



HEALTH PLAN DEFINITIONS AND ACRONYMS

DEFINITIONS

The following are definitions of terms frequently used in the Contract between the Contra Costa Health Plan (CCHP or Health Plan) and the Department of Health Care Services (DHCS) and Centers for Medicare and Medicaid Services (CMS).

Abuse describes practices that may directly or indirectly result in unnecessary costs to the Medicare program and Medi-Cal program. Abuse includes any practice that does not provide patients with medically necessary services or meet professionally recognized standards of care.

Admission, Discharge and Transfer (ADT) Feed is a standardized data feed that is updated consistently and in real-time. Data are sourced from a health facility, such as a hospital, that include member demographic and healthcare Encounter Data at the time of admission, discharge and transfer from the facility. Demographic information within the feed must meet requirements of the most recent version of the California Data Exchange Framework's Technical Requirements for Exchange Policy and Procedure. The information must conform to United States Core Data for Interoperability (USCDI) requirements of the California Data Exchange Framework.

Administrative Cost means only those costs that arise out of the Health Plan's operations as specified in 28 California Code of Regulations (CCR) section 1300.78.

Administrative Subhealth plan means a Subhealth plan that contractually assumes administrative obligations of Health Plan under the Contract. Administrative obligations include functions such as Credentialing verification or claims processing. However, functions related to coordinating or directly delivering health care services to Members, such as Care Coordination, are not administrative functions.

Adult Day Health Care (ADHC) means an organized day program of therapeutic, social and health activities and services. This is provided to people aged 55 years or older, or to other adults with functional impairments, either physical or mental. The purpose is to restore or maintain optimal capacity for self-care as set forth in 22 CCR section 78007.

Advance Directive is a legal document that provides instructions for medical care and only go into effect if the Member cannot communicate their own wishes. The two most common advance directives for health care are the living will and the durable power of attorney for health care. They are recognized under California law.

Adverse Benefit Determination (ABD) means any of the following actions taken by the Health Plan:

- A. The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting or effectiveness of a covered benefit;
- B. The reduction, suspension or termination of a previously authorized service;

- C. The denial, in whole or in part, of payment for a service. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of Clean Claim is not an ABD;
- D. The failure to provide services in a timely manner, as defined by the State;
- E. The failure to act within the required timeframes for standard resolution of Grievances and Appeals;
- F. For a resident of a rural area with only one Medi-Cal managed care health plan, the denial of the Member's request to obtain services outside of the network; or
- G. The denial of a Member's request to dispute financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance and other enrollee financial liabilities.

Affiliate is an entity or individual that is connected to another through contract, ownership or otherwise. An Affiliate is controlled by or is under the control of the Health Plan. An Affiliate provides services to or receives services from Health Plan.

All Plan Letter (APL) or Policy Letter (PL) is a binding document that has been dated, numbered and issued by DHCS. It is how DHCS conveys information or interpretation of changes in policy or procedure at the Federal or State levels, and provides instruction to the Health Plan, if applicable, on how to implement these changes on an operational basis.

Allied Health Personnel are specially trained, licensed or credentialed health workers other than physicians, podiatrists and nurses.

Alternative Format Selection (AFS) is the choice a Member or their Authorized Representative (AR) makes to receive information and materials in an alternate format. Alternate formats include Braille, audio format, large print (no less than 20-point Arial font) and accessible electronic format, such as data compact disc.

American Indian is any individual who has been determined eligible as an "Indian" under 42 Code of Federal Regulations (CFR) section 438.14(a).

Appeal means a review by the Health Plan of an Adverse Benefit Determination (ABD), which includes one of the following actions:

- A. A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting or effectiveness of a Covered Service;
- B. A reduction, suspension or termination of a previously authorized service;
- C. The denial, in whole or in part, of payment for a Covered Service, except payment denials based solely because the claim does not meet the definition of a Clean Claim;

- D. Failure to provide services in a timely manner; or
- E. Failure to act within the timeframes provided in 42 CFR section 438.408(b).

Application Programming Interface (API) means a way for two or more computer programs to communicate with each other. The calls that make up the API are also known as subroutines, methods, requests or endpoints.

Asthma Preventive Services (APS) is defined as information about the basic facts of asthma, proper use of long-term controllers and quick relief medications, evidence-based self-management techniques and self-monitoring skills, and actions to mitigate or control environmental exposures that exacerbate asthma symptoms.

Authorized Representative (AR) means any individual appointed in writing by a competent Member or Potential Member, to act in place or on behalf of the Member or Potential Member for purposes of assisting or representing the Member or Potential Member with Grievances and Appeals, State Hearings, Independent Medical Reviews and in any other capacity as specified by the Member or Potential Member.

Auxiliary Aid means "auxiliary aids and services" as defined in 28 CFR section 36.303(b) that assist Members with disability to communicate, receive and understand information.

Basic Population Health Management (Basic PHM) means an approach to care that ensures that needed programs and services are made available to each Member, regardless of the Member's Risk Tier, at the right time and in the right setting. Basic PHM includes federal requirements for Care Coordination.

Behavioral Health refers to a state of mental, emotional and social well-being or behaviors and actions that affect wellness. Behavioral health is a key component of overall health. The term is also used to describe the support systems that promote well-being, prevent mental distress and provide access to treatments and services for mental health conditions.

Behavioral Health Services in Medi-Cal includes three main types of services: Specialty Mental Health Services (SMHS), Non-Specialty Mental Health Services (NSMHS) and Substance Use Services.

Behavioral Health Treatment (BHT) services consist of Applied Behavioral Analysis and other generally accepted evidence-based approaches that prevent or minimize the adverse effects of behaviors that interfere with learning and social interaction and promote, to the maximum extent practicable, the functioning of a member, including those with or without autism spectrum disorder (ASD).

BHT Provider means a Qualified Autism Services (QAS) Provider, QAS Professional or QAS Paraprofessional who provides treatment services as defined by Health & Safety Code section 1374.73.

Beneficiary Identification Card (BIC) is a plastic card issued by DHCS to a Member. The BIC is used to verify a Member's eligibility for Medi-Cal benefits, allowing Medi-Cal providers to bill for your medical and dental care.

Bright Futures Periodicity Schedule is also known as the Periodicity Schedule. This is a schedule of screenings and assessments recommended at each well-child visit from infancy through adolescence. The recommendations come from the American Academy of Pediatrics and Bright Futures.

California Advancing and Innovating Medi-Cal (CalAIM) Terms and Conditions means those terms and conditions issued and approved by the federal Centers for Medicare and Medicaid Services (CMS). It includes any attachments, appendices or similar documents, and subsequent amendments thereto, that govern implementation of the respective components of the CalAIM initiative pursuant to CA Welfare and Institutions Code Section 14184.101 (2025).

California Children's Services (CCS)-Eligible Condition is specified in California Code of Regulations, Title 22, Division 2, Subdivision 7, Chapter 3, Article 2, Sections 41515.1 to 41518.9. CCS applicants diagnosed with at least one of the specified conditions shall be medically eligible for participating in the CCS program.

California Children Services (CCS) Provider means any of the following Providers when used to treat Members for a CCS-Eligible Condition:

- A. A medical Provider that is paneled by the CCS Program, pursuant to Health and Safety Code (H&S), Article 5 (commencing with section 123800) of Chapter 3 of Part 2 of Division 106.
- B. A licensed acute care hospital approved by the CCS Program.
- C. A special care center approved by the CCS Program.

CCS Case Manager is a qualified individual who helps CCS members with getting special doctors and referrals to other agencies, such as public health nursing and regional centers, as part of the CCS program.

CCS Liaison means primary points of contact for the coordination of services between Health Plan and county CCS Program who ensure the appropriate communication and care coordination are ongoing between the Health Plan and county CCS Program, facilitate quarterly meetings, and provide updates to the county CCS Program as appropriate.

CCS Program is a State program for children with certain diseases or health problems. Through this program, children up to 21 years old can get the health care and services they need. The program administered as a partnership between the county health department and DHCS to provide Medically Necessary services to treat California Children's Services (CCS)-Eligible Conditions.

Capitation Payment is a way of paying health care providers or organizations in which they receive a predictable, upfront, set amount of money to cover the predicted cost of all or some of the health care services for a specific patient over a certain period.

Care Coordination is the organization of a patient's care across multiple health care providers.

Care Management Plan (CMP) is a written document of decisions on patient care. The plan is

developed with the Member, their family, the Member's Authorized Representative (AR), caregiver, case manager or the Member's doctors and specialists. The plan assesses the Member's medical condition, needs, goals and interventions. The plan may also have recommendations for clinical and non-clinical service needs.

Center of Excellence means a designation assigned to a transplant program by DHCS upon confirmation that the transplant program meets DHCS' criteria.

Certified Nurse Midwife (CNM) is a highly trained healthcare professional or registered nurse who specializes in the comprehensive care of women throughout the stages of pregnancy, childbirth and the postpartum period.

Child or Children and Youth, regardless of whether the term is capitalized or not, means a Member less than age 21.

Children and Youth with Special Health Care Needs (CYSHCN) include infants, children and youth from birth to age 21 who have one or more chronic physical, developmental, behavioral or emotional conditions and require special health and support services. The identification, assessment, treatment, and coordination of care for CYSHCN must comply with the requirements of 42 CFR sections 438.208(b)(3), 438.208(b)(4), and 438.208(c)(2) through (4).

Clean Claim is a healthcare payment request that contains every piece of information the payer needs to process and pay it without asking the provider for anything else.

Cold-Call Marketing means a phone call made without any prior contact from a Member or a Potential Member. This phone call is for the purpose of Marketing.

Community Based Adult Services (CBAS) is a community-based day health program that provides services to older adults and adults with chronic medical, cognitive or behavioral health conditions and/or disabilities that make them at risk of needing institutional care.

CBAS Discharge Plan of Care means planning that begins at the time of Member's admission to a hospital or institution to ensure that necessary care, services and supports are in place in the community before the Member leaves. This is to reduce readmission rates, improve Member and family preparation, enhance Member satisfaction, assure post-discharge follow-up, increase medication safety and support safe transitions. The discharge plan is prepared by a CBAS Provider pursuant to 22 CCR section 78345.

CBAS Emergency Remote Services (ERS) under specified emergency situations, are a temporary arrangement where CBAS services are provided in alternative settings such as the community, in or at the doorstep of the CBAS participant's home or via telehealth. This is to allow for immediate response to address the continuity of care needs of CBAS participants when an emergency prevents them from receiving services at their center.

CBAS Individual Plan of Care (IPC) means a written plan of care developed by a CBAS center's

multidisciplinary team, as specified in the CalAIM Terms and Conditions or as specified in any subsequent demonstration amendment or renewal, or successive demonstration, waiver or other Medicaid authority governing the provision of CBAS.

CBAS Provider means an Adult Day Health Care (ADHC) center that is licensed by the California Department of Public Health (CDPH) to provide ADHC services, is enrolled as a Medi-Cal Provider and has been certified as a Community Based Adult Services (CBAS) Provider by the California Department of Aging.

Community Health Assessment (CHA) refers to a state, tribal, local, or territorial health assessment that identifies key health needs and issues through systematic, comprehensive data collection, and analysis.

Community Health Improvement Plan (CHIP) uses the results of community health assessment activities and the community health improvement process. It is a long-term, systematic effort to address public health problems based on the results of community health assessment activities and the community health improvement process. A plan is typically updated every three to five years.

Community Health Worker (CHW) may include individuals known by a variety of job titles, including promotores, community health representatives, navigators and other non-licensed public health workers, including violence prevention professionals as set forth in APL 22-016.

Community Reinvestment Plan means a document that outlines how a Medi-Cal managed care plan will reinvest to address unmet needs of Members and their communities, such as health-related social needs, which have a significant impact on health and well-being per APL 25-004.

Community Supports are services that help Members with their health needs and make sure they can live well and safely on their own at home.

Community Supports Provider means entities that the Health Plan has determined can provide the Community Supports to eligible Members in an effective manner consistent with culturally and linguistically appropriate care, as outlined in Exhibit A, Attachment III, Subsection 5.2.11 (Cultural and Linguistic Programs and Committees).

Complex Care Management (CCM) or chronic care management is managing a patient's multiple (two or more) chronic or complex conditions expected to last at least 12 months or until their death. Chronic or complex conditions place the patient at significant risk of death, acute exacerbation or decompensation or functional decline. CCM is a critical primary care service that contributes to better patient health and care.

Complex Care Needs means the multifaceted health and social support requirements of Members who face significant barriers to achieving and maintaining health and stability. This includes individuals with multiple chronic conditions, functional impairments, behavioral health challenges, or those requiring extensive care coordination due to social determinants of health.

CCM Care Manager means an individual identified as a single point-of-contact responsible for the provision of Complex Care Management (CCM) services for a Member.

Confidential Information means facts, documents or records in any form that are recognized as private or "confidential" by any law, regulation or contract.

Contract means a written agreement between two parties that is enforceable by law.

Contract Revenues means the amount of Medi-Cal managed health care Capitation Payments, Supplemental Payments, additional payments and other revenue paid to the Health Plan by DHCS under a contract.

Contractor's Representative means an individual appointed by the Health Plan. This individual is responsible for implementing the Contract, receiving notices on the Contract and taking actions and making representations related to the compliance with the Contract.

Correctional Facility means State prisons, county jails and youth correctional facilities.

Corrective Actions means specific identifiable activities or undertakings of the Health Plan which address Contract deficiencies or noncompliance.

Cost Avoid or **Cost Avoidance** means the practice of requiring Providers to bill liable third parties before to seeking payment from the Medi-Cal program.

County Social Services Department means a county agency responsible for determining the initial and continued eligibility of an individual for participation in the Medi-Cal program or for providing services as specified in a health plan's Contract with DHCS or CMS.

Covered Services means Medi-Cal or Medicare health care services an eligible Member can get from participating in Medi-Cal or Medicare programs. Covered Services are provided by Medicare and Medi-Cal providers as described in Member Handbooks. [Click the link to see the Member Handbooks published on the Contra Costa Health Plan website.](#)

Credentialing is the recognition of professional or technical competence of a health care provider per APL 22-013. The credentialing process may include registration, certification, licensure, and professional association membership. The credentialing process ensures that providers are properly licensed and certified as required by state and federal law.

Deemed Exhaustion means a health plan did not notify its Member correctly or timely about their service(s) per Member's rights under the Knox-Keene Act.

Department of Health Care Services (DHCS) or Department is the federally designated single state agency responsible for financing and administering the state's Medicaid program, Medi-Cal, which provides health care services to low-income persons and families who meet defined eligibility requirements. DHCS is also the single state agency for Substance Abuse and the State Mental Health Authority. DHCS administers county-operated community mental health and substance use disorder

programs, together known as behavioral health. DHCS also administers California Children's Services (CCS), Genetically Handicapped Persons Program (GHPP) and other health-related programs, as provided by statute and/or regulation.

DHCS Comprehensive Quality Strategy is required by the Medicaid and Children's Health Insurance Program (CHIP) Managed Care Final Rule (42 CFR 438.340). Each state Medicaid agency, including DHCS, maintains a written quality strategy to assess and improve the quality of health care and services provided by all Medicaid managed care entities.

DHCS Contract Manager or **DHCS Program Contract Manager** means the designated DHCS employee who is the primary contact within DHCS for the Health Plan. The DHCS Contract Manager is responsible for receiving and sending notices and other documents from and to the Health Plan relating to the Contract.

DHCS Contracting Officer means the DHCS individual authorized to act on behalf of DHCS to make decisions and direct appropriate actions under the Contract.

Department of Managed Health Care (DMHC) is the California department responsible for administering the Knox-Keene Health Care Service Plan Act of 1975.

Developmental Disability (DD) means, as defined by the Lanterman Developmental Disabilities Services Act (1977) at W&I section 4512(a)(1), a disability that originates before an individual attains 18 years of age, continues, or can be expected to continue, indefinitely. And constitutes a substantial disability for that individual. This term includes intellectual disability, cerebral palsy, epilepsy and autism. This term also includes disabling conditions found to be closely related to intellectual disability but does not include other handicapping conditions that are solely physical in nature.

Director means the Director of DHCS.

Directed Payment Initiative means a payment arrangement that directs certain expenditures made by the Health Plan under a Contract and that is either approved by CMS as described in 42 CFR section 438.6(c) or established pursuant to 42 CFR sections 438.6(c)(1)(iii)(A) and 438.6(c)(2)(ii) and documented in a rate certification approved by CMS.

Discharge Planning means planning that begins at the time of admission to a hospital or facility to ensure that necessary care, services and supports are in place in the community before a Member leaves the hospital or facility in order to reduce readmission rates, improve Member and family preparation, enhance Member satisfaction, assure post-discharge follow-up, increase medication safety and support safe transitions.

Discrimination Grievance means any complaint or grievance alleging discrimination prohibited by State non-discrimination law, including, without limitation, the Unruh Civil Rights Act and GC section 11135 and federal non-discrimination law, including the following, without limitation:

- A. Title VI of the Civil Rights Act of 1964;

- B. Title IX of the Education Amendments of 1972;
- C. The Age Discrimination Act of 1975;
- D. Sections 504 and 508 of the Rehabilitation Act of 1973 (29 USC sections 794 and 794d), as amended; and
- E. Section 1557 of the Patient Protection and Affordable Care Act of 2010 (42 USC section 18116).

Doula means a birth worker who provides health education, advocacy and physical, emotional and nonmedical support for pregnant and postpartum persons before, during and after childbirth, otherwise known as the perinatal period, for up to one year after pregnancy and provides support during miscarriage, stillbirth and abortion (pregnancy termination) as set forth in APL 23-024.

Downstream Subhealth plan means an individual or an entity that has a Downstream Subhealth plan Agreement with a Subhealth plan or a Downstream Subhealth plan. A Network Provider is not a Downstream Subhealth plan solely because it enters into a Network Provider Agreement.

Downstream Fully Delegated Subhealth plan means a Downstream Subhealth plan that contractually assumes all duties and obligations of Health Plan under the Contract, through the Subhealth plan, except for those contractual duties and obligations where delegation is legally or contractually prohibited. A managed care plan can operate as a Downstream Fully Delegated Subhealth plan.

Downstream Partially Delegated Subhealth plan means a Downstream Subhealth plan that contractually assumes some, but not all, duties and obligations of a Subhealth plan under the Contract, including, for example, obligations regarding specific Member populations or obligations regarding a specific set of services. Individual physician associations and medical groups often operate as Downstream Partially Delegated Subhealth plans.

Downstream Administrative Subhealth plan means a Downstream Subhealth plan that contractually assumes administrative obligations of a Subhealth plan under the Contract. Administrative obligations include functions such as credentialing verification or claims processing. However, functions related to coordinating or directly delivering health care services for Members, such as Utilization Management (UM) or Care Coordination, are not administrative functions.

Downstream Subhealth plan Agreement means a written agreement between a Subhealth plan and a Downstream Subhealth plan or between any Downstream Subhealth plans. The Downstream Subhealth plan Agreement must include a delegation of Health Plan's and Subhealth plan's duties and obligations under the Contract.

Drug Medi-Cal (DMC) means the State system wherein Members receive Covered Services from DMC-certified Substance Use Disorder (SUD) treatment Providers.

Drug Medi-Cal Organized Delivery System (DMC-ODS) means a program for the organized delivery of Substance Use Disorder (SUD) services to Medi-Cal-eligible individuals with SUD residing in a county that has elected to participate in the DMC-ODS. Critical elements of DMC-ODS include providing a

continuum of care modeled after the American Society of Addiction Medicine (ASAM) Criteria® for SUD treatment services, increased local control and accountability, greater administrative oversight, creation of utilization controls to improve care and efficient use of resources, evidence-based practices in substance use treatment and increased coordination with other systems of care.

Durable Medical Equipment (DME) means Medically Necessary medical equipment as defined by 22 CCR section 51160 that a Provider prescribes for a Member that the Member uses in the home, in the community or in a facility that is used as a home.

Dyadic Care means to serve both parent(s) or caregiver(s) and Child together as a dyad. It is a form of treatment that targets family well-being as a mechanism to support healthy child development and mental health. It is provided within pediatric Primary Care settings whenever possible and can help identify behavioral health interventions and other behavioral health issues, provide referrals to services and help guide the parent-Child or caregiver-Child relationship. Dyadic Care fosters team-based approaches to meeting family needs, including addressing mental health and social support concerns, and it broadens and improves the delivery of pediatric Preventive Care.

Dyadic Service means a family and caregiver-focused Model of Care intended to address developmental and behavioral health conditions of Children as soon as they are identified. Dyadic Services include Dyadic Behavioral Health (DBH) well-child visits, Dyadic Comprehensive Community Supports Services, Dyadic Psychoeducational Services and Dyadic Family Training and Counseling for Child Development.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) means screening and diagnostic services to determine physical or mental defects in beneficiaries under age 21. The services also help determine health care, treatment and other measures to correct or ameliorate any defects and chronic conditions discovered.

Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity. This includes 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 one or more of the following:

- A. Placing the Member's health in serious jeopardy;
- B. Serious impairment to bodily functions;
- C. Serious dysfunction to any bodily organ or part; or
- D. Death.

Emergency Medical Transportation (EMT) means transportation services for an Emergency Medical Condition and includes emergency air transportation.

Emergency Preparedness and Response Plan is a plan to respond to every emergency in a timely, collaborative, organized and effective manner.

Emergency Services means inpatient and outpatient covered services that are furnished by a qualified Provider. The services are needed to evaluate or stabilize an Emergency Medical Condition as defined in 42 CFR section 438.114 and H&S section 1317.1(a)(1).

Encounter means an instance of direct Provider-to-Member interaction, regardless of the setting where the Provider is diagnosing, evaluating or treating the Member's condition.

Encounter Data means the information that describes health care interactions between Members and Providers relating to the receipt of any item(s) or service(s) by a Member.

Enhanced Care Management (ECM) is a statewide Medi-Cal managed care plan (MCP) benefit that provides equitable, person-centered and community-based care management for members most in need. ECM serves as the highest level of care management within the MCP Population Health Management continuum and is delivered by community-based providers equipped to address the diverse needs across ECM Populations of Focus (POF). Participating members work with a Lead Care Manager who connects with them in the settings most accessible and comfortable for them, whether in the community, a clinical setting or their home.

ECM Lead Care Manager means a Member's designated Enhanced Care Management (ECM) care manager who works for the ECM Provider organization or as staff of the Health Plan. This person is responsible for coordinating all aspects of ECM and any Community Supports as a part of the Member's multi-disciplinary care team, which may include other care managers.

ECM Populations of Focus or Populations of Focus refers to the most vulnerable, high-risk Medi-Cal members who receive the highest tier of care management to improve health outcomes and reduce high-cost utilization.

ECM Provider means community-based entities with experience and expertise providing intensive, in-person care management services to Members in one or more of the ECM Populations of Focus.

Enrollment means the process by which a Potential Member becomes a Member of the Health Plan.

Excluded Entities or Excluded Providers means entities, Providers and individuals that are excluded from participating in federally funded health care programs for a variety of reasons, such as a conviction for Medicare or Medicaid Fraud.

Excluded Service is a specific service or treatment that is not covered under an insurance policy or agreement.

External Quality Review (EQR) means the analysis and review by the External Quality Review Organization (EQRO) of aggregated information on quality, timeliness and access to the health care services that the Health Plan furnishes to its Members.

External Quality Review Organization (EQRO) means an organization that meets the competence and independence requirements set forth in 42 CFR section 438.354. The organization performs External Quality Review (EQR) and other EQR-related activities.

Family Therapy means a type of psychotherapy covered under the Medi-Cal Non-Specialty Mental Health Services (NSMHS) benefit. It involves at least two family members. Family therapy sessions address family dynamics as they relate to mental status and behavior(s). The sessions are focused on improving relationships and behaviors in the family and between family members, such as between a Child and parent(s) or caregiver(s).

Federal Financial Participation (FFP) means federal expenditures provided to reimburse allowable State expenditures made under the approved California Medicaid State Plan, waivers or other similar federal Medicaid authority.

Federally Qualified Health Center (FQHC) is a safety net provider that delivers prevention and primary service in an outpatient clinic setting.

Federally Qualified Health Maintenance Organization (FQHMO) means a prepaid health delivery plan that has fulfilled the requirements of the Health Maintenance Organization Act along with its amendments and regulations. The organization has also obtained the federal government's qualification status under 42 USC Section 300(e).

Fee-For-Service (FFS) means the Medi-Cal delivery system in which Providers submit claims to and receive payments from DHCS for Medi-Cal Covered Services rendered to Medi-Cal recipients.

File and Use means a submission to DHCS that does not need review and approval before the health plan uses or implements it. DHCS can require edits on or after the health plan is already using it or implementing it.

Financial Performance Guarantee means cash or cash equivalents that are immediately redeemable upon demand by DHCS, in an amount determined by DHCS, which must not be less than three full months of capitation.

Financial Statements are reports prepared by the Health Plan to present its financial performance and position at a point in time. The reports include a balance sheet, income statement, statement of cash flows, statement of equity and accompanying footnotes prepared in accordance with Generally Accepted Accounting Principles (GAAP).

Fiscal Year (FY) means any 12-month period for which annual accounts are kept. The State Fiscal Year (SFY) is July 1 through June 30, and the federal Fiscal Year (FY) is October 1 through September 30.

Fraud is an 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.

Freestanding Birthing Center (FBC) is a health facility that is not a hospital where childbirth is planned to occur away from the pregnant woman's residence. The center is licensed or otherwise approved by the State to provide prenatal labor and delivery or postpartum care and other ambulatory services.

Fully Delegated Subhealth plan means a Subhealth plan that contractually assumes all duties and obligations of the Health Plan under a contract, except for those contractual duties and obligations

where delegation is legally or contractually prohibited. A managed care plan can operate as a Fully Delegated Subhealth plan.

Governing Board means Contra Costa Health Plan's Board of Directors, or a similar body, and its executive management. This group has the authority to manage and direct the Plan's affairs and activities, including but not limited to, approving initiatives and establishing the Plan's policies and procedures.

Grievance is an expression of dissatisfaction (other than an organization determination) with any aspect of the operations, activities or behavior of a health plan or its providers, regardless of whether remedial action is requested.

Health Disparity is a measurable difference in health that exists between specific population groups. This is a rigorously derived and data-driven determination operationalized by quantifiable metrics.

Health Equity means the reduction or elimination of Health Disparities, Health Inequities or other disparities in health that adversely affect vulnerable populations.

Health Inequity is systematic differences in the health status of different population groups. These inequities have significant social and economic costs both to individuals and societies.

Healthcare Effectiveness Data and Information Set (HEDIS®) is the set of standardized performance measures sponsored and maintained by the National Committee for Quality Assurance (NCQA).

Implementation Period is a period of time when the Health Plan is undertaking any readiness requirements required by DHCS before performance of the contract begins. The Implementation Period begins with DHCS awarding the contract. It extends to the effective date that begins the Operations Period.

Incentive Arrangement means any payment mechanism approved by CMS in accordance with the requirements of 42 CFR section 438.6(b) under which the Health Plan may receive incentive payments in addition to Capitation Payments for meeting targets.

Independent Medical Review (IMR) is a review of the Health Plan's denial of a Member's request for health care service as not Medically Necessary, experimental or investigational by an independent physician(s) who is contracted with DMHC. The IMR decision is binding on the Health Plan but not the Member who may still request a State Hearing after an IMR.

Indian Health Care Provider (IHCP) means a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in Section 4 of the Indian Health Care Improvement Act (IHCA) at 25 USC Section 1603.

Indian Health Service (IHS) means an agency within the United States Department of Health and Human Services responsible for providing federal health services to American Indians and Alaska Natives. The IHS is the principal federal health care provider and health advocate for these populations

and provides a comprehensive Indian health care delivery system.

Indian Health Services Memorandum of Agreement Provider (IHS/MOA) an agreement between CMS and IHS to allow states to claim 100 percent federal medical assistance for payments made by the state for services rendered to Medicaid-eligible American Indians and Alaska Natives through an IHS owned or leased facility or a tribal “638” facility.

In-Home Supportive Services (IHSS) provides in-home assistance to eligible aged, blind and disabled individuals as an alternative to out-of-home care. IHSS enables recipients to remain safe in their own homes.

Initial Health Appointment (IHA), previously called Initial Health Assessment, is an assessment that must be completed within 120 days of Member’s enrollment in the Health Plan. This is for new Members and it must include a history of the Member’s physical and Behavioral Health, an identification of risks, an assessment of need for preventive screens or services and health education and a diagnosis and plan for treatment of any diseases.

Incurred but Not Reported (IBNR) Claim Estimate means a financial accounting of all services that have been performed but have not been invoiced or recorded. This can also be estimates of costs for medical services provided for which a claim has not yet been filed.

Intermediate Care Facility (ICF) are health facilities licensed by the Licensing and Certification Division of the California Department of Public Health to provide 24-hour-per-day residential services for people with developmental disabilities or related conditions.

Joint Commission (JC) is an organization that provides health care accreditation and related services that support performance improvement in health care organization. It is composed of representatives of the American Hospital Association, the American Medical Association, the American College of Physicians, the American College of Surgeons and the American Dental Association.

Justice Involved (JI) Individuals means individuals who are currently incarcerated or were formerly incarcerated within the past 12 months.

Knox-Keene Health Care Service Plan Act of 1975 (KKA) is the law that regulates health care service plans and is administrated by DMHC, commencing with H&S Section 1340 et seq.

Laboratory Testing Site is any laboratory and any Provider site, such as a Primary Care Provider (PCP) or Specialist office or clinic, that performs tests or examinations on human biological specimens derived from the human body.

Licensed Midwife (LM) is an individual licensed to practice midwifery and assist a woman in normal childbirth as defined in California Business and Professions Code (B&P) Section 2507.

Limited English Proficiency (LEP) means an inability or a limited ability to speak, read, write or understand the English language at a level that permits the Member to interact effectively with Providers or Health Plan employees.

Local Educational Agency (LEA) is a school district, county office of education, charter school, community college district, California State University campus or University of California campus.

Local Government Agency (LGA) is a local governmental entity including, but not limited to, a county child welfare agency, county probation department, county Behavioral Health department, county social services department, county public health department, school district or county office of education.

Local Health Department (LHD) is a municipal, county or regional public health department.

Long-Term Care (LTC) is assistance for people who can no longer perform basic daily activities on their own. Relevant to the elderly, the need for care can be due to the natural process of aging, a sickness or the progression of Alzheimer's, Parkinson's disease or another type of dementia. Per Medicaid, it is help for people who have chronic, ongoing illnesses or disabilities. Because of these conditions, it is required care that is the same as the care provided in a nursing home.

Long-Term Services and Supports (LTSS) refers to a broad range of health and health-related services and supports needed by individuals who lack the capacity for self-care due to physical, cognitive or mental disabilities or conditions. Often an individual's disability or condition results in the need for hands-on assistance or supervision over an extended period of time.

Marketing means any activity conducted by or on behalf of the Health Plan where information regarding the services offered by the Health Plan is distributed to persuade or influence Potential Members to enroll.

Marketing Materials are materials produced in any medium by or on behalf of the Health Plan that can be reasonably interpreted as Marketing to Potential Members. Marketing Materials include, but are not limited to, all printed materials, illustrated materials, digital materials, videos and media scripts.

Marketing Representative is a person who is engaged in Marketing activities on behalf of the Health Plan.

Medi-Cal Eligibility Data System (MEDS) is the automated eligibility information processing system operated by DHCS. This system provides online access for Medi-Cal recipient information and update of Medi-Cal recipient eligibility data.

Medi-Cal FFS Rate is the rate that DHCS pays Providers on a per unit or per procedure billing code basis.

Medi-Cal Provider Manual is a multi-part document usually for health plan or health service providers. The document identifies Medi-Cal benefits and billing codes published and maintained by DHCS.

Medical Home means a model of organization of Primary Care that delivers the core functions of primary health care, which is comprised of comprehensive care, patient-centered, coordinated care, accessible services and quality and safety.

Medical Records are records of Member medical information, including but not limited to medical history, care or treatments received, test results, diagnoses and prescribed medications.

Medically Necessary or **Medical Necessity** are health care services or supplies that are needed to diagnose or treat an illness, injury, condition, disease or its symptoms. Medically necessary health care services or supplies meet accepted standards of medicine.

Member or **Enrollee** is a person who has enrolled with the Health Plan.

Member Assignment is the written notification and assignment of a Potential Member to the Medi-Cal managed care health plan of the Member's choice. If the Potential Member fails to make a timely choice, DHCS designates the Medi-Cal managed care health plan for the Potential Member.

Member Handbook or **Evidence of Coverage (EOC)** is a document that describes the health care benefits and services that are available to a Member. [Click the link to see the Member Handbooks published on the Contra Costa Health Plan website.](#)

Member Information are documents that are vital or critical to obtaining benefits or services, and includes, but is not limited to the following:

- A. Member Handbook;
- B. Provider Directory;
- C. Welcome packet(s);
- D. Marketing Information;
- E. Forms and letters, including Notice of Actions (NOA), notices related to Grievances or Appeals, such as Grievance and Appeal acknowledgement and resolution letters, the Health Plan's preventive health reminders, surveys, notices advising of the availability of free language assistance; and
- F. Newsletters.

Memorandum of Understanding (MOU) is a formal written agreement between Health Plan and Local Government Agencies, county programs and third-party entities.

Minimum Performance Level (MPL) refers to the Health Plan's minimum performance requirements for select Quality Performance Measures.

Minor Consent Services are services of a sensitive nature which minors under the age of 18 do not need parental consent to access if, in the opinion of the attending professional person, they are mature enough to participate intelligently in the outpatient services. [Click the link to find the full list of services in the Member Handbooks published on the Contra Costa Health Plan website.](#)

Model of Care (MOC) is a framework for providing ECM and Community Supports, including its policies and procedures for partnering with ECM and Community Supports Providers.

National Committee for Quality Assurance (NCQA) is an organization responsible for the accreditation of managed care plans and other health care entities. NCQA develops and manages health care measures that assess the Quality of Care and Quality of Service that Members receive.

National Provider Identifier (NPI) is a unique identification number for covered health care providers. Covered health care providers, all health plans and health care clearinghouses must use NPIs in the administrative and financial transactions adopted under HIPAA. An NPI is a ten-position, intelligence-free numeric identifier (ten-digit number).

Network means Primary Care Providers (PCPs), Specialists, hospitals, ancillary Providers, facilities and other Providers with whom the Health Plan entered into Network Provider Agreements with.

Network Provider means any Provider or entity that has a Network Provider Agreement with the Health Plan, Health Plan's Subhealth plan or Health Plan's Downstream Subhealth plan. A Network Provider receives Medi-Cal funding directly or indirectly to order, refer or render services under the agreement. A Network Provider is not a Subhealth plan or Downstream Subhealth plan by virtue of the Network Provider Agreement.

Network Provider Agreement is a written, legal agreement between a Network Provider and Health Plan, Subhealth plan or Downstream Subhealth plan.

Network Provider Data means information concerning all Network Providers who render services to Members in the Health Plan's service area. It is also information about the provider groups, Subhealth plans or Downstream Subhealth plans, if any, under which a Network Provider renders those services.

No Wrong Door is a DHCS policy or policies that ensures Medi-Cal beneficiaries receive timely mental health services without delay, regardless of the delivery system where they seek care. The policy ensures Medi-Cal beneficiaries can maintain treatment relationships with trusted providers without interruption per APL 22-005.

Non-Emergency Medical Transportation (NEMT) is transportation by ambulance, wheelchair van or litter van for those who cannot use public or private transportation to get to their medical appointment.

Non-Medical Transportation (NMT) is transportation by private or public vehicle for people who do not have another way to get to their medical appointment.

Non-Specialty Mental Health Services (NSMHS) are Medi-Cal-covered mental health services provided through managed care plans for individuals with mild to moderate mental health needs, including those under 21 who are eligible for EPSDT benefits.

Operations Period is the period of time between the effective date of the first month of operations through the last month of the Health Plan's capitation and provision of services to Members.

Other Health Coverage (OHC) is health coverage from another entity that is responsible for payment of the reasonable value of all or part of the health care services provided to a member. OHC may result from a health insurance policy or other contractual agreement or legal obligation to pay for health care services provided to a member, excluding tort liability. OHC may originate under state (other than the Medi-Cal program), federal or local medical care programs or under other contractual or legal entitlements.

Partially Delegated Subhealth plan is a subhealth plan that contractually assumes some, but not all, duties and obligations of Health Plan under the Contract. This includes, for example, obligations regarding specific member populations or obligations regarding a specific set of services. Individual physician associations and medical groups often operate as Partially Delegated Subhealth plans.

Pass-Through Payment is a temporary payment policy that lets providers get reimbursed separately for certain drugs, biologics or medical devices on top of the usual bundled payment. It is meant to bridge the gap while new or high-cost technologies are being adopted so providers are not penalized financially before those items are built into standard payment rates.

Phaseout Period is the period of time after the Operations Period or Contract extension ends. The Phaseout Period extends until all activities required during the Phaseout Period for each Service Area are fully completed.

Population Health Management (PHM) establishes a cohesive, statewide approach that ensures Medi-Cal members have access to a comprehensive program that leads to longer, healthier and happier lives, improved health outcomes and health equity. PHM is designed to proactively assess and address the care needs of Medi-Cal members with tailored interventions.

Population Health Management (PHM) Service is a service that collects and links Medi-Cal beneficiary information from disparate sources. The service performs Risk Stratification and Segmentation (RSS) and Risk Tiering functions, conducts analytics and reporting, identifies gaps in care, performs other population health functions and allows for multi-party data access and use in accordance with state and federal laws, regulations and policies.

Population Health Management Strategy (PHMS) is an annual deliverable that the Health Plan must submit to DHCS, requiring Health Plan to demonstrate that it is responding to identified community needs, providing other updates on its PHM program as requested by DHCS and informing DHCS quality assurance and Population Health Management program compliance and impact monitoring efforts.

Population Needs Assessment (PNA) is a multi-year assessment under the PHM Program where the Health Plan identifies and responds to the medical and social needs of its Members and the community in which they live per APL 23-021.

Post-Payment Recovery (PPR) is the Health Plan's efforts to recover the cost of the services from other third-party payors responsible for the payment of a member's health care services.

Post-Stabilization Care Services means covered services related to an emergency medical condition

that are provided after a member is stabilized to maintain the stabilized condition or to improve or resolve the member's condition.

Potential Member or Potential Enrollee means a Medi-Cal beneficiary who resides in the Health Plan's service area and is subject to mandatory enrollment or who may voluntarily elect to enroll, but is not yet enrolled, in a Medi-Cal managed care health plan.

Prescription Drug means a drug or medication that can only be accessed through a provider's prescription.

Preventive Care means health care designed to prevent disease, illness, injury and its consequences.

Primary Care means health care usually rendered in ambulatory settings by Primary Care Providers (PCP) and mid-level practitioners that emphasizes the member's general health needs.

Primary Care Provider (PCP) is a Provider responsible for supervising, coordinating and providing initial and Primary Care to members. PCPs initiate referrals, maintain the continuity of member care and serve as the medical home for members. The PCP is a general practitioner, internist, pediatrician, family practitioner, non-physician medical practitioner or obstetrician-gynecologist (OB-GYN). For seniors and persons with disability (SPD) members, a PCP may also be a specialist or clinic.

Prior Authorization means a formal process requiring a Provider to obtain advanced approval for the amount, duration and scope of non-emergent covered services.

Program Data means data that includes but is not limited to grievance data, appeals data, medical exemption request denial reports and other continuity of care data, out-of-network request data and Primary Care Provider (PCP) assignment data as of the last calendar day of the reporting month.

Provider means any individual or entity that is engaged in the delivery of services or ordering or referring for those services and is licensed or certified to do so.

Provider Directory is the Health Plan's listing of all Network Providers. It includes the Provider's contact information, whether the Provider is accepting new Members, the hours of operation, what languages are available in the Provider office and whether the Provider office has accommodations, including offices, exam rooms and equipment for people with physical disabilities.

Provider Dispute Resolution Mechanism means the Health Plan's obligation to include a timely, fair and cost-effective dispute resolution process where Network Providers, Subhealth plans, Downstream Subhealth plans and out-of-Network Providers can submit disputes.

Provider-Preventable Condition (PPC) means a condition occurring in an inpatient acute care hospital setting or a condition occurring in any health care setting that meets the criteria as stated in 42 CFR Section 447.26(b).

Qualified Autism Services (QAS) Paraprofessional is an individual who is employed and supervised by a QAS Provider to provide Medically Necessary Behavioral Health Treatment (BHT) services to

members.

QAS Professional is an Associate Behavioral Analyst, Behavior Analyst, Behavior Management Assistant or Behavior Management Consultant as defined in the California Medicaid State Plan. A QAS Professional provides Medically Necessary Behavioral Health Treatment (BHT) services to Members.

QAS Provider is a licensed practitioner or Board-Certified Behavior Analyst (BCBA) who designs, supervises or provides treatment plans for autism and related developmental disorders.

Quality Improvement (QI) means systematic and continuous actions that lead to measurable improvements in the way health care is delivered and outcomes for members.

Quality Improvement and Health Equity Committee (QIHEC) is a committee facilitated by the Health Plan's medical director, or the medical director's designee, in collaboration with the Health Equity Officer. The committee meets at least quarterly to direct all Quality Improvement and Health Equity Transformation Program (QIHETP) findings and required actions.

Quality Improvement and Health Equity Transformation Program (QIHETP) is a program through which Managed Care Plans monitor, evaluate and take effective actions to address any needed improvements in the quality and health equity of care delivered to their members.

Quality Measure Compliance Audit is a thorough assessment of the Health Plan's information system capabilities and compliance with (HEDIS®) specification to ensure accurate, reliable and publicly reportable data.

Quality of Care is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.

Quality Performance Measures seek to measure the degree to which evidence-based treatment guidelines are followed, where indicated, and assess the results of care. The use of quality measurement helps strengthen accountability and support performance improvement initiatives at many levels.

Quantitative Treatment Limitation (QTL) is a limit on the scope or duration of a covered service that is expressed numerically.

Rating Period is a period of 12 months selected by DHCS for which actuarially sound capitation rates are developed and documented in the rate certification submitted to CMS. This is required by 42 CFR Section 438.7(a).

Regional Center (RC) is a nonprofit, community-based entity that is contracted by the Department of Developmental Services. A Regional Center develops, purchases and manages services for Members with Developmental Disabilities and their families.

Restricted Provider Database (RPD) means the database maintained by DHCS that lists Providers who are placed under a Medi-Cal payment suspension while under investigation based upon a credible

allegation of Fraud. Or, Providers who are placed on a temporary or indefinite Medi-Cal suspension while under investigation for Fraud, Abuse or Enrollment violations.

Retrospective Review means the process of determining medical necessity after treatment has been given.

Risk Sharing Mechanism is when participants agree to be held financially responsible, or take on a certain level of financial risk, for the quality and cost of health care services. This structure incentivizes participants to improve quality and lower costs through strategies like care coordination and preventive care.

Risk Stratification and Segmentation (RSS) means the process of separating Member populations into different risk groups or meaning subsets. Information from population assessments and other data sources are used to do this. RSS results in the categorization of all Members with care needs at all levels and intensities.

Risk Tiering means the assigning of Members to low, medium-rising or high risk tiers that are standardized at the state level. The goal is to determine the appropriate level of care management or other specific services for Members at each risk tier.

Rural Health Clinic (RHC) is an entity defined in 42 USC section 1395x(aa)(2) to provide Primary Care and ambulatory services.

Safety-Net Provider is a provider who delivers health care services to patients regardless of their ability to pay. The providers may consist of public hospitals, community health centers, local health departments and other providers who serve a disproportionate share of uninsured and low-income patients.

School Site means a facility or location used for public kindergarten, elementary, secondary or postsecondary purposes. School Site also includes a location not owned or operated by a public school, or public school district, if the school or school district provides or arranges for the provision of Medically Necessary treatment of a mental health or Substance Use Disorder to its students at that location, including off-campus clinics, mobile counseling services and similar locations.

Screening, Assessment, Brief Intervention and Referral to Treatment (SABIRT) Services means comprehensive, integrated delivery of early intervention and treatment services for Members with Substance Use Disorders (SUD), as well as those who are at risk of developing SUDs.

Senior and Person with Disability (SPD) means a Member who falls under a specific SPD aid code as defined by DHCS.

Service Area means the county or counties that the Health Plan is approved to operate under a Contract. A Service Area may be limited to designated zip codes (under the U.S. Postal Service) within a county.

Service Location means the location where a Member obtains covered services.

Significant Change means changes in covered services, benefits, geographic service area, composition of payments to its Network, or enrollment of a new population.

Site Review means surveys and reviews conducted by DHCS or the Health Plan to ensure that Network Provider, Subhealth plan and Downstream Subhealth plan sites have sufficient capacity to provide appropriate health care services, carry out processes that support continuity and coordination of care, maintain Member safety standards and practices, and operate in compliance with all applicable federal, state and local laws and regulations.

Skilled Nursing Care means covered services provided by nurses, technicians or therapists during a stay in a Skilled Nursing Facility or in a Member's home.

Skilled Nursing Facility (SNF) is a type of inpatient facility that provides short or long-term skilled nursing care and rehabilitation services to patients. These facilities provide 24-hour medical support to patients requiring transitional care following a qualifying hospital stay for illness, injury or surgery.

Social Drivers of Health (SDOH) means the conditions in the environments where 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. SDOH refers to community-level factors. They are sometimes called social determinants of health or health related social needs.

Special Care Center is a center that provides comprehensive, coordinated health care to California Children's Services (CCS) and Genetically Handicapped Persons Program (GHPP) clients with specific medical conditions.

Specialist is a Provider who has completed advanced education and clinical training in a specific area of medicine or surgery. Specialists include, but are not limited to, those Specialists listed in W&I Section 14197.

Specialty Mental Health Provider is a person or entity who is licensed, certified, otherwise recognized or authorized under the California law governing the healing arts and who meets the standards for participation in the Medi-Cal program to provide Specialty Mental Health Services.

Specialty Mental Health Service (SMHS) is a Medi-Cal covered mental health service provided or arranged by county mental health plans for members in their counties that need Medically Necessary Specialty Mental Health Services.

Standing Referral means a referral by a Primary Care Provider (PCP) to a Specialist for more than one visit to the Specialist, as indicated in the treatment plan, if any, without the Primary Care Provider having to provide a specific referral for each visit.

State means the State of California.

State Hearing is a hearing with a State Administrative Law Judge to resolve a Member's dispute about an action taken by the Health Plan, its Network Providers, Subhealth plans or Downstream Subhealth plans.

State Supported Services means Medi-Cal services that are funded entirely by the state, and for which the state does not receive matching federal funds. These services are covered by the Health Plan through their Secondary Contract with DHCS for State Supported Services.

Street Medicine means a set of health and social services developed specifically to address the unique needs and circumstances of individuals experiencing unsheltered homelessness, delivered directly to them in their own environment that Contractor may offer to their Members. The fundamental approach of Street Medicine is to engage people experiencing unsheltered homelessness exactly where they are and on their own terms to maximally reduce or eliminate barriers to care access and follow-through. Street Medicine utilizes a whole person, patient-centered approach to provide Medically Necessary health care services, as well as address Social Drivers of Health that impede health care access.

Street Medicine Provider means a Provider that renders street medicine services as offered by the Health Plan to their Members. Street Medicine Providers may provide services in various roles, such as the member's assigned PCP, through a direct contract with the Health Plan, as an ECM Provider, as a Community Supports Provider or as a referring or treating contracted Provider as set forth in APL 24-001.

Subacute Care is a level of care needed by a patient who does not require hospital acute care, but who requires more intensive licensed skilled nursing care than is provided to most patients in a skilled nursing facility, as defined in 22 CCR Section 51124.5.

Subcontractor means an individual or entity that has a Subcontractor Agreement with Health Plan that relates directly or indirectly to the performance of Health Plan's contractual obligations. A Network Provider is not a Subcontractor solely because it enters into a Network Provider Agreement.

Subcontractor Agreement means a written agreement between Health Plan and a Subcontractor. The Subcontractor Agreement must include a delegation of Health Plan's duties and obligations under the Contract.

Subcontractor Network means a Network of a Subcontractor or Downstream Subcontractor, where the Subcontractor or Downstream Subcontractor is delegated risk and is responsible for arranging for the provision of and paying for Covered Services as stated in their Subcontractor or Downstream Subcontractor Agreement.

Substance Use Disorder (SUD) is a complex condition in which there is uncontrolled use of a substance despite harmful consequences. The disorder is set forth in the Diagnostic and Statistical Manual of Mental Disorders Fifth Edition, published by the American Psychiatric Association.

Supplemental Payment means a payment in addition to the Capitation Payment made by DHCS to Health Plan according to the Contract.

Suspended and Ineligible Provider List is the list containing the names of former Medi-Cal Providers suspended from or ineligible for participation in the Medi-Cal program. [Click here to see the](#)

[Suspended and Ineligible Provider List.](#)

Targeted Case Management (TCM) means services which assist Members within specified target groups to gain access to needed medical, social, educational, and other services, as set forth in 42 USC Section 1396n(g). In prescribed circumstances, TCM is available as a Medi-Cal benefit and a discrete service through State or local government entities and their contractors.

Telehealth is the use of electronic information and telecommunication technologies to support long-distance clinical health care, patient and professional health-related education, health administration and public health.

Template Data means data reports submitted to DHCS by health plans, which includes, but is not limited to, data of Member populations, health care benefit categories or program initiatives.

Third Party Tort Liability (TPTL) means the contractual responsibility or tort liability of an individual or entity other than the Health Plan or the Member for the payment of claims for injuries or trauma sustained by a Member.

Threshold Languages/Threshold or Concentration Standard Languages means the non-English threshold and concentration standard languages in which the Health Plan is required to provide written translations of Member Information, as determined by DHCS.

Transitional Care Service means a service provided to all Members transferring from one setting, or level of care, to another to another institution or lower level of care, including home settings.

Treatment Authorization Request (TAR) is a form needed to pre-approve certain Fee-For-Service (FFS) procedures and services that are subject to authorization by Medi-Cal field offices before reimbursement can be approved.

Tribal Federally Qualified Health Center (Tribal FQHC) means a Tribal Health Program funded under the authority of Public Law 93-638 at 25 USC Sections 5301 et seq. These Health Programs have elected to participate in Medi-Cal Tribal FQHCs and are subject to the payment terms of APL 21-008. Reimbursement of Tribal FQHCs is through an Alternative Payment Methodology (APM), which is set at the federal Indian Health Service All-Inclusive Rate. The APM rate is updated annually and published in APL 21-008, Attachment #1. A list of Tribal FQHCs is published in APL 21-008, Attachment #2.

Tribal Health Program means an American Indian tribe or tribal organization that operates any health program, service, function, activity, or facility funded, in whole or part, by the Indian Health Service through, or provided for in, a contract or compact with the Indian Health Service under the Indian Health Service under the Indian Self Determination and Education Assistance Act and is defined in 25 USC section 1603(25).

United States Department of Health and Human Services (U.S. DHHS) is a federal agency that oversees CMS that works in partnership with state governments to administer the Medicaid program, the Children's Health Insurance Program (CHIP) and health insurance portability standards.

Urban Indian Organization means a nonprofit corporate body situated in an urban center, governed by an urban American Indian controlled board of directors, as defined in 25 USC section 1603(29). Urban Indian Organizations participate in Medi-Cal as Tribal Federally Qualified Health Centers (Tribal FQHCs) or community clinics and are reimbursed via the Prospective Payment System or at Fee-For-Service rates.

Urgent Care is when a patient's condition, illness or injury is not life-threatening, but medical care is needed to prevent serious deterioration of health following the onset of an unforeseen condition or injury.

Utilization Management (UM) or Utilization Review is the evaluation of the Medical Necessity, appropriateness, and efficiency of the use of health care services, procedures and facilities.

Vaccines for Children (VFC) Program is a federally funded program that provides free vaccines for eligible children age 18 or younger (including all Medi-Cal eligible children age 18 or younger) and distributes immunization updates and related information to participating Providers.

Waste means the overutilization or inappropriate utilization of services and misuse of resources.

Withhold Arrangement means any payment mechanism approved by CMS in accordance with the requirements of 42 CFR Section 438.6(b) under which a portion of a capitation rate is withheld from the Health Plan, with a portion or all of the withheld amount to be paid to the Health Plan for meeting targets specified in the Contract.

Working Capital Ratio means a liquidity ratio, calculated as current assets divided by current liabilities, that measures Contractor's ability to pay its current liabilities with current assets. Working Capital Ratio is computed in accordance with Generally Accepted Accounting Principles (GAAP).

Working Day(s) means Monday through Friday, except for state holidays as identified at the California Department of Human Resources State Holidays page.

"Your Rights" Attachment is a written notice that the Health Plan sends to the Member. The notice explains the Member's rights to challenge, free of charge, the Health Plan's action. It also explains the Member's right to file an Appeal with the Health Plan, a Deemed Exhaustion and the right to request a State Hearing or an Independent Medical Review (IMR).

ACRONYMS LIST

The following acronyms are abbreviations for the corresponding terms. This Acronyms List is provided for the convenience of the parties. It is not an exhaustive or exclusive list of all acronyms that Contra Costa Health Plan uses. If there are inconsistencies, the Health Plan defers to publications from CMS, DHCS, DMHC and any other related federal and state laws.

Acronyms	Corresponding Terms
AAP	American Academy of Pediatrics
ABD	Adverse Benefit Determination
ACE	Adverse Childhood Experience
ACIP	Advisory Committee on Immunization Practices
ACOG	American College of Obstetrician and Gynecologists
ADA	Americans with Disabilities Act of 1990
ADHC	Adult Day Health Care
ADO	Alternate Dispute Officer
ADT	Admission, Discharge and Transfer
AFS	Alternative Format Selection
AIDS	Acquired Immune Deficiency Syndrome
APL	All Plan Letter
API	Application Programming Interface
APS	Asthma Preventive Service
AR	Authorized Representative
ASAM	American Society of Addiction Medicine
ASD	Autism Spectrum Disorder
Basic PHM	Basic Population Health Management
BHT	Behavioral Health Treatment
C&L	Cultural & Linguistic
CalAIM	California Advancing and Innovating Medi-Cal
CBAS	Community Based Adult Services
CB-CME	Community-Based Care Management Entities
CCM	Complex Care Management
CCR	California Code of Regulations
CCS	California Children's Services
CDPH	California Department of Public Health

Acronyms	Corresponding Terms
CFR	Code of Federal Regulations
CHA	Community Health Assessment
CHIP	Community Health Implementation Plan
CHW	Community Health Worker
CLIA	Clinical Laboratory Improvement Act
CLPPB	Childhood Lead Poisoning Prevention Branch
CMP	Care Management Plan
CMS	The Centers for Medicare and Medicaid Services
CNM	Certified Nurse Midwife
COBA	Coordination of Benefits Agreement
COHS	County Organized Health Systems
CPSP	Comprehensive Perinatal Services Program
CPT	Current Procedural Terminology
CQI	Continuous Quality Improvement
CRC	Caregiver Resource Center
CSHCN	Children with Special Health Care Needs
DDS	Department of Developmental Services
DF	Disclosure Form
DHCS	Department of Health Care Services
DMC	Drug Medi-Cal
DMC-ODS	Drug Medi-Cal Organized Delivery System
DME	Durable Medical Equipment
DMFEA	Office of the Attorney General, Division of Medi-Cal Fraud and Elder Abuse
DMHC	Department of Managed Health Care
DOT	Direct Observed Therapy
D-SNP	Dual-Eligible Special Needs Plan
DUR	Drug Use Review
DVBE	Disabled Veteran Business Enterprises
ECM	Enhanced Care Management
EMT	Emergency Medical Transportation
EPSDT	Early and Periodic Screening, Diagnostic and Treatment

Acronyms	Corresponding Terms
EQR	External Quality Review
EQRO	External Quality Review Organization
ERS	CBAS Emergency Remote Services
FBC	Freestanding Birthing Centers
FDA	United States Food and Drug Administration
FFP	Federal Financial Participation
FFS	Fee-For-Service
FQHC	Federally Qualified Health Center
FSR	Facility Site Review
GAAP	Generally Accepted Accounting Principles
GC	California Government Code
H&S	Health and Safety Code
HCBS	Home and Community-Based Services
HCO	Health Care Options
HEDIS®	Healthcare Effectiveness Data and Information Set
HIE	Health Information Exchange
HIPAA	The Health Insurance Portability and Accountability Act of 1996
HIV	Human Immunodeficiency Virus
HMO	Health Maintenance Organization
HPA	Health Plan Accreditation
ICD-10	International Classification of Diseases, Tenth Revision
ICF/DD	Intermediate Care Facility Developmentally Disabled
ICF/DD-H	Intermediate Care Facility/Developmentally Disabled Habilitative
ICF/DD-N	Intermediate Care Facility/Developmentally Disabled Nursing
IEP	Individualized Education Plan
IFSP	Individualized Family Service Plan
IHA	Initial Health Appointment
IHCP	Indian Health Care Provider
IHS	Indian Health Service
IHSP	Individualized Health and Support Plan
IHSS	In-Home Supportive Services
IMD	Institution for Mental Diseases

Acronyms	Corresponding Terms
IMR	Independent Medical Review
IPA	Independent Physician/Provider Associations
IPC	Individual Plan of Care
IT	Information Technology
JC	Joint Commission
JI	Justice Involved
KKA	Knox-Keene Health Care Service Plan Act of 1975
LEA	Local Education Agency
LEP	Limited English Proficiency
LGA	Local Government Agency
LHD	Local Health Department
LM	Licensed Midwife
LTC	Long-Term Care
LTSS	Long-Term Services and Support
MAT	Medications for Addiction Treatment (or Medication-Assisted Treatment)
MCH	Maternal and Child Health
MEDS	Medi-Cal Eligibility Data System
MFTP	Money Follows the Person
MHP	County Mental Health Plan
MIS	Management and Information System
MLR	Medical Loss Ratio
MOC	Model of Care
MOU	Memorandum of Understanding
MPL	Minimum Performance Level
MSSP	Multipurpose Senior Service Program
NABD	Notice of Adverse Benefit Determination
NAR	Notice of Appeal Resolution
NCQA	National Committee for Quality Assurance
NDC	National Drug Code
NEMT	Non-Emergency Medical Transportation
NISTSP	National Institute of Standards and Technology Special Publication

Acronyms	Corresponding Terms
NMT	Non-Medical Transportation
NOA	Notice of Action
NP	Nurse Practitioner
NPI	National Provider Identifier
NQTL	Non-Quantitative Treatment Limitation
NSMHS	Non-specialty Mental Health Service
OHC	Other Health Coverage
PACE	Program for All-Inclusive Care for the Elderly
PCC	California Public Contract Code
PCP	Primary Care Provider
PHI	Protected Health Information
PHM	Population Health Management
PHMS	Population Health Management Strategy
PI	Personal Information
PIA	Prison Industry Authority
PIP	Performance Improvement Project
PIR	Privacy Incident Reporting
PIU	Program Integrity Unit
PL	Policy Letter
PNA	Population Needs Assessment
PPC	Provider-Preventable Condition
PPR	Post-Payment Recovery
PSCI	Personal, Sensitive, and/or Confidential Information
QAS	Qualified Autism Services
QI	Quality Improvement
QIHEC	Quality Improvement and Health Equity Committee
QIHETP	Quality Improvement and Health Equity Transformation Program
QSO	Qualified Service Organization
QTL	Quantitative Treatment Limitation
RC	Regional Center
RHC	Rural Health Clinic
RPD	Restricted Provider Database

Acronyms	Corresponding Terms
RSS	Risk Stratification and Segmentation
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SDOH	Social Drivers of Health
SED	Serious Emotional Disturbance
SFTP	Secure File Transfer Protocol
SMHS	Specialty Mental Health Services
SMI	Serious Mental Illness
SNF	Skilled Nursing Facility
SPD	Senior and Person with Disability
STC	Special Terms and Conditions
STD	Sexually Transmitted Disease
SUD	Substance Use Disorder
TAR	Treatment Authorization Request
TB	Tuberculosis
TCM	Targeted Case Management
TDD	Telecommunication Devices for the Deaf
TNE	Tangible Net Equity
TPTL	Third Party Tort Liability
TTY	Telephone Typewriters
U.S. DHHS	United States Department of Health and Human Services
UM	Utilization Management
US DOJ	United States Department of Justice
USC	United States Code
USPSTF	United States Preventive Services Task Force
VFC	Vaccines for Children
W&I	Welfare and Institutions Code
WCM	Whole Child Model
WIC	Women, Infants and Children Supplemental Nutrition Program