**ATTACHMENT A**

**Definitions & Acronyms**

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

**A**

Abuse–For purposes of program integrity, provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid and Children’s Health Insurance Program (CHIP) or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. Abuse also includes Client/Member practices that result in unnecessary cost to the Medicaid and CHIP program (see 42 CFR § 455.2).

Access – The Member’s ability to receive covered services to achieve optimal outcomes, as evidenced by the CONTRACTOR(S) successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined under 42 CFR § 438.68 (network adequacy standards) and 42 CFR § 438.206 (availability of services).

Action – As in the case of a CONTRACTOR(S), is the denial, in whole or in part, of a payment for a service to a Provider.

Admission – Entry into a facility for the purpose of receiving inpatient medical treatment.

Adult Care Homes – As defined in 39-923, Article 9 A. 1., Adult Care Homes are “any nursing facility, nursing facility for mental health, intermediate care facility for the mentally retarded, assisted living facility, residential health care facility, home plus, boarding care home and adult day care facility, all of which are classifications of adult care homes and are required to be licensed by the secretary of aging.”

Advance Directives – 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.

Adverse Benefit Determination – As defined in 42 CFR § 438.400, as in the case of a CONTRACTOR(S) as related to a Member:

1. The denial or limited authorization of a requested service, including the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
2. The reduction, suspension, or termination of a previously authorized service.
3. The denial, in whole or in part, of payment for a service.
4. The failure to provide services in a timely manner, as defined by the State.
5. The failure of the CONTRACTOR(S) to act within the timeframes provided in 42 CFR § 438.408(b)(1) and (2) regarding the standard resolution of Grievances and Appeals.
6. For a resident of a rural area with only one managed care organization, the denial of a Member's request to exercise his or her right, under 42 CFR § 438.52(b)(2)(ii), to obtain services outside the network.
7. The denial of a Member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Member financial liabilities.

Automated Information Management System – A comprehensive data set of demographic, client status, and encounter data for the Mental Health consumers served by local Community Mental Health Centers in Kansas.

Annual Open Enrollment – The period designated by the State when Members can elect to transfer from one CONTRACTOR to another CONTRACTOR without good cause.

American National Standards Institute – A national organization founded to develop voluntary business standards in the United States.

Appeal – A request for a CONTRACTOR(S) to review an Adverse Benefit Determination for a Member or an Action for a Provider.

**B**

Behavioral Health Services – Mental health and Substance Use Disorder covered services.

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

**C**

Capitation Payment – A method of payment based on the actuarially sound capitation rate the State makes periodically to a CONTRACTOR(S) on behalf of each Member enrolled under the CONTRACT for the provision of Covered Services.

Care Management – Applies systems, science, incentives, and information to improve medical practice and assist consumers and their support system to become engaged in a collaborative process designed to manage an individual’s comprehensive behavioral health, physical health, and long‑term services and supports conditions more effectively. The goal of care management is to achieve an optimal level of wellness and improve coordination of care while addressing social determinants of health and independence.

Case Management – A collaborative process of assessment, planning, facilitation, service coordination, evaluation, and advocacy for options and services to meet an individual’s and family’s comprehensive health needs (behavioral health, physical health, and long‑term services and supports) through communication and referral to available resources to ensure needs are met. Additionally, case management addresses Social Determinants of Health and Independence that include but are not limited to housing, domestic violence, and food assistance.

Children’s Health Insurance Program – The Kansas program operated by the State under Title XXI of the Social Security Act, and related State and Federal rules and regulations for children up to age 19 who will receive all Medicaid medically necessary services except for Local Education Agencies, Early Childhood Intervention, and target Case Management services.

Children with Special Healthcare Needs – Young persons with disabilities or diseases which require specialty care and who qualify for services under Special Health Services, Title V, through the Kansas Department of Health & Environment and are enrolled in the KanCare, the CONTRACTOR(S) must contact the Bureau of Children and Families within Kansas Department of Health & Environment.

Chronic Condition – A condition or disease that is persistent or otherwise long-lasting (usually longer than three months) in its effects or a disease that comes with time, such as, but not limited to arthritis, asthma, cancer, Chronic Obstructive Pulmonary Disease, diabetes and viral diseases, such as Hepatitis C and HIV/AIDS.

Clean Claims – Claims that can be processed without obtaining additional information from the Participating Provider of the service or from a third party. It does not include a claim from a provider who is under investigation for fraud or abuse or a claim under review for Medical Necessity.

CLIA Standards – A set of standards issued by the Centers for Medicare and Medicaid Services (CMS) to ensure consistency of laboratory services.

Centers for Medicare & Medicaid Services – Division within the Federal Department of Health and Human Services which administers Medicare and oversees the State's administration of Medicaid.

Children’s Health Insurance Program – Title XXI of the Social Security Act.

Coordination of Benefits – Provision regulating payments to eliminate duplicate coverage when a Beneficiary or Member is covered by multiple issuers.

Community Service Coordinator – A service coordinator employed by an entity who is under contract with the CONTRACTOR to perform certain service coordination activities and who is based in the Member’s community.

Community Service Providers – A community developmental disability organization or affiliate thereof, including but not limited to Area Agencies on Aging, Centers for Independent Living and Aging and Disability Resource Centers.

Complex Condition – A condition involving multiple morbidities that requires the attention and coordination of multiple providers or facilities.

Conflict Free Case Management – When the individual providing service coordination is not employed by, does not have a financial interest in, nor is affiliated to any degree with the Participating Provider of services. The exception being when the State determines that only one entity in a geographic area is willing and qualified to provide case management and/or develop person-centered service plans. In these cases, the State must develop conflict of interest protections, including separation of entity and Participating Provider functions within Participating Provider entities, which must be approved by the Centers for Medicare & Medicaid Services. (42 CFR § 441.301(c) (1) (vi) and § 441.730(b)).

Consumer Assessment of Healthcare Providers and Systems – Surveys that ask consumers to report on and evaluate their experiences with health care. These surveys cover topics that are important to consumers and focus on aspects of quality that consumers are best qualified to assess, such as the communication skills of Participating Providers and ease of access to health care services.

Contractor – Defined as the MCO who has entered into a CONTRACT with the State to provide KanCare covered services to a Member.

Copayment – A fixed dollar amount that a Member must pay when he/she receives a particular covered service, as specified by the State.

Covered Services – All Medicaid and CHIP services provided by a CONTRACTOR in any setting, including but not limited to medical care, behavioral health care, and long-term services and supports.

Critical Incident – Critical Incidents shall include but not be limited to the following incidents:

1. Unexpected death of a Member, including deaths occurring in any suspicious or unusual manner, or suddenly when the deceased was not attended to by a physician.
2. Suspected physical, mental, or sexual mistreatment, abuse, and/or neglect of a Member.
3. Suspected theft or financial exploitation of a Member.
4. Severe injury sustained by a Member.
5. Medication error involving a Member.
6. Inappropriate/unprofessional conduct by a Participating Provider involving a Member.

**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 CONTRACTOR(S)’ roster which results in a cessation of services for that Member from that CONTRACTOR(S).

Drug, Supply, or Device – Refers to 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.
3. Any article intended to affect the structure or any function of the bodies of human beings.
4. Any article intended for use as a component of any article specified in 1, 2, or 3 above.

Durable Medical Equipment – 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.
5. Is rented or purchased as determined by the State.

**E**

Electronic Health Record – A record in digital format that is a systematic collection of electronic health information. Electronic health records may contain a range of data, including demographics, medical history, medication and allergies, immunization status, laboratory test results, radiology images, vital signs, personal statistics such as age and weight, and billing information.

Electronic Protected Health Information – A subset of protected health information and means individually identifiable health information that is transmitted by or maintained in electronic media.

Electronic Visit Verification – State authorized system used for verification that home‑ and community‑based services are performed and submitted as claims to the CONTRACTOR(S).

Eligibility Broker – An individual or entity that performs choice counseling.

Emergency Medical Condition – 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 – Covered inpatient and outpatient services that are as follows:

1. Furnished by a Participating Provider that is qualified to furnish these services.
2. Needed to evaluate or stabilize an emergency medical condition.

Emergent 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 Participating Provider.

Encounter Data – The information relating to the receipt of any item(s) or service(s) by a Member under the CONTRACT that is subject to the requirements of 42 CFR § 438.242 and 42 CFR § 438.818.

Enrollment – The assignment of a Beneficiary into a CONTRACTOR(S).

Enrollment Area – The geographic area within which eligible beneficiaries/beneficiaries must reside in order to enroll in the CONTRACTOR(S) under this CONTRACT.

Early and Periodic Screening, Diagnosis and Treatment – A program of preventive health care, well child examinations with appropriate tests and immunizations. It is called the KAN Be Healthy Program in Kansas.

External Quality Review – The analysis and evaluation by an external quality review organization, of aggregated information on quality, timeliness, and access to the health care services that a CONTRACTOR (described in 42 CFR § 438.310(c)(2)), or their CONTRACTOR(S) furnish to Medicaid beneficiaries.

External Quality Review Organization – An organization that meets the competence and independence requirements set forth in 42 CFR § 438.354, and performs external quality review, other external quality review‑related activities as set forth in 42 CFR § 438.358, or both.

**F**

Fee-For-Service – The payment method by which the State reimburses Participating Providers for each Covered Service rendered to a patient.

Fiscal Agent – An entity that provides managed care broker functions.

Financial Relationship – A direct or indirect ownership or investment interest (including an option or non-vested interest) in any entity. This direct or indirect interest may be in the form of equity, debt, or other means, and includes any indirect ownership or investment interest no matter how many levels removed from a direct interest or a compensation arrangement with an entity.

Formulary – A listing of drugs, supplies, or devices.

Federally Qualified Health Center – An entity that has entered into an agreement with the Centers for Medicare & Medicaid Services 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/herself 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 Adverse Benefit Determination or 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 regardless of whether remedial action is requested. Grievance includes a Member’s right to dispute an extension of time proposed by the CONTRACTOR to make a Service Authorization decision.

**H**

Health Insurance Provider’s Fee – For those Private Coverage Organizations with a liability for payment of this fee, the State’s actuary intends to recognize the costs associated with this fee as “reasonable, appropriate, and attainable costs” to be considered in actuarially sound payments to the plans. The Health Insurance Provider’s Fees due each year (the “feeyear”) is calculated by the IRS from information on net premiums written for the prior calendar year (the “data year”) filed by the insurers on Form 8963.

Health Risk Assessment – An extensive health questionnaire, conducted by a service coordinator using a person-centered approach, to evaluate an individual’s health risks, quality of life, social determinants of health and independence, available services and supports. The health risk assessment determines the appropriate needs assessment that should be conducted for the individual. (42 CFR § 438.208(b)(3)).

Health Screening – An initial, brief, health questionnaire for all Members, conducted by a service coordinator or Member of the service coordination team, to determine the appropriate next course of action for care, including the need for a Health Risk Assessment.

Healthcare Effectiveness Data and Information Set – Healthcare effectiveness data and information set is a tool used by more than 90% of America's health plans to measure performance on important dimensions of care and service. Because so many plans collect Healthcare Effectiveness Data and Information Set data, and because the measures are so specifically defined, Healthcare Effectiveness Data and Information Set makes it possible to compare the performance of health plans on an "apples‑to-apples" basis.

Health Information Exchange – Refers to the electronic movement of health-related data and information among organizations according to agreed standards, protocols, and other criteria.

Health Information Technology – Refers to electronic systems that make it possible for Participating Providers to better manage Member care through secure use and sharing of health information.

High Fidelity Wraparound – A structured approach to service planning and coordination for youth and their families with complex needs that is built on key system of care values (e.g., youth-guided, family-driven, team-based, collaborative, individualized, culturally responsive, and outcomes-based) and adheres to specified procedures (e.g., engagement, individualized care planning, identifying strengths, leveraging natural supports, and monitoring process).

Home‑ and Community‑Based Services– Provides opportunities for Members to receive services in their own home or community rather than institutions or other isolated settings. These programs serve a variety of targeted populations groups, such as people with intellectual or developmental disabilities, physical disabilities and/or mental illnesses and are authorized under the 1915(c) waivers.

Hospital Readmission – 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.

**K**

KAN Be Healthy – The name of the federally mandated Early and Periodic Screening & Diagnosis Treatment Program in Kansas.

KAN Be Healthy Program Participant – An individual under the age of 21 who is eligible for Medicaid or an individual under the age of 19 who is eligible for CHIP, 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.
2. To provide treatment that corrects or ameliorates defects and chronic conditions that are found.

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

Kansas Client Placement Criteria Screening Inventory –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.

Kansas Modular Medicaid System – The system which will process fee-for-service claims and encounter data related to managed care as well as provide a number of operational, administrative and data supports to the KanCare program.

KDHE-DHCF – The Kansas Department of Health and Environment, Division of Health Care Finance. KDHE-DHCF is the single-state Medicaid Agency for Kansas and the State Agency responsible for the administration and management of the KanCare medical assistance program and CHIP.

Key Personnel – The managed care organization's Chief Executive Officer and other managed care organization officers as designated within the RFP.

**L**

Limited English Proficient – Potential Members and Members who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English may be limited English proficient and may be eligible to receive language assistance for a particular type of service, benefit, or encounter.

Lock-In – The restriction, through limitation of the use of the medical identification card to designated medical Participating Providers, pharmacy, and/or hospitals, of a Member’s access to medical services because of abuse.

Long‑Term Services and Supports – Millions of Americans, including children, adults, and seniors, need long-term care services as a result of disabling conditions and chronic illnesses. Medicaid is the primary payer across the nation for long-term care services. Medicaid allows for the coverage of these services through several vehicles and over a continuum of settings, ranging from institutional care to community‑based long-term services and supports.

**M**

Marketing – Any communication, from a CONTRACTOR to a Member who is not enrolled in that CONTRACTOR, that can reasonably be interpreted as intended to influence the Member to enroll in that particular CONTRACTOR(S)’ product, or either to not enroll in or to disenroll from another CONTRACTOR(S)’ product. Marketing does not include communication to a Beneficiary from the issuer of a qualified health plan, as defined in 45 CFR § 155.20, about the qualified health plan.

Marketing Materials – Materials that are produced in any medium, by or on behalf of the CONTRACTOR and can reasonably be interpreted as intended to market the CONTRACTOR to potential Members.

Managed Care – 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. The Managed Care program in Kansas is referred to as KanCare.

Managed Care Organization – As defined at 42 CFR § 438.2, an managed care organization is either a federally qualified Health Maintenance Organization 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 Members as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Members within the area served by the entity, and meets the solvency standards of 42 CFR § 438.116.

Maximum Allowable Cost Pricing – A payment model contractually agreed to in the marketplace by all participants. It includes payers and pharmacies and ensures employers and consumers – those purchasing health insurance benefits – get the lowest possible price on generic drugs.

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

Medicaid Management Information System – The system, known as Kansas Modular Medicaid System, which will process fee-for-service claims and encounter data related to managed care as well as provide a number of operational, administrative and data supports to the KanCare program.

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 for the FFS program and issued by the CONTRACTOR(S) for KanCare, upon determination of eligibility for Medicaid and CHIP.

Medical Necessity – Defined in K.A.R. 30-5-58 and the State will reference this citation in any discussion regarding the definition of medical necessity. In addition, 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 Supplies –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.
3. Are used in the home and certain institutional settings.

MediKan Program – A State-funded program for the indigent that is both time-limited and limited in scope of services designed to serve adults with some level of disability that does not meet the SSA-defined definition of disability.

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 CONTRACTOR enrollment information which the State will transmit to the CONTRACTOR every month in accordance with an established notification schedule.

Must – A term, like “shall,” that is used throughout the KanCare RFP that means the requirement(s) is mandatory.

**N**

National Association of Insurance Commissioner– The United States’ standard setting and regulatory support organization created and governed by the chief insurance regulators from the 50 states, the District of Columbia, and five United States territories. Through the National Association of Insurance Commissioner, State insurance regulators establish standards and best practices, conduct peer review and coordinate their regulatory oversight. National Association of Insurance Commissioner staff supports these efforts and represents the collective views of State regulators domestically and internationally. National Association of Insurance Commissioner Members, together with the central resources of the National Association of Insurance Commissioner, form the national system of State-based insurance regulation in the United States.

National Average Drug Acquisition Cost – The Centers for Medicare & Medicaid Services contracted with Myers and Stauffer LLC, a national certified public accounting firm, to conduct surveys of retail community pharmacy prices, including drug ingredient costs, to develop the National Average Drug Acquisition Cost pricing benchmark. The National Average Drug Acquisition Cost survey process focuses on retail community pharmacy drug ingredient costs. The survey collects acquisition costs for covered outpatient drugs purchased by retail community pharmacies, which include invoice purchase prices from independent and chain retail community pharmacies.

Needs Assessment – A process, conducted by a service coordinator, to assess an individual’s need for services and supports (including but not limited to, physical health, behavioral health, and long‑term services and supports) and the gaps that exist in addressing identified needs. (42 CFR § 438.210(b) (2) (iii)).

Non-Covered Services – Services for which Medicaid or CHIP will not provide reimbursement, including services that have been denied due to the lack of medical necessity.

Non-Participating Provider – Any Provider that has not entered into a provider agreement with a CONTRACTOR(S) or Subcontractor(s) to serve Members.

**O**

Occupational Therapy – 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.
3. Be prescribed by the attending physician.

Offer Point – The rate, within the Initial Actuarially Sound Capitation Rate Range after accounting for all additional payment components (e.g., projected quality incentives earned), at which the State is willing to contract with any Bidder willing to accept this rate. The Offer Point is only employed if the initial cost proposals submitted by the Bidders are not acceptable to the State. If the State employs the Offer Point, the State has the option of either: 1) selecting a different Offer Point for each winning bidder based upon the relative position of their submitted statewide blended rate within the Initial Actuarially Sound Capitation Rate Range, or 2) selecting the same Offer Point for all winning bidders. The initial agreed upon rate will be determined between the State and the Bidders after all proposals are submitted which may or may not include the use of an Offer Point and/or Best and Final Offer(s). If the State updates the Initial Actuarially Sound Capitation Rate Range to incorporate more recent information, the initial agreed upon rate will remain at the same position in the Final Actuarially Sound Capitation Rate Range relative to the Initial Actuarially Sound Capitation Rate Range.

Open Panel – A CONTRACTOR accepting all willing Participating Providers or a primary care provider who is accepting new Medicaid/Children’s Health Insurance Program Members.

Other Developmental Disability – 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:
4. Self-care.
5. Understanding and the use of language.
6. Learning and adapting.
7. Mobility.
8. Self-direction in setting goals and undertaking activities to accomplish those goals.
9. Living independently.
10. Economic self-sufficiency.
11. 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.

Other Employment Programs – Programs such as, Individual Placement and Supported Employment, which is an [evidence-based](https://en.wikipedia.org/wiki/Evidence-based_medicine) approach to [supported employment](https://en.wikipedia.org/wiki/Supported_employment) for people who have a mental illness. Individual Placement and Support (IPS) supports people in their efforts to achieve steady, meaningful employment in mainstream competitive jobs, either part-time or full-time. This stands in contrast to other vocational rehabilitation approaches that employ people in [sheltered workshops](https://en.wikipedia.org/wiki/Sheltered_workshop) and other set-aside jobs. IPS has been extensively researched and proven to be effective.

Out of Plan Coverage – Medical or long-term services and supports rendered to a Member by a Non-Participating Provider of a CONTRACTOR or Subcontractor.

Out-of-State Provider – 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 Participating Providers.
5. Alcohol and drug program Participating Providers.

Outcomes – Changes in patient health, functional status, satisfaction, or goal achievement that result from health care or supportive services.

Outpatient Treatment – 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 – Any item available for purchase without a prescription order.

Overpayment – Any payment made to a Participating Provider or Non-Participating Provider by the CONTRACTOR to which the Participating Provider or Non-Participating Provider is not entitled to under Title XIX or Title XXI of the Social Security Act or any payment to a CONTRACTOR by the State to which the CONTRACTOR is not entitled.

Owner – Sole proprietor, Member of a partnership, or a corporate stockholder with 5% or more interest in the corporation. The term “owner” shall not include minor stockholders in publicly held corporations.

**P**

Participating Provider – Any Provider that has entered into a provider agreement with a CONTRACTOR(S) or Subcontractor(s) to serve Members and receives Medicaid or CHIP funding directly or indirectly to order, refer, or render Covered Services.

Person-Centered Service Plan – A written service plan developed jointly with an individual (and/or the individual’s authorized representative) that reflects the services and supports that are important for the individual to meet the needs identified through a needs assessment, what is important to the individual with regard to preferences for the delivery of such services and supports and the providers of the services and supports. (42 CFR § 441.725(a) and (b)).

Pharmacist – 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 – 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.
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.

Pharmacy Provider Network – A network of pharmacies qualified to participate in the Kansas Medical Assistance Program pharmacy program that is willing to comply with the CONTRACTOR(S)’ payment rates and terms and to adhere to quality standards established by the CONTRACTOR(S).

Physical Therapy – 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.
4. Is prescribed by the attending physician.

Plan of Service – A written document that describes and records the Member’s goals and service needs in accordance with State policy. The Plan of Service records the strategies to meet goals and interventions selected by the Member and team to support them in improving the Member’s health and wellbeing and addressing Social Determinants of Health and Independence.

Positive Behavioral Support – A set of research-based strategies used to increase quality of life and decrease problem behavior by teaching new skills and making changes in a person’s environment.

Post-Stabilization Care Services – Covered services, related to an emergency medical condition that are provided after an enrollee is stabilized to maintain the stabilized condition, or, under the circumstances described in 42 CFR § 438.114(e) to improve or resolve the Member's condition.

Potential Member – A Medicaid or CHIP Beneficiary who is subject to mandatory enrollment or may voluntarily elect to enroll in KanCare, but is not yet a Member of a specific CONTRACTOR

Practitioner – 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.

Preferred Drug List – A listing of prescription products recommended by a Pharmacy and Therapeutics’ committee as being safe, efficacious, and cost-effective choices for clinician consideration when prescribing.

Prescribed – The issuance of a prescription order by a practitioner.

Prescription – Refer to either of the following:

1. A prescription order.
2. A prescription medication.

Prescription Medication – 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.

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

Primary Care – All health care services and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, pediatrician, or other licensed practitioner as authorized by the State, to the extent the furnishing of those services is legally authorized in the State in which the practitioner furnishes them.

Prior Authorization – Approval granted for payment purposes by the CONTRACTOR to a Provider to provide specified Covered Services to a specified Member.

Protected Health Information – Shall have the same meaning as the term "protected health information" in 45 CFR. § 160.103 and is individually identifiable information in any medium pertaining to the past, present or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual, that CONTRACTOR receives from Kansas Department of Health & Environment or that CONTRACTOR creates or receives on behalf of Kansas Department of Health & Environment. The terms “Protected Health Information” apply to the original data and to any health data derived or extracted from the original data that has not been de-identified.

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

Provider – Any individual or entity that is engaged in the delivery of Covered Services, or ordering or referring for those Covered Services, and is legally authorized to do so by the State in which it delivers the Covered Services. This term may be used when referring to both Participating and Non-Participating Providers.

Provider Preventable Conditions –The minimum set of conditions, including infections and events, which have been identified for non-payment according to the State’s Medicaid State Plan.

Psychiatric Residential Treatment Facility – Any non-hospital facility with a provider agreement with a State Medicaid Agency to provide the inpatient services benefit to Medicaid-eligible individuals under the age of 21 (psychiatric under 21 benefit).

Prudent Layperson – A person who possesses an average knowledge about health, health care, and medicine.

**Q**

Quality Assurance and Performance Improvement Program – The coordinated application of two mutually reinforcing aspects of a quality management system: Quality Assurance and Performance Improvement. Where quality assurance takes a systematic, comprehensive, and data-driven approach to maintain the quality of care and services delivered to all populations and across all settings of care and performance improvement requires the implementation of action steps, in an ongoing and iterative fashion, to improve the outcomes of the care and services delivered.

**R**

Rapid-Cycle Process Improvement – An iterative quality improvement process that uses a four stage approach often referred to as the Plan-Do-Study-Act model, each iteration of the process should occur in a rapid sequential fashion that takes less than three months to complete.

Regional Alcohol & Drug Assessment Center (Heartland RADAC) – A private, 501(c) 3, non-profit organization, incorporated in 1998 as a licensed alcohol and drug treatment program that provides assessment and referral services, as well as care coordination and case management services for individuals seeking substance abuse services.

Rate Cell – A set of mutually exclusive categories of Members that is defined by one or more characteristics for the purpose of determining the capitation rate and making a capitation payment; such characteristics may include age, gender, eligibility category, and region or geographic area.

Rating Period – A period of 12 months selected by the State for which the actuarially sound capitation rates are developed and documented in the rate certification submitted to CMS as required by 42 CFR § 438.7(a).

Readily Accessible– Electronic information and services which comply with modern accessibility standards such as section 508 guidelines, section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines 2.0 AA and successor versions.

Regulation – A Federal or State agency statement of general applicability designed to implement or interpret law, policy, or procedure.

Risk – The possibility of monetary loss or gain by the CONTRACTOR resulting from service costs exceeding or being less than Capitation Payments made to it by the State.

Rural– An area identified as rural by the United States Census Bureau as an area that is not urban.

Rural Health Clinic – An entity that has been determined by the Centers for Medicare & Medicaid Services 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.

**S**

Self-Direction – Participants/Members, 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.

Serious and Persistent Mental Illness – A client meets the definition of an adult with a serious and persistent mental illness if he/she meets the criteria for a Dimension I diagnosis of:

1. Serious and Persistent Mental Illness.
2. Schizophrenia or Other Psychotic Disorder (DSM diagnosis of 295.xx, 297.xx, 298.xx).
3. Major Depressive Disorder or Bipolar Disorder (DSM diagnosis of 296.xx, severe, recurrent, not in full remission).
4. Anxiety disorder, personality disorder or a combination of mental disorders sufficiently disabling to meet criteria of functional disability.

Service Authorization – The process of receiving written approval from the CONTRACTOR for specified Covered Services or products prior to the Covered Services or products being rendered.

Service Coordination – Name used in KanCare for the comprehensive, holistic, integrated approach to coordinating and monitoring all of an individual’s care (behavioral health, physical health, long‑term services and supports and social determinants of health and independence) through direct support, provider referrals, and linkages to community resources.

Shall – A term, like “must,” that is used throughout the KanCare RFP that means the requirement(s) is mandatory.

Significant Change in Condition – A change in an individual’s health status as the result of factors including, but not limited to, loss of caregiver, hospitalization, institutionalization, change in residence, fall or other incident, warranting a reassessment of need for services and supports to safely support the individual.

Single State Medicaid Agency – Kansas Department of Health & Environment, which is legally authorized and responsible for administering the provisions of the State Plan for Medical Assistance (Medicaid) and the administration of CHIP on a statewide basis.

Social Determinants of Health – Conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks *(Healthy People 2020).*

Social Determinants of Independence – An individual’s goals that help them achieve sustainable improvements and advancement in their lives. Addressing Social Determinants of Independence in conjunction with Social Determinants of Health accelerates an individual’s path to higher levels of independence and attainment of their vision for a good life.

State Plan – Plan approved by the Centers for Medicare & Medicaid Services governing the Kansas Medicaid Program.

Start Date – The date the CONTRACT for services becomes effective.

State – The State of Kansas, including, but not limited to, any entity or agency of the State.

State Fair Hearing – An administrative hearing involving the presentation of evidence and argument before a presiding officer from the Kansas Office of Administrative Hearings concerning an Adverse Benefit Determination or an Action. The presiding officer will hear the matter, determine the result, and issue a decision.

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 CONTRACTOR and Subcontractor.

Subcontractor – An individual or entity with a Subcontract with a CONTRACTOR that relates directly or indirectly to the performance of the CONTRACTOR(S)’ obligations under the CONTRACT. A Participating Provider is not a Subcontractor by virtue of a provider agreement with the CONTRACTOR.

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**

Telemedicine – Connecting Participating Providers with Members at distant sites for purposes of evaluation, diagnosis, and treatment through two-way, real time interactive communication.

Telementoring – Technologies such as the Project ECHO model to connect community primary care providers with specialists remotely located to provided consultations, grand rounds, education, and to fully extend the range of care available within a community practice.

Telemonitoring *–* Technologies that target specific disease type (i.e., congestive heart failure) or high utilizers of health services, particularly emergency room services and medication regimen management. Technologies are available that measure health indicators of patients in their homes and transmit the data to an overseeing provider. The provider, who might be a physician, nurse, social worker, or even a non‑clinical staff Member, can filter Member questions and report to a clinical team as necessary.

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. (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, which provides health insurance coverage to uninsured children from low-income families, who are not Title XIX eligible.

Title 21 –Portion of the [Code of Federal Regulations](https://en.wikipedia.org/wiki/Code_of_Federal_Regulations) that governs food and drugs within the [United States](https://en.wikipedia.org/wiki/United_States) for the [Food and Drug Administration](https://en.wikipedia.org/wiki/Food_and_Drug_Administration), the [Drug Enforcement Administration](https://en.wikipedia.org/wiki/Drug_Enforcement_Administration), and the [Office of National Drug Control Policy](https://en.wikipedia.org/wiki/Office_of_National_Drug_Control_Policy).

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 its resulting CONTRACT(S).

**U**

Urban – An area identified as urban by the United States Census Bureau.

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 Care – 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 Nursing Facility 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. It is expected that these operators staying on the line with the Beneficiary until the Beneficiary is handed off to another entity. For example a call center staff calling a non‑emergent medical transportation Subcontractor and staying on the line to explain what the Member needs and then introducing the parties, asking if there is anything else they can assist with, and then handing the Beneficiary over to the Subcontractor.

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

WORK Program – A State Plan package of benefits that provides personal services, as well as other services, for employed persons with disabilities.

| Acronym | Definition |
| --- | --- |
| **A** | |
| ACIP | Advisory Commission on Immunization Practices |
| AD | Adults with Disabilities |
| ADA | Americans with Disabilities Act |
| ADA | American Dental Association |
| ADAP | AIDS Drug Assistance Program |
| ADT | Admission Discharge Transfer |
| AIMS | Automated Information Management System |
| AIR | Adverse Incident Reporting System |
| AMA | American Medical Association |
| ANSI | American National Standards Institute |
| API | Active Pharmaceutical Ingredient |
| APM | Alternative Payment Model |
| APN | Advanced Practice Nursing |
| APRN | Advanced Practice Registered Nurse |
| APS | Adult Protective Services |
| ARRA | American Recovery and Reinvestment Act |
| ARs | Account Receivables |
| AT | Assistive Technology |
| ASAM | American Society of Addiction Medicine |
| AVRS | Automated Voice Response System |
| **B** | |
| BAA | Business Associate Agreement |
| BH CMO | Behavioral Health Medical Officer/Medical Director |
| BP | Blood Pressure |
| BRE | Business Rules Engine |
| BSRB | Behavioral Sciences Regulatory Board |
| **C** | |
| CAH | Critical Access Hospital |
| CAHPS® | Consumer Assessment of Healthcare Providers and Systems (the acronym "CAHPS" is a registered trademark of the Agency for Healthcare Research and Quality) |
| CAP | Corrective Action Plan |
| CARC | Claim Adjustment Reason Codes |
| CDC | Centers for Disease and Control |
| CDDO | Community Developmental Disability Organization |
| CDT | Code on Dental Procedures and Nomenclature |
| CEO | Chief Executive Officer |
| CFR | Code of Federal Regulations |
| CHF | Congestive Heart Failure |
| CHIP | Children’s Health Insurance Program |
| CLIA | Medicaid Clinical Laboratory Improvement Amendments |
| CMHC | Community Mental Health Center |
| CMO | Chief Medical Officer |
| CMS | Centers for Medicare and Medicaid Services |
| COB | Coordination of Benefits |
| COPD | Chronic Obstructive Pulmonary Disease |
| CPST | Community Psychiatric Support and Treatment |
| CPT | Current Procedure Terminology |
| CRD | Chronic Renal Disease |
| CRNA | Certified Registered Nurse Anesthetists |
| CRO | Consumer Run Organization |
| CSSP | Customer Self Service Portal |
| CYSHCN | Children and Youth with Special Health Care Needs |
| **D** | |
| DCF | Department of Children and Families |
| DD | Developmental Disability |
| DEERS | Defense Enrollment Eligibility Reporting System |
| DHCF | Division of Health Care Finance |
| DME | Durable Medical Equipment |
| DOB | Date of Birth |
| DOD | Date of Death |
| DSH | Disproportionate Share Hospital Payments |
| DWA | Data Warehouse and Analytics |
| DUR | Drug Utilization Review or Report |
| **E** | |
| EBP | Evidence-Based Practices |
| ED | Emergency Department |
| EDI | Electronic Data Interface |
| EHR | Electronic Health Record |
| EMC | Electronic Media Claims |
| EOB | Evidence of Benefits |
| EPSDT | Early and Periodic Screening, Diagnosis and Treatment |
| EQR | External Quality Review |
| EQRO | External Quality Review Organization |
| ER | Emergency Room |
| ESB | Enterprise Service Bus |
| ESRD | End State Renal Disease |
| EVV | Electronic Visit Verification |
| EVV | Electronic Visit Verification |
| **F** | |
| FAQ | Frequently Asked Questions |
| FBC | Free Standing Birth Center |
| FDA | Food and Drug Administration |
| FE | Frail Elderly |
| FEB | Front End Billing |
| FFP | Federal Financial Participation |
| FFS | Fee-For-Service |
| FMS | Financial Management Services |
| FQHC | Federally Qualified Health Center |
| **G** | |
| GAAP | Generally Accepted Accounting Principles |
| GAO | General Accounting Office |
| GAR | Grievance and Appeals Report |
| GME | Graduate Medical Education |
| GTG | Good to Go Report (WORK) |
| **H** | |
| HCBS | Home and Community-Based Services |
| HCPCS | Health Care Common Procedure Coding System |
| HEDIS | Healthcare Effectiveness Data and Information Set |
| HHS | Department of Health and Human Services |
| HIE | Health Information Exchange |
| HIO | Health Information Organization |
| HIPAA | Health Insurance Portability and Accountability Act |
| HIPF | Health Insurance Provider’s Fee |
| HIT | Health Information Technology |
| HITECH | Health Information Technology for Economic Clinical Health Act |
| HIV | Human Immunodeficiency Virus |
| HIX | Health Insurance Exchange |
| HRA | Health Risk Assessment |
| HUD | US Housing and Urban Development |
| **I** | |
| ICD | International Classification of Diseases |
| ICF | Intermediate Care Facility |
| ICF/IDD | Intermediate Care Facilities for Individuals with Intellectual and Developmental Disabilities |
| ICN | Internal Control Number |
| IDD | Individuals with Intellectual and Developmental Disabilities |
| IDEA | Individuals with Disabilities Education Act |
| IEP | Individual Education Plan |
| IFSP | Independent Family Services Plan |
| IHCPs | Indian Health Care Providers |
| IID | Individuals with Intellectual Disability |
| ILC | Independent Living Center |
| ILC | Independent Living Counselor (WORK Program) |
| IPS | Individual Placements and Supports |
| IRS | Internal Revenue Service |
| ISP | Infrastructure Security Plan |
| I/T/U | Indian Health Service/Tribal/Urban Indian Health |
| **K** | |
| KCPC | Kansas Client Placement Criteria |
| KDADS | Kansas Department for Aging and Disability Services |
| KDHE | Kansas Department of Health and Environment |
| KEES | Kansas Eligibility and Enforcement System |
| KHA | Kansas Hospital Association |
| KHIN | Kansas Health Information Network |
| KID | Kansas Insurance Department |
| KMAP | Kansas Medical Assistance Program |
| KMMS | Kansas Modular Medicaid System |
| KMS | Kansas Medical Society |
| KSA | Kansas Statutes Annotated |
| **L** | |
| LACIE | Lewis and Clark Health Information Exchange |
| LEAs | Local Education Agencies |
| LEP | Limited English Proficiency |
| LTC | Long‑Term Care |
| LTSS | Long‑Term Services and Supports |
| **M** | |
| M&I | Maternal and Infant (Title V Program) |
| MAC | Maximum Allowable Cost |
| MAT | Medication Assisted Treatment |
| MCO | Managed Care Organization |
| MCS | Managed Care Services |
| MDL | Maintenance Drug List |
| MFCU | Medicaid Fraud Control Unit |
| MFP | Money Follows the Person Grant |
| MH | Mental Health |
| MHPAEA | Mental Health Parity and Addictions Equity Act |
| MIPS | Merit-based Incentive Payment System |
| MITA | Medicaid Information Technology Architecture |
| MLR | Medical Loss Ratio |
| MMIS | Medicaid Management Information System |
| MTM | Medication Therapy Management |
| **N** | |
| NADAC | National Average Drug Acquisition Cost |
| NAIC | National Association of Insurance Commissioners |
| NCPDP | National Council for Prescription Drug Programs |
| NCQA | National Committee for Quality Assurance |
| NDC | National Drug Codes |
| NEMT | Non-Emergency Medical Transportation |
| NF | Nursing Facility |
| NFMH | Nursing Facility for Mental Health |
| NOMS | National Outcomes Measurement System |
| NPI | National Provider Identifier |
| NQTL | Non-Quantitative Treatment Limits |
| **O** | |
| OB/GYN | Obstetrics and Gynecology |
| OI | Other Insurance |
| OIG | Office of the Inspector General |
| OIM | Oracle Identity Management |
| OP | Out Patient |
| OT | Occupational Therapy |
| OTC | Over the Counter |
| **P** | |
| P4P | Pay for Performance |
| PA | Prior Authorization |
| PA | Physician Assistants |
| PACE | Program for All-Inclusive Care for the Elderly |
| PARIS | Public Assistance Reporting Information System |
| PBM | Pharmacy Benefit Manager |
| PBS | Positive Behavior Support |
| PCP | Primary Care Provider or Primary Care Physician |
| PCS | Procedure Coding System |
| PCSP | Person Centered Service Plan |
| PD | Physical Disability |
| PDL | Preferred Drug List |
| PHI | Personal/Protected Health Information |
| PIP | Performance Improvement Project |
| PMDD | Presumptive Medical Disability Determination |
| PMPM | Per Member Per Month |
| PNC | Procurement Negotiating Committee |
| POA | Power of Attorney |
| POS | Point/Place of Service |
| PPACA | Patient Protection and Affordable Care Act |
| PPL | Patient Pay Liability |
| PPS | Prospective Payment System |
| PRTF | Psychiatric Residential Treatment Facility |
| PT | Physical Therapy |
| P4P | Pay for Performance |
| **Q** | |
| QAPI | Quality Assessment & Performance Improvement |
| QI | Quality Initiative |
| QM | Quality Management |
| QMB | Qualified Medicare Beneficiary |
| QMS | Quality Management Strategy |
| **R** | |
| RA | Remittance Advices |
| RADAC | Regional Alcohol and Drug Assessment Center |
| RARC | Remittance Advice Remark Codes |
| REST | Representational State Transfer |
| RFP | Request for Proposal |
| RHC | Rural Health Clinic |
| RN | Registered Nurse |
| **S** | |
| SAMHSA | Substance Abuse and Mental Health Services Administration |
| SBIRT | Screening Brief Intervention and Referral to Treatment |
| SED | Serious Emotional Disturbance |
| SFTP | Secured File Transfer Protocol |
| SMHP | State Medicaid HIT Plan |
| SNAP | Supplemental Nutrition Assistance Program |
| SOA | Service-Oriented Architecture |
| SOBRA | Sixth Omnibus Budget Reconciliation Act |
| SP | Medicaid State Plan |
| SPMI | Serious and Persistent Mental Illness |
| SSA | Social Security Administration |
| SSI | Supplemental Security Income |
| SSMA | Single State Medicaid Agency |
| SSN | Social Security Number |
| ST | Speech Therapy |
| STC | Specific Therapeutic Class |
| STCs | Special Terms and Conditions |
| STD | Sexually Transmitted Diseases |
| SUD | Substance Use Disorder |
| **T** | |
| TA | Technology Assisted |
| TAT | Turnaround Time |
| TB | Tuberculosis |
| TBI | Traumatic Brain Injury |
| TCM | Targeted Case Management |
| TIN | Tax Identification Number |
| 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) |
| Title 21 | Of the Food and Drug Administration – Federal rules that governs food and drugs within the United States |
| TPL | Third Party Liability |
| TTY/TTD | TeleTypewriter/Telecommunications Device |
| **U** | |
| UM | Utilization Management |
| UR | Utilization Review |
| URL | Universal/Uniform Resource Locator |
| USDA | U.S. Department of Agriculture |
| **V** | |
| VPAT | Voluntary Product Accessibility Template |
| **W** | |
| WIC | Special Supplemental Food Program for Women, Infants and Children |
| WSDL | Web Services Definition Language |