Managed Care Community of Practice
Glossary

Term	Description
1115 Waiver	A CMS waiver that gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that promote the objectives of the Medicaid and CHP programs. The purpose of these demonstrations, which give States additional flexibility to design and improve their programs, is to demonstrate and evaluate new policy approaches.
Accountable Care Organization (ACO)	A group of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their Medicare patients.
Acute Care	Care provided for a short-term illness or injury. Often occurs in a hospital.
Affordable Care Act (ACA)	Officially named the Patient Protection and Affordable Care Act and often referred to as "ObamaCare," the ACA was signed into law on March 24, 2010, with various provisions phasing into effect over a ten year period. The law's intention is to lower health care costs while expanding access to insurance.
AIDS Drug Assistance Program (ADAP)	Provides free medications for the treatment of HIV/AIDS and opportunistic infections to help people with partial insurance and those who have a Medicaid spend down requirement.
Ambulatory Care	Care that does not require a hospitalization. Includes care delivered in an outpatient setting at a hospital and care delivered at physicians' offices, clinics, and other facilities.
Ambulatory Patient Groups (APGs)	An outpatient payment system designed to reimburse Hospital Outpatient Departments, Hospital Emergency Service Departments, freestanding diagnostic and treatment centers, and ambulatory surgery centers for services provided.
Authorization/Preauthorization	Approval, granted by a managed care plan, for a consumer to receive a health care product or service, such as a specific medical, mental health and/or substance use treatment. Preauthorization is when prior approval by a managed care plan is required before services can be rendered.
Balancing Incentive Plan (BIP)	Authorizes federal grants to States to increase access to non-institutional long-term services and supports as of October 1, 2011.
Behavioral Health (BH)	A term that includes both mental health conditions and substance use disorders.
Behavioral Health Organization (BHO)	Responsible for concurrent inpatient utilization review, monitoring inpatient discharge planning, and working with inpatient facilities, outpatient providers, and local governments to ensure appropriate service planning and continuity of care for high needs individuals with mental illness. MCOs can subcontract BHOs to oversee behavioral health services.
Beneficiary	A consumer, or his or her dependent, who enrolls with a managed care plan, and is entitled to receive coverage and payment for health care products and services covered by the contract with the plan.
Business Associate Agreement (BAA)	An agreement not to use or further disclose PHI, other than what is permitted or required by the agreement or as required by law. This includes using the appropriate safeguards to prevent use or disclosure of the PHI other than as provided for by the agreement. The agreement includes implementing administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of any electronic PHI that it creates receives, maintains, or transmits on behalf of the covered entity.

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Term	Description
Capitation	A payment system in which health care providers (practitioners, hospitals, pharmacists, etc.) receive a fixed payment per member per month (or year), regardless of how many or few services the patient uses.
Care Coordinating Organization (CCO) or People First Care Coordination Organization Health Homes (CCO/HHs)	
Care Coordination	An activity by a person or entity (e.g., Health Homes) formally designated as primarily responsible for coordinating services furnished by providers involved in a member's care. This coordination may include care provided by network or non-network providers. Organizing care involves the marshaling of personnel and other resources needed to carry out all required member care activities; it is often facilitated by the exchange of information among participants responsible for different aspects of the member's care.
Care Coordination Data Definitions (CCDD)	A CCO/HH must ensure the Life Plan employs the Care Coordination Data Definitions (CCDD). The CCDD establishes data standards between OPWDD and comprehensive care coordination providers. These standards allow care coordination providers to share necessary Life Plan data with OPWDD. The current CCDD is a continually evolving document and will progressively advance as the CCO/HH program evolves and is implemented and the I/DD population transitions to Managed Care.
Care Management - Managed Care	Overall system of benefit package service/management administered by the MCO and partners which encompasses utilization management, care coordination, facilitating continuity of care during care transitions (i.e., changes in levels of care, member relocation to a new residence, etc.), management of the quality of care, chronic condition management, and independent peer review.
Case Management	A process managed care plans may use to review the care that patients receive. The goal of case management is to ensure that patients receive the appropriate service from the right provider, at the right time, and in the least costly setting.
Case Rate	A payment system in which the managed care plan pays health care providers an all-inclusive fee to provide care for a patient, based on the patient's diagnosis, or the medical treatments for an agreed upon episode of care.
Category of Service (COS)	A 4-digit code that denotes the type of claim to be entered.
Certified EHR Technology (CEHRT or EHR)	Technology that has been certified as compliant with the most recent certification standards from the Office of the National Coordinator for Health Information Technology (ONC). CEHRT is required in many health care programs, such as Health Homes, to improve the quality and experience of care and reduce costs through safe, secure, seamless and standardized health information exchange.
Claims Form	Documentation (electronic or paperwork) that patients and health care providers file with managed care plans in order to receive payment for services.
Clinical Decision Support (CDS)	Provides health care providers and patients with person-specific information, intelligently filtered, and available at points of care or query, to enhance health and health care. CDS enhances health-related decisions and actions with pertinent, organized clinical knowledge and patient information to improve health and healthcare delivery, as well as decision-making in the clinical workflow.
Clinical Pathway	A medical "roadmap" that helps health care providers identify the most appropriate course of treatment for a specific patient, based on that patient's clinical situation.

Term	Description
Clinical Practice Guidelines	Systematically developed statements regarding assessment and intervention practices. These guidelines were created to assist with practitioner and patient/consumer decisions about appropriate health care for specific circumstances. The goals of clinical practice guidelines are to describe appropriate care based on the best available scientific evidence and broad consensus; reduce inappropriate variation in practice; provide a more rational basis for referral; provide a focus for continuing education; promote efficient use of resources; and act as a focus for quality control.
Clinical Quality Measures (CQM)	Tools to measure and track the quality of health care services provided by eligible professionals, eligible hospitals and critical access hospitals (CAHs) across the health care system. CQMs measure many aspects of patient care, such as: health outcomes, clinical processes, patient safety, efficient use of health care resources, care coordination, patient engagements, population and public health and adherence to clinical guidelines. (Also see eCQMs)
Coinsurance	The portion of health care costs not paid by the managed care plan, for which the consumer is responsible. Coinsurance usually is expressed as a fixed proportion of the managed care plan's allowable charge. For example, if a plan pays 80 percent of its allowable charge for a covered service, the consumer is responsible for the remaining 20 percent as coinsurance.
Community Inclusion	The full participation by an individual living with mental illness and/or substance use disorders in living arrangements, activities, organizations and groups of his/her choosing in the community.
Computerized Provider Order Entry (CPOE)	An electronic application that allows direct entry and transmission of a physician's orders for diagnostic and treatment services (such as medications, laboratory, and other tests), rather than on paper or prescription pads. The application automatically compares the order against standards for dosing, checks for allergies or interactions with other medications, and warns the physician about potential problems.
Conflict Free Case Management (CFCM)	Federal Home and Community-Based Settings rule, 42 CFR 441.301(c)(1)(vi), effective March 2014 requires that "Providers of HCBS for the individual, or those who have an interest in or are employed by a provider of HCBS for the individual must not provide case management or develop the personcentered service plan (Life Plan)." The intention of this Federal rule is to ensure that Case Management services are person-centered and promote the individual's interests, not those of the provider agencies.
Consumer	A member who is receiving or has received mental health/substance use disorder services.
Consumer Assessment of Healthcare Providers and Systems (CAHPS)	A survey that asks consumers to report on and evaluate their experiences with health care.
Continuous Quality Improvement (CQI)	A quality management process where health care providers constantly evaluate the administration and clinical aspects of the services they provide and strive to improve, become more efficient and effective. Data and advance planning are critical to this process.
Contracted Provider	A hospital, practitioner, network of hospitals and practitioners, or other healthcare providers who enter into a legal agreement with a managed care plan to care for the plan's members for negotiated prices.
Coordinated Assessment System (CAS)	An assessment tool specifically tailored to capture the unique health and support needs of individuals with I/DD in New York State. The CAS is used to help develop the Life Plan for individuals in a CCO/HH. The CAS is being implemented in phases and until it is implemented Statewide, the DDP2 will be the assessment tool used to determine CCO/HH PMPM rates and for the development of the Life Plan where applicable.
Coverage	Decision making process that identifies what services or products are benefits under the employer's or consumer's contract with the plan. Covered products or services are eligible to be paid for by the plan.

Term	Description
Credentialing	A system used by managed care plans to assess the qualifications of practitioners or other health care providers who are contracted.
Cultural Competence	Having the capacity to provide appropriate services/care within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities.
Dashboard	A business intelligence dashboard is a data visualization tool that displays the current status of metrics and key performance indicators for an enterprise.
Data Use Agreement	A legally binding agreement between the Requestor and NYSDOH by defining the terms and conditions of the MCD release, should DOH accept the Requestor's Agreement. An additional purpose of the DUA is to assure DOH that a Requestor will maintain the security of MCD that DOH releases to the Requestor.
Deductible	A form of cost sharing in a managed care plan, in which a consumer pays a fixed dollar amount of covered expenses each year, before the plan begins paying its share of costs.
Delivery System Reform Incentive Payment (DSRIP)	In NYS this program will promote community-level collaborations and focus on system reform, specifically a goal to achieve a 25 percent reduction in avoidable hospital use over five years. Safety net providers will be required to collaborate to implement innovative projects focusing on system transformation, clinical improvement and population health improvement (DOH).
Developmental Disability	A severe, chronic disability which originated at birth or during childhood, is expected to continue indefinitely, and substantially restricts the individual's functioning in several major life activities.
Developmental Disability Profile - 2 (DDP2)	Developmental Disabilities Profile may be used to provide an accurate and thorough description of the skills and challenges of a person with developmental disabilities that are related to their service needs. Aggregate DDP-2 data is also used to describe, plan, and manage the system of services.
Disease / Immunization Registry	An electronic tool for tracking the clinical care and outcomes of a defined patient population. They are often used to track and improve care for people with chronic disease or condition, such as diabetes, coronary artery disease, or asthma. It is important to assess disease/immunization registry functionality when selecting or upgrading a certified EHR. Some EHR systems enable providers to create internal registries for clinical diagnostics, medication efficacy, and quality improvement and other specific functions such as: printing individual patient reports, progress reports, registry-generated exception reports, and/or stratified population reports. (A disease/immunization registry differs from a "Patient Registry," which is primarily used for research, and is "an organized system that uses observational study methods to collect uniform clinical and other data to evaluate specified outcomes for a population defined by a particular disease, condition, or exposure, and that serves a predetermined scientific, clinical, or policy purposes.)
Electronic Clinical Quality Measures (eCQMS)	eCQMs are electronic specifications for CQMs approved for submission to CMS programs and associated with providers' ability to deliver high-quality care or relate to long term goals for quality health care.. Measuring and reporting eCQMs helps to ensure the health care system is delivering effective, safe, efficient, patient-centered, equitable, and timely care. Vocabulary value sets used by eCQMs consist of codes and terms drawn from standard vocabularies and includes SNOMED CT®, RxNorm, and ICD-10-CM to represent the clinical concepts found in EHR patient data as defined by the eCQMs (e.g., patients with diabetes, clinical visit). Providers must ensure their health IT systems either capture or can map to these codes in order to report eCQMs. The value sets are available at Value Set Authority Center (VSAC) (access credentials through with Unified Medical Language System® Metathesaurus License) and the Data Element Catalog contains the complete set of eCQMs and value set names.

Term	Description
Electronic Data Interchange (EDI)	EDI is an electronic communication method that provides standards for exchanging data via any electronic means. The predominant standard in the Us is the ANSI ASC X12 (X12) standard.
Electronic Health Record (EHR)	A systematic collection of health information about patients/populations that can be shared electonically across different health care settings. The EHR has incentive programs that reward eligible professionals, eligible hospitals, and critical access hospitals if they adopt, upgrade or demonstrate meaningful use of certified EHR technology. The EHR encompasses both billing and medical record (EMR) components.
Electronic Quality Assurance Reporting Requirements (eQARR)	eQARR is DOH's electronic system for annual reporting on measures of managed care performance in the areas of provider network, child and adolescent health, women's health, adult health, behavioral health, and satisfaction with care. eQARR measures are primarily adopted from the National Committee for Quality Assurance's (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®) with NY-specific measures added to address public health issues of particular importance in NY.
eMedNY	Electronic Medicaid System of NY. Allows NY Medicaid providers to submit claims and receive payments for Medicaid-covered services provided to eligible individuals.
e-Prescribing (eRx)	eRx enables eligible health care providers to enter prescription information into a computer device – like a tablet, laptop, or desktop computer – and securely transmit the prescription to pharmacies using a special software program and connectivity to a transmission network. When a pharmacy receives a request, it can begin filling the medication right away. eRx helps improve *health care quality* and patient safety by reducing medication errors and checking for drug interactions; and streamlines care and reduces costs by enabling providers to electronically request prescription refills in a more convenient, cost-effective and safer approach for doctors, pharmacies, and patients.
Evidence-Based Practice (EBP)	Clinical interventions, which have documented evidence of their effectiveness generating the desired positive health and wellness effects in the clients.
Federally Qualified Health Centers (FQHC)	They are federally funded health centers or clinics that focus on serving underserved areas and populations.
Fee for Service (FFS)	Payment in specific amounts for specific services rendered. Payment may be made by an insurance company, the patient, or a government program such as Medicare or Medicaid. The form of payment is in contrast to payment retainer, salary, or other contract arrangements (to Physicians or other suppliers of service); and premium payment or membership fee for insurance coverage (by the patient).
Front Door	The Front Door refers to the process by which OPWDD connects individuals to the services they need and want by providing assistance in navigating the steps involved in determining OPWDD eligibility, identifying needs, goals and preferences and developing a plan for obtaining those services
Full-Time Equivalent Employee (FTE)	The hours worked by full time employees plus the hours worked by part time employees divided by the number of hours worked during a full time year determines how many full-time equivalent employees a business has. This unit is used for health care reform and small business tax credits.
Fully Integrated Dual Advantage (FIDA)	Integrates service delivery for acute care, long-term care, and behavioral health under a single payment per beneficiary for those eligible for both Medicaid and Medicare.
Fully Integrated Dual Advantage (FIDA) - I/DD	A fully-integrated managed care plan for individuals with intellectual and evelopmental disabilities who have dual Medicare-Medicaid eligibility. NY State contracts with Partners Health Plan (the managed care entity) to coordinate the delivery of covered services for individuals who are eligible and who elect to enroll voluntarily.

Term	Description
Health and Recovery Plan (HARP)	HARPs will manage care for adults with significant behavioral health needs. They will facilitate the integration of physical health, mental health, and substance use services for individuals requiring specialized expertise, and/or tools and protocols that are not consistently found within most medical plans.
Health Commerce System (HCS)	An electronic resource designed to protect the confidentiality of data by requiring that organizations adhere to NYSDOH health data security standards. This secure website can be used to send/request data and reports. The HCS is maintained by the NYSDOH Bureau of HEALTHCOM Network Systems Management.
Health Home	A person-centered care management entity created in the Patient Protection and Affordable Care Act (see ACA) enabling individuals with chronic care illnesses to better manage their conditions, reduce the need for hospitalizations, and avoid emergency room visits.
Health Home Services	Services as defined in Section 1945(h)(4) of the Social Security Act including: comprehensive Care Management; care coordination and health promotion; comprehensive transitional care from inpatient to other settings; individual and family support; referral to community and social support services; and the use of health information technology to link services as feasible.
Health Information Exchange (HIE)	HIE provides the capability to securely and electronically move clinical information among disparate healthcare information systems, and maintain the meaning of the information being exchanged. (HIMSS) HIE can be used as a noun or a verb – as a noun it means an entity dedicated to the secure exchange of health data or as a verb it means the electronic exchange of health data. The goal of HIE is to facilitate access to, and retrieval of, clinical data to provide *safe, timely, efficient, effective, equitable and patient-centered care.*
Health Information Technology (Health IT)	Health IT is a broad concept that encompasses an array of technologies. Health IT is the use of computer hardware, software, or infrastructure to record, store, protect, and retrieve clinical, administrative, or financial information. It includes massive systems, as well as the recent wave of mobile Apps, wearables and digital feedback systems.
Health Information Technology for Economic and Clinical Health Act (HITECH)	HITECH Act, which was part of the American Recovery and Reinvestment Act of 2009 (ARRA), established the Medicare and Medicaid EHR Incentive program to incentivize the adoption and meaningful use of EHRs to advance the triple aim.
Health Insurance Portability and Accountability Act (HIPAA)	This act protects the privacy of individually identifiable health information and sets the national standard for the level of security necessary to protect the electronic storage of health information. Signed into law by President Clinton in 1996, updated in 2013 to include implementation of the HITECH Act via the Final Omnibus Rule.
Healthcare Effectiveness Data and Information Set (HEDIS)	A tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. Altogether, HEDIS consists of 75 measures across 8 domains of care.
Home and Community Based Services (HCBS)	Home and community-based services provide opportunities for Medicaid beneficiaries to receive services in their own home or community; HCBS refers to 1915(i)-like services. Adult HCBS services include Crisis Respite, Education and Employment, Family Supports, Peer Supports, Non-Medical Transportation and Habilitation/Rehabilitation.
Independent Practice Association (IPA)	A corporation (nonprofit or for profit) and/or LLC that contracts directly with providers of medical or medically related services, or another IPA in order to contract with one or more MCOs.
Integrated Care & Supports	The care that results from a practice team of primary care and behavioral health clinicians and other service and support providers working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population. This care may address developmental disabilitues, mental health and substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization.

Term	Description
Integrated Delivery System (IDS)	An organized, coordinated, and collaborative network of various healthcare providers that are connected with the goal of offering a continuum of services to a particular patient population or community.
Intellectual and Developmental Disability (I/DD)	Intellectual disability disorders are characterized by a limited mental capacity and difficulty with adaptive behaviors. Developmental disability refers to severe long-term disability that affects cognitive ability and/or physical functioning. The latter encompasses the former but also includes physical disabilities and manifests by age 22.
Intellectual Disability	A disability characterized by significant limitations in both intellectual functioning and in adaptive behavior, which covers a range of everyday social and practical skills.
Interdisciplinary Team (IDT)	Also known as the care planning team. The team of individuals who participate in the person-centered planning process and the development of an individual's Life Plan. The team must be comprised of the individual and/or their family/representative, Care Manager, primary providers of developmental disability services and other providers either as requested by the individual and their family member/representative.
Interoperability	Interoperability means the "ability of two or more systems or components to exchange information and to use the information that has been exchanged." (IEEE Standard Computer Compilation of Standard Glossaries, New York, NY: 1990) Connecting Health and Care for the Nation: A Shared Nationwide Interoperability Roadmap version 1.0 (Roadmap) [PDF - 3.7 MB] provides a detailed overview of the nationwide roadmap for interoperability from the HHS Office of the National Coordinator of Health Information Technology (ONC).
Level of Care (LOC)	The intensity of medical care being provided by the physician or health care facility.
Level of Care Guidelines	Written criteria designed for use by qualified BH professionals in making level of care decisions based on an individual's symptoms, history, likelihood of treatment response, available resources and other relevant clinical information. The purpose of the level of care determination is to assure that a Plan member in need of service is placed in the least restrictive, but most clinically appropriate level of care available, consistent with NYS medical necessity criteria. May also be called placement criteria.
Life Plan	The Life Plan is created using the person-centered planning process described above. The Life Plan is also known as the person-centered plan of care.
Local Governmental Unit (LGU)	As defined under Article 41 of the NYS Mental Hygiene Law, each LGU has a Director of Community Services responsible for the oversight and planning of the local mental hygiene system. This includes mental health, substance use, and developmental disability services.
Long Term Care (LTC)	Care that recurs or continues over long periods of time, often serving people with chronic physical or mental disorders.
Long Term Services and Supports (LTSS)	Services and supports used by individuals of all ages with functional limitations and chronic illnesses who need assistance to perform routine daily activities such as bathing, dressing, preparing meals and administering medications.
Managed Care Organization (MCO)	Qualified Mainstream Managed Care Organization that meets the qualifications established by this RFQ to manage behavioral health services for Medicaid beneficiaries.
Managed Care Plans	Includes the Mainstream MCO, Managed Care Organizations, and Health and Recovery Plans.
Managed Care Technical Assistance Center (MCTAC)	Provides trainings and resources to support BH providers in New York State with the successful transition to Medicaid managed care.
Managed Long Term Care (MLTC)	A care management program for individuals in the community as an alternative to a nursing home or health-related facility.

Term	Description
Medicaid Analytics Performance Platform (MAPP)	The MAPP web-application in the Health Commerce System (HCS) that is a performance management system designed to provide tools and program performance management technologies to Performing Provider Systems (PPSs) to assist their effort in transformative projects through the Delivery System Reform Incentive Payment (DSRIP) Program. The MAPP supports care management efforts for the HH programs, who have been designated by the PPS´s Lead or Alternate Gatekeeper and processed by the Department´s DSRIP Team. It includes the Provider Network Tool, Attribution Tool, Project Plan Application Tool, Implementation Plan to capture the PPS quarterly updates, and will include the DSRIP Dashboard Performance Module with DSRIP performance and improvement indicator dashboard capabilities.
Medicaid Management Information System (MMIS)	The 21st Century Cures Act requires that enrollable providers in Medicaid Managed Care networks be Medicaid Enrolled. Programs must enroll for a provider number such as the MMIS.
Medicaid Redesign Team (MRT)	The Medicaid Redesign Team was established by Governor Cuomo in January 2011 as a means of finding new ways to lower Medicaid spending in New York State (CHC NYS).
Medical Loss Ratio (MLR)	The percent of premium an insurer spends on claims and expenses that improve health care quality. New York State has imposed an MLR of 89%. This means that for every dollar spent in the transition to managed care, 89 cents must be used to pay for services.
Medical Necessity	New York law defines "medically necessary medical, dental, and remedial care, services, and supplies" in the Medicaid program as those "necessary to prevent, diagnose, correct, or cure conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity, or threaten some significant handicap and which are furnished an eligible person in accordance with state law" (N.Y. Soc. Serv. Law, § 365-a).
Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)	A federal law that prohibits group health plans and health insurance issuers from imposing less favorable benefit limitations on mental health or substance use disorder benefits than on medical/surgical benefits.
National Provider Identifier (NPI)	NPI is a unique identification number for covered health care providers. NYS Medicaid will transition to the use of NPI for all providers. NPI will assist NYS ability to recognize and properly reimburse claims.
Natural Supports	Relationships that occur in everyday life in the community where a consumer lives and works. Natural supports can include, but are not limited to, family members, friends, neighbors, clergy, and other acquaintances. Such supports help consumers develop a sense of social belonging, dignity, and self-esteem.
New York eHealth Collaborative (NYeC)	NYeC is a not-for-profit organization, working in partnership with the New York State Department of Health to improve healthcare for all New Yorkers through health information technology (Health IT). Since 2006, NYeC has worked to help New York State achieve the Triple Aim by developing policies and standards that support the utilization of Health IT, assisting healthcare providers in adopting and effectively using EHRs, and coordinating the development of the Statewide Health Information Network for New York.
Office for People with Developmental Disabilities (OPWDD)	The New York State office that coordinates services for more than 126,000 New Yorkers with developmental disabilities. OPWDD provides services directly and oversees a network of nonprofit service providing agencies.
Office of Alcoholism and Substance Abuse Services (OASAS)	The New York State office that oversees the addiction services system including nearly 1,600 prevention, treatment, and recovery programs.
Office of Mental Health (OMH)	The New York State office that operates psychiatric centers and regulates/oversees more than 4,500 programs across the state. These programs include inpatient and outpatient programs, emergency, community support, and residential and family care programs.

Term	Description
Office of the National Coordinator for Health Information Technology (ONC)	ONC was established as an HHS Office of the Secretary by Executive Order in 2004, to lead national health IT efforts. ONC is the principal federal entity responsible to coordinate nationwide efforts to implement and use the most advanced health information technology and the electronic exchange of health information.
Onboarding	Technical & administrative process by which a provider joins an HIE or interoperable system and secure communications are established and all appropriate Business Associate Agreements, contracts and consents are put in place. State activities related to on-boarding might include the HIE's activities involved in connecting a provider to the HIE so that the provider is able to successfully exchange data and use the HIE's services. The 90 percent HITECH match is available to cover a state's reasonable costs (e.g., interfaces and testing) to on-board providers to an HIE.
Opioid Treatment Program (OTP)	A federally regulated (overseen by SAMHSA), accredited, and certified program that provides treatment for opioid dependence.
Participating Provider	A hospital or practitioner who signs a contract with a managed care plan and agrees to care for plan members for negotiated fees and conditions specified in the contract. Typically, when plan members see participating providers, they have low co-payments and no paperwork to file with the plan. To become a participating provider, a provider must be a contracted provider and fully credentialed.
Patient-centered Medical Homes (PCMH)	A model of care where each patient has an ongoing relationship with a personal physician who leads a team that takes collective responsibility for patient care.
Per Member Per Month (PMPM)	The amount a provider or a managed care organization receives per month for each patient or member.
Performance Improvement Project (PIP)	A concentrated effort on a particular problem in one area of the facility or facility wide; it involves gathering information systematically to clarify issues or problems, and intervening for improvements.
Performing Provider System (PPS)	An entity responsible for performing a DSRIP project, requires collaboration between a number of hospitals and/or agencies.
Permanent Supportive Housing (PSH)	Housing with continued occupancy for a qualified tenant as long as the tenant's household pays the rent and complies with the lease or applicable landlord/tenant laws. The tenants are linked with supportive services that are: flexible and responsive to their individualized needs; available when needed by tenants; and if necessary, accessible where the tenant lives. Housing meets the U.S. Department of Housing and Urban Development housing quality standards and is made available by New York State, its designee, or directly with other qualified housing organizations. Housing is affordable to the eligible target population (monthly rent and utilities do not exceed 30% of monthly income).
Personal Health Records (PHRs)	PHRs contain the same types of information as EHRs—diagnoses, medications, immunizations, family medical histories, and provider contact information—but are designed to be set up, accessed, and *managed by patients* . Patients can use PHRs to maintain and manage their health information in a private, secure, and confidential environment. PHRs can include information from a variety of sources including clinicians, home monitoring devices, and patients themselves.
Personal Outcome Measures (POM) & CQL POM	A tool developed by the Council on Quality and Leadership (CQL) that uses 21 indicators to understand the presence, importance and achievement of outcomes, involving choice, health, safety, social capital, relationships, rights, goals, dreams, employment and more. Insight gained during a POM interview can be used to inform a person-centered plan, and at an aggregate level, influence an organization's strategic plan. OPWDD has embraced the Council on Quality and Leadership's (CQL) Personal Outcome Measures (POMs) as the person centered quality of life measurement that will be used as a critical quality measure.

Term	Description
Person-Centered Planning Process	A process directed by the individual that helps us learn how they want to live and describes what supports are needed to help them move toward a life they consider meaningful and productive. The planning process empowers the individual by building on their abilities and skills, promoting a quality lifestyle that supports the individual in finding ways to contribute to their community. Other factors which impact the individual's life, such as health and wellness, are also considered during the planning process.
Portal	Electronic gateway or Internet site providing access or links to other sites.
Preferred Provider Organization (PPO)	A managed care organization that has a more limited provider network; services obtained from outside the network are not covered or feature higher cost-sharing levels.
Prepaid Inpatient Health Plan (PIHP)	A type of managed care arrangement that provides prepaid capitation payments to managed care entities that arrange for inpatient hospital care.
Primary Care Provider (PCP)	The health care professional mainly responsible for the care of a patient, especially in an outpatient setting.
Prospective Payment System (PPS)	A method of reimbursement in which Medicare payment is made based on a predetermined, fixed amount. The payment amount for a particular service is derived based on the classification system of that service (for example, diagnosis-related groups for inpatient hospital services).
Psychiatric Advance Directive	A legal document giving instructions for future mental health treatment or appointing an agent to make future decisions about mental health treatment. The document is used when the person who created the document experiences acute episodes of psychiatric illness and becomes unable to make or communicate decisions about treatment.
Quality Assurance Reporting Requirements (QARR)	Federal and New York State tool used to measure the performance of health plans and practitioners on important aspects of care and service.
Recovery Focus	A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.
Referral	Managed Care plan may require beneficiary to see primary care physician and get approval for other services in the plan, such as diagnostic tests, care from a specialist, or physical therapy.
Regional Health Information Organization (RHIO) / Qualified Entities (QE)	A RHIO, or QE (Qualified Entity), is a local hub where a region's electronic health information is stored and shared. There are eight RHIOs in New York State that each cover different geographic areas, and are the backbone of the SHIN-NY, providing the services that make secure, vital access to a patient's health information possible statewide.
Request for Qualification (RFQ)	RFQ- Request for Qualification, RFP - Request for Proposals, RFI - Request for Information
Revenue Cycle Management (RCM)	All administrative and clinical functions that contribute to the capture, management, and collection of client service revenue. This describes the life cycle of a client account from creation to payment collection and resolution. The client account cycle is supported by a number of additional activities necessary to assure that revenue collection is maximized and all encounters are billable and meet regulatory requirements.
Safety Net Assistance (SNA)	A New York State temporary assistance program. Individuals who receive little or no income and less than $2000 in resources are eligible, especially those who aren't eligible for other programs such as single adults, childless couples, children living apart from adults, etc.
Screening, Brief Intervention and Referral to Treatment (SBIRT)	A screening and intervention procedure conducted in primary care, ED or in some specialty care settings to screen for risky substance use and provide a brief intervention or when indicated, a referral to treatment.
Serious Mental Illness (SMI)	A diagnosable mental disorder experienced by an adult that is sufficiently severe and enduring to cause functional impairment in one or more life areas and a recurrent need for mental health services.

Term	Description
Social Determinant of Health (SDH)	Conditions in which people are born, grow, live, work. Their circumstances are affected by the distribution of money, power, and resources. VBP contractors in Level 2 or Level 3 agreements will be required statewide to implement at least one SDH intervention. DOH has created a reporting template that will be used to measure progress.
Specialized I/DD Managed Care Plan	Specialized Medicaid Managed Care Plans with a focus on I/DD services. The goal is the creation of a model of care that enables qualified Specialized I/DD Managed Care Plans throughout the State to meet the needs of individuals with I/DD. The State anticipates the release of a qualification document to certify I/DD experienced, provider-led I/DD Specialized Managed Care Plans in September 2018.
State Approved Functional Needs Assessment	OPWDD requires that individuals determined eligible for OPWDD services have a completed state approved functional needs assessment that is used to inform the comprehensive assessment process. When the CAS has been completed for an individual, that CAS functions as OPWDD's State approved functional needs assessment to inform the comprehensive assessment process. If a CAS has not yet been completed for the individual, then the DDP2 is the State approved functional needs assessment to be used to inform the comprehensive assessment process.
State Medicaid Agency (SMA)	For New York State this is the NYS Department of Health.
State Plan Amendment (SPA)	An agreement between a state and the federal government describing how that state administers its Medicaid and CHIP programs.
Statewide Health Information Network of New York (SHIN-NY)	SHIN-NY is a "network of networks" that links New York's eight regional health information organizations (RHIOS) or Qualified Entities (QEs) throughout the state.
Substance Abuse and Mental Health Services Administration (SAMHSA)	The agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation by reducing the impact of substance abuse and mental illness.
Substance Use Disorder (SUD)	Refers to substance abuse and substance dependence and measured on a continuum from mild to severe depending on how many relevant symptoms an individual exhibits. Each substance has its own separate use disorder but is diagnosed based on the same overarching criteria symptoms.
Supplemental Security Income (SSI)	A program that pays benefits to disabled adults and children who have limited income and resources.
Temporary Assistance to Needy Families (TANF)	A program geared at helping families achieve self-sufficiency where children can be cared for in their own homes and parents are less dependent on assistance.
The Centers for Medicare and Medicaid Services (CMS)	The federal agency that administers or oversees Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP). Covers 100 million people and strives to coordinate better care at lower costs.
The New York State Department of Health (DOH)	A statewide government department that focuses on issues related to the general health of the residents of New York.
Transition Age Youth (TAY)	Individuals under age 23 transitioning into the adult system from any OMH, OASAS or OCFS licensed, certified, or funded children's program. This also includes individuals under age 23 transitioning from State Education 853 schools (These are operated by private agencies and provide day and/or residential programs for students with disabilities).
Trauma-Informed	SAMHSA defines as "A program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; responds by fully integrating knowledge about trauma into policies, procedures, and practices; and seeks to actively resist re-traumatization."
Triple Aim	Improved Health, Better Healthcare and Consumer Experience, Lower Costs

Term	Description
Utilization Management (UM)	Procedures used to monitor or evaluate clinical necessity, appropriateness, efficacy, or efficiency of behavioral health care services, procedures, or settings and includes ambulatory review, prospective review, concurrent review, retrospective review, second opinions, care management, discharge planning, and service authorization.
Utilization Review (UR)	A review to determine whether health care services that have been provided, are being provided or are proposed to be provided to a patient, whether undertaken prior to, concurrent with or subsequent to the delivery of such services are medically necessary.
Value Based Payment (VBP)	A methodology of arrangements which incentivize value and quality of care, in contrast to the current arrangement of incentivizing quantity of care.