HealthChoices Definitions

Access - The availability of appropriate services to people who need them in a manner that facilitates their use. Access is more than having insurance coverage or the ability to pay for services. It is also determined by the availability of services, acceptability of services, cultural appropriateness, location, hours of operation, transportation and cost.

Accountability Requirements -A system of criteria, procedures, and indicators through which the process of care and the achievement of outcomes by a service provider or network are monitored; ideally involves a specific arrangement that ties continued funding to results and holds service providers/system responsible for the quality of their services.

Accountable - Service providers are accountable to the users of the services. Consumers and their families are involved in planning, implementing, monitoring, and evaluating services.

Accreditation – An official decision made by a recognized organization that a health care plan, network, or other delivery system complies with applicable standards.

Actuarial Analysis - Examination of the pattern of service utilization and need across specific consumer cohorts over a specified period of time.

Actuary – A person who determines insurance policy rates, reserves and dividends, as well as conducts various other statistical studies.

Adjudicate – A determination to pay or reject a claim.

Admission Certification – A form of utilization review in which assessment is made of the medical necessity of a patient's admission to a hospital or other inpatient institution to ensure that such care is needed. Lengths of stay appropriate for the patient's diagnosis are usually assigned, and payment by any program requiring certification is assured. Certification can be done before admission (pre-admission) or shortly after (concurrent).

Administrative Costs – Expenses incurred to provide administrative services required by a health plan such as claims processing, billing, enrollment, and other overhead costs.

Administrative Services Only Contract – A contract between an insurance company and a self funded plan where the insurance company performs administrative services only and assumes only administrative risk. The services can include claims processing, utilization review, or actuarial analysis.

Administrative Services Only – A contractual agreement whereby an MCD provides only the administrative services required by a health plan or payer.

Adverse Selection – Occurs when an insurance product attracts members who are sicker than the general population. Excessively high rates and unusually generous benefit packages can cause adverse selection.

Advocacy – The process by which various stakeholders (consumers, families, providers, payers) make their perspectives known and affect the process of change.

AFDC – Aid to Families with Dependent Children. Former name of family support program, now called TANF (Temporary Assistance to Needy Families).

Affiliate – Any individual, corporation, partnership, joint venture, trust, unincorporated organization or association, or other similar organization (hereinafter "Person"), controlled by or under common control with a private sector BH-MCO, including a private sector BH-MCO subcontracting with a county, joinder, or other county grouping, or a private sector BH-MCO's parents(s), whether such common control be direct or indirect. Without limitation, all officers, or persons, holding five (5%) percent or more of the outstanding ownership interest of the private sector BH-MCO's or private sector BH-MCO's parent(s), directors and subsidiaries of the private sector BH-MCO, shall be presumed to be affiliates for purposes of this RFP. For purposes of this definition, "control" means the possession, directly or indirectly, of the power (whether or not exercised) to direct or cause the direction of the management or policies of a person, whether through the ownership of voting securities, other ownership interest, or by contract or otherwise, but not limited to the power to elect a majority of the directors of a corporation or trustees of a trust, as the case may be.

Agreement - The HealthChoices Behavioral Health Agreement.

Alliance – A group of providers who join together to increase their cost effectiveness by sharing resources and developing group purchasing arrangements.

Alternate Delivery Systems – Health services provided in other than an inpatient, acute-care hospital. Examples within general health services include skilled and intermediary nursing facilities, hospice programs, and home health care. Alternate delivery systems are designed to provide needed services in a more cost-effective manner. Most of the services provided by community mental health centers fall into this category.

Ambulatory Care Facility – A facility that provides healthcare services such as surgery on an outpatient basis, meaning an individual does not stay overnight. Most inpatient facilities such as hospitals also offer ambulatory services. Ambulatory is sometimes called outpatient.

Ancillary Services – Laboratory tests, X-rays, and all other hospital services other than room, board and nursing services are ancillary services.

Appeal – A request from a member for a reversal of a denial by the BH-MCO of authorization to provide service prescribed for the member by an in-plan, appropriately qualified practitioner.

Appropriateness - The degree of positive fit between a person's specific health care needs and available services. This is a term used to evaluate planned treatment protocols. Appropriateness of services may be determined by such factors as level of service needs and severity of illness; treatment options; cultural-match of clinician, organization, and client: motivation; and informed consents.

At-Risk Contracting – A contractual arrangement between a payer and service provider that: (1) assigns prospective and pre-set funding, generally on an annual basis; (2) makes continued funding contingent on performance; (3) involves a risk and reward sharing arrangement that transfers some or all of the utilization risk to the service provider; and (4) allows the service provider flexibility in the design of services, as long as outcomes are achieved.

Authorization – Approval for a specific service to be delivered to a member. It represents agreement that the service is clinically necessary under the VBH-PA Medical Criteria.

Average Length of Stay – The average number of days that an episode of care lasts; calculated by the total number of patient days or units of service incurred over a given period, divided by the total number of episodes.

Back-Filling – The process of restoring utilization of beds or placements in a residential facility after occupancy has been reduced and the freed-up resources reallocated. Example: Agency A reduces its use of the state hospital through funding obtained by decreased utilization, and Agency B back-fills the recently vacated beds with new admissions.

Behavioral Health Managed Care Organization (BH-MCO) - An entity, which manages the purchase and provision of Behavioral Health Services under this Agreement.

Behavioral Health Rehabilitation Services for Children and Adolescents (BHRS) (formerly EPSDT "Wraparound") – Treatment and therapeutic interventions prescribed by a psychologist or psychiatrist provided on an individual basis in the person's own environment such as the home, school and community. These services include Therapeutic Support Staff (TSS), Behavioral Specialist Consultants (BSC), Mobile Therapy (MT) and specialized services as approved.

Behavioral Health Residential Treatment Facility – An In-Plan services mental health or drug and alcohol residential treatment facility.

Behavioral Health Services – Services that are provided to Members to treat mental health and/or substance abuse diagnoses/disorders.

Behavioral Health (BH) Services Provider – A Provider, practitioner, or vendor/supplier who contracts with a BH-MCO to provide behavioral health services under the HealthChoices Behavioral Health Program.

Beneficiary – A person certified eligible to participate in the social insurance programs that do not use means tests, such as Medicare Part A and SSDI.

Bulletin – (Medical Assistance Bulletin) – a formal mailing to Medical Assistance providers to relay various information to them (change in MA policy, change in billing procedures, fee schedule changes, etc.)

Cancellation – Discontinuation of the contract for any reason prior to the expiration date.

Capitation – A fee the Department pays periodically to a Primary Contractor for each Member enrolled under an agreement for the provision of covered In-Plan Services, whether or not the Member received the services during the period covered by the fee.

Capitation Funding – A method of at-risk contracting between a payor and a provider that involves preset funding for the number of persons covered by the benefit plan. Payment of a provider or organization for services to a given population based on a fixed amount per person for a stated period of time rather than on the cost of actual services *rendered* (fee-for-service). The plan provides all covered services with additional costs to the enrollee. Health maintenance organizations typically use a capitation payment plan.

Care Management Supervisor – see Service Management/Manager.

Carve-Out – A payer strategy in which a payer separates ("carves-out") a portion of the benefit, such as behavioral health, and hires a managed behavioral health program or managed care organization to provide these benefits. This permits the payer to create a behavioral health benefits package, get to market quicker with such a package, and maintain greater control of their costs. Many HMOs and

insurance companies adopt this strategy because they do not have in-house expertise related to behavioral health or the service "carved-out."

Case Management – A process by which the services provided to a specific enrollee are coordinated and managed to achieve optimum outcome in the most cost-effective manner. Case management is a method of managing the provision of care to members with catastrophic or high cost medical conditions to improve the continuity and quality of care, while simultaneously decreasing the cost. Case managers are the nurses, physicians, and social workers employed by health plans and providers that coordinate the medical care of individuals that are enrolled in a health plan and/or admitted to a health care facility.

Case-Rate Funding – A method of at-risk contracting between a payor and provider that involves prospective and preset funding. The amount of funding is assigned on the basis of the number and type of enrolled persons who present for services.

CASSP – Child and Adolescent Service System Program: Involves activities that are designed to promote inter-departmental cooperation between agencies such as Children and youth Services, Juvenile Court, and Education; and to encourage parental participation in systems advocacy for children's programs.

Categorical Eligibility – In Medicaid, an indication that persons are certified eligible by class, or "category" rather than individually, when meeting the entry requirements and being enrolled in one program automatically qualifies the recipient for another program. SSDI beneficiaries are categorically eligible for Medicaid in most, but not all, states. Medicare beneficiaries with income below the poverty line and assets at twice the SSI threshold are categorically eligible for Medicaid.

Centralized Utilization Management – Utilization is managed prospectively and/or retrospectively for multiple service providers by a regionally centralized agency.

ChildLine – The statewide agency which receives reports or child abuse and neglect, and manages the Child Abuse Registry. The ChildLine number is 1-800-932-0313.

Children and Adolescents in Substitute Care – (CISC) Children and adolescents living outside their homes in the legal custody of a public agency, in any of the following settings: shelter homes, foster family homes, group homes, supervised independent living, residential treatment facilities, residential placement (other than youth development centers) for children and adolescents who have been adjudicated dependent or delinquent.

CHIP – Children Health Insurance Program. Designed by Pennsylvania in 1992 for children who do not qualify for other types of health insurance. CHIP is free, or low-cost, for uninsured children under age 19, and provides physical, behavioral, dental and vision care and medicine.

Claim – A request by an individual (or his or her provider) to an individual's insurance company to pay for services obtained from a healthcare professional.

Clean Claim – A claim that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in the Primary Contractor's claims processing computer system, and those originating from human errors. It does not include a claim under review for medical necessity, or a claim that is from a Provider who is under investigation by a governmental agency or the Primary Contractor or BH-MCO for fraud or abuse. However, if under investigation by the Primary contractor or BH-MCO, the Department must have prior notification of the investigation.

Client Information System (CIS) – The Department's automated file of Medical Assistance eligible recipients.

Co-Insurance – Coinsurance is a provision in a member's coverage that limits the amount of coverage provided by the plan to a certain percentage of charges. Managed care organizations use coinsurance to encourage members to use in-network services in point of service plans.

Community Rating – The practice of some prepayment plans whereby rates are calculated using a broad range of populations in a community or region. Result is that net rate of premiums for plan subscribers are reasonably uniform and not dependent on individual claim experience or the experience of any group. This is the rating methodology required of federally qualified HMOs and of HMOs under the laws of many states, and occasionally indemnity plans under certain circumstances. Under such a rating system, the HMO is permitted to factor in differences for age, sex, mix (average contract size), and industry factors; not all factors are necessarily allowed under state laws. By averaging costs of treatment over large populations, this method is probably fairest. Rates can be raised for plans serving low use beneficiaries such as young, healthy people. Rates can be lowered with adverse selection, those whose members may be older and more dependent upon receiving health care.

Community-Based Natural Supports – Services are offered in the least coercive manner and most natural setting possible. Consumers are encouraged to use the natural supports in the community and to integrate into the living, working, learning and leisure activities of the community.

Complaint – A dispute or objection filed with the BH-MCO regarding a participating health care provider or the coverage, operations or management policies of a BH-MCO, including, but not limited to, 1) a denial because the requested services is not a covered benefit; 2) failure of the BH-MCO to meet the required timeframes for providing a service; 3) failure of the BH-MCO to decide a complaint or grievance within the specified timeframes; 4) a denial of payment after a service(s) has been delivered because the service was provided without authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program; 5) a denial of payment after a service(s) has been delivered because the service is not a covered benefit. The term does not include a grievance.

Computer-Based Patient Record – A term for the process of replacing the traditional paper-based chart through automated electronic means; generally includes the collection of patient-specific information from various supplemental treatment systems, i.e. a day program and a personal care provider; its display in graphical format; and its storage for individual and aggregate purposes: Also called *Electronic Medical Record, On-Line Medical Record, Paperless Patient Chart*.

Concurrent Review – A review conducted by the BH-MCO during a course of treatment to determine whether services should continue as prescribed or should be terminated, changed or altered.

Consumer – A person who receives and/or purchases services; some differentiate a consumer from a customer in that a consumer also advocates for service quality and appropriateness, whereas "customer" refers to any person receiving and/or purchasing services.

Consumer Satisfaction – The subjective evaluation by a recipient of the services they received and/or the manner in which they were provided.

Consumer-Centered/Empowered - Services are organized to meet the needs of each consumer, rather than the needs of the managed care program or needs of service providers. Services incorporate consumer

self-help approaches and are provided in a manner that allows persons to retain the greatest possible control over their own lives.

Continued Stay Review - A review conducted by an internal or external auditor to determine if the current place of service is still the most appropriate to provide the level of care by the client.

Continuity of Care - Coordination of the range of services available to an individual consumer so that an optimal service mix is provided at all times without disruption; the concept can apply to the current service mix, the flow of services over time, the consistency of the consumer-provider relationship and the seamless transfer of a consumer between service levels or entities.

Continuous Quality Improvement - A management principle that emphasizes the ongoing improvement of the process of service delivery through the incorporation of empirically derived approaches and the institution of systems of internal monitoring, feedback, and organizational learning.

Continuum of Care – A series of service elements which may include provision of the following: non-hospital (residential) services, hospital services, partial hospitalization services, outpatient services and transitional living services.

Contract Risk - The risk that the obligations of a current contract could impact the ability to do business at a later date.

Coordinated - Services and supports are coordinated on both the local system level and on an individual consumer basis in order to reduce fragmentation and to improve efficiency and effectiveness with service delivery. Agencies must work in collaboration to meet the variety of needs that people with psychiatric disabilities have.

Co-Payment – The portion of a claim or medical expense that a member must pay out of pocket. For example, an HMO may require members to pay a $15 co-payment to visit a primary care physician. Health plans reimburse providers the allowable/negotiated charge less the patient's co-payments and deductibles.

Cost-Effectiveness – The degree to which a service accomplished its intended goal at an acceptable cost.

Cost-Sharing – The money paid by a patient for health services covered under his or her insurance plan over and above the premium share. It includes co-insurance, co-payments, and deductibles. Cost-sharing is a strategy used by insurance companies and employers to decrease premiums. It is also used as an incentive for people not to buy unneeded medical services.

Cost-Shifting – Charging higher prices for health services for people with "richer" insurance plans to compensate for being paid less by others. It results from large third-party payers (private and public) being able to negotiate discounts for people covered under their plans. Cost-shifting also results from the provision of services to the uninsured. Proponents of insurance coverage for everyone point out that society is already paying most of the health costs for the uninsured through cost-shifting.

County Assistance Office – The county offices of the Department which administer the Medical Assistance program at the local level. Department staff in this office performs necessary Medical Assistance functions such as determining recipient eligibility.

County Operated BH-MCO – An entity organized and directly operated by county government to manage the purchase and provision of behavioral health services under the HealthChoices Program as a Primary Contractor.

Credentialing – The process of obtaining and reviewing the documentation of professional providers. Such documentation includes licenser, certifications, and evidence of malpractice insurance, malpractice history, and so forth.

Crisis Intervention Services – Immediate response and intervention services available 24 hours per day, 7 days per week designed to ameliorate or resolve the precipitating stress of the crisis situation. Services are provided to adults, adolescents and children who exhibit an acute problem of disturbed thought, behavior, mood or social relationships. The service provides a rapid response to crisis situations that threaten the well-being of an individual or others. Services include intervention, assessment, counseling, screening and disposition by telephone and may include walk-in, mobile and crisis residential covered systems.

Cultural Competency – The understanding of the social, linguistic, ethnic, and behavioral characteristics of a community or population and the ability to translate systematically that knowledge into practices in the delivery of behavioral health services. Such understanding may be reflected, for example, in the ability to: identify and value differences; acknowledge the interactive dynamics of cultural differences; continuously expand cultural knowledge and resources with regard to population served; collaborate with the community regarding services provisions and delivery; and commit to cross-cultural training of staff and develop policies to provide relevant, effective programs for the diversity of people served.

D&A Outpatient – Evaluation and treatment services provided at a licensed facility to persons who can benefit from psychotherapy and substance use/abuse education. Services are provided in regularly scheduled treatment sessions for a maximum of 5 hours per week by qualified D&A treatment staff.

Database Management System – An information processing concept introduced in the late 1970s which separated data from the computer applications that created or processed that data, thus making data more accessible and minimizing the amount of programmer time needed to maintain computer programs.

Day – A calendar day unless otherwise specified in the Agreement.

Days (or Visits) Per 1,000 – An indicator calculated by taking the total number of days (for inpatient, residential, or partial hospitalization) or visits (for outpatient) received by a specific group for a specified period of time (usually one year). This number is then divided by the average number of covered members or lives in that group during the same period and multiplies by 1,000. A measure used to evaluate utilization management performance.

Deductible – The portion of a subscriber's health care expenses that must be paid out of pocket before any insurance coverage applies.

Deliverables – Those documents, records, and reports furnished to the Department for review and/or approval in accordance with the terms of the Agreement.

Denial of Services – A determination made by a BH-MCO in response to a Provider's or Member's request for approval to provide a service of a specific amount, duration and scope which:

- Disapproves the request completely, or
- Approves provision of the requested services(s), but for a lesser amount, scope or duration than requested, or
- Disapproves provision of the requested service(s), but approves provision of an alternative service(s), or
- Reduces, suspends, or terminates a previously authorized service.

Note: A denial of a request for services must be based upon one of the following four reasons, along with an explanation for the reason, which must be explicitly stated on the notice of action:

1. The service requested is not a covered service.
2. The services requested is a covered services but not for this particular recipient (due to age, etc.)
3. The information provided is insufficient to determine that the service is medically necessary.
4. The service requested is not medically necessary.

Department/DPW – The Pennsylvania Department of Public Welfare

Department of Public Welfare Fair Hearing – A hearing conducted by the Department of Public Welfare, Bureau of Hearings and Appeals in response to an appeal by a BH-MCO member.

Diagnosis Related Group (DRG) – A statistical system of classifying hospital inpatient stays into groups for purpose of payment.

Discharge Planning – The evaluation of a member's mental health or substance abuse service needs, or both, in order to arrange for appropriate care after discharge from one level of care to another level of care.

Discounted Fee-For-Service – An agreed upon rate for service between the provider and payer that is usually less than the provider's full fee. This may be a fixed amount per service, or a percentage discount. Providers generally accept such contracts because they represent means to increase their volume or reduce their chances of losing volume.

Discretionary Funds (Profit) – Capitation payments and investment income that are not expended for purchase of services for plan members (in-plan, supplemental, or cost/effective alternatives), administrative costs, risk and contingency, equity requirements or reinvestment.

Disenrollment – The process of terminating coverage.

Drug and Alcohol Addictions Professional – A nationally accredited addictions practitioner or a person possessing a minimum of a bachelor's degree in social science and two (2) years experience in treatment/case management services for persons with substance abuse/addiction disorders.

Drug Formulary – A listing of drugs that a physician may prescribe. HMOs may require physicians to use only formulary drugs unless there is a valid medical reason to use non-formulary drugs to fill a prescription.

Drug Utilization Review – Either concurrent and retrospective management of an insured population's drug utilization. The goal of such management is to reduce the cost of drug therapies. Methods used include substitution of generic drugs for name brands, using a formulary to limit the universe of drugs

that can be prescribed, use of co-payments for prescriptions, and encouraging the use of drugs that will trigger rebates for discounts.

Durable Medical Equipment – Medical equipment, such as wheelchairs and specialty beds that are used only to care for a medical condition.

Early Periodic Screening, Diagnosis, and Treatment (EPSDT) – This program covers screening and diagnostic services to determine physical or mental defects in recipients under age 21, as well as health care and other measures to correct or ameliorate any defects and chronic conditions discovered.

Eligibility Verification System (EVS) – An automated system available to MA providers and other specified organizations for on-line verification of MA eligibility, prepaid capitation, MCO enrollment, third party resources, and scope of benefits.

Emergency Medical Condition – 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 to result in:

a) Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in jeopardy,
b) Serious impairment to bodily functions, or
c) Serious dysfunction of any bodily organ or part.

Emergency Services – Covered inpatient and outpatient services that are furnished by a provider qualified to furnish such services under the Medical Assistance Program and are needed to evaluate or stabilize an emergency medical condition.

Enhanced Services – Another name for EPSDT

Emergent – Demonstrated, observable need for observation, treatment, and/or close supervision of a HealthChoices behavioral health member to prevent dangerous behavior by the member directed to self or others or is experiencing acute intoxication or withdrawal.

Employee Assistance Programs (EAPs) – Mental health and substance abuse, counseling services that are offered by insurance companies or employers. Typically, individuals do not have to pay directly for services provided through an EAP.

Episode of Care – A construct that groups all the treatment provided for a specific condition over a continuous, defined period of time; often used to analyze service cost, quality, and utilization patterns.

EPSDT – The Early and Periodic Screening, Diagnosis, and Treatment Program for individuals under the age of 21.

Family Based Mental Health Services – Evaluation and treatment services provided to a specific child in a family, but focuses on strengthening the whole family system to increase their ability to successfully manage their child's behavioral and emotional issues. Services are provided by licensed agencies employing a mental health professional and a mental health worker as a team to provide treatment and case management interventions. Services are provided in the home of the family.

Federal Financial Participation (FFP) – The funds paid to states by the federal government as its share of costs for Medicaid services.

Federal Medical Assistance Percentage (FMAP) – The precise percentage of the FFP. The FMAP is different in each state and is annually calculated through a formula based on a state's per capita income and other factors. Under current law, it cannot be less than 50%. In the poorest states, it can be just over 75%.

Fee-for-Service (FFS) – Payment by the Department to providers on a per-service basis for health care services provided to Medical Assistance recipients.

Fee-for-Service Reimbursement – A payment approach that pays providers for each unit of service delivered. Insurers pay providers a percentage of the total charge of fixed fee-for-service (FFS) rates by procedural code. Traditional FFS insurance products do not traditionally limit a member's choice of providers to a predefined network of hospitals and physicians. PPOs and other derivations of traditional FFS insurance products limit a member's access to a defined group of providers.

Fee Schedule – A listing of the maximum fee that a health plan will pay for a certain service based on billing codes. Also called Table of Allowances.

Federally Assisted MA – A federal and state funded program which provides MA only (Medically Needy Only and Non-Money Payment) to Pennsylvania individuals and families whose income and resources are below established standards and who do not qualify for the TANF Program.

Federally Qualified Health Clinic (FQHC/Rural Health Clinic (RHC)) – An entity which is receiving a grant as defined under the Social Security Act, 42 U.S.C.A. 1396d(1) or is receiving funding from such a grant under a contract with the recipient of such a grant, and meets the requirements to receive a grant under 42 U.S.C.A. 1396d(1).

Flexible – The development and delivery of services and supports are flexible as possible in order to meet the needs of a wide diversity of persons in the geographic area. Flexibility includes having a wide variety of services, of variable intensity available at a wide range of times and delivered in a wide range of environments.

Freedom of Choice – In Medicaid, a state must generally ensure that beneficiaries are free to obtain services from any qualified provider (Section 102(a)(23) of the Social Security Act). Exceptions are possible via waiver (see 1915 waiver).

Full Capitation – A term used more broadly than the strict definition of capitation to refer to any payment system in which an MCO provides and bears the utilization risk for all services included in the benefit package according to a prospectively funded at-risk contracting arrangement tied to covered lives.

Full Utilization Risk – Risk sharing arrangement in which the payer transfers to the service provider full responsibility for potential rewards and costs of utilization.

Gatekeeper – A person who screen patients and makes referrals to other providers. The gatekeeper, who is often a primary care physician or other professional (e.g. case manager), serves as the patient's first contact in a managed care system and controls access to other providers in the system. The gatekeeper will authorize access to the rest of the health care system, including specialty services, inpatient hospital services, and ancillary services.

Gatekeeper Model – A primary care case management model used by health plans. The gatekeeper model requires all care, except for true emergencies, be authorized by a member's primary care physician before care is rendered. The authorization granted by a gatekeeper physician comes as a referral.

General Assistance (GA) State Only – A state funded program which provides cash grants and MA (Categorically Needy) or MA only (Medically Needy Only and Non-Money Payments) to Pennsylvania individuals and families whose income and resources are below established standards and who do not qualify for the TANF Program.

Global Budget – The overall amount spent on specific health services by all buyers of services. In some health reform plans, this amount would be set as a progressive target each year by a governmental body. If spending exceeds the amount in the global budget, sanctions (including price controls) may be applied.

Global Capitation (Risk Contract) – A capitation arrangement in which an entity agrees to provide all (or most) of a beneficiary's health's services. Traditionally, the entity must provide physician and hospital services for a fixed per member per month payment. The entity receives the capitated payments regardless of the volume or intensity of services provided.

Grievance – A request to have a BH-MCO or utilization review entity reconsider a decision solely concerning the Medical Necessity and appropriateness of a health care service. A grievance may be filed regarding a BH-MCO decision to 1) deny, in whole or part, payment for a service if based on lack of Medical Necessity; 2)) deny or issue a limited authorization of a requested service, including the type or level of service; 3) reduce, suspend, or terminate a previously authorized service; 4) deny the requested service, but approve an alternative service.

Group Model HMO – A type of HMO medical center where many different services are provided in unified medical center locations. Staff usually treat only HMO members.

Health Care Financing Administration (HCFA) – The agency within the U.S. Department of health and Human Services that oversees the Medicaid and Medicare programs. There are regional HCFA offices throughout the county, each responsible for working with a group of states.

Health Care Quality Unit (HCQU) – Serves as the entity responsible to county mental retardation programs for the overall health status of individual screening services in county mental retardation programs.

HealthChoices (HC) Program – The name of Pennsylvania's 1915(b) waiver program to provide mandatory managed health care to Medical Assistance (MA) recipients.

HealthChoices Behavioral Health (HC-BH) Program – The mandatory managed care program, which provides Medical Assistance recipients with behavioral health services in the Commonwealth.

HealthChoices Physical Health (HC-PH) Program – The mandatory managed care program, which provides Medical Assistance recipients with physical health services in the Commonwealth.

HealthChoices Library – A collection of reference documents and materials, relevant to the Health Choices physical and behavioral health programs available for use by potential and current contractors.

HealthChoices Southeast (HC-SE) Zone – The HealthChoices mandatory managed care program to be implemented in Bucks, Chester, Delaware, Montgomery, and Philadelphia Counties.

HealthChoices Southwest (HC-SW) Zone – The HealthChoices mandatory managed care program to be implemented in Allegheny, Armstrong, Beaver, Butler, Fayette, Greene, Indiana, Lawrence, Washington, and Westmoreland Counties.

HealthChoices Zone (HC Zone, Project Area) – County groupings designated by the Department for participation in the HC-BH Program.

Health Insurance Portability and Accountability Act of 1996 (HIPAA) – Requires improved efficiency in healthcare delivery by standardizing electronic data interchange, and protection of confidentiality and security of health data through setting and enforcing standards, standardization of electronic patient health, administrative and financial data and unique health identifiers for individuals, employers, health plans and health care providers. It also involves security standards for protecting the confidentiality and integrity of "individually identifiable health information," past, present or future.

Health Maintenance Organization - A Commonwealth licensed risk-bearing entity which combines delivery and financing of health care and which provides basic health services to enrolled Members for a fixed pre-paid fee.

Health Beginnings – An MA program which covers children and adolescents born after September 30, 1983, and women during pregnancy and the postpartum needs.

Healthy Horizons – An MA program which provides non-money payment (NMP) and/or payment of the Medicare premium, deductibles, or coinsurance to disabled persons and persons age 65 and over. *Exception: An individual who is determined eligible for Healthy Horizons for cost sharing coverage only (categories PG and PL) will not be enrolled in the HC-SW Program).*

Incurred But Not Reimbursed - Refers to claims which reflect services already delivered, but, for whatever reason, have not yet been reimbursed. These are bills "in the pipeline."

Immediate Need – A situation in which, in the professional judgment of the dispensing registered pharmacist and/or prescriber, the dispensing of the drug at the time when the prescription is presented is necessary to reduce or prevent the occurrence or persistence of a serious adverse health condition.

Indemnity Health Plan – Also called Fee-for-service. This plan was the most common before the rise of HMOs, IPAs and PPOs. With indemnity plans, the individual pays a predetermined percentage of the cost of health care services, usually up to an annual "stop loss" limit, and the insurance company (or self-insured employer) pays the rest. The usual split is 20% for the individual and 80% for the insurer. Fees for services are defined by the providers. Indemnity plans offer individuals the freedom to choose their healthcare professionals.

Independent Enrollment Assistance Program (IEAP) – The program responsible to assist Members in enrolling in the HC-SW Program, including the selection of a health plan and Primary Care Practitioner, and obtaining information regarding the HC-SW physical and behavioral health programs.

Independent Enrollment Specialist – The IEAP individual who will be responsible to assist recipients with selecting a PH-MCO and Primary Care Practitioner, and providing information about the HC-SW physical and behavioral health programs.

Independent Practice Association (IPA)- An organization that has contracts with groups of independent physicians.

Information Management - The identification, collection, analysis and use of various types of data within a system to further the organization's missions and goals.

Inpatient Services – Shall mean twenty-four (24) hour services that provide medical intervention for mental health or substance abuse diagnosis, or both. For example: Inpatient Mental Health Services, Inpatient Substance Abuse Services, and Detoxification.

Inpatient Psychiatric Hospital – Evaluation and treatment services provided in a licensed psychiatric unit of a community hospital or a community psychiatric hospital that is not part of a medical hospital. Services are provided to persons with acute illness where safety for self or others is an issue. Services are provided by psychiatrists, nurses and social services staff. Persons may be involuntarily committed for evaluation and treatment.

Inpatient and Non-Hospital D&A Detoxification – An observation and treatment process where persons who are drug and/or alcohol dependent are assisted through the detoxification process. Services are provided in a community hospital or a residential program under the direction of a physician and nursing staff. This type of care utilizes multi-disciplinary staff to provide treatment and supports specific to psychoactive substance abuse.

Inpatient and Non-Hospital D&A Rehabilitation – Treatment services provided in a licensed community residential program or a hospital, following a detoxification process where a full range of treatment and supportive services are provided for the addicted person in acute distress. Interventions include social, psychological and medical services to assist the person whose addiction symptomatology is demonstrated by moderate impairment of social, occupational, and/or school functioning. Rehabilitation is a treatment goal.

In-Plan Services – Services, which are included in the HC-SW behavioral health capitation, rate and are the payment responsibility of the primary contractor.

Institution for Mental Disease (IMD) – A facility of more than 16 beds in which at least 50% of the residents have a primary diagnosis of mental illness at the time of admission. IMDs cannot receive Medicaid funds for services to patients ages 22-64.

Intensive Case Management – A series of coordinated staff activities, in conjunction with the client, that determine what services are needed and how these services will be coordinated and provided in a timely manner.

Intensive Outpatient – An organized non-residential treatment service in which the client resides outside the facility. It provides structured psychotherapy and client stability through increased periods of staff intervention. Services are provided according to a planned regimen consisting of regularly scheduled treatment sessions at least 3 days per week, for a total time between 5-10 hours per week.

Interagency Team – A multi-system planning team comprised of the child, when appropriate, the adolescent, at least one accountable family member, a representative of the county mental health and/or drug and alcohol program, the case manager, the prescribing physician or licensed psychologist, in person

when possible, or by consultative conference call, and as applicable, the county children and youth, juvenile probation, mental retardation, and drug and alcohol agencies, a representative of the responsible school district, BH-MCO, PH-MCO and/or PCP, other agencies that are providing services to the child or adolescent, and other community resource persons as identified by the family. The purpose of the interagency team is to collaboratively assess the needs and strengths of the child and family, formulate the measurable goals for treatment, recommend the services, treatment approaches and methods, intensity and frequency of interventions and develop the discharge goals and plan.

Issuing Office – The Department's Division of Procurement.

Joinder – Local authorities of any county who have joined with the local authorities of any other county to establish a county mental health and mental retardation program, subject to the provisions of the Mental Health and Mental Retardation Act of 1966 (50 P.S. 4201 (2)), or a drug and alcohol program pursuant to the Drug and Alcohol Services Act of 1972 (71 P.S. 1690 10} et.seq.). In the HC-SW area, the county joinders are Armstrong and Indiana Counties.

Juvenile Detention Center – A publicly or privately administered, secure residential placement for:

- Children and adolescents alleged to have committed delinquent acts who are awaiting a court hearing;
- Children and adolescents who have been adjudicated delinquent and are awaiting disposition or awaiting placement; and
- Children and adolescents who have been returned from some other form of disposition and are awaiting a new disposition (e.g., court order regarding custody of child, placement of child, or services to be provided to the child upon discharge from the Juvenile Detention Center).

Lead Agency – In progressive mental health community support systems, a single agency is designated the lead agency and vested with full clinical and fiscal authority and responsibility for collaborating with clients in achieving their desired outcomes. Lead agency teams collaborate with clients by providing key services as well as accessing and contracting or otherwise arranging for services from external specialized agencies or other health and human service systems.

LOS – An acronym for length-of-stay, LOS is a term for the number of days an individual stays in a hospital or inpatient facility.

Managed Behavioral Health Program - An organization that assumes the responsibility for managing the behavioral health benefit for an employer or payer organization under a "carve out" arrangement. The management may range from utilization management services to the actual provision of the services through its own organization or provider network. Reimbursement may be on a fee-for-service, shared risk, or full-risk basis. Also called a Managed Care Organization.

Managed Care Organization – An entity that that manages the purchase and provision of physical or behavioral health services under the HC Program.

Managed Care - Any health care delivery system in which various strategies are employed to optimize the value of provided services by controlling their cost and utilization, promoting their quality; and measuring performance to ensure cost-effectiveness. A managed care system actively manages both the medical and financial aspect of a patient's care.

Managed Care Plan – A benefit package for in-plan services (regular medical care, mental health care, drug and alcohol abuse, etc.)

Management Service Organization – An organization that provides management and administrative support services to individual clinicians and group practices.

Maximum Dollar Limit – The maximum amount of money that an insurance company will pay for claims within a specific time period. Maximum dollar limits may be based on types of illness or types of service. Sometimes they are specified in terms of lifetime, or annually. Mental Health is usually treated in a discriminatory fashion in terms of annual or lifetime limits, typically much less than limits for other illnesses.

MCO Assessment – An assessment imposed upon the revenues of DPW's Medicaid managed care organizations pursuant to 62 P.S. 801-B et seq.

Means Test – An examination of a person's income and assets to determine if the person is eligible for a program. Medicaid requires a means test, Medicare does not. SSI does; SSDI does not.

Medicaid – A joint federal-state program, enacted in 1965 under Title XIX of the Social Security Act, to help pay for health care for the poor. Some benefits are federally mandated, while some are state-optional. Thus, coverage varies from state to state.

Medicaid Eligibility – The rules that determine whether a person qualifies for the Medicaid program. Recipients of AFDC and SSI are, in most states, categorically eligible.

Medicaid Mandatory Services – Services that the federal government requires to be included in a state's Medicaid program. The state can set its own limits (number of days, visits, etc.) even on mandatory services. Services may include hospital services, nursing facility services, physician's services, lab and X-ray, EPSDT, family planning, home health care, and nurse practitioners.

Medicaid Optional Services – There are more than thirty different services that a state may elect to cover under Medicaid. Such services include case management, clinic services, and psychosocial rehabilitation among those of benefit to persons with mental illness.

Medicaid Recipient – A person enrolled in Medicaid, which is paying his or her medical costs.

Medicaid State Plan – The document that describes a state's Medicaid program. Each state is required to submit a plan to HCFA for review and approval. A state plan amendment is a modification to add or delete optional services, or to alter the amount, duration or scope of a plan. Amendments may be made annually, but must be approved by HCFA.

Medicaid Waiver – A provision of federal law that allows HCFA to permit a state Medicaid program design that does not comply with federal law as long as certain safeguards and other criteria are met.

Medical Loss Ratio: - The ratio between the cost to deliver medical care and premium collected by the plan.

Medically Necessary or Medical Necessity – Clinical determinations to establish a service or benefit which will, or is reasonably expected to:

- Prevent the onset of an illness, condition, or disability
- Reduce or ameliorate the physical, mental, behavioral, or developmental effects of an illness, condition, injury or disability;
- Assist the individual to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the individual and those functional capacities appropriate for individuals of the same age.

Medicare – A totally federally-run and financed health insurance plan authorized under Title XVIII of the Social Security Act for eligible persons over age 65 and certain severely disabled individuals.

Medicare HMO- A contract between an HMO and the Health Care Financing Administration to provide services to Medicare beneficiaries under which the health plans receive a fixed monthly payment for enrolled Medicare members. In exchange for the fixed monthly payment, the HMO and its providers must provide all services-at-risk. When at risk, a provider is liable for costs that exceed an expected level.

Medicare Select Product - Medicare Select is a supplemental insurance policy introduced in 1992. Medicare Select does not alter or change the actual Medicare cash payment made to hospitals or physicians. Medicare Select decreases the cost of health care for the beneficiary by waiving all or part of the member's co-payment and deductible, in exchange for a premium less costly than for traditional supplemental policies.

Meet Special Needs – Services are adapted to meet the special needs of people with mental illness who are affected by one or more of such factors as old age, substance abuse, physical disability, loss of sight/hearing, HIV/AIDS, and involvement in the criminal justice system.

Member (Enrollee) – A Medicaid or Medical Assistance recipient who is currently enrolled in the HC-BH Program.

Member Month – One Member covered by the HC Behavioral Health Program for one month.

Mental Health Professional – A person trained in a generally recognized clinical discipline including, but not limited to, psychiatry, social work, psychology, and nursing, who has a graduate degree and mental health clinical experience, or a Registered Nurse with at least two years of mental health clinical experience.

Methadone and Levo-Alpha-Acetyl-Methadol (LAAM) – Medication used to achieve stabilization or prevent withdrawal symptoms. Slow withdrawal or outpatient detoxification of the person from the maintenance medication is part of this treatment process.

Minority Business Enterprise – A business concern which is a sole proprietorship, owned and controlled by a minority; a partnership or joint venture controlled by minorities in which 51% of the beneficial ownership interest is held by minorities; or a corporation or other entity controlled by minorities in which 51% of the voting interest and 51% of the beneficial ownership interest are held by minorities.

MISA – Mental Illness/Substance Abuse is a term used to indicate the existence of co-existing disorders of substance abuse and mental illness

Multi-County Entity – Two or more counties which form a legally binding agreement or formed, and entity such as a 501c (3), which established Articles of Incorporation and have intergovernmental agreement which form the basis to enter into a Single Agreement with the Department under the HC-BH Program.

Network – The system of participating providers and institutions in a managed care plan.

OMH - Office of Mental Health & Substance Abuse (OMH) area offices are responsible for the supervision and direction of the state mental hospitals and for monitoring and providing program consultation and technical assistance to county mental health programs and providers within an assigned geographical area. Each area office is responsible for annual planning and budget review, as well as monitoring state and federal allocations to all programs and hospitals. Area offices are also responsible for the licensure of community mental health service providers.

On-Site Reviews – A formal review process, periodically undertaken by Department staff and other designated representatives to determine the readiness of the Primary Contractor and a BH-MCO contractor to accept Members and to manage and administer the purchase and provision of behavioral health services under this Agreement.

Open-Ended HMO – HMOs that allow enrolled individuals to use out-of-plan providers or make their choice at the "point of service." Enrollees still receive partial or full coverage and payment for services.

Open Enrollment Period – The period when an employee may change health plans; usually occurs once a year.

Other County Grouping – Two or more counties, at least one of which is not a Joinder, which submit a single proposal to become the primary contractor for all of the counties in the grouping.

Out-of-Area Services – In-plan services provided to a Member while the Member is outside the project area.

Out-of-Network Provider – A behavioral health services provider who does not have a written provider agreement with the BH-MCO and is, therefore, not included or identified as being in the BH-MCO provider network.

Out-of-Plan Services – Services which are not included as in-plan, capitated services, but which have been determined by the BH-MCO to be either cost effective alternatives or necessary supplements to in-plan services.

Out-of-Pocket Maximum – A pre-determined, limited amount of money that an individual must pay for medical services before an insurance company or self-insured employer will pay 100% for that individual's health care expenses.

Outcomes – The results of receiving a healthcare service. Outcomes measures assess the results of a person receiving a particular service. For example, outcomes research might examine the percentage of persons who return to full functioning, those that partially recover, and those who die as a result of a given surgical procedure. In mental illness, outcomes should be linked to quality-of-life measures as well as more traditional clinical measures of symptom reduction.

Outcome Measures – Statistical barometers of the effectiveness of treatment for a particular disease or condition, including morbidity, mortality, cost, and patient satisfaction.

Outcomes Research – Formal studies designed to measure the effectiveness of a given service or benefit package.

Outlier – One who does not fall within the norm; term typically used in utilization review. A provider who uses either too many or too few services. For example: anyone whose utilization differs two (2) standard deviations from the mean on a bell curve is termed an outlier.

Outpatient – Someone receiving healthcare service, but does not stay overnight in a hospital or other inpatient facility. Many insurance companies have identified a list of tests and procedures (including surgery) that will not be paid for unless they are performed on an outpatient basis.

Outpatient Services – Shall mean mental health and substance abuse services provided in an ambulatory care setting, such as a mental health or substance abuse clinic, hospital outpatient department, community health center, or Provider's office. Outpatient Services include such services as Individual, Family, Couple, and Group Therapy; Medication Management, Diagnostic Evaluations, Case Management, and Family Based Services.

Parent – The biological or adoptive mother or father, or the legal guardian of the child, or a responsible relative or caretaker (including foster parents) with whom the child regularly resides.

Partial Capitation – Generic term that refers to a payment system in which some services included in the benefit package are funded according to an at-risk contracting arrangement and some are funded through fee-for-service or other traditional forms of reimbursement.

Partial Hospitalization – The provision of psychiatric, psychological, social and other therapies on a planned and regularly scheduled basis. Designed for those clients who could benefit from more intensive services than are offered in outpatient treatment projects, but who do not require 24 hour inpatient care.

Participating Provider – A provider who has contracted with a health plan to provide specific services for a negotiated reimbursement.

Payer/Payor – The public or private organization that is responsible for payment for health care expenses.

Peer Review – The retrospective evaluation of provided services by clinical staff with training equivalent to that of the providing clinician.

Peer Review Organization (PRO) – Independent physician-directed organizations or programs that assess the quality of care and medical necessity of services provide.

Peer Support Services – Services provided by consumers for consumers.

Per Member Per Month – Specifically applies to a revenue to or cost by a provider for each enrolled member each month.

Per Member Per Year - Specifically applies to a revenue to or cost by a provider for each enrolled member each year.

Performance Measure – A measure that describes the health care being provided. Current performance measures indicate whether a health plan or provider has appropriately provided certain services expected to lead desirable outcomes.

Persons in Recovery – Individuals who have abstained from drugs and alcohol for at least one year following participation in drug and alcohol treatment.

Physical Health Managed Care Organization (PH-MCO) – An entity, which has contracted with the Department to manage the purchase and provision of physical health services under the HC-SW program.
Point-of-Care Technology – Those technologies which enable physicians and other clinicians to electronically record findings, enter orders, and review information from the location at which care is provided.

Practice Guidelines – Systematically developed descriptions of sound medical practices that assist clinicians in making appropriate decisions regarding health care provided for specific medical conditions.

Pre-Admission Certification – A prospective review of the need for a specific health care service according to specific criteria.

Pre-Existing Condition – A medical condition excluded from coverage by an insurance company because it was believed to exist prior to the issuance of an individual's policy. This is a major impediment to someone seeking a new insurance plan.

Preferred Provider Organization (PPO) – A Commonwealth licensed person, partnership, association, or corporation which establishes, operates, maintains or underwrites in whole or in part a preferred Provider arrangement, as defined in 31 Pa. Code Subsection 152.2.

Prepaid Inpatient Health Plan (PIHP) – An entity that provides medical services to enrolled recipients, under contract with the Medicaid agency and on the basis of prepaid capitation fees, but is not subject to requirements in Section 1903(m)(2)(A) of Title XIX of the Social Security Act.

Primary Care Practitioner (PCP) – A specific physician, physician group, or a certified registered nurse practitioner operating under the scope of his/her licensure who has received an exception from the Department of Health, responsible for supervising, prescribing and providing primary care services and locating, coordinating, and monitoring other medical care and rehabilitation services and maintaining continuity of care on behalf of a Member.

Primary Contractor – A County or Multi-County Entity, which has a HealthChoices Agreement with the Department to manage the purchase and provision of behavioral health services.

Primary Diagnosis – The condition established after study to be chiefly responsible for occasioning the visit for outpatient settings or admission for inpatient settings.

Prior Authorization – A determination made by a Primary Contractor or its BH-MCO to approve or deny a Provider's request to provide a service or course of treatment of a specific duration and scope to a Member prior to the provider's initiating provision of the registered service.

Prior Authorized Services – In-plan services for which a BH-MCO services provider must obtain, pursuant to Department approved BH-MCO policies and procedures, the BH-MCO's approval in advance of the provider's initiating provision of the requested service.

Priority Populations(s) – Members with serious mental illness and/or addictive disease, and children and adolescent members with or at risk of serious emotional disturbance and/or who abuse substances and who, in the absence of effective behavioral health treatment and rehabilitation services, care coordination and management are at risk of separation from their families through placement in long term treatment facilities, homelessness, or incarceration, and/or present a risk of serious harm to self or others. Drug and alcohol priority populations include child and adolescent substance abusers and persons with addictive diseases including pregnant women and women with dependent children, intravenous drug users and persons with HIV/AIDS who abuse substances. Mental health priority populations include persons with serious mental illness and children and adolescents with or at risk of serious emotional disturbances. Refer to Appendix Q.

Private Sector BH-MCO – A Commonwealth licensed BH-MCO, which has contracted with the Department or county government to manage the purchase and provision of behavioral health services under this Agreement.

Project Area – The ten county HealthChoices geographic area including Allegheny, Armstrong, Beaver, Butler, Fayette, Greene, Indiana, Lawrence, Washington, and Westmoreland Counties.

Project Officer – Sole point of contact in the Department for this RFP.

PROMISe – (Provider Reimbursement and Operational Information System) is the HIPAA compliant claims processing and management information system implemented by the Department in 2004.

Proposer – A party or parties submitting a proposal under this RFP.

Proposers' Library – A collection of reference documents and materials, relevant to the HealthChoices physical and behavioral health programs available for use by proposers.

Prospective Reimbursement – Any method of payment to service providers calculated over a specified time period prior to the actual provision of services.

Protocols - Refers to the standardized, pre-developed criteria for the application of specific interventions designed to improve the condition of the client. Protocols include application guidelines to indicate what interventions are to be provided for how long, and by whom.

Provider – A person, firm, or corporation which provides behavioral health or medical services or supplies to recipients.

Provider Agreement – Any written agreement between the BH-MCO and a provider to render clinical or professional services to recipients to fulfill the requirement of the contract resulting from this RFP.

Provider Incentive Payments – Some HMOs pay providers incentive payments when patient care is managed in such a manner that the cost and quality of services provided exceed agreed upon targets.

Psychiatric Outpatient – Evaluation and treatment services provided to persons who may benefit from periodic visits that may include psychiatric and psychological evaluation, medication management, individual or group therapy. Services are provided by licensed facilities under the supervision of a psychiatrist or by private credentialed practitioners.

Psychiatric Partial Hospitalization – Treatment services provided from 3 to 6 hours per day up to 5 days per week in a licensed facility. Evaluation, treatment and medication are provided under the

supervision of a psychiatrist for persons who need more intensive treatment than psychiatric outpatient. Services are provided for a short duration of time for persons acutely ill and for longer periods for persons experiencing long-term serious mental illness. Services are typically provided in a therapeutic group setting.

Quality Assurance – A set of measures, requirements and tasks used to determine the quality of service. These items include the hiring process, chart reviews, complaint procedures, clinical supervision, in-service training, referral guidelines, internal utilization, team meetings, critical incident reviews, etc.

Quality Management – A formal methodology and set of activities designed to access the quality of services provided and which includes a formal review of care, problem identification, and corrective action to remedy any deficiencies and evaluation of actions taken.

Readiness Review – A formal review process, prior to program implementation and periodically thereafter, undertaken by Department staff and other designated representatives to determine the readiness of the primary contractor and a BH-MCO subcontractor to accept members and to manage and administer the purchase and provision of behavioral health services under this RFP.

Reasonable and Customary Fees – The average fee charged by a particular type of health care practitioner within a geographic area. This term is used to define the amount an insurer will pay for a specific test or procedure. If fees are higher than the approved amount, the individual may be responsible for paying the difference.

Recipient – A person eligible to receive physical and behavioral health services under the MA program in the Commonwealth of Pennsylvania.

Referral - A referral is a document that shows a beneficiary's primary care physician or the HMO's utilization management staff has determined the patient needs medical attention for a covered service. When beneficiaries utilize medical services without a referral from their primary care physician. The member may be responsible for the charges incurred.

Reinsurance – (RBRVS) A method of determining physicians' fees based on the time, training, skill and other factors required to deliver various services.

Reinvestment Funds – Capitation revenues from DPW and investment income which are not expended during an Agreement year by the Primary Contractor and its BH-MCO for purchase of services for members, administrative costs, Risk and Contingency Funds, and equity requirements, but may be used in a subsequent Agreement year to purchase start-up costs for In-Plan Services, development or purchase of Supplemental Services or non-medical services, contingent upon DPW approval of the Primary Contractor's reinvestment plan.

Related Parties – Any Affiliate that is related to the Primary Contractor or its BH-MCO by common ownership or control (see definition of "Affiliate") and:

1. Performs some of the primary contractor or subcontracting BH-MCO's management functions under contract or delegation;
2. Furnished services to members under a written agreement; or
3. Leases real property or sells materials to the primary contractor or subcontracting BH-MCO at a cost of more than $2,500 during any year of a HealthChoices Behavioral Health contract with the Department

Relative Value Scale – (RVS) is the compiled table of relative value units, which is a value given to each procedure or unit of service. As payment systems, RVS is used to determine a formula which multiplies the RVU by a dollar amount, called a converter.

Report Card – A public accounting of the quality of services, compared over time and among providers. The report card grades providers on pre-determined, measurable quality and outcome indicators. It is intended for use by consumers and payers.

Residential Treatment Services – Comprehensive mental health treatment services for children with severe disturbances or mental illness. These services are provided in Residential Treatment Facilities (RTF's), which must be licensed by OCY&F under Chapter 3800. The facility must have a service description approved by OMHSAS, be certified by OMHSAS through annual on-site review, have a utilization review plan in effect and be enrolled in the MA program.

Retrospective Review –A review conducted by the BH-MCO to determine whether or not services were delivered as prescribed and consistent with the BH-MCO payment policies and procedures.

Risk – The chance of loss, the degree of probability of loss, or the amount of possible loss to the insurance company. Capitation financing has moved risk from the insurance company to the provider.

Risk and Contingency Funds – Per Member Per Month (PMPM) capitation funds received by the Primary Contractor pursuant to the Agreement, which are not expended on services (In-Plan, Supplemental, or cost effective alternatives) or administrative functions and which are in excess of the Equity Reserve required to be maintained under the Agreement. Risk and Contingency Funds to not include Reinvestment Funds, or funds designated in a reinvestment plan submitted to DPW.

Risk Assuming PPO – A Commonwealth licensed PPO which meets the definition of a risk assuming PPO pursuant to Pennsylvania Regulations Title 31, Chapter 152, and Subsection 152.2.

Risk Corridors - Risk corridors establish target fees, thereby creating a financial incentive to improve the quality and control the cost of services provided to members of an HMO. When actual fees go above or below target fees, the HMO applies penalties and rewards to the participating providers. The penalties and awards are usually levied at 25th. 50th and 75th percentiles of the corridors. Providers should limit the utilization of risk corridors to establishing capitation rates.

Risk Pools - Managed care organizations use risk pools in capitated payment arrangements to control resource utilization. As in the use of withholds. The managed care organization withholds a portion of the capitated payment to a provider to cover predetermined expenses. Examples of services covered by the risk pool could include lab tests, specialty services, and/or hospitalizations. At a predetermined time, the managed care organization distributes the balance (contributions less expenses) of the risk pool to the participating providers. Since the costs of certain services are paid from the risk pool, there is a financial risk associated with providing certain services.

Risk Sharing - An arrangement between the program administrator and provider whereby the provider shares any funds remaining at the end of the period that have not been expended for services. They also share in shortages occasioned when spending for program services exceeds the available budget.

Rural – Consists of territory, persons, and housing units in places which are designated as having less than 2,500 persons {U.S. Bureau of Census definition}.

Single County Authority – The agency designated by the local authorities in a county or joinder to plan, fund and administer drug and alcohol activities in that county or joinder. The local authorities are the final fiscal and management authority.

Section 1115 Waiver – A statutory provision that allows a State to operate its system of care for Medicaid enrollees in a manner different form that proscribed by the Center for Medicare and Medicaid Services (CMS), in an attempt to demonstrate the efficacy and cost-effectiveness of an alternative delivery system through research and evaluation.

Section 1915(b) Waiver – The section of the Social Security Act that allows states to waive "freedom of choice." States may require beneficiaries enrolled in HMOs or other managed care programs to select a physician to serve as their primary case manager.

Service Management/Manager – The BH-MCO function/staff with responsibility to authorize and coordinate the provision of In-Plan services. Care Management/Manager is synonymous.

Single-Stream Funding – The consolidation of multiple sources of funding into a single stream. It is a key approach used in progressive mental health systems to see that "funds follow consumers."

Special Needs Population - Members whose complex medical, psychiatric, behavioral or substance abuse conditions, living circumstances and/or cultural factors necessitate specialized outreach, assistance in accessing services and/or service delivery and coordination on the part of the MCO and its provider network.

SSI with Medicare – Monthly cash payments made to persons who are aged, blind, or determined disabled for over two years under the authority of Title XVI of the Social Security Act, as amended, Section 1616(a) of the Social Security Act, or Section 212(A) of Pub. L. 93-66. This category automatically receives MA.

SSI without Medicare – Monthly cash payments made to persons who are aged, blind, or have been disabled for less than two years and will become eligible for Medicare when the disability has lasted for two years, under the authority of Title XVI of the Social Security Act, as amended, Section 1616(a) of the Social Security Act, or Section 212(A) of Pub. L. 93-66. This category automatically receives MA.

Staff Model HMO – An HMO in which staffs are salaried employees and provide services only to HMO enrollees.

Start Date – The first date on which Members are eligible for behavioral health services under the Agreement, and on which the primary contractor is at risk for providing behavioral health services to members.

Statewideness – Generally, states must provide the same Medicaid benefits to everyone throughout the state, although exceptions are possible through waivers.

Strengths-Based – Services built upon the assets and strengths of consumers to promote growth and movement toward independence.

Stop-Loss – The practice of an HMO or insurance company of protecting itself or its contracted medical group against part or all losses above a specified dollar amount incurred in the process of caring for its

policyholders. This usually involves the HMO or insurance company purchasing insurance from another company to protect itself. This is also referred to as reinsurance.

Subcontract – Any contract (except provider agreements, utilities, and salaried employees) between the primary contractor or a subcontracting BH-MCO and an individual, firm, university, governmental entity, or nonprofit organization to perform part or all of the BH-MCO's responsibilities.

Subcontractor – Any person other than the Primary Contractor or its BH-MCO who enters into a Subcontract.

Supplemental Security Income (SSI) – Title XVI of the Social Security Act authorizes direct payments to the aged, blind, and disabled poor. In most states, SSI recipients are categorically eligible for Medicaid.

Supplemental Services – MA eligible mental health and drug and alcohol services purchased in lieu of or in addition to an In-Plan Service.

Target Case Management (Intensive Case management and Resource Coordination) – Case management services provided to assist children, adolescents and adults with serious mental illness or emotional disturbance to obtain treatment and supports necessary to maintain a healthy and stable life in the community. Caseload sizes are limited to ensure adequate attention to the person's needs as they change. Emphasis is given to housing, food, treatment services, and use of time, employment and education. Intensive case management services are available 24 hours a day, 7 days per week.

Temporary Assistance to Needy Families (TANF) and TANF-Related MA – A federal block grant program, matched with state funds, which provides cash payments and MA, or MA only (Medically Needy Only and Non-Money Payment) to families which contain dependent children who are deprived of the care of support of one or both parents due to absence, incapacity, or unemployment of a parent.

Third Party Liability (TPL) – Any individual, entity, (e.g. insurance company) or program (e.g., Medicare) that may be liable for all or part of a Member's health care expenses.

Title XVIII (Medicare) – A federally financed health insurance program administered by CMS, covering almost all Americans sixty-five (65) years old and older and certain individuals under sixty-five (65) who are disabled or have chronic kidney disease. The program provides protection with an acute care focus under two parts: Part A covers inpatient hospital services, post-hospital care in skilled nursing facilities and care in patients' homes; and Part B covers primarily physician and other outpatient services

Total Quality Management – The creation and implementation of organization systems that promote quality at all levels of the organization; focuses on integration of corporate culture, quantitative measurement and the needs of the consumer.

Urban – Consists of territory, persons, and housing units in places which are designated as having 2,500 persons or more. These places must be in close geographic proximity to one another [U.S. Census Bureau definition].

Urgent – Any illness or severe condition which under reasonable standards of medical practice would be diagnosed and treated within a twenty-four (24) hour period and if left untreated, could rapidly become a crisis or emergency situation. Additionally, it includes situations such as when a Member's discharge from a hospital will be delayed until services are approved or a Member's ability to avoid hospitalization depends upon prompt approval of services.

Utilization - The rate at which medical services are provided; patterns or rates of use of a single service or type of service (e.g. hospital care, physician visits, prescription drugs). Measurement of utilization of all clinical services. This is usually done in terms of dollar expenditures. For example: use is expressed in rates per unit of population at risk for a given period (e.g. number of hospital admissions per 1.000 persons over age sixty-five per year or number of visits to a physician per person per year for family planning services).

Utilization Management – The process of evaluating the necessity, appropriateness and efficiency of behavioral health care services against established guidelines and criteria.

Utilization Review - The process of using predefined criteria to evaluate the necessity and appropriateness of allocated services and resources to ensure that a facility's services are necessary, cost-efficient, and effectively utilized. Also determines the medical necessity, efficiency, and appropriateness of the level of services provided, in advance, as the services are provided, or after the fact. Utilization review may be done by a committee; professional standards review organization, peer review group, public agency, or private company.

Waiting Period – A period of time when a plan enrollee is not covered by insurance for a particular problem or pre-existing condition.

Waiver – A process by which a state may obtain an approval from CMS for an exception to a federal Medicaid requirement(s).

Withholds - A withhold is a predetermined dollar amount withheld from a capitated or fee-for-service payment to cover the risk a health plan incurs in the event of budget overruns or catastrophic claim encounters. Disbursement of the withholds to providers is scheduled in predetermined intervals; is based on predetermined criteria; and is adjusted for overall profitability of the insurer. The objectives of withholds are to protect the solvency of health plans and to provide incentives to providers to control unnecessary utilization of resources and promote the practice of quality care.

Women's Business Enterprise – A small business concern which is: a sole proprietorship, owned and controlled by a woman; a partnership or joint venture controlled by women in which as least 51% of the beneficial ownership is held by women; or a corporation or other entity controlled by women in which at least 51% of the voting interest and 51% of the beneficial ownership interest is held by women.

WRAP – A self-help tool which empowers the person to work on and maintain his/her own recovery. It is flexible, individualized, easy to learn and easy to update. It includes sections on developing a wellness toolbox, identifying triggers and warning signs, averting a crisis and developing a crisis plan.

Wrap-Around Services – Services developed and/or approved by an interdisciplinary service team which is community based, centered on the strengths of the consumer and family and includes the delivery of coordinated, highly individualized services in three or more life domain areas (such as home, school or community).