Behavioral Health Integration Glossary of Terms

KEY ENTITIES and PROGRAMS

Child and Adolescent Supplemental Security Income Program (CASSIP)
The Medicaid managed care program specifically designed to provide comprehensive primary, specialty, in-patient, behavioral health, and long-term care to SSI or SSI-eligible children and adolescents.

D.C. Health Care Alliance (Alliance)
A public program designed to provide medical assistance to needy District residents who are not eligible for federally financed Medicaid benefits. The Alliance provides comprehensive coverage of health care services for eligible residents of the District.

D.C. Healthy Families
A program that provides free health insurance to DC residents who meet certain income and U.S. citizenship or eligible immigration status to qualify for DC Medicaid. The DC Healthy Families program covers doctor visits, vision and dental care, prescription drugs, hospital stays, and transportation for appointments. DC Healthy Families also offers special programs for newborn babies, children with disabilities or special health care needs, and people with HIV and AIDS.

D.C. Immigrant Children's Program (ICP)
A health coverage program that is offered to children under age 21 who are not eligible for Medicaid due to citizenship or immigration status. The ICP includes a range of health care services to include primary care services, doctor visits, prescription drugs, dental services, and wellness programs. To be eligible for the ICP, you must be a resident of the District of Columbia, have no other health insurance, including Medicaid and Medicare and meet a certain income threshold. Services covered under the Immigrant Children Program are very similar to the services covered under Medicaid for children under age twenty-one (21).

Department of Behavioral Health (DBH)
The State Behavioral Health Authority in the District of Columbia tasked by statute, D.C. Official Code § 7-1141.06, with the responsibility of regulating and arranging for all authorized publicly funded Behavioral Health Services and supports for District residents.

Department of Health Care Finance (DHCF)
The Agency within the District of Columbia Government responsible for administering all Medicaid services under Title XIX (Medicaid) and Title XXI (CHIP) of the Act, for eligible beneficiaries, including the DC Medicaid Managed Care Program and oversight of its managed care Contractors, as well as the Alliance and including all agents and Contractors of DHCF.

District of Columbia State Plan for Medical Assistance (State Plan)

The State Plan is a comprehensive written statement submitted by the DHCF describing the nature and scope of its Medicaid program and giving assurance that it will be administered in conformity with the specific requirements of Title XIX regulations, and other applicable official issuances of the U.S. Department of Health and Human Services. The State Plan contains all information necessary for CMS to determine whether the plan can be approved to serve as a basis for Federal Financial Participation (FFP) in the State program.

Managed Care Organization (MCO)
An organization participating in the District's Medicaid Managed Care Program, Alliance, and Immigrant Children's Program and including any of the MCO's employees, Providers, agents, or contractors for the provision of comprehensive health care services to Enrollees on a prepaid, capitated basis for a specified benefits package to specified Enrollees.
For each enrollee, the MCO receives a capitated rate (pre-determined, Actuarily-sound dollar amount) from DHCF to pay for care provided to enrollees. The District makes the payment regardless of whether the Enrollee receives services during the period covered by the payment.

Ombudsman
Entity that engages in impartial and independent investigation of individual Grievances, advocates on behalf of consumers, and issues recommendations. This function may be operated by an organization independent of the Contractor or by a designated and appropriately delineated and empowered unit in a government agency.
Both DBH and DHCF have an Office of the Ombudsman for assistance to Consumers and Beneficiaries.

INDIVIDUALS

Beneficiary
An individual who is eligible for medical assistance under a State Plan or Waiver under title XIX of the Social Security Act.
This is the preferred term when referring to an individual receiving benefits in the DC Medicaid Program.

Client
An individual admitted to a substance use disorder treatment or recovery program and is assessed to need SUD treatment services or recovery services.
This is the preferred term for an SUD service recipient for the Department of Behavioral Health.

Consumer
An individual served by a DBH-certified Provider for mental health services.
This is the preferred term for a MH services recipient for the Department of Behavioral Health.

Disenrollment
The process of changing enrollment from one MCO to another, changing enrollment from an MCO to the DC Medicaid Fee for Service Program, or termination from the DC Medicaid Program.

Dual Eligible
An individual who is enrolled in both Medicare and the DC Medicaid Program.

Enrollee
An individual who is currently enrolled in an MCO participating in the District's DC Healthy Family Program (DCHFP), Alliance, CASSIP, or Immigrant Children's Program.

Member – An individual who has joined a Psychosocial Rehabilitation Clubhouse. Clubhouses uses the term Member in opposition to client, consumer, patient, or other terms to indicate a person is receiving care.

PROVIDERS

Certified Provider (DBH Certified Provider)
A community behavioral health provider certified by DBH to deliver mental health, substance use disorder or co-occurring behavioral health care services.
DBH Certification is the process used by DBH to review and determine which behavioral health providers are eligible (i.e., deemed qualified and eligible) to offer services as part of the public behavioral health system in the District.

Credentialed Staff
Unlicensed staff or staff who are not qualified practitioners that are credentialed by the SUD or MHRS provider to perform certain MHRS or SUD services, or components of MHRS or SUD services under the clinical supervision of a qualified practitioner.

Credentialing (MCOs Credential)
The process of formal recognition and attestation of a Provider's current professional competence and performance through an evaluation of a Provider's qualifications and adherence to the applicable professional standard for direct patient care or peer review. Credentialing verifies, among other things, a Provider's license, experience, certification(s), education, training, malpractice and adverse clinical occurrences, clinical judgment, technical capabilities, and character by investigation and observation.

Network
All contracted or employed Providers with an MCO, DHCF, and/or DBH, who provide covered services to Enrollees.

Non-Participating Provider
A Provider that is not a member of the Contractor's Provider network.

School-Based Health Center
A health care site located on school building premises which provides, at a minimum, onsite, age-appropriate primary and preventive health services with parental consent, to children in need of primary health care.

SERVICES

Behavioral Health Services
The umbrella term for mental health conditions (including psychiatric illnesses and emotional disorders) and substance use disorders (involving addictive and chemical dependency disorders). The term also refers to preventing and treating cooccurring mental health conditions and substance use disorders (SUDS).

Care Coordination
Services that ensure all Medicaid, Alliance and ICP Enrollees gain access to necessary medical, behavioral, social and other health-related services (including education-related health services) as described in section C.5.31.

Care Plan
A multidisciplinary Care Plan for each Enrollee in case management. It includes specific services to be delivered, the frequency of services, expected duration, community resources, all funding options, treatment goals, and assessment of the Enrollee environment. The Plan is updated at least annually and when the Enrollee condition changes significantly. The Plans are developed in collaboration with the attending physician and Enrollee and/or Guardian/personal representative.

Case Management Services
Case Management services are comprehensive services furnished to assist Enrollees, eligible under the State Plan with access to needed medical, social, educational and other services including all of the following in accordance with (42 C.F.R. § 440.169(d)). An assessment of an eligible individual; Comprehensive assessment and periodic reassessment of individual needs to determine the need for any medical, educational, social or other services Development (and periodic revision) of a specific care plan based on information collected through the assessments; Referral to services including the coordination of such services; and Monitoring and follow-up activities to determine whether: (i) services are being furnished in accordance with the individual's care plan; (ii) services in the care plan are adequate; (iii) there are changes in the needs or status of the eligible individual.

Covered Services
The items and services, transportation, and case management services that, taken together, constitute the services that the Contractor must provide to Enrollees under District and Federal law. The term also encompasses any additional items and services described by the Contractor as being available to Enrollees.

Excluded Services
Health care services that are not covered by a health plan.
Individuals or Providers may be financially responsible for services received or provided that are excluded from the individual's covered services.

Formulary

In accordance with 42 U.S.C. § 1396r-8(d)(4), the list of prescription drugs covered by the Contractor without the need for an exception by DHCF.
This is the preferred term for the list of prescription drugs that are covered by a Health Plan.

Long-Term Services and Supports (LTSS)
Services and supports provided to beneficiaries of all ages who have functional limitations and/or chronic illnesses, that have the primary purpose of supporting the ability of the beneficiary to live or work in the setting of their choice, which may include the individual's home, a worksite, a provider-owned or controlled residential setting, a nursing facility, or other institutional setting.

Medically Necessary (Services)
Services for individuals that promote normal growth and development and prevent, diagnose, detect, treat, ameliorate the effects or a physical, mental, behavioral, genetic, or congenital condition, injury, or disability and in accordance with generally accepted standards of medical practice, including clinically appropriate, in terms of type, frequency, extent, site and duration and considered effective for the Enrollee's illness, injury, disease, or physical or mental health condition.
It is very important that health care services are only provided when medically necessary, and for individuals to be treated at the least restrictive level of care that allows for safe recovery.

Prescription Drug Coverage
Health insurance or Plan that helps pay for prescription drugs and medications.

Prescription Drugs
A pharmaceutical drug that legally requires a medical prescription to be dispensed.

Preventive Services
Services recommended by a physician or other licensed practitioner of the healing arts acting within the scope of authorized practice under District law to: (1) prevent disease, disability, and other health conditions or their progression; (2) prolong life; and (3) promote physical and mental health and efficiency.
Active and consistent participation in Preventative Services is a good way to avoid illness. Examples of Preventative Services include Annual Physicals, Routine Dental Care, Health Screenings, and Wellness Activities.

Primary Care
Medical and health care items and services that are lawful under District law and that are of the type customarily furnished by or through a licensed medical professional considered to be a member of a primary care specialty, such as a general family practice, family medicine, internal medicine, obstetrics and gynecology, and pediatrics.

Prior Authorization or Preauthorization (Authorization)
The process used to determine whether to approve a treatment request involving services covered under the Contract. (See also "Service Authorization").

Referral Services
Any specialty, inpatient, outpatient, or laboratory services that a physician or physician group orders or arranges but does not furnish directly.

Psychiatric Residential Treatment Facility (PRTF)
Twenty-four (24) hour treatment facility primarily for children with significant behavioral problems who need long-term treatment.

Screening Services
The use of standardized tests given under medical direction in the mass examination of a designated population to detect the existence of one or more particular diseases or health deviations or to identify for more definitive studies individuals suspected of having certain diseases.

Severe Mental Illness (SMI)
Diagnosable mental, behavioral, or emotional disorder (including those of biological etiology) which substantially impairs the mental health of the person or is of sufficient duration to meet diagnostic criteria specified within the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-V) or its International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD-10-CM) equivalent (and subsequent revisions) with the exception of DSM-V "V" codes, substance use disorders, intellectual disabilities and other developmental disorders, or seizure disorders, unless those exceptions co-occur with another diagnosable mental illness.

Substance Use Disorder Services
Management and care of a patient living with alcohol or drug abuse, a condition which is identified as having been caused by that abuse, or both, in order to reduce or eliminate the adverse effects upon the patient.

Telemedicine
A service delivery model that delivers healthcare services through a two-way, real time interactive video-audio communication for the purpose of evaluation, diagnosis, consultation, or treatment.

Transportation Services (Non-Emergency)
Mode of transportation that is appropriate to an Enrollee's medical needs. Acceptable forms of transportation include, but are not limited to bus, subway, or taxi vouchers, wheelchair vans, and ambulances.

CLAIMS and PAYMENTS

Fee-for-Service (FFS)
Payment to Providers on a per-service basis for health care services provided to Medicaid beneficiaries not enrolled in a Medicaid Managed Care Program.

Medicaid Management Information System (MMIS)

A federally required mechanized claims processing and information retrieval system. The objectives of the system and its enhancements include the Title XIX program control and administrative costs; service to beneficiaries, Providers, and inquiries; operations of claims control and computer capabilities; and management reporting for planning and control.
MMIS is a computer system that DHCF uses to pay, count, and analyze all the services paid for Beneficiaries.

Value Based Purchasing (VBP)
Linking provider payments to improved performance by health care providers. This form of payment holds health care providers accountable for both the cost and quality of care they provide. It attempts to reduce inappropriate care and to identify and reward the best performing providers.

QUALITY and ACCOUNTABILITY

Access
As it pertains to external quality review, means the timely use of services to achieve optimal outcomes, as evidenced by managed care plans successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined under § 438.68 (Network adequacy standards) and § 438.206 (Availability of services).

Cultural Competence
Skills, behaviors, and attitudes integrated into policies, procedures and practices to allow the Contractor, Provider, or Government Agency, to respond sensitively and respectfully to people of various cultures, primary spoken languages, races, ethnic backgrounds and religions, and sexual orientations, and to communicate with them accurately and effectively to identify and diagnose, treat and manage physical and behavioral health conditions through appropriate plans for treatment and self- care.

Fair Hearing
An administrative process run by the District that gives applicants and Enrollees the opportunity to contest Adverse Benefit Determinations regarding eligibility and benefits.
If you or a family member are denied treatment you believe is medically necessary, you can appeal through a Fair Hearing.

Fraud
As defined in 42 C.F.R. § 455.2, 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. It includes any act that constitutes Fraud under applicable federal, or District law.

Grievance
An oral or written expression of dissatisfaction about any matter other than an Adverse Benefit Determination. Grievances may 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 Enrollee's right, regardless of whether remedial action is requested. Grievance includes an Enrollee's right to dispute an extension of time proposed by the MCO to make an authorization decision.

HEDIS® (Healthcare Effectiveness Data and Information Set)
A set of performance measures developed by the National Committee for Quality Assurance (NCQA) to measure the quality of health care furnished by health plans.
HEDIS Measures are the Primary Tools used by the District to measure the performance of our Medicaid Program.

National Committee on Quality Assurance (NCQA)
An independent 501(c)(3) non-profit organization in the United States that works to improve health care quality through the administration of evidence-based standards, measures, programs, and accreditation.

Utilization Management
An objective and systematic process for planning, organizing, directing, and coordinating health care resources to provide Medically Necessary, timely and quality health care services in the most cost-effective manner.

Utilization Review Criteria
Detailed standards, guidelines, decision algorithms, models, or informational tools that describe the clinical factors to be considered relevant to making determinations of medical necessity including, but not limited to, level of care, place of service, scope of service, and duration of service.

Waste
Overutilization of services or other practices that, directly or indirectly, result in unnecessary costs of the healthcare system.