Care means a basic level of health care usually rendered in ambulatory settings by general practitioners, family practitioners, internists, obstetricians, pediatricians, and mid-level practitioners. This type of care emphasizes caring for the Member's general health needs as opposed to specialists focusing on specific needs.

Primary Care Physician (PCP) means a Physician responsible for supervising, coordinating, and providing initial and Primary Care to patients and serves as the Medical Home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, or obstetrician/gynecologist (OB/GYN). For SPD beneficiaries, a PCP may also be a specialist or clinic in accordance with W & I Code 14182 (b) (11).

Primary Care Provider means a person responsible for supervising, coordinating, and providing initial and Primary Care to patients; for initiating referrals; and, for maintaining the continuity of patient care. A Primary Care Provider may be a Primary Care Physician (PCP) or Non-Physician Medical Practitioner.

Prior Authorization means a formal process requiring a health care provider to obtain advance approval to provide specific services or procedures.

Provider Grievance means an oral or written expression of dissatisfaction about any matter other than an action (as identified within the definition of Appeal)

Quality Improvement (QI) means the result of an effective Quality Improvement System.

Quality Improvement Projects (QIPs) means studies selected by Medi-Cal Managed Care Plans, either independently or in collaboration with DHCS and other participating health plans, to be used for quality improvement purposes. The studies include four phases and may occur within a 24-month time frame.

Quality Improvement System (QIS) means the systematic activities to monitor and evaluate the medical care delivered to Members according to the standards set forth in regulations and Contract language. Contractor must have processes in place, which measure the effectiveness of care, identify problems, and implement improvement on a continuing basis.

Quality of Care means the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.

Quality Indicators means measurable variables relating to a specific clinic or health services delivery area which are reviewed over a period of time to screen delivered health care and to monitor the process or outcome of care delivered in that clinical area.

Safety-Net Provider means a provider of comprehensive primary care and/or acute hospital inpatient services that provides these services to a significant total number of Medi-Cal and charity and/or medically indigent patients in relation to the total number of patients served by the provider. Examples of safety net providers include Federally Qualified Health Centers;

Definitions Used in Managed Care

governmentally operated health systems; community health centers; rural and Indian Health Service Facilities; disproportionate share hospitals; and, public, university, rural, and children's hospitals.

Screening, Brief Intervention, and Referral to Treatment (SBIRT) means services provided by a primary care physician to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol.

Seniors and Persons with Disabilities (SPD) means Medi-Cal beneficiaries who fall under specific Aged and Disabled aid codes as defined by the department (See Eligible Beneficiary).

Sensitive Services means those services related to:

- A. Family Planning
- B. Sexually Transmitted Disease (STD)
- C. Human Immunodeficiency Virus testing

Service Area means the county or counties that the Contractor is approved to operate in under the terms of this Contract. A Service Area may have designated ZIP Codes (under the U.S. Postal Service) within a county that are approved by DHCS to operate under the terms of this Contract.

Service Location means any location at which a Member obtains any health care service provided by the Contractor under the terms of this Contract.

Skilled Nursing Facility (SNF) means, as defined in 22 CCR 51121(a), any institution, place, building, or agency which is licensed as a SNF by DHCS or is a distinct part or unit of a hospital, meets the standard specified in Section 51215 of these regulations (except that the distinct part of a hospital does not need to be licensed as a SNF) and has been certified by DHCS for participation as a SNF in the Medi-Cal program. Section 51121(b) further defines the term "Skilled Nursing Facility" as including terms "skilled nursing home", "convalescent hospital", "nursing home", or "nursing Facility".

Specialty Mental Health Provider means a person or entity who is licensed, certified or otherwise recognized or authorized under State law governing the healing arts to provide Specialty Mental Health Services and who meets the standards for participation in the Medi-Cal program.

Specialty Mental Health Service means:

- A. Rehabilitative services, which includes mental health services, medication support services, day treatment intensive, day rehabilitation, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential services, and psychiatric health facility services.
- B. Psychiatric inpatient hospital services. Targeted Case Management.
- C. Psychiatrist services. Psychologist services.
- D. EPSDT supplemental specialty mental health services.

Standing Referral means a referral by a Primary Care Physician to a specialist for more than one visit to the specialist, as indicated in the treatment plan, if any, without the primary care physician having to provide a specific referral for each visit.

Definitions Used in Managed Care

Subacute Care means, as defined in 22 CCR 51124.5, a level of care needed by a patient who does not require hospital acute care but who requires more intensive licensed skilled nursing care than is provided to the majority of patients in a SNF.

Subcontract means a written agreement entered into by the Contractor with any of the following:

- A. A provider of health care services who agrees to furnish Covered Services to Members.
- B. Any other organization or person(s) who agree(s) to perform any administrative function or service for the Contractor specifically related to fulfilling the Contractor's obligations to DHCS under the terms of this Contract.

Supplemental Security Income (SSI) means the program authorized by Title XVI of the Social Security Act for aged, blind, and disabled persons.

Targeted Case Management (TCM) means services which assist Medi-Cal Members within specified target groups to gain access to needed medical, social, educational and other services. In prescribed circumstances, TCM is available as a Medi-Cal benefit as a discrete service, as well as through State or local government entities and their contractors.

Telehealth means a method of delivering health care services by using information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a Member's health care while the Member is at a separate location from the health care provider. Telehealth facilitates the Member's self-management and caregiver support for the Member.

Traditional Provider means any physician who has delivered services to Medi-Cal beneficiaries within the last six months either through Medi-Cal FFS or a Medi-Cal Managed Care plan. The term includes physician and hospital providers only, either profit or non-profit entities, publicly or non-publicly owned and operated.

Urgent Care means services required to prevent serious deterioration of health following the onset of an unforeseen condition or injury (i.e., sore throats, fever, minor lacerations, and some broken bones).

Utilization Review means the process of evaluating the necessity, appropriateness, and efficiency of the use of medical services, procedures and Facilities.

Definitions Source: GMC Boilerplate Contract

Note: This list is not exhaustive.