18. Glossary of Terms

Access to Care: The extent to which a patient/member is able to obtain healthcare services at the time they are needed or within a preset time frame as established by Healthfirst or by regulatory agencies. Access, including telephone access, is defined by the availability and acceptability of medical services to the member, the location of healthcare providers, transportation, hours of operation, the cost of care, and the ability to schedule appointments.

Action: A service authorization determination or other activity of Healthfirst or its subcontractor that results in the denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; failure to provide services in a timely manner, as defined by applicable state law and regulation and Section 15 of the Medicaid Contract; or failure of Healthfirst to act within the time frames for resolution and notification of determinations regarding Complaints, Action Appeals, and Complaint Appeals.

Additional Benefits: Healthcare services not covered by original Medicare and reductions in premiums or cost-sharing for Medicare-covered services.

Advance Directives: Legal documents allowing competent adults to provide information regarding treatment should they become incapacitated and unable to speak for themselves.

Ancillary Services/Providers: A term used to describe the additional services and the providers/facilities of those services that are related to medical care. They include apnea or sleep study centers, fetal/uterine monitoring, audiology and hearing services; chiropractors, dental care; diagnostic imaging and radiology services; dentists, dialysis; durable medical equipment; home healthcare and home infusion therapy; hospice, laboratory services; orthotic and prosthetic equipment; outpatient rehabilitation; pharmacy services; physical, occupational, and speech therapy; skilled nursing facilities; and routine vision care.

Appeal: A formal request by a provider or member for review and reconsideration of a health-plan decision. An appeal request initiates a formal review process.

Appropriate Transfer: One in which the transferring hospital provides medical treatment to reduce the risks to the individual, sends all relevant medical records to the receiving hospital, and uses qualified personnel and transportation equipment for the transfer.

Authorization Number: A unique number generated by the Medical Management department when a request for authorization of services has been approved. Authorization numbers are communicated to the provider of service; they should be referenced on all claims and correspondence related to those services.

Authorized Services: Medical, ancillary, or behavioral healthcare services that require authorization beyond a routine referral from the Medical Management department. Generally, authorization must be obtained in advance of services in order for the provider to receive reimbursement.

Auto-Assignment: A process by which an eligible person, mandated to enroll in managed care but who has not enrolled within sixty (60) days, is assigned to a Prepaid Health Services Plan (PHSP) or HMO contracted with a local Department of Social Services such as a Medicaid Managed Care Provider.

Balance Billing: A provider billing a member for the difference between the amount the provider charges for the services rendered and the amount the provider has been reimbursed for the health plan. Healthfirst providers are prohibited from balance-billing members for any covered services.

Behavioral Health Services: Services to address mental health disorders and/or chemical dependency.

Beneficiary: An eligible person is an individual who the Center for Medicaid Services (CMS) determines to be eligible for Medicaid and who meets all the other conditions for enrollment in the health plan.

Benefits: The services to which health plan members are entitled under their designated Healthfirst program.

Capitation Payment: A fixed amount of money paid to a provider, hospital, or other provider per-member-

per-month to cover the cost of a specific scope of services which must be provided or arranged for by the provider pursuant to the provider's contract with Healthfirst.

Care Management: The process of planning for treatment and services, assessing the appropriateness of services, and following up to review the effectiveness of services to ensure that members receive efficient, effective, high-quality care that meets their healthcare needs in a cost-effective manner.

Center for Health Dispute Resolution (CHDR): An independent CMS contractor that reviews appeals by members of Medicare managed care plans.

Centers of Medicare & Medicaid Services (CMS): An organization within the United States Department of Health and Human Services that administers the Medicare program and certain aspects of State Medicaid programs; formerly known as the Healthcare Financing Administration.

Chemical Dependence Services: Examination, dependency, level-of-care determination, treatment, rehabilitation, or habilitation of persons suffering from chemical abuse or dependence; includes the provision of alcoholism and/or substance abuse services.

Child/Teen Health Program (C/THP): This is a program of early and periodic screening, including inter-periodic, diagnostic, and treatment services that New York State offers all Medicaid-eligible children younger than age 21. Care and services are provided in accordance with the periodicity schedule and guidelines developed by the NYSDOH. The services include administrative services designed to help families obtain services for children including outreach, information, appointment scheduling, administrative care management, and transportation assistance to the extent that transportation is included in the benefit package.

Claim Review/Reconsideration: The process by which a claim is reviewed at the provider's request to reconsider the payment determination made when the claim was processed.

Clean Claim: A claim for services that includes all required information and documentation, passes all system edits, and does not require any additional review to determine the medical necessity and appropriateness of services provided.

Clinical Peer: A provider having the same or a substantially similar specialty as the provider under review during the hearing process.

Coinsurance: A fixed percentage of the total amount paid for a healthcare service that can be charged to a member on a per-service basis.

Concurrent Review: An assessment of inpatient hospital care or ambulatory services by trained clinical review staff, during the period that those services are being provided, to assess the appropriateness and duration of care and treatment plans and to facilitate discharge planning.

Coordination of Benefits (COB): The process of assigning primary, secondary, and residual financial responsibility for coverage of healthcare services when an individual is eligible for benefits from more than one insurer or benefits program.

Copayment: A fixed amount that can be charged to a member on a per-service basis.

Cost Sharing: The amount of deductibles, coinsurance, and copayments that the member is responsible for paying on a per-service basis.

Covered Services: Services that must be furnished or paid for in accordance with the subscriber agreement or Evidence of Coverage between the health plan and the member, or covered by the applicable Medicaid, Medicare or CHP program.

Current Procedural Terminology (CPT): A recognized industry standard of descriptive terms and code identifiers for reporting medical services and procedures performed by physicians and other healthcare providers. CPT codes are used in conjunction with ICD-9 diagnostic codes for claims data and other reporting of services provided.

Credentialing: This process reviews and verifies a provider's credentials and experience prior to said provider's being approved for participation in a health plan. Specific review criteria are applied to ensure that the provider's credentials are appropriately verified initially and at ongoing intervals.

Cultural Competence: A provider's effective method of communicating with members who have limited proficiency in English or limited reading skills, diverse cultural and ethnic backgrounds, and physical or mental disabilities, in order to facilitate the member's decision-making regarding medical treatment options. In addition, cultural competence includes offering the option of receiving no treatment.

Custodial Care: Care furnished for the purpose of meeting nonmedically necessary personal needs which could be provided by a person without professional skills or training. Custodial care is not covered unless provided in conjunction with Skilled Nursing Care.

Detoxification Services: Medically Managed Detoxification Services; and Medically Supervised Inpatient and Outpatient Withdrawal Services as defined in Appendix K – Prepaid Benefit Package Definitions of Covered and Noncovered Services of the Medicaid Managed Care Contract.

Direct Access: Access to specialty care services that do not require a referral from the member's PCP. Members may access these services at their own discretion without prior approval.

Direct Admission: This is a situation in which a member has been seen in the provider's office and the provider has made a determination that immediate admission to an inpatient hospital facility is medically necessary.

Disenrollment: Disenrollment is the process by which a member's entitlement to receive services from a health plan is terminated and the member is removed from the plan. Reasons for disenrollment may include, but not be limited to, loss of eligibility as well as disenrollment "for cause."

Discharge Planning: The planning and arranging for post-hospital services to ensure that members are discharged from inpatient care with timely arrangements in place for all necessary and appropriate post-hospital care.

Drug Formulary: A continuously updated list of preferred prescription medications. For Healthfirst, the formulary is developed by the Healthfirst Medical Affairs department and takes into consideration cost and efficiency. The formulary contains FDA-approved brand-name and generic drugs.

Durable Medical Equipment (DME): Equipment that can withstand repeated use by one (1) member, is primarily and customarily used to serve a medical purpose, is generally not useful to a person in the absence of illness or injury, and is appropriate for use in the member's home.

Effective Date of Enrollment: The date on which a health plan member can begin to receive services from the health plan.

Electronic Funds Transfer/Electronic Remittance Advice (EFT/ERA): A convenient service for the automatic reimbursement of Healthfirst claims. EFT is the direct electronic deposit of claim reimbursements into a provider's bank account, and ERA is the statement that allows providers to reconcile these reimbursements to their member accounts.

Eligible Person: An individual who the local Department of Social Services or State authority determines to be eligible for Medicaid and who meets all the other conditions for enrollment in the health plan.

Emergency Medical Condition – PHSP: A medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in: (i) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition, placing the health of that person or others in serious jeopardy; or (ii) serious impairment to such person's bodily functions; or (iii) serious dysfunction of any bodily organ or part of such person; or (iv) serious disfigurement of such person.

Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient

severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: 1) serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child; 2) serious impairment to bodily functions; or 3) serious dysfunction of any bodily organ or part.

Emergency Services: Covered inpatient and outpatient services that are (i) furnished by a provider qualified to provide emergency services and (ii) needed to evaluate or stabilize an emergency medical condition.

Enrollment Broker: An agent or contractor of the state or county who assists in educating and enrolling potential managed care members, assists in explaining the differences between managed care and fee-for-service, and offers nonbiased enrollment counseling.

Enrollment Roster: A report circulated each month to participating primary care providers to identify and provide demographic information on the health plan members who are in that provider's member panel for that month.

Evidence of Coverage (EOC): The contract between the member and Healthfirst Medicare putting forth the terms of the coverage for medically necessary healthcare services.

Explanation of Payment (EOP): A form or report that provides a detailed explanation of the payment or denial of payment in response to a provider's claim for reimbursement of services.

External Appeal: A request to the state for an independent review of a health plan's denial of services.

Extra Help: Medicare members with limited income and resources may qualify for financial assistance with paying for prescription drug costs (i.e., monthly premium, yearly deductible, and prescription coinsurance payments). The Centers for Medicare & Medicaid Services (CMS) provide (or pay for) extra help. The amount of extra help depends on the individual's income and resources.

- **Please Note:** Medicare members who have lost their Medicaid status are **required** to reapply for Extra Help.

Family Planning Services: Offering, arranging, and furnishing of those health services which enable individuals, including minors who may be sexually active, to prevent or reduce the incidence of unintended pregnancies. Family planning and reproductive healthcare include the following medically necessary services and related drugs and supplies that are furnished or prescribed by or under the supervision of a physician or nurse practitioner:

- Contraception, including insertion or removal of an IUD, insertion or removal of Norplant, and injection procedures involving pharmaceuticals such as Depo-Provera.
- Screening and treatment for STDs.
- Screening for anemia, cervical cancer, glycosuria, proteinuria, hypertension, breast disease, pregnancy, and pelvic abnormality/pathology.
- Termination of pregnancy services (provider must document duration of pregnancy).

Such services include those education and counseling services needed to render the services effective.

Fee-for-Service (FFS): The traditional healthcare payment system under which providers receive a payment for each service provided based upon a contractually agreed-upon fee schedule.

Grace Period: A 'grace period' is a period of extra time that a member is given to pay their monthly premium should they miss a payment. The grace period provision for a Leaf Plan or Leaf Plan Premier member depends on the subsidy or tax credit that the member qualifies for. Members who receive no premium subsidies or federal tax credits have up to 30 days to pay their premium after their premium due date. Members who receive premium subsidies have up to 90 days to pay their premium after their premium due date.

Grievance Process: The formal process by which health plan members or providers can communicate

complaints and seek remedies from the health plan.

Guaranteed Eligibility: The period beginning on the member's effective date of enrollment with the health plan and ending six (6) months thereafter during which the enrollment of and capitation payments on behalf of the member continue even if a change in the member's financial or other circumstances ordinarily would have rendered him or her ineligible to receive any Medicaid-reimbursed services.

Health Care Proxy: A formal document that enables a health plan member to designate a trusted individual to make healthcare decisions on his or her behalf should the member lose the ability to make decisions on his or her own.

Health Plan Employer Data and Information Set (HEDIS®): HEDIS is a set of standardized performance measures designed to ensure that consumers, purchasers, and the general public can access information that allows for reliable comparison of the performance of different healthcare plans.

Home Health Agency: A licensed or certified agency under Part A of Medicare that provides intermittent skilled nursing care and other therapeutic services in the member's home.

Home Healthcare: Services provided by a Home Health Agency. The services may consist of the following:

- intermittent or part-time nursing visits rendered by an RN;
- intravenous therapy as ordered by the provider;
- home health aid services under the direction and supervision of an RN;
- other health services to be delivered in the home setting as requested/approved by the PCP/specialist and authorized by Medical Management.
- Home Healthcare services may require the use of durable medical equipment, oxygen and respiratory equipment, and other medical supplies.

Hospice: An organization or agency certified by Medicare that is primarily engaged in providing pain relief, symptom management, and supportive services to terminally ill members and their families.

International Classification of Diseases, 9th Edition (Clinical Modification) (ICD9-CM): This is an industry standard listing and coding system used by providers for reporting medical conditions and diagnoses. ICD-9 codes are used in conjunction with CPT-4 codes for claims data and other clinical data reporting.

Informed Consent: A legal concept requiring the member, the member's guardian, or the member's legal representative to be advised of and to understand the risks of a proposed medical procedure or treatment prior to approving such procedure or treatment. Informed consent is usually provided in writing.

In-Network: The designation given to medical care services provided by providers, hospitals, and other providers that have participation agreements with the health plan.

Lock-in Period: The time beginning 90 days after the effective date of enrollment in the health plan by a social services official and ending 12 months after the effective date of enrollment, during which the member may not disenroll from the health plan except for certain specified reasons.

Low Income Subsidy (LIS): See Extra Help.

Marketing: Any activity of the health plan by which information about the health plan is made known to eligible persons for the purpose of persuading them to enroll with the health plan.

Managed Care: A comprehensive, coordinated approach to the provision of healthcare services that combines medical services with administrative procedures to ensure timely access to high-quality, medically appropriate, and cost-effective care. Managed care emphasizes primary and preventive care and focuses on the appropriate utilization of specialty care, emergency room services, and inpatient hospital care.

Medicare Advantage Organization: A public or private entity organized and licensed by the state as a risk-

bearing entity that is certified by CMS as meeting the Medicare Advantage plan contract requirements. Formerly Medicare + Choice Organization.

Medicare Advantage Plan: Health benefits coverage offered under a policy or contract by a Medicare Advantage Organization that includes a specific set of benefits offered at a uniform premium and uniform level of cost-sharing to all Medicare beneficiaries residing in the service area of the Medicare Advantage Organization. Formerly Medicare + Choice Plan.

Medicaid: A federal program created in 1965 under Title XIX—Medical Assistance of the Social Security Act. The program is administered and operated individually by participating state and local governments providing medical benefits and services to eligible persons who meet income or medical need criteria. The federal and state governments share Medicaid program costs.

Medical Management: The Healthfirst Medical Management department whose function it is to promote the efficient use of healthcare services and quality of care.

Medical Management Program: The program of utilization management, clinical review, and quality improvement established by Healthfirst to assure that the proper level and quality of care is provided to members.

Medical Record: A complete record that documents care received by the member, including inpatient, outpatient, and emergency care, in accordance with all applicable laws, rules, and regulations, which is signed by the medical professional rendering the services.

Medically Necessary – PHSP: Applies to healthcare and services that are necessary to prevent, diagnose, correct, or cure conditions in a 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.

Medically Necessary: Medical or hospital services which are determined by Healthfirst to be 1) rendered for the treatment or diagnosis of an illness or injury; 2) are appropriate for the symptoms, consistent with diagnosis, and otherwise in accordance with sufficient scientific evidence and professionally recognized standards; 3) are not furnished primarily for the convenience of the member, the attending physician, or other provider of service; and 4) are furnished in the most economically efficient manner which may be provided safely and effectively to the member.

Medical Staff: A hospital's or ambulatory surgery center's medical staff, as that term is defined in the bylaws of the hospital or ambulatory surgery center.

Medicare: The federal government health insurance program established by Title XVIII of the Social Security Act.

Medicare Part A: Hospital insurance benefits, including inpatient hospital care, Skilled Nursing Facility Care, Home Health Agency Care, and Hospice care offered through Medicare.

Medicare Part B: Medical insurance benefits that are optional and require the payment of a premium. Covers provider and certain nonprovider services.

Medicare Part D: Prescription drug insurance available to everyone with Medicare and provided by private companies.

- Effective January 1, 2006.

Medicare Basic Benefits: All healthcare services that are covered under Medicare Part A and Part B programs (except hospice services), additional services that are covered by Medicare funds, and other services for which a member is required to pay a premium.

Medicare Benefit Period: A period beginning with the first day of a Medicare-covered inpatient hospital stay and ending with the close of a period of 60 consecutive days during which the member was neither an inpatient of a hospital nor of a SNF.

Member: An individual who is covered by Healthfirst, including newborn children of persons who have

enrolled in benefit programs offered by Healthfirst.

Noncontracting Medical Provider or Facility: Any professional, organization, or health facility licensed and/or certified by the state or Medicare to deliver or furnish healthcare services but not under contract with Healthfirst to provide such services.

Nonparticipating Provider: A provider of medical care and/or services with which the health plan has no provider agreement.

Nonprescription/Over-the-Counter (OTC) Drugs and Medical/Surgical Supplies: Nonprescription drugs and supplies listed on the New York State Fee schedule as listed in the MMIS pharmacy Provider Manual.

Notice of Discharge and Medicare Appeal Rights (NODMAR): A notice issued to Healthfirst Medicare Plan members receiving inpatient hospital care or to their representative when it is determined that the current care is no longer medically necessary or is custodial in nature.

Obstetric and Gynecologic (OB/GYN) Providers: A group of providers including obstetricians, gynecologists, certified nurse midwives, and nurse practitioners with training in obstetrics and/or gynecology that provide women's healthcare services to Healthfirst members.

Optional Supplemental Benefits: Services not covered by Medicare that a member must purchase as a part of a Medicare Advantage plan that are paid for directly or on behalf of a member in the form of premiums or cost-sharing.

Organizational Determination: A decision whether or not coverage is necessary and appropriate.

Original Medicare: The payment system by which doctors, hospitals, and other providers are paid a specific amount for each service performed as it is rendered and identified by a claim for payment.

Participating Provider: A hospital, physician, ambulatory surgical center, home healthcare agency, pharmacy, multispecialty group practice, or other healthcare provider that has entered into an agreement to provide services covered under benefit plans marketed by Healthfirst.

Peer Review Organization (PRO): An independent contractor paid by CMS to review medical necessity, appropriateness, and quality of medical care and services provided to Medicare beneficiaries.

Premium: The amount that must be paid for your health insurance or plan on a monthly, quarterly, or yearly basis.

Prior Authorization: The process whereby a provider must receive approval from the Medical Management department prior to rendering services. Services are authorized in accordance with nationally recognized standards of medical care.

Prepaid Health Services Plan (PHSP): A public or private organization organized under the laws of the State of New York and certified by the State Department of Health under Section 4403-A of the New York State Public Health Law.

Prescription Drugs: Those drugs that are listed on the New York State List of Medicaid Reimbursable Drugs.

Primary Care Covered Services: Those provider services covered by Healthfirst as described in the PCP agreement.

Primary Care Provider (PCP): A qualified physician or nurse practitioner or team of no more than four (4) qualified physicians/nurse practitioners who provide all required primary care services contained in the benefit package to members. Medical residents may be used as part of the PCP delivery system under the supervision of a qualified attending physician. PCPs specialize in internal medicine, family practice, pediatrics, or general practice. For the Medicare and commercial programs, geriatricians may participate as PCPs.

Provider Agreement: Any written contract between the health plan and a participating provider to provide medical care and/or services under this agreement.

Prepaid Capitation Plan Roster: The monthly reporting mechanism by which all Medicaid Managed Care Plans currently enrolling recipients in New York State (and any county within which these plans operate) are informed of specifically which recipients a managed care plan will be servicing for the coming month.

Provider's Members: Those members who have been assigned by Healthfirst to the provider, including newborn children of members who have been assigned to the provider, for the provision of medically necessary covered services. These members comprise the participating provider's panel.

Provider Network: The providers with whom Healthfirst contracts or makes arrangements to furnish covered healthcare services to Healthfirst members.

Qualified Health Plan (QHP): An insurance plan that is certified by the Federal or State Health Insurance Marketplace, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements established by the Marketplace in which it is sold. Qualified health plans began coverage in 2014 under the Affordable Care Act. The QHPs offered by Healthfirst on the NY State of Health website are known as the Healthfirst Leaf Plans and Leaf Premier Plans.

Quality Improvement Organization (QIO): An independent organization under contract with the Centers for Medicare and Medicaid Services (CMS) for the purpose of improving the quality of care for Medicare beneficiaries, protecting the integrity of the Medicare Trust Fund, and protecting Medicare beneficiaries by addressing individual cases such as beneficiary complaints.

Quality Improvement Program (QIP): A program for reviewing, assessing, ensuring, and making determinations regarding the quality of the healthcare delivery system serving Healthfirst members. This includes review of the timeliness, quality, and appropriateness of medical care by the Health Care Quality Council and external peer review bodies.

Reconsideration: An appeal of an initial determination that was not favorable.

Referrals: A health plan–approved recommendation given to one participating provider from another participating provider (usually from a PCP to a participating specialist) in order to arrange for certain medical services for a Member within the health plan's active provider network. A referral facilitates a provider's effort in coordinating a member's healthcare needs. Leaf Plan and Leaf Premier Plan members must obtain referrals from their PCPs to arrange for certain specialist services in order to ensure the plan will cover these services.

Service Area: The specific geographic area where members reside and the health plan is authorized to operate. A geographic area approved by New York State and CMS within which an eligible individual may enroll in Healthfirst.

Skilled Nursing Care: Services that can only be performed by or under the supervision of licensed nursing personnel.

Skilled Nursing Facility (SNF): A facility that provides inpatient Skilled Nursing Care, rehabilitation services, or other related health services. This term does not apply to convalescent nursing homes, rest homes, or facilities for the aged that primarily furnish custodial care including training in routines of daily living.

Specialty Care Provider: A physician or other provider in a medical specialty (e.g., cardiology, dermatology, or orthopedics) who provides clinical services to a Healthfirst member upon referral by the member's primary care provider.

Sterilization: Any medical procedure, treatment or operation performed for the purpose of rendering an individual permanently incapable of reproducing.

Urgent Medical Condition – PHSP: A medical condition manifesting itself by acute symptoms of sufficient severity that, in the assessment of a prudent layperson possessing an average knowledge of medicine and health, could reasonably be expected to result in serious impairment of bodily functions, serious dysfunction of a bodily organ, body part, or mental ability, or any other condition that would place the health or safety of that person or another individual in serious jeopardy in the absence of medical or behavioral treatment within

24 hours.

Urgently Needed Services: Covered services provided when a member is temporarily absent from the plan's service area (or, under unusual and extraordinary circumstances, provided when the member is in the service area but the plan's provider network is temporarily unavailable or inaccessible) when such services are medically necessary and immediately required as a result of an unforeseen illness, injury, or condition and it is not reasonable, given the circumstances, to obtain the services through the member's PCP.
No