LHPC INSTITUTE

Glossary of Health Care Terms and Acronyms

** Content courtesy of CenCal Health*

A

A&I (Audits and Investigations). Branch of the California Department of Health Services that performs regular financial and medical audits of all Medi-Cal contracted health plans in the state.

ABD (Aged, Blind or Disabled). One of the categories that qualifies a person for Medi-Cal coverage through the SSI program.

ACA The Patient Protection and Affordable Care Act. Otherwise referred to as the Affordable Care Act.

ACCESS FOR INFANTS AND MOTHERS PROGRAM (See "AIM").

ACO (Accountable Care Organizations) Groups of doctors, hospitals and other health care providers who come together voluntarily to provide coordinated high-quality care to Medicare patients. The goal of coordinated care is to ensure patients get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors.

ADHC (Adult Day Health Care). A benefit of the Medi-Cal program under which medical day care is provided to qualifying seniors at a center established for that purpose.

ADLs (Activities of Daily Living). Basic activities such as dressing, toileting and eating, that are used to determine whether a patient qualifies for specific levels of coverage by Medi-Cal.

ADMISSIONS. Refers to admissions to inpatient facilities (hospitals or nursing facilities).

ADVANCE CARE PLANNING. Consultation and counseling between a Provider and a Member, family member, or legally-recognized decision-maker covering such topics as defining the Member's goals of care, planning for future intensity of care provided, and defining patient-specific plans for future care, which may be additionally documented in the form of advance directives or a Physician's Orders for Life-Sustaining Treatment (POLST) Form.

AEVS (Automated Eligibility Verification System). One of several methods offered by EDS to providers to determine if a Medi-Cal patient is eligible, to reduce their SOC (if any), and/or to reserve a Medi-Service for non-managed care beneficiaries by using the keypad of the user's telephone.

AFDC (Aid to Families with Dependent Children). State cash assistance program for families and dependent children; Medi-Cal is an automatic benefit when one qualifies for AFDC. Under the federal welfare reform act, it has now been replaced by "CalWorks".

AID CODE. This code indicates how a person has qualified for the Medi-Cal program; there are nearly 150 such codes.

AIDS (Acquired Immunodeficiency Syndrome). A disease that disables a person's natural immune system, for which there is currently no cure. Most patients who contract AIDS eventually qualify for Medi-Cal coverage.

AIM (Access for Infants and Mothers). A program, administered by MRMIB, that is funded by premiums paid by members, and State tobacco tax funds, and covers women during their pregnancy. The women are generally the "working poor" — they are employed by small employers who have no health insurance, or the dependents of someone so employed. The family income cannot exceed 250% of the FPL, and the person cannot be eligible for Medi-Cal.

ALLIED HEALTH PROVIDERS. Health care professionals other than physicians (e.g., physical therapists, podiatrists, chiropractors).

ALLOWABLE COSTS. The portion of charges billed by providers that qualify as reimbursable. Almost always less than the actual billed charges.

ALOS (See "Average Length of Stay"). AMBULATORY CARE Same as outpatient services (e.g., a physician office visit). These are services that do not require institutionalization of a patient.

ANCILLARY SERVICES Used to describe additional services performed in conjunction with a physician's care, such as lab and x-ray testing.

APM (Alternative Payment Method) Public hospital entity selects a population for which it is held accountable, a defined set of quality metrics and some level of risk for cost of care.

APS Abbreviation for "Adult Protective Services", a unit within the County Department of Social Services that is charged with ensuring the safety of those who are no longer competent to handle their own affairs.

AUTHORIZATION The approval of medical care qualifying for reimbursement. Can be prior, concurrent, or retrospective.

AVERAGE LENGTH OF STAY (ALOS) Refers to the average number of days of hospitalization. ALOS is calculated by dividing the total days by the total admissions for a specified period of time.

AWP Abbreviation for "Average Wholesale Price." One of the determinants of the price paid for a pharmaceutical product.

B

BAT (Baseline Assessment Tool) An instrument used by external auditors to assess the accuracy and quality of a health plan's data reporting under the HEDIS® program.

BBA (Balanced Budget Act). The BBA was passed into law by Congress in 1997; it is well known throughout the health industry for its severe reductions in payments for Medicare providers. Hospitals and Medicare HMOs were particularly hard hit by the provisions of this Act.

BCEDP (Breast Cancer Early Detection Program). A special State Medi-Cal program that provides reimbursement for breast cancer screening and detection services.

BENEFICIARY A member covered by Medi-Cal.

BIC (Beneficiary Identification Card). A permanent plastic card issued to Medi-Cal beneficiaries that has an electronic strip that contains information about the person. It does not guarantee eligibility.

BOARD-CERTIFIED Used to describe a physician who has passed an examination given by a medical specialty board, and who has met all the requirements for certification as a specialist in that medical specialty.

BOARD-ELIGIBLE Used to describe a physician who is eligible to take the specialty board examination because they have met all the other requirements to be certified (i.e., completed necessary training and practice requirements).

C

CAHHS (California Association of Hospitals and Health Systems). Formerly the California Hospital Association. The statewide hospital trade group in California.

CAHPS (Consumer Assessment and Health Plan Survey). A member survey designed for measuring the strengths and weaknesses of health plans; it is a tool that has been standardized by the state and federal governments and can be used by any health plan.

CAHP (California Association of Health Plans). State HMO trade group.

CALHEERS (California Healthcare Eligibility, Enrollment and Retention System). An automated system that serves as the consolidated system support of eligibility, enrollment and retention for Medi-Cal, Healthy Families and Covered California.

CALWORKS See "AFDC."

CAPITATION A payment in the form of a per capita (or per person) amount.

CASE MANAGEMENT Describes the responsibility of the PCP to provide and/or arrange for the provision of coordinated, continuous medical services for the patients under his/her care.

CASE MANAGER A term for the health professional (usually the PCP) who is responsible for the case management of a patient.

CBAS (Community-Based Adult Services). Offers services to eligible older adults or adults with disabilities to restore or maintain the capacity for self-care and delay/prevent inappropriate institutionalization. Formerly referred to as adult day health services.

CBO (Community-Based Organization) Refers to nonprofit agencies in the community that provide needed human services to the local population, usually at reduced or no cost.

CCI (Coordinated Care Initiative). Refers to a program to help provide extra support for low-income seniors and persons with disabilities, including those who are dually eligible for Medi-Cal and Medicare. Includes options for dually eligible individuals to combine their benefits from Medi-Cal and Medicare into a single integrated health coverage product and to receive care coordination services.

CCR (California Code of Regulations) The administrative regulations for State programs; Medi-Cal regulations are found at Title 22 of the CCR.

CCS (California Children Services) A State program, under the auspices of DHS, for physically challenged or severely disabled children, up to the age of 21.

CCU (Coronary Care Unit). Acute inpatient bed unit in a hospital, used for coronary care patients in need of intensive care and monitoring.

CERTS (Claims and Eligibility Real Time System). Software distributed by EDS that allows the user to electronically submit pharmacy claims, verify eligibility, clear SOC liability and make Medi-Reservations using a personal computer.

CHAMPUS Refers to the federal government's health care program for those serving in or retired from military service (now referred to as "TRICARE" or "TRICARE/CHAMPUS").

CHCF Refers to the California Healthcare Foundation, a charitable foundation endowed with moneys from the conversion of Blue Cross of California from a nonprofit to for-profit entity.

CHDP (Child Health and Disability Prevention Program). California's version of the federal EPSDT program. It provides for the payment of regular screening checkups and immunizations for children.

CIN (Client Index Number). A unique nine-character number assigned to every person who qualifies for Medi-Cal. The CIN appears on the front of the BIC when the recipient has no Social Security number.

CMAC (California Medical Assistance Commission). Established by State law in 1983, CMAC is responsible for negotiating Medi-Cal contracts with hospitals and certain other health systems in California. Commissioners are appointed by the Governor and the Speaker of the Assembly.

CME (Continuing Medical Education). Programs under which physicians, nurses and other medical professionals receive ongoing education in their fields as is required to maintain their license to practice.

CMS (The Center for Medicare and Medicaid Services). Formerly known as the Health Care Financing Administration, or HCFA, this federal agency, under the authority of the U.S. Department of Health and Human Services, oversees the Medicare and Medicaid programs.

COA (Categories of Aid). Homogenous risk groups that are based on Medi-Cal eligibility (aid codes).

COB (Coordination of Benefits). Pertains to the handling of claims for patients who have more than one insurance coverage. Medi-Cal, by state and federal law, must attempt to first collect from the other carrier when a patient has Medi-Cal and other coverage.

COBRA (Consolidated Omnibus Budget Reconciliation Act). Sometimes used to refer to the annual federal budget law; sometimes also called OBRA.

COHS (County Organized Health System). Refers to the 6 health plans that have contracted with DHS to administer the Medi-Cal program for an entire county. CenCal Health, HPSM, CCAH, GCHP, CalOptima and PHC are the six COHS plans in California, covering the counties of Santa Barbara, San Luis Obispo, San Mateo, Orange, Solano, Napa, Yolo, Santa Cruz, Merced, Ventura and Monterey.

CONCURRENT REVIEW An assessment of persons currently in an acute care hospital, SNF or ICF conducted by health plan utilization management staff. The assessment is done to determine the medical necessity of the stay under Medi-Cal guidelines.

COPAYMENT Amount that a subscriber of a health insurance plan must pay for use of specific medical services covered by the plan.

CPSP (Comprehensive Perinatal Services Program). A state program that is designed to ensure that pregnant women in the Medi-Cal program receive timely and adequate prenatal care (including nutritional counseling, psychosocial assessments, health education, etc.).

CPE (Certified Public Expenditures). An expenditure certified by a public agency to represent its contribution in providing care to Medicaid recipients or uninsured persons. May not include public funds that originated as state Medicaid payments. Does not involve the transfer of funds to the Medicaid agency. Federal government provides federal share to Medicaid agency.

CPT (Current Procedural Terminology). Descriptive terms and codes used for reporting on claim forms, medical services and procedures performed by physicians and certain other providers. Each service or procedure is identified with its own unique 5-digit code.

CREDENTIALING The process followed by a health plan in determining that the providers with whom it contracts are properly licensed and can provide quality care to its members.

CROSSOVER See "Medi-Medi."

CURRENT RATIO A common measure of financial strength, it is the ratio of current assets to current liabilities. The measure indicates a company's ability to meet its current obligations.

CRVS (California Relative Value Scale). A listing of procedure codes and their values; used for billing and assigning reimbursement values to services rendered by physicians.

D

DEPARTMENT OF HEALTH CARE SERVICES (DHCS) The department in California State government responsible for health program administration. These responsibilities include the State FFS Medi-Cal program and the Medi-Cal Managed Care programs. DHCS is a department of the California Health and Human Services Agency.

DEPARTMENT OF MANAGED HEALTH CARE (DMHC) The department in California State government responsible for the licensing and monitoring of health care services plans.

DHHS (Department of Health and Human Services). The federal department responsible for administration of all federal health programs. The DHSS Center for Medicare and Medicaid Services (CMS) oversees the Medicare and Medicaid programs.

DHCS See "Department of Health Care Services."

DISCHARGE PLANNING The activities carried out by hospital and nursing home staffs in evaluating a patient's needs for appropriate care after discharge from the inpatient setting and coordinating that care.

DISPROPORTIONATE SHARE HOSPITAL (DSH) Hospitals that serve what is defined by federal and state laws as a "disproportionate" share of Medicaid, Medicare and noninsured (no pay) patients that are eligible to receive additional payments from various sources in an effort to compensate the hospitals for this service.

DMC-ODS Drug Medi-Cal Organized Delivery System. Waiver program designed to create a coordinated and comprehensive set of full substance use disorder (SUD) services.

DMHC See "Department of Managed Health Care."

DME (Durable Medical Equipment). Equipment that can tolerate repeated use and is primarily needed because of a medical condition. Some such equipment require prior authorization by SBRHA in order to be reimbursable. Examples of common DME are hospital beds, wheelchairs and oxygen equipment.

DRGs (Diagnosis-Related Groups). The method used by the federal Medicare program to reimburse hospitals for inpatient services. The method classifies services according to diagnoses, and there is a set reimbursement for each DRG regardless of the patient's length of stay in the hospital.

DRUG FORMULARY A listing of prescription drugs that are approved for coverage and that can be dispensed without prior authorization.

DSH See "Disproportionate Share Hospital".

E

ED Stands for Emergency Department; see "ER."

ELECTRONIC MEDICAL RECORD (EMR) Refers to a system in which a medical record is maintained in an electronic format.

EMERGENCY Under State Medi-Cal regulations, defined as a situation in which, if immediate medical care is not rendered, loss of life or permanent disability would result.

ENCOUNTER FORM The form used by a primary care provider to report the rendition of any capitated services to case-managed patients.

EOB (Explanation of Benefits). The form sent by a health plan to a provider who has billed for services that may be accompanied by a payment (check) and explains the disposition or status of any claims outstanding (i.e., how much was paid, if claim was denied and why, or claim is pended and why). In the Medicare program, it is referred to as an EOMB (Explanation of Medicare Benefits). Sometimes also referred to as an RA (Remittance Advice).

EOC (Evidence of Coverage). A document required by State regulations that discloses to prospective and current members all details of their health care coverage through a health plan.

EPSDT (Early Periodic Screening, Detection and Treatment). The federal program, called the CHDP program in California (see "CHDP").

EQRO (External Quality Review Organization). An independent review organization that contracts with the California Department of Health Services to perform quality of care audits of contracting Medi-Cal managed care plans.

ER (Emergency Room). The hospital department that is equipped and staffed to treat emergency conditions and is open 24 hours a day.

EVIDENCE OF COVERAGE See "EOC."

EW (Eligibility Worker) An employee of DSS who is responsible for determining eligibility for public assistance programs, such as CalWorks.

F

FAME (Fiscal Intermediary Access to MEDS). Eligibility information supplied by DHS to the FI in order to process FFS claims.

FEDERAL POVERTY LEVEL (FPL) This is the income level set by the federal government and revised each year, below which a family is considered in poverty. It is widely used for eligibility in many federal and state assistance programs, including welfare cash grants and qualification for Medi-Cal and other health programs for low-income persons. Sometimes also referred to as "Federal Income Guidelines."
FFS (Fee-for-Service). Refers to the method of payment to providers, in which the provider is paid a set fee for each service provided. The traditional method of payment to providers of medical services.

FI (Fiscal Intermediary). The contractor who is responsible for processing and paying claims for health programs. For the Medi-Cal program, EDS is the contracted FI (see "EDS").

FIRST 5 Also known as the Children and Families Commission, this body makes the decisions on how local tobacco tax moneys are to be expended, restricted to services for children age 5 and under. There is also a state FIRST 5 Commission that allocates the California share of these tax moneys.

FISCAL YEAR (FY) The 12-month period used by an organization for recording and reporting of financial information. The Authority's fiscal year runs from July 1 to June 30.

FMAP (Federal Medicaid Assistance Percentage). The specified percentage of a state's Medicaid program expenditures that are paid by the federal government.

FPL (see "Federal Poverty Level").

FQHC (Federally Qualified Health Center). Pursuant to federal law, certain medical providers can qualify as a FQHC provider. Once qualified, the provider is entitled to receive payment from Medicaid at 100 % of its reasonable costs as determined by DHS. The program is intended to provide financial assistance to those "safety net" providers who see a disproportionate share of Medicaid patients so they can remain in business to provide these services.

G

GATEKEEPER The name often used to describe the primary care physician (PCP) in a managed care delivery system, since the PCP controls access to most medical services needed by the patient.

GENERIC DRUG A chemical equivalent of a name-brand drug that is manufactured by another company since the original patent on the name brand has expired. The generic version is usually less expensive and therefore many managed care programs either encourage or require the use of generics when available and when the prescribing physician permits substitution.

GEOGRAPHIC MANAGED CARE (GMC) One of the three Medi-Cal managed care programs administered by DHS in which several health plans contract directly with DHS in a certain area, and compete for Medi-Cal patients. The only currently operating GMC plans are in Sacramento and San Diego counties.

GENETICALLY HANDICAPPED PERSON'S PROGRAM (GHPP) A special Medi-Cal program for persons who qualify under California regulatory requirements.

GMC (see "Geographic Managed Care").

GPP (Global Payment Program). Waiver program developed to assist designated public hospitals (DPH) to provide health care to the uninsured.

H

HCBS (Home and Community Based Services). A waiver program under Medi-Cal that allows Medi-Cal clients to receive medical services in their homes, thus avoiding institutionalization.

HCPCS (HCFA Common Procedural Coding System). A listing of services, procedures and supplies, and their associated codes, used by physicians and other providers in billing for services. HCPCS includes CPT codes, and national and local alpha-numeric codes. The national codes are developed by HCFA to supplement the CPT codes. They include physician services not included in CPT, as well as non-physician services such as ambulance, physical therapy and DME. The local codes are developed by local Medicare carriers in order to supplement the national codes. HCPCS codes are 5-digit codes with the first digit being a letter, followed by four numbers. HCPCS codes beginning with A through V are national and those beginning with W through Z are local.

HEALTHY FAMILIES PROGRAM (HFP) The California version of the federal State Children's Health Insurance Program (S-CHIP). It is a program of health care for children, financed by federal and state moneys, and subscriber contributions.

HEALTHY KIDS A program now in existence in several California counties that provides health coverage for children under the age of 19 who do not qualify for Medi-Cal or Healthy Families.

HEDIS (Health Effectiveness Data and Information Set). A standardized set of quality measures that are being increasingly used by health plans and regulators to measure the weaknesses and strengths of individual plans.

HFP or **HF** (see "Healthy Families Program").

HIPAA (Health Insurance Portability and Accountability Act). This Act established the requirements that must be met by all health plans and providers viz. regarding standards governing electronic transactions and confidentiality of medical record information.

HMO (Health Maintenance Organization). An entity that provides or arranges for the provision of coverage of comprehensive medical services for a fixed, prepaid premium. The term was first officially used when the Federal HMO Act was passed in the early 1970s. More than 40 million people are now enrolled in HMOs nationwide. HMOs use a managed care approach to delivering services. There are three basic types of HMOs — staff model (services provided by facilities owned by the HMO, with physicians employed by the HMO), group model (services provided under a contract with a medical group or groups, such as Kaiser Permanente Medical Group), and Independent Practice Association (or IPA, in which the HMO contracts with an association representing multiple providers in private practice, which in turn contracts with the individual providers, who see patients with many different payor sources.

HOME HEALTH SERVICES. Medically necessary health services provided at the home of a Member as prescribed by a PCP or Participating Physician. Such Home Health Services shall include diagnostic and treatment services that can reasonably be provided in the home, including services performed by a registered nurse, post-natal and newborn care and assessment, licensed nurse services, certified home health aide services, clinical social worker services, and qualified outpatient rehabilitation therapy services (such as physical, occupational, and speech therapy).

HOSPICE OR HOSPICE CARE. A specialized form of interdisciplinary health care that is designed to alleviate the physical, emotional, social and spiritual discomforts of a Member who has a medical prognosis of six months or less to live and is provided in lieu of curative treatment for the terminal condition.

I

IBNR (Incurred But Not Reported). Refers to the costs associated with medical services rendered but not yet billed.

ICD-9-CM (International Classification of Diseases — 9th Revision, Clinical Modification). The listing of standard diagnosis codes and their accompanying definitions.

ICD-10-CM (International Classification of Diseases — 10th Revision, Clinical Modification). The listing of standard diagnosis codes and their accompanying definitions. CMS requires the use of the ICD-10-CM code set for dates of service on and after October 1, 2015.

ICF (Intermediate Care Facility). A facility providing a level of care to individuals who do not require the level of care provided in a SNF, but do require care above that provided in a Board and Care facility (Board and Care facility services are not covered by the Medi-Cal program). ICF facilities are usually for the developmentally disabled; hence, the common acronym ICF-DD-H, a residential care facility that seeks to care for and habilitate developmentally disabled clients.

ICU (Intensive Care Unit) The specialized department in an acute care hospital that provides treatment for very ill/severely injured patients.

IGT (Intergovernmental Transfer) The transfer of public funds between or within levels of government where states used transferred funds as a match for federal funds.

IHSS (In-Home Supportive Services). Services provided with State funding to homebound persons in order to assist with ADLs. IHSS is not a Medi-Cal benefit. IHSS workers (also known as "providers") are employed by a Public Authority established and managed by the County DSS.

INPATIENT A patient is being treated in an institutional health facility (usually refers to in-hospital status).

IPA (Independent Practice Association). See "HMO."

IQIP (Internal Quality Improvement Project). A project proposed by the Authority and approved by DHS that fulfills established guidelines for interventions with a member population that can improve health status. These projects can be of either a clinical or non-clinical nature.

K

KNOX-KEENE HEALTH CARE SERVICE ACT Passed by the California Legislature in 1976, the Act establishes stringent regulations for the monitoring of organized health plans operating in the State. The implementation of these regulations rests with the Department of Managed Health Care (DMHC). The regulations require that health plans apply and receive a Knox-Keene license in order to operate in the State.

L

LAO (Legislative Analyst's Office). This Office provides independent advice to the California Legislature.

LI (See "Local Initiative").

LOCAL HEALTH PLANS OF CALIFORNIA (LHPC) LHPC is a statewide trade association comprised of California’s 16 local Medi-Cal managed care plans.

LOCAL INITIATIVE (LI) One of the plans that operates under one of the three models for Medi-Cal managed care in California. Under the State's "two-plan model" of managed care, this is the plan administered by a public agency, and competes for patients with the "mainstream" or private plan in a county.

LONG-TERM CARE (LTC) Refers to the care for patients in long-term care facilities (most commonly SNFs) who are in need of nursing care and assistance with ADLs.

LTC (See Long-Term Care).

LTSS (Long-Term Care Services and Supports). Refers to a broad range of services by paid or unpaid caregivers that assist people who have limitations in their ability to care for themselves due to a physical, cognitive, or chronic health condition that is expected to continue for at least 90 days

M

MAIC or **MAC** (Maximum Allowable Ingredient Cost) Refers to a pricing methodology for generic pharmaceuticals.

MANAGED CARE Refers to a system of health care delivery that organizes providers (generally around a primary care model), influences the utilization and cost of services, and has mechanisms to monitor and assure good quality of care. Managed care systems integrate clinical and administrative services in a cost-effective manner, which assures the availability of care in the most appropriate setting.

MCO Refers to "Managed Care Organization."

MEDICAID The federal program, begun in 1965, that was intended to provide medical benefits to low-income patients. Each State administers its own program. The costs are shared between the federal and state governments (in California, the program is called "Medi-Cal").

MEDI-CAL Name for the Medicaid program in California.

MEDICALLY NECESSARY A service or treatment that is appropriate for a patient's diagnosis, and that, if not rendered, would adversely affect the patient's condition. The Medi-Cal program covers only medically necessary services.

MN or **MEDICALLY NEEDY ONLY (MNO)** Aid category for persons eligible for Medi-Cal only, with no cash grant.

MEDICARE The federally administered program, begun in 1965 that covers basic medical, hospital and (limited) pharmaceutical services (but not extended long term institutional care) for the elderly and disabled. Part A covers inpatient costs and Part B covers outpatient costs.

MEDI-MEDI Refers to persons eligible for both Medicare and Medi-Cal programs; also referred to as "crossover" patients or "dual eligibles". Medicare pays first.

MEDS (Medi-Cal Eligibility Data System). The California automated system that is used to record all eligibility information for Medi-Cal beneficiaries.

MEMBER A person covered under a health care program.

MLR (Medical Loss Ratio). A measure of how much of a premium dollar (or per member payment) is spent on medical care.

MMCD (Medi-Cal Managed Care Division). The section of DHS that is responsible for overseeing the operations of the contracting Medi-Cal managed care health plans in California.

MORBIDITY The incidence and severity of sicknesses and accidents in a defined class of persons.

MORTALITY The death rate at each age as determined from prior experience.

MOU Abbreviation for "Memorandum of Understanding." Generally used to memorialize an agreement between two parties when a lengthy detailed contract is not necessary.

MSSP (Multipurpose Senior Service Program) MSSP sites provide social and health care management for frail elderly clients who are certifiable for placement in a nursing facility but who wish to remain in the community.

N

NCQA (National Committee on Quality Assurance). A private organization that was originally sponsored by national health plans that is now independent. The NCQA establishes health plan quality standards and issues highly sought-after certifications for plans that meet those standards.

NDC (National Drug Code). Refers to the uniform codes assigned to all pharmaceuticals approved by the FDA. Also can be used to refer to National Data Corporation, which provides an electronic "switch" between health plans and pharmacies for filing drug claims.

NICU (Neonatal Intensive Care Unit). An intensive care unit for infants of low birth weights and life-threatening medical conditions.

NMT (Non-Medical Transportation). A Medi-Cal covered benefit that includes transport of beneficiaries to and from Medi-Cal covered medical, mental health, substance abuse or dental services. Includes roundtrip transportation to obtain covered Medi-Cal services by passenger car, taxicab or any other form of public or private conveyance. Does not include transportation by ambulance, litter van or wheelchair vans as these may be covered as non-emergency medical transportation (NEMT) services.

O

OB Obstetrics. "OBs" refers to obstetricians.

OILs (Operating Instruction Letters). Confidential written instructions sent to the Medi-Cal fiscal intermediary (FI) from DHS that direct the FI to make changes to the Medi-Cal reimbursement system.

OMB The Office of Management and Budget, Executive Office of the President. Oversees the budget for all federal government agencies, including CMS (which administers Medicaid and Medicare).

OSHPD The Office of Statewide Health Planning and Development — a California State government agency.

OTC (Over the Counter). Refers to drugs and medical supplies that can be sold without a prescription.

OUTPATIENT Services that are rendered in an ambulatory (walk-in) setting as opposed to an inpatient setting.

P

PALLIATIVE CARE. Patient- and family-centered care that optimizes quality of life by anticipating, preventing and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social and spiritual needs, and facilitating patient autonomy, access to information and choice.

PART A. Medicare Part A. The portion of Medicare that is financed by a tax on earnings paid by employers and employees, and pays for hospital and other inpatient services in the Medicare program.

PART B. Medicare Part B. The portion of Medicare that is financed by general revenues and premiums, and pays for physician and other outpatient services in the Medicare program.

PART C. Medicare Part C. Medicare managed care.

PART D. Medicare Part D. The portion of Medicare that is financed by general revenues and premiums, and pays for prescription drugs in the Medicare program.

PBM (Pharmacy Benefit Manager) A company that provides to health plans management of their pharmaceutical benefits.

PCP (Primary Care Physician). A general internist, pediatrician, general practitioner, family practitioner or obstetrician who contracts with a health plan for a capitated payment and, in return, agrees to provide primary medical services and to coordinate most all other care needed for a defined group of members.

PDR (Physician's Desk Reference). This book has long been considered the authoritative source of information on pharmaceuticals. Used primarily by physicians when prescribing for patients.

PEER REVIEW The process of evaluation of the quality of medical care rendered, using medical professionals, through review of medical records, grievance reports, and other methods.

PERS (Public Employee Retirement System). The retirement system for California state and local government employees.

PICU (Pediatric Intensive Care Unit). A specialized care unit for children within an acute care hospital.

PMPM Refers to "per member per month."

POS DEVICE (Point of Service Device). An electronic device, offered by EDS to Medi-Cal providers, through which a BIC can be swiped to obtain information on a patient's eligibility, to reduce their SOC (if any) and/or to reserve a Medi-Service.

PPO (Preferred Provider Organization). A program in which contracts are negotiated with selected providers at discounted rates; members of a PPO who receive their services from the preferred providers usually pay little or no fees for doing so, but pay significantly more if they see a non-contracted provider. PPOs generally charge higher premiums than HMOs.

PRIMARY CARE Refers to basic, general medical services rendered by a PCP.

PRIME (Public Hospital Redesign and Incentives in Medi-Cal). Pay-for-performance-like program for public and district hospital delivery system transformation. Funds do not flow through managed care plans. Hospitals must implement PRIME projects and meet benchmark goals to receive payments.

PRIOR AUTHORIZATION The process of obtaining approval for coverage of a service prior to rendering of the service. Many Medi-Cal benefits are covered only with prior authorization. Failure to obtain usually will mean that Medi-Cal (or the Medi-Cal managed care plan) will not pay the claim for that service.

PRO (Professional Review Organization). Organizations with which CMS contracts to be responsible for evaluating the appropriateness of Medicare services and claims. The PRO for California is CMRI (California Medical Review, Inc.).

PROSPECTIVE AUTHORIZATION See "Prior Authorization."

Q

QA (Quality Assurance) Also referred to as quality improvement — or "QI" — since the purpose of a QA program is to monitor the quality of care delivered by contracted providers, detect problems, inform providers and work with them to improve care so that it meets established community standards.

QAIP The Quality Assessment and Improvement Plan — a document developed and maintained by a Medi-Cal managed care plan and approved by DHS that sets forth the agency-wide quality improvement activities. This document is reviewed and updated as needed by the CIC on an annual basis.

QI Abbreviation for "Quality Improvement." See "QA."

QM Abbreviation for "Quality Management."

R

RDT (Rate Development Template). An excel template used to collect health plan costs, utilization and other information to support DHCS capitation rate development.

REINSURANCE Reinsurance is also known as "excess risk" or "stop-loss" coverage. It is designed to limit a plan's exposure for high-cost cases. Reinsurance can take two forms — individual and aggregate.

RETROACTIVE AUTHORIZATION The process of obtaining coverage of a service or procedure after it has been rendered. Medi-Cal regulations are very specific as to what services for which — and under what conditions — retroactive authorization can be granted.

RETROSPECTIVE AUTHORIZATION See "Retroactive Authorization."

RFP (Request for Proposals). A document that requests competitive proposals and costs bids for one or more specific services.

RISB Rehabilitation Institute of Santa Barbara.

ROBERT WOOD JOHNSON FOUNDATION (RWJF) A charitable foundation that funds many health care projects.

S

SED Severely Emotionally Disturbed Children. The County's Department of Alcohol, Drug and Mental Health Services is responsible for the treatment of such children.

SERVICE AREA Refers to the geographical area in which a health plan is licensed to operate.
SNF (Skilled Nursing Facility). A freestanding or distinct unit of a hospital that provides 24-hour skilled nursing care to its residents who are certified for that level of care.

SOC (Share of Cost). The out-of-pocket amount that some persons must pay each month toward the cost of their medical expenses before they become eligible for Medi-Cal coverage for that month.

SPECIALIST PHYSICIAN A physician who has specialized in a specific area of medicine by virtue of advanced education and training.

SSA The federal Social Security Administration.

SSI (Supplemental Security Income). Federal grant assistance program for aged, blind and disabled persons. Those receiving SSI automatically qualify for Medi-Cal.

SSN Social Security Number.

SUD Substance Use Disorder.

SWIPE CARD READER Also referred to as a credit card reader of swipe card device. This device connects to a personal computer, allowing the user to pass the BIC through and obtaining Medi-Cal information about the patient. When using this device in conjunction with SBHI's PNS software, no information needs to be keyed in separately.

T

TANF (Temporary Assistance for Needy Families). Federal program that assists families with children when the parents or other responsible relatives cannot provide for the family's basic needs.

TNE (Tangible Net Equity). Under the Knox-Keene Act, and included in the Authority's contract with DHS, are minimum requirements for TNE. This measure is a guideline for a plan's ability to meet its obligations and the maintenance of a prudent reserve.

TPA (Third Party Administrator). In health care, generally an entity that performs claims processing and other administrative services under contract to a health plan or employer with self-insured plans.

TRICARE See "CHAMPUS."

U

UM (Utilization Management). The formal review of utilization of services, and the appropriateness of the services, conducted by a health plan's Health Services Department staff professionals on prospective, concurrent and retrospective bases.

UPL Stands for "Upper Payment Limit." This is the level of payment PMPM under the Medi-Cal FFS program; the capitation payments to Medi-Cal managed care plans by DHS cannot exceed this threshold.

UR (Utilization Review). See "UM."

UTILIZATION The measurement of the frequency of the use of services by members. Usually expressed as the number of services used per year per 1,000 members (e.g., the SBHI hospitalization rate is approximately 600 days per 1,000 members per year).

V

VBAC (Vaginal Birth After Cesarean). Refers to the practice of having a woman deliver vaginally subsequent to one or more deliveries by c-section.

VBP (Value-Based Purchasing). Refers to the linking of health care provider payments to improved performance. Intended to hold providers accountable for both the cost and quality of care provided, and attempts to reduce inappropriate care and identify and reward the best-performing providers.

W

WIC (Women, Infants, and Children's Program). A program that provides nutritional counseling and food coupons (for milk, infant formula and nutritional foods) for no- or low-income pregnant and lactating women, and for infants and children up to the age of 18 months.

WPC (Whole Person Care Program). Pilot programs to integrate health, behavioral health and social services for a target population of high-risk, high utilizers of Medi-Cal.