ATTACHMENT C
Definitions & Acronyms

As used throughout this Request for Proposals, the following terms shall have the meanings set forth below unless the context clearly indicates otherwise.

A

Accept Medicaid Assignment - Means the provider will accept the Medicaid-allowed payment rate as payment in full for services provided to a recipient.

Accept Medicare Assignment - Means the provider will accept the Medicare-allowed payment rate as payment in full for services provided to a recipient.

Access - Ability of a beneficiary to receive adequate medical care with all necessary services being available and close.

Action – (Grievance Process) 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; or the failure of the health plan to act within established time requirements (provided in 42 CFR 438.408(b)) for service accessibility.

Additional Services - Health care that the MCO agrees to provide beyond the required covered services.

Administrative Services Organization - Any public or private entity this is organized primarily for the purpose of providing administrative services in support of health care services.

Admission - Means entry into a hospital for the purpose of receiving inpatient medical treatment.

Advance Directives – Means a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated.

AIMS – A comprehensive data set of demographic, client status, and encounter data for the Mental Health consumers served by local Community Mental Health Centers (CMHCs) in Kansas.

Annual Resurvey – Annual licensure and certification surveys conducted by KDOA.

ANSI - A national organization founded to develop voluntary business standards in the United States.

Appeal **-** A request for review of an action, as action is defined in this section.

Appeal Process - The health plan's process for handling of appeals that complies with the requirements specified including, but not limited to, the procedural steps for a beneficiary to file an appeal, the process for resolution of an appeal, the right to access the State Fair Hearing system, and the timing and manner of required notifications.

Average Length of Stay – Average number of days of service provided to each nursing facility resident.

Average Nursing Facility Utilization – The average number of nursing facility days of service provided for each nursing facility eligible beneficiary.

B

Beneficiary - See "Eligible Beneficiary."

Border Cities - means those communities outside of the state of Kansas but within a 50-mile range of the state border.

C

Capitated Managed Care - Means a type of managed care plan that uses a risk-sharing reimbursement method whereby providers receive fixed periodic payments for health services rendered to plan members. Capitated fees shall be set by contract with providers and shall be paid on a per person basis regardless of the amount of services rendered or costs incurred.

Capitation - A method of payment the State makes periodically to a contractor on behalf of each recipient enrolled under the contract for the provision of medical services under the State plan.

Clean Nursing Facility Claims – Claims that do not trigger an edit for denial or suspension.

Clean claims - Claims that can be processed without obtaining additional information from the provider of the service or from a third party.

CLIA Standards - A set of standards issued by the Health Care Financing Administration (HCFA) to ensure consistency of laboratory services.

CMS - a division within the federal Department of Health and Human Services which administers Medicare and oversees the state's administration of Medicaid.

COB - Provision regulating payments to eliminate duplicate coverage when a beneficiary is covered by multiple group plans.

Community Service Providers – Means a community developmental disability organization or affiliate thereof.

Consultant - Any corporation, company, organization or person or their affiliates retained by the State to provide assistance in this project or any other project, not the MCO or subcontractor.

Covered Services - Those services which the MCO is required to provide under this contract.

D

Day - except where the term working/business day is expressly used, all references to “days” in this contract shall be construed as calendar days.

Disenrollment - the removal of a member from the MCO’s roster which results in a cessation of services for that member.

Drug, supply, or device - means the following:

(1) Any article recognized in the official United States pharmacopoeia, another similar official compendium of the United States, an official national formulary, or any supplement of any of these publications;
(2) any article intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease in human beings; and
(3) any article intended to affect the structure or any function of the bodies of human beings; and
(4) any article intended for use as a component of any article specified in paragraphs a., b., or c. above.

Durable medical equipment or DME - Means equipment that meets these conditions:

(1) Withstands repeated use;

(2) is not generally useful to a person in the absence of an illness or injury;
(3) is primarily and customarily used to serve a medical purpose;
(4) is appropriate for use in the home; and
(5) is rented or purchased as determined by the State.

E

Eligible Beneficiary or Beneficiary - A person who receives Title XIX coverage in accordance with the Medicaid State Plan or who receives Title XXI coverage.

Eligible Provider or Provider - A health care provider enrolled with the MCO to provide health care services to Title XIX and Title XXI recipients.

Emergency Medical Condition - Means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:
(1) Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
(2) Serious impairment to bodily functions.
(3) Serious dysfunction of any bodily organ or part.

Emergency Services: - Means covered inpatient and outpatient services that are as follows:
(1) Furnished by a provider that is qualified to furnish these services.
(2) Needed to evaluate or stabilize an emergency medical condition.

Emergent Primary Care Services - Those services provided in a physician's office or minor emergency center in response to an emergency (e.g., high temperature, persistent vomiting or diarrhea, or symptoms which are of a sudden or severe onset but which do not require emergency room services).

Encounter - When a member receives services from a given health care provider.

Enrollment - The assignment of a beneficiary or eligible beneficiary eligible into a MCO.

Enrollment Area - the geographic area within which eligible beneficiaries/beneficiaries must reside in order to enroll in the MCO under this contract.

EPSDT - A program of preventive health care, well child examinations with appropriate tests and immunizations. It is called the KAN Be Healthy Program in Kansas.

F

Fair Hearing - A formal meeting where an impartial Hearings Officer, assigned through the Office of Administrative Hearings, listens to all of the facts and then makes a decision based on the law.

Federally Qualified MCO - An MCO which has received special designation by CMS, to allow a minimum enrollment guarantee provision.

Fee-For-Service - The payment method by which the State reimburses providers for each medical service rendered to a patient.

Formulary - means a listing of drugs, supplies, or devices

FQHC - An entity that has entered into an agreement with CMS and is receiving a grant or funding from a grant under Section 329, 330, or 340 of the Public Health Service Act.

Fraud - intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal and state laws and regulations.

G

Grievance - An expression of dissatisfaction about any matter other than an action. Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights.

Grievance Process **-** The health plan process for handling of grievances that complies with the requirements including, but not limited to, the procedural steps for a member to file a grievance, the process for disposition of a grievance, and the timing and manner of required notifications.

Grievance System **–** Each MCO and PIHP must have a system in place for enrollees that include a grievance process, an appeal process, and access to the State's Fair Hearing system. Any grievance system requirements apply to all three components of the grievance system not just to the grievance process.

H

HCBS – Home and community based services provided through multiple 1915(c) waivers.

Hospital Readmission - Means the subsequent admission of a member as an inpatient into a hospital within 30 days of discharge as an inpatient from the same (transfers from an acute care bed to a psychiatric bed in the same hospital or transfers between hospitals are not considered readmissions).

I

Indian Health Clinic - There are three types of Indian Health Clinics:
(1) Indian Health Services clinic (abbreviation AI'): These are operated by Indian Health Services.
(2) 638 Clinic (abbreviation AT'): These are operated by the Tribes according to Public Law 93-638.
(3) Indian Urban Health Clinic (abbreviation AU'): These clinics are operated with a Provider type under Title V Public Law, 94-437.

Inquiry - A request from a member for information that would clarify health plan policy, benefits, procedures, or any aspect of health plan function but does not express dissatisfaction.

K

KAN Be Healthy - The name of the federally mandated Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program in Kansas.

Kan Be Healthy program participant - Means an individual under the age of 21 who is eligible for Medicaid, and who has undergone a Kan Be Healthy medical screening in accordance with a specified screening schedule. The medical screening shall be performed for the following purposes:
(1) To ascertain physical and mental defects; and
(2) to provide treatment that corrects or ameliorates defects and chronic conditions that are found.

Kan Be Healthy dental-only participant - Means an individual under the age of 21 who is eligible for Medicaid, and has undergone only a Kan Be Healthy dental screening in accordance with a specified screening schedule. The dental screening shall be performed for the following purposes:
(1) To ascertain dental defects; and

(2) to provide treatment that corrects or ameliorates dental defects and chronic dental conditions that are found.

Kan Be Healthy vision-only participant - Means an individual under the age of 21 who is eligible for Medicaid, and who has undergone only a Kan Be Healthy vision screening in accordance with a specified screening schedule. The vision screening shall be performed for the following purposes:
(1) Ascertain vision defects; and
(2) provide treatment that corrects or ameliorates vision defects and chronic vision conditions that are found.

KCPC – Means the Kansas-based criteria established using the American Society of Addiction Medicine Criteria as a basis for determining the level of treatment a Member needs.

KCPC Screening Inventory – Means the standardized, computer-based assessment tool which gathers BioPsychoSocial information for a Member utilizing criteria established by the American Society of Addiction Medicine for determining the level of treatment a Member needs.

Key Personnel - The MCO's Chief Executive Officer and other MCO officers as designated within the RFP.

L

Lock-in - Means the restriction, through limitation of the use of the medical identification card to designated medical providers, pharmacy and/or hospitals, of a consumer's access to medical services because of abuse.

LTC – A variety of services which help meet both the medical and non-medical needs of people with a chronic illness or disability who cannot care for themselves for long periods of time in a nursing facility.

M

Managed Care - Means a system of managing and financing health care techniques and concepts to ensure that services provided to members are necessary, efficiently provided, and appropriately priced.

MCO - As defined at 42 CFR 438.2, an MCO is either a federally qualified Health Maintenance Organization (HMO) or any other public or private entity this is organized primarily for the purpose of providing health care services, makes the services it provides to its Medicaid enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid recipients within the area served by the entity, and meets the solvency standards of 42 CFR 438.116.

Medicaid - The Kansas Medical Assistance Program operated by the State under Title XIX of the Federal Social Security Act, and related State and Federal rules and regulations.

Medicaid Program Provider Manuals - Service specific documents created by the Kansas Medicaid fiscal agent to describe policies and procedures applicable to the program generally and that service specifically.

Medical Identification Card - An identification card issued by the State, upon determination of eligibility for Medicaid.

Medical necessity - means that a health intervention is an otherwise covered category of service, is not specifically excluded from coverage, and is medically necessary, according to all of the following criteria:
a. "Authority". The health intervention is recommended by the treating physician and is determined to be necessary by the secretary or the secretary's designee.
b. "Purpose". The health intervention has the purpose of treating a medical condition.

c. "Scope". The health intervention provides the most appropriate supply or level of service, considering potential benefits and harms to the patient.

d. "Evidence". The health intervention is known to be effective in improving health outcomes. For new interventions, effectiveness shall be determined by scientific evidence as provided herein. For existing interventions, effectiveness shall be determined as provided in paragraph 67.i.

e. "Value". The health intervention is cost-effective for this condition compared to alternative interventions, including no intervention. "Cost-effective" shall not necessarily be construed to mean lowest price. An intervention may be medically indicated and yet not be a covered benefit or meet this regulation's definition of medical necessity.

f. Interventions that do not meet this regulation's definition of medical necessity may be covered at the choice of the secretary or the secretary's designee. An intervention shall be considered cost effective if the benefits and harms relative to costs represent an economically efficient use of resources for patients with this condition. In the application of this criterion to an individual case, the characteristics of the individual patient shall be determinative.

g. The following definitions shall apply to these terms only as they are used in this subsection 67.;

1) "Effective" means that the intervention can be reasonably expected to produce the intended results and to have expected benefits that outweigh potential harmful effects.

2) "Health intervention" means an item or service delivered or undertaken primarily to treat a medical condition or to maintain or restore functional ability. For this regulation's definition of medical necessity, a health intervention shall be determined not only by the intervention itself, but also by the medical condition and patient indications for which it is being applied.

3) "Health outcomes" means treatment results that affect health status as measured by the length or quality of a person's life.

4) "Medical condition" means a disease, illness, injury, genetic or congenital defect, pregnancy, or a biological or psychological condition that lies outside the range of normal, age-appropriate human variation.

5) "New intervention" means an intervention that is not yet in widespread use for the medical condition and patient indications under consideration.

6) "Scientific evidence" means controlled clinical trials that either directly or indirectly demonstrate the effect of the intervention on health outcomes. However, if controlled clinical trials are not available, observational studies that demonstrate a causal relationship between the intervention and health outcomes may be used. Partially controlled observational studies and uncontrolled clinical series may be considered to be suggestive, but shall not by themselves be considered to demonstrate a causal relationship unless the magnitude of the effect observed exceeds anything that could be explained either by the natural history of the medical condition or potential experimental biases.

7) "State designee" means a person or persons designated by the State to assist in the medical necessity decision-making process.

8) "Treat" means to prevent, diagnose, detect, or palliate a medical condition.

9) "Treating physician" means a physician who has personally evaluated the patient.

h. Each new intervention for which clinical trials have not been conducted because of epidemiological reasons, including rare or new diseases or orphan populations, shall be evaluated on the basis of professional standards of care or expert opinion as described below in paragraph 67.i.

i. The scientific evidence for each existing intervention shall be considered first and, to the greatest extent possible, shall be the basis for determinations of medical necessity. If no scientific evidence is available, professional standards of care shall be considered. If professional standards of care do not exist, or are outdated or contradictory, decisions about existing interventions shall be based on expert opinion. Coverage of existing interventions shall not be denied solely on the basis that there is an absence of conclusive scientific evidence. Existing interventions may be deemed to meet this regulation's definition of medical necessity in the absence of scientific evidence if there is a strong consensus of effectiveness and benefit

expressed through up-to-date and consistent professional standards of care or, in the absence of those standards, convincing expert opinion.

j. The CONTRACTOR is responsible for covering services related to the following:
   1) The prevention, diagnosis, and treatment of health impairments;
   2) The ability to achieve age-appropriate growth and development;
   3) The ability to attain, maintain or regain functional capacity.

Medical necessity in psychiatric situations - Means that there is medical documentation that indicates either of the following:
(1) The person could be harmful to himself or herself or others if not under psychiatric treatment; or
(2) the person is disoriented in time, place, or person.

Medical supplies - Means items that meet these conditions:
(1) Are not generally useful to a person in the absence of illness or injury;
(2) are prescribed by a physician; and
(3) are used in the home and certain institutional settings.

MediKan Program - A state/federal program for the indigent who are blind, aged, disabled or members of families with dependent children.

Member - A Title XIX or Title XXI beneficiary who has been certified by the State as eligible to enroll under this contract, and whose name appears on the MCO enrollment information which the State will transmit to the MCO every month in accordance with an established notification schedule.

Mental retardation - Means any significant limitation in present functioning that meets these requirements:
(1) Is manifested during the period of birth to age 18;
(2) Is characterized by significantly sub average intellectual functioning as reflected by a score of two or more standard deviations below the mean, as measured by a generally accepted, standardized, individual measure of general intellectual functioning; and
(3) Exists concurrently with deficits in adaptive behavior, including related limitations in two or more of the following areas: communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure, and work.

MMIS - The Medicaid Management Information System which processes fee-for-service claims and encounter data for managed care.

N

NF Admissions – Count of residents admitted to nursing facilities.

NF Discharges – Number of beneficiaries discharged from nursing facilities.

NF Diversion Rate – Rate at which nursing facility eligible beneficiaries are cared for in the community rather than being admitted to a nursing facility.

NF Utilization Rate – The average number per 100 of nursing facility eligible beneficiaries that receive nursing facility services.

Non-covered services - Means services for which Medicaid will not provide reimbursement, including services that have been denied due to the lack of medical necessity.

Notice of Action - A written explanation to the provider or consumer of an action being taken.

O

Occupational therapy - Means the provision of treatment by an occupational therapist registered with the American occupational therapy association. The treatment shall meet these requirements:
(1) Be rehabilitative and restorative in nature;
(2) Be provided following physical debilitation due to acute physical trauma or physical illness; and
(3) Be prescribed by the attending physician.

Open Enrollment Period - Time during which eligible individuals may elect to enroll in or transfer between available health care programs.

Open Panel – A MCO accepting all willing providers or a primary care provider (PCP) who is accepting new Medicaid/CHIP members.

Orthotics and prosthetics - Means devices that meet these requirements:
(1) Are reasonable and necessary for treatment of an illness or injury;
(2) Are prescribed by a physician;
(3) Are necessary to replace or improve functioning of a body part; and
(4) Are provided by a trained orthotist or prosthetist.

Other developmental disability - Means a condition or illness that meets the following criteria:
(1) Is manifested before age 22;
(2) May reasonably be expected to continue indefinitely;
(3) Results in substantial limitations in any three or more of the following areas of life functioning:
    (a) Self-care;
    (b) Understanding and the use of language;
    (c) Learning and adapting;
    (d) Mobility;
    (e) Self-direction in setting goals and undertaking activities to accomplish those goals;
    (f) Living independently; or
    (g) Economic self-sufficiency; and
(4) Reflects the need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services that are of extended or lifelong duration and are individually planned and coordinated.

Out of Plan Coverage - Medical care rendered to a member by a provider not affiliated with the MCO or under subcontract to the MCO.

Out-of-state provider - Means any provider that is physically located more than 50 miles beyond the border of Kansas, except those providing services to children who are wards of the secretary. The following shall be considered out-of-state providers if they are physically located beyond the border of Kansas:
(1) Nursing facilities;
(2) Intermediate care facilities;
(3) Community mental health centers;
(4) Partial hospitalization service providers; and
(5) Alcohol and drug program providers.

Outpatient treatment - Means services provided by the outpatient department of a hospital, a facility that is not under the administration of a hospital, or a physician's office.

Over-the-counter - Means any item available for purchase without a prescription order.

Owner - Means a sole proprietor, member of a partnership, or a corporate stockholder with five percent or more interest in the corporation. The term "owner" shall not include minor stockholders in publicly held corporations.

P

PAHP- Means an entity that:
(1) Provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State plan payment rates;
(2) Does not provide or arrange for and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees; and
(3) Does not have a comprehensive risk contract.

Participating Provider - Any physician, hospital, pharmacy, optometrist, or other health care professional or facility that has entered into a professional service agreement to serve the MCO's members.

Pharmacist - Means any person duly licensed or registered to practice pharmacy by the state board of pharmacy or by the regulatory authority of the state in which the person is engaged in the practice of pharmacy.

Pharmacy - Means the premises, laboratory, area, or other place meeting these conditions:
(1) Where drugs are offered for sale, the profession of pharmacy is practiced, and prescriptions are compounded and dispensed;
(2) That has displayed upon it or within it the words “pharmacist,” “pharmaceutical chemist,” “pharmacy,” “apothecary,” “drugstore,” “druggist,” “drugs,” “drug sundries,” or any combinations of these words or words of similar import; and
(3) Where the characteristic symbols of pharmacy or the characteristic prescription sign “Rx” are exhibited. The term “premises” as used in this subsection refers only to the portion of any building or structure leased, used, or controlled by the registrant in the conduct of the business registered by the board at the address for which the registration was issued.

Physical therapy - Means treatment that meets these criteria:
(1) Is provided by a physical therapist registered in the jurisdiction where the service is provided or by the Kansas board of healing arts;
(2) Is rehabilitative and restorative in nature;
(3) Is provided following physical debilitation due to acute physical trauma or physical illness; and
(4) Is prescribed by the attending physician.

Physician extender - Means a person registered as a physician’s assistant or licensed advanced registered nurse practitioner in the jurisdiction where the service is provided, and who is working under supervision as required by law or administrative regulation.

PIHP- Means an entity that:
(1) Provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State plan payment rates;
(2) Provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and
(3) Does not have a comprehensive risk contract.

Potential Enrollee - Means a Medicaid recipient who is subject to mandatory enrollment or may voluntarily elect to enroll in a given managed care program, but is not yet an enrollee of a specific MCO.

Practitioner - Means any person licensed to practice medicine and surgery, dentistry, or podiatry, or any other person licensed, registered, or otherwise authorized by law to administer, prescribe, and use prescription-only drugs in the course of professional practice.

Prescribed - Means the issuance of a prescription order by a practitioner.

Prescription - Means either of the following:
(1) A prescription order; or
(2) A prescription medication.

Prescription medication - Means any drug, supply, or device that is dispensed according to a prescription order. If indicated by the context, the term "prescription medication" may include the label and container of the drug, supply, or device.

Prescription-only - Means an item available for purchase only with a prescription order.

Preventive Care - Health care that emphasizes prevention, early detection and early treatment.

Primary diagnosis - Means the most significant diagnosis related to the services rendered

Prior Authorization - Approval granted for payment purposes by the MCO for its active, specified enrollees by the State (or it's designee) to a provider to render specified services to a specified beneficiary.

Provide –To furnish directly, or authorize and pay for the furnishing of, a covered service to an enrolled beneficiary.

PRTF – An inpatient treatment facility that provides comprehensive mental health treatment to children and adolescents.

Prudent lay person – A person who possesses an average knowledge about health, healthcare and medicine.

R

Reasonable Effort –Documentation of verbal and written contacts with providers of health care services outside the MCO.

Regulation - A federal or state agency statement of general applicability designed to implement or interpret law, policy or procedure.

Reinsurance - insurance purchased by an insurance company or health plan from another insurance company to protect against losses. Also called stop-loss insurance.

RHC - An entity that has been determined by CMS to meet the requirements of Section 1861 (aa)(2) of the Social Security Act and 42 Code of Federal Regulations part 491; and has an agreement with CMS to provide rural health clinic services under Medicare.

Risk - The possibility of monetary loss or gain by the MCO resulting from service costs exceeding or being less than payments made to it by the State.

S

Self-Direction – Means that participants, or their representatives, if applicable, have decision-making authority over certain services and take direct responsibility to manage their services with the assistance of a system of available supports. The self-directed service delivery model is an alternative to traditionally delivered and managed services such as an agency delivery model. It allows participants to have the responsibility for managing all aspects of service delivery in a person-centered planning process. Promotes personal choice and control over the delivery of waiver and State plan services, including who provides the services and how services are provided.

Shelter – Homeless shelters are temporary residences for homeless people which seek to protect vulnerable populations from the often devastating effects of homelessness while simultaneously reducing the environmental impact on the community.

SP – Plan approved by CMS governing the Kansas Medicaid Program.

SSMA – KDHE, which is legally authorized and responsible for administering the provisions of the State Plan for Medical Assistance (Medicaid) on a statewide basis.

Start Date - The date the contract for services becomes effective.

State Fiscal Year - The annual period used by the State for accounting purposes, which begins July 1 and ends June 30 of the following calendar year. (Note: the Federal fiscal year begins October 1 and ends September 30 of the following calendar year).

Subcontract - Any written agreement between the MCO and another party to fulfill the requirements of this contract.

Subcontractor - Party contracting with the MCO to perform services under this agreement.

Subrogation - procedure where an insurance company recovers from a third party when the action resulting in medical expense (e.g. auto accident) was the fault of another person.

T

Third-Party - Any individual entity or program which is or may be liable to pay all or part of the expenditures for Title XIX beneficiaries furnished under a State Plan.

Title XIX - The provisions of Title 42 United States Code Annotated Section 1396 et. seq. (The Social Security Act), including any amendments thereto. Title XIX provides medical assistance for certain individuals and families with low incomes and resources.

Title XXI - The provisions of the Social Security Act as amended in August, 1997 to add Title XXI (known at the federal level as the Children's Health Insurance Program (CHIP), which provides health insurance coverage to uninsured children from low-income families, who are not Title XIX eligible.

Transportation - A covered service available for the purpose of transporting a beneficiary to a health facility or health practitioner providing covered services under this RFP and it's resulting contract(s).

U

Urgent Primary Care Services - Those services provided in a physician's office in response to persistent rash, recurring high grade temperature, non-specific pain or fever.

Urgent Services - Covered services required in order to prevent a serious deterioration of a member's health that results from unforeseen illness or an injury.

Utilization Management - Evaluation of necessity and appropriateness of health care services according to set guidelines.

Utilization Report - A report that provides information regarding evaluation of necessity and appropriateness of health care services according to set guidelines.

V

Valid NF Claims – Claims for Medicaid approved nursing facility resident days.

W

Waiver – Federally approved requests to waive certain specified Medicaid rules.

Warm Transfer – A listening phone line staffed by people usually in recovery. Warm transfer operators are trained to listen to anonymous callers, offer compassion and validation, and assist callers in connecting with their own internal resources and strengths, as well as community resources.

Wellness - Preventive health care designed to reduce health care utilization and costs.

Acronym	Definition
A	
AAA	Area Agencies on Aging
AAP	American Academy of Pediatrics
AAPS	Addiction and Prevention Services
ABD	Aged, Blind and Disabled
ACH	Adult Care Home
ACIL	Attendant Care for Independent Living
ACIP	Advisory Committee on Immunization Practices
ADA	Americans with Disabilities Act
ADA	American Dental Association (depending upon context)
ADA-CAP	Americans with Disabilities Act Communications Accommodations Project
ADAAG	Americans with Disabilities Act Accessibility Guidelines
ADAP	AIDS Drug Assistance Program
ADC	Adult Day Care
ADL	Activities of Daily Living
AFDC	Aid to Families with Dependent Children
AIMS	Automated Information Management System
ALF	Assisted Living Facility
ALOS	Average Length of Stay
ALS	Advanced Life Support
AMA	American Medical Association
ANE	Abuse, Neglect or Exploitation
ANSI	American National Standards Institute
APS	Adult Protective Services
ARNP	Advanced Registered Nurse Practitioner
ASAM	American Society of Addiction Medicine
ASD	Autism Spectrum Disorders
AT	Assistive Technology
AVRS	Automated Voice Response System
B	
BAA	Business Associate Agreement
BCH	Boarding Care Home
BG	Block Grant
BMI	Body Mass Index
BSRB	Behavioral Sciences Regulatory Board
C	
CAD	Coronary Artery Disease
CAH	Critical Access Hospital
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CAP	Corrective Action Plan
CARC	Claim Adjustment Reason Codes
CARE	Client Assessment Referral and Evaluation
CBA	Community Based Alternatives
CBO	Community-Based Organization
CDC	Centers for Disease Control
CDDO	Community Developmental Disability Organization
CDT	Code on Dental Procedures and Nomenclature
CEO	Chief Executive Officer
CFR	Code of Federal Regulations
CHF	Congestive Health Failure

CHIP	Children's Health Insurance Program
CIL	Centers for Independent Living
CLIA	Medicaid Clinical Laboratory Improvement Amendments
CLIC	Centers for Independent Living
CME	Case Management Entity
CMHC	Community Mental Health Center
CMS	Centers for Medicare and Medicaid Services (U.S. Department of Health & Human Services)
COB	Coordination of Benefits
COPD	Chronic Obstructive Pulmonary Disease
CPI	Crisis Prevention Institute
CPT	Current Procedural Terminology
CRD	Chronic Renal Disease
CSHCN	Children with Special Health Care Needs
CSP	Community Service Providers
CSS	Community Supports and Services
CSW	Customer Service Worksheet
D	
DBHS	Disability and Behavioral Health Services
DD	Developmental Disability
DEERS	Defense Enrollment Eligibility Reporting System
DHCF	Division of Health Care Finance
DME	Durable Medical Equipment
DMH	Division of Mental Health
DRA	Deficit Reduction Act
DRG	Diagnosis Related Group
DTaP	Diphtheria and Tetanus Toxoids and Acellular Pertussis
DUI	Driving Under the Influence
DUR	Drug Utilization Review
E	
EBP	Evidence Based Practice
ECI	Early Childhood Intervention
EDI	Electronic Data Interface
EHR	Electronic Health Record
EPLS	Excluded Parties List System
EPSDT	Early and Periodic Screening, Diagnosis and Treatment
EQR	External Quality Review
EQRO	External Quality Review Organization
ESD	Expedited Service Delivery
ESRD	End-Stage Renal Disease
EVV	Electronic Visit Verification
F	
FDA	Food and Drug Administration
FE	Frail Elderly
FFP	Federal Financial Participation
FFS	Fee-For-Service
FMS	Financial Management System
FQHC	Federally Qualified Health Center
FTE	Full Time Equivalent
FY	Fiscal Year
G	

GCN	Generic Code Number
H	
HBIG	Hepatitis B Immune Globulin
HBsAg	Hepatitis B Surface Antigen
HCBS	Home and Community Based Services
HCERA	Health Care and Education Reconciliation Act of 2010
HCPCS	Health Care Common Procedure Coding System
HEDIS	Healthcare Effectiveness Data and Information Set
HepA	Hepatitis A
HepB	Hepatitis B
HH	Health Home
HHA	Home Health Agencies
HHS	The United States Department of Health and Human Services
HI	Head Injury
Hib	Haemophilus Influenzae Type B Conjugate
HIE	Health Information Exchange
HIO	Health Information Organization
HIPAA	Health Insurance Portability and Accountability Act
HIPPS	Health Insurance Premium Payment System
HIS	Health Information System
HIT	Health Information Technology
HIV	Human Immunodeficiency Virus
HMM	Health Maintenance Monitoring
HP	Home Plus
HPV	Human Papillomavirus Vaccine
HPV2	Bivalent HPV Vaccine
HPV4	Quadrivalent HPV Vaccine
HSA	Health Savings Account
I	
IA	Information and Assistance
IADL	Instrumental Activities of Daily Living
IBP/POC	Individualized Behavioral Program Plan of Care
ICF	Intermediate Care Facility
ICF/MH	Intermediate Care Facility for Mental Health
ICF/MR	Intermediate Care Facility for Mental Retardation
ICM	Independent Case Management
IcMMIS	Interchange Medicaid Management Information System
ICP	Individual Care Plan
IDEA	Individuals with Disabilities Education Act
IEP	Individual Education Plan
IFSP	Independent Family Services Plan
IIMC	Intermittent Intensive Medical Care
IIS	Intensive Individual Supports
ILC	Independent Living Center
IMD	Institution of Mental Disease
IP	Inpatient
IPV	Inactivated Poliovirus Vaccine
ISS	Interactive Survey System
IT Policy 1210	Kansas Information Technology Policy 1210: State of Kansas Web Accessibility Requirements
IUD	Intrauterine Device

IV	Intravenous
IVP	Inactivated Poliovirus Vaccine
K	
KAAAA	Kansas Association of Area Agencies on Aging (aka K4A)
KAR	Kansas Administrative Regulation
KBH	Kan Be Healthy
KBI	Kansas Bureau of Investigation
KCPC	Kansas Client Placement Criteria
KDHE	Kansas Department of Health and Environment
KDOA	Kansas Department on Aging
KHA	Kansas Hospital Association
KHIN	Kansas Health Information Network
KHS	Kansas Health Solutions
KHIE	Kansas Health Information Exchange
KID	Kansas Insurance Department
KMAP	Kansas Medical Assistance Program
KMED	Kansas Medical Eligibility Determination
KMS	Kansas Medical Society
KSA	Kansas Statutes Annotated
L	
LAC	Licensed Addiction Counselor
LACIE	Lewis and Clark Health Information Exchange
LAIV	Live, Attenuated Influenza Vaccine
LCAC	Licensed Clinical Addictions Counselor
LCE	Low Cost Estimate
LEA	Local Education Agencies
LEIE	List of Excluded Individuals/Entities
LMHP	Licensed Mental Health Professional
LTC	Long Term Care
M	
M&I	Maternal and Infant (Title V Program)
MAT	Medication Assisted Treatment
MATLOC	Medical Assistive Technology Level of Care Instrument
MCO	Managed Care Organization
MCS	Managed Care Services
MCV4	Meningococcal Conjugate Vaccine, Quadrivalent
MED	Medicare Exclusion Database
MFCU	Medicaid Fraud Control Unit
MFP	Money Follows the Person Grant
MH	Mental Health
MMIS	Medicaid Management Information System
MMR	Measles, Mumps and Rubella
MR	Mental Retardation or Mentally Retarded
MRT	MCO Report Template
MTM	Medication Therapy Management
N	
NAEPP	National Asthma Education and Prevention Program
NAIC	National Association of Insurance Commissioners
NCPDP	National Council for Prescription Drug Programs
NCQA	National Committee for Quality Assurance
NDC	National Drug Code

NEMT	Non-Emergency Medical Transportation
NF	Nursing Facility
NHLBI	National Heart, Lung and Blood Institute
NOMS	National Outcomes Measurement System
NPI	National Provider Identifier
NPPES	National Plan & Provider Enumeration Systems
O	
OAH	Office of Administrative Hearings
OP	Outpatient
OT	Occupational Therapy
OTC	Over-the-Counter
P	
P4P	Pay for Performance
PA	Prior Authorization
PACE	Program for All-Inclusive Care for the Elderly
PAHP	Pre-Paid Ambulatory Health Plan
PARIS	Public Assistance Reporting Information System
PASARR/PASRR	Preadmission Screening and Resident Reviews
PATH	Projects for Assistance in Transition from Homelessness
PBM	Pharmacy Benefit Managers
P-Card	Procurement Card
PCCM	Person Centered Case Management or Primary Care Case Management
PCP	Primary Care Provider or Primary Care Physician
PCV	Pneumococcal Conjugate Vaccine
PCV7	7-Valent PCV
PCV13	13-Valent PCV
PD	Physical Disability
PDL	Preferred Drug List
PERS	Personal Emergency Response System
PHI	Personal/Protected Health Information
PIHP	Pre-Paid Inpatient Plan
PIP	Performance Improvement Project
PIR	Payment Integrity Report
PMDD	Presumptive Medical Disability Determination
PMPM	Per Member Per Month
PNC	Procurement Negotiating Committee
POC	Plan of Care
POS	Point of Service
PPACA	Patient Protection and Affordable Care Act
PPSV	Pneumococcal Polysaccharide Vaccine
PRTF	Psychiatric Residential Treatment Facility
PR	Psychical Rehabilitation
PS	Peer Support
PT	Physical Therapy
PW	Pregnant Women
Q	
QA	Quality Assurance
QAP	Quality Action Plan
QAPI	Quality Assessment & Performance Improvement
QI	Quality Initiative
QM	Quality Management

QMP	Quality Management Plan
QMPH	Qualified Mental Health Professional
OTC	Over-the-Counter
R	
RA	Remittance Advice
RADAC	Regional Alcohol and Drug Assessment Center
RARC	Reason & Remark Codes
RCIL	Resource Center for Independent Living
REC	Regional Extension Center
RFP	Request for Proposal
RHC	Rural Health Clinic
RHCF	Residential Health Care Facility
RPRF	Real and Personal Property Fee
RV	Rotavirus
S	
SA	Substance Abuse
SAMHSA	Substance Abuse and Mental Health Services Administration
SA-PIHP	Substance Abuse – Prepaid Inpatient Health Plan
SAPT	Substance Abuse Prevention and Treatment
SBIRT	Screening Brief Intervention/Referral to treatment
SED	Serious Emotional Disturbance
SEHP	State Employee Health Plan
SFTP	Secure File Transfer Protocol
SGF	State General Fund
SHS	Special Health Services
SMC	Specialized Medical Care
SMHH	State Mental Health Hospital
SMHP	State Medicaid HIT Plan
SNF	Skilled Nursing Facility
SNIP	Strategic National Implementation Process
SOBRA	Sixth Omnibus Budget Reconciliation Act
SP	Medicaid State Plan
SPMI	Serious and Persistent Mental Illness
SRS	Kansas Department of Social and Rehabilitation Services
SSA	Social Security Administration
SSI	Supplemental Security Income
SSMA	Single State Medicaid Agency
ST	Speech Therapy
STD	Sexually Transmitted Diseases
SUD	Substance Use Disorder
T	
TA	Technology Assisted
TANF	Temporary Assistance for Needy Families (called TAF in Kansas)
TB	Tuberculosis
TBI	Traumatic Brain Injury
TCM	Targeted Case Management
TD	Tetanus and Diphtheria Toxoids
Tdap	Tetanus and Diphtheria Toxoids and Acellular Pertussis
TEDS	Treatment Episode Data Set
Title XIX	Of the Social Security Act – Federal Funds Source for Medicaid
Title XXI	Of the Social Security Act – Federal funds source for health insurance for low-

	income children (CHIP)
TIV	Trivalent Inactivated Influenza Vaccine
TPL	Third Party Liability
TTY/TTD	TeleTypewriter/Telecommunications Device
U	
UAI	Uniform Assessment Instrument
UM	Utilization Management
UR	Utilization Review
URL	Universal/Uniform Resource Locator
V	
VAERS	Vaccine Adverse Event Reporting System
VFC	Vaccines for Children
VO-KS	ValueOptions - KS
VPAT	Voluntary Product Accessibility Template
W	
WIC	Special Supplemental Food Program for Women, Infants and Children