



Glossary of Terms

Adverse Action: Any decision by the SMO to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested. 42 CFR 438.214(c).

Adverse Determination: An admission, availability of care, continued stay, or other health care service that has been reviewed by a SMO, and based upon the information provided, does not meet the SMO's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, and the requested service is therefore denied, reduced, suspended, delayed, or terminated.

Appeal: A request for a review of an action pursuant to 42 CFR 438.400(b).

Appeal Procedure: A formal process whereby a Member has the right to contest an adverse determination/action rendered by a SMO, which results in the denial, reduction, suspension, termination, or delay of health care benefits/services. The appeal procedure shall be governed by Louisiana Medicaid rules and regulations and any and all applicable court orders and consent decrees.

Community supports/necessary conditions: Conditions at the system or organizational level that need to be in place to ensure that the wraparound process for individual families is likely to be well-implemented and succeed in achieving positive outcomes. Community supports fall into six themes: *community partnership; collaborative action; fiscal policies and sustainability; access to needed supports and services; human resource development and support; and accountability.*

Coordinated System of Care (CSoC) Community team: A group of stakeholders from across interest groups who provide leadership, strategic planning, support, sanction, and accountability to your wraparound process. Members of the community team typically include representatives of child-serving systems, provider organizations, family advocacy organizations, community and business groups, and representatives of the children and families served by the system or wraparound initiative.

Care Coordination: Deliberate organization of Member care activities by a person or entity formally designated as primarily responsible for coordinating services furnished by providers involved in a Member's care. This coordination may include care provided by network or non-network providers. Organizing care involves the marshalling of personnel and other resources needed to carry out all required Member care activities; it is often facilitated by the exchange of information among participants responsible for different aspects of the Member's care.

Care Management: Overall system of medical management encompassing utilization management, referral, case management, care coordination, continuity of care and transition care, chronic care management, quality care management, and independent review.

Case Management: Refers to a collaborative process of assessment, planning, facilitation, and advocacy for options and services to meet a Member's needs through communication and available resources to promote high quality, cost-effective outcomes. Case management services are defined as services provided by qualified staff to a targeted population to assist them in gaining timely access to the full range of needed services; these services may include medical, social, educational, and other support services. Case management services include an individual needs and diagnostic assessment, individual treatment plan development, establishment of treatment objectives, and outcomes monitoring

Claim: A request for payment for benefits received or services rendered.

Clean Claim: A claim that has no defect or impropriety (including any lack of required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payment of the claim. It does not include a claim from a provider who is under investigation for fraud or abuse or a claim under review for medical necessity.

Co-Occurring Disorders (COD): The presence of mental and addictive disorders. Clients said to have COD have one or more addictive disorders, as well as one or more mental disorders.

Coordinated System of Care CSoC Eligible: Children and youth eligible for services under the CSoC.

Denied Claim: A claim for which no payment is made to the network provider by the SMO for any of several reasons, including but not limited to, the claim is for non-covered services, the provider or Member is ineligible; the claim is a duplicate of another transaction.

Electronic Health Records: A computer-based record containing health care information. This technology, when fully developed, meets provider needs for real-time data access and evaluation in medical care. Implementation of EMR increases the potential for more efficient care, speedier communication among providers, and management of SMOs.

Eligible: An individual qualified to receive services through the SMO, consistent with the eligibility requirements of DHH, DCFS, OJJ, DOE, and the local education agencies.

Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain), such 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: 1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, 2) serious impairment to bodily functions, or 3) serious dysfunction of any bodily organ or part.

Emergency Services: Covered inpatient and outpatient services that are furnished by a provider who is qualified to furnish these services under 42 CFR 438.114(a) and 1932(b)(2) and that are needed to screen, evaluate, and stabilize an emergency medical condition. Services are defined under Section 1867 (e) of the Social Security Act ("anti-dumping provisions"). If an emergency medical

condition exists, the SMO is obligated to pay for the emergency service. Coverage of emergency services must not include any prior authorization requirements and the “prudent layperson” standard shall apply to both in-plan and out-of-plan coverage. In the event that client resides in a PRTF or TGH, the SMO will not reimburse the residential facility for emergency medical services.

Emergent : Serious or extreme risk of harm, such as current suicidal ideation with expressed intentions; recent use of substances resulting in decreased inhibition of harmful behaviors; repeated episodes of violence toward self and others; or extreme compromise of ability to care for oneself leading to physical injury.

Encounter Data: Records of medically-related services rendered by a provider to a SMO Member on a specified date of service. This data is inclusive of all services for which the SMO has any financial liability to a provider.

Enrollee: A Louisiana Medicaid or CHIP eligible (recipient) who is currently enrolled in a SMO. This definition may also include a person who is qualified for Medicaid and whose application has been approved but who may or may not be receiving services.

Enrollment: The process conducted by DHH to enroll a Medicaid or CHIP eligible into a SMO.

Evidence-Based Practice: Clinical interventions that have demonstrated positive outcomes in several research studies to assist individuals in achieving their desired goals of health and wellness.

Facilitator: A person who is trained to coordinate the wraparound process for an individual family. This person may also be called care coordinator, navigator, wraparound specialist, resource facilitator or some other term. The person in the facilitator role may change over time, depending on what the family thinks is working best. For example, a parent, caregiver, or other team member may take over facilitating team meetings after a period of time.

Family: For the purposes of the CSoC, family is defined as the primary care giving unit and is inclusive of the wide diversity of primary care giving units in our culture. Family is biological, adoptive or self-created unit of people residing together consisting of adults) and/or child(ren) with adult(s) performing duties of parenthood for the child(ren). Persons within this unit share bonds, culture, practices and a significant relationship. Biological parents, siblings and other with significant attachment other individual living outside the home are included in the definition of family. For the purposes of the psychoeducation service, “family” is defined as the persons who live with or provide care to a person served on the waiver, and may include a parent, spouse, sibling, children, relatives, grandparents, guardians, foster parents or others with significant attachment to the individual.

Family Support Organization (FSO): A Family-run, nonprofit corporation governed by a board of directors know as its Local Coordination Council. The FSO provides essential component of Wraparound services including Parent Support and Training, Youth Support and Training. Children and Families enrolled in CSoC services are supported through the wraparound process by FSO staff and services.

Flexible funds: Dollars that are available to individual child and family teams that can be used to provide flexible, creative or unique services, supports or strategies.

Flexible services: A term that is often used to describe flexibly funded or delivered in-home activities. Any number of community based services can be included in this definition, ranging from in-home workers, respite care, transportation, mentoring or other creative community-based approaches.

Grievance: An expression of Member/Provider dissatisfaction. Examples of grievances include dissatisfaction with quality of care, quality of service, rudeness of a provider or a network employee, and network administration practices. Administrative grievances are generally those relating to dissatisfaction with the delivery of administrative services, coverage issues, and access to care issues.

Individualized Plan of Care (IPoC): The IPoC or Plan of Care (POC) identifies the waiver services, as well as other services and supports that a person needs in order to live successfully in the community and, therefore, avoid institutionalization. It must reflect the full range of a participant's service needs and include both the Medicaid and non-Medicaid services, along with informal supports that are necessary to address those needs. When non-waiver services and supports are needed to meet the needs of the participant, their provision must be monitored. The IPoC must contain, at a minimum, the services that are furnished, the amount and frequency of each service, and the type of provider to furnish each service. The IPoC must be revised, as necessary, to add or delete services or modify the amount and frequency of services. The IPoC must be reviewed at least annually, or whenever necessary, due to a change in the participant's needs.

LMHP: A Licensed Mental Health Practitioner (LMHP) is an individual who is licensed in the State of Louisiana to diagnose and treat mental illness or substance abuse acting within the scope of all applicable state laws and their professional license. A LMHP includes individuals licensed to practice independently:

- Medical Psychologists
- Licensed Psychologists
- Licensed Clinical Social Workers (LCSWs)
- Licensed Professional Counselors (LPCs)
- Licensed Marriage and Family Therapists (LMFTs)
- Licensed Addiction Counselors (LACs)
- Advanced Practice Registered Nurses (must be a nurse practitioner specialist in Adult Psychiatric & Mental Health, and Family Psychiatric & Mental Health or a Certified Nurse Specialists in Psychosocial, Gerontological Psychiatric Mental Health, Adult Psychiatric and Mental Health, and Child-Adolescent Mental Health and may practice to the extent that services are within the APRN's scope of practice)

In addition to licensure, service providers that offer addiction services must demonstrate competency as defined by the Department of Health and Hospitals, state law (ACT 803 of the Regular Legislative Session 2004) and regulations. Anyone providing addiction or behavioral health services must be certified by DHH, in addition to their scope of practice license. LMFTs and LACs are not permitted to diagnose under their scope of practice under state law. LPCs are limited by scope of practice under state law to diagnosing conditions or disorders requiring mental health counseling and may not use appraisal instruments, devices or procedures for the

purpose of treatment planning, diagnosis, classification or description of mental and emotional disorders and disabilities, or of disorders of personality or behavior, which are outside the scope of personal problems, social concerns, educational progress and occupations and careers. Per the State's practice act and consistent with State Medicaid Regulation, Medical and Licensed Psychologists may supervise up to two Clinical Psychologists.

LMMIS: Louisiana Medicaid Management Information System.

Louisiana Behavioral Health Partnership: The Louisiana Behavioral Health Partnership managed by DHH-OBH oversees the Behavioral Health Statewide Management Organization (SMO). The SMO will manage behavioral health services for Medicaid and Non-Medicaid eligible populations served by the Office of Behavioral Health (OBH), Department of Children and Family Services (DCFS), the Department of Education (DOE) and Office of Juvenile Justice (OJJ) and funded through state general funds and block grants, including services for individuals with co-occurring mental health and addictive conditions. The SMO will help improve access, quality and efficiency of behavioral health services for children not eligible for the Coordinated System of Care (CSoc), and adults with Serious Mental Illness (SMI) and Addictive Disorders. Also, the SMO will develop a qualified provider network to offer a full array of services to meet the needs of people with behavioral health challenges. The selected SMO will be a qualified behavioral health managed care organization (BH-MCO) with experience and demonstrated success in providing managed behavioral health care services with complex, publicly-funded behavioral health programs, to operate a pre-paid inpatient health plan (PIHP), as defined in 42 CFR 438.2, for behavioral health services provided to children, youth, and adults .

Medicaid/CHIP Eligible: Refers to an individual determined eligible, pursuant to federal and State law, to receive medical care, goods and services for which DHH may make payments under the Medicaid or CHIP programs.

Medicaid/CHIP Recipient: An individual who has been determined eligible for the Medicaid or CHIP program that may or may not be currently enrolled in the Program, and on whose behalf payment is made.

Medicaid Eligibility Determination: The process by which an individual may be determined eligible for Medicaid or Medicaid-expansion CHIP program.

Medically Necessary Services: Health care services that are in accordance with generally accepted evidence-based medical standards, or that are considered by most physicians (or other independent licensed practitioners) within their respective professional organizations to be the standard of care. In order to be considered medically necessary, services must be: 1) deemed reasonably necessary to diagnose, correct, cure, alleviate, or prevent the worsening of a condition or conditions that endanger life; cause suffering or pain; or have resulted or will result in a handicap, physical deformity, or malfunction; and 2) not be more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease. Any such services must be clinically appropriate, individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and neither more nor less than what the recipient requires at that specific point in time. Services that are experimental, non-FDA approved, investigational, or cosmetic are specifically excluded from Medicaid coverage

and will be deemed “not medically necessary”. The Medicaid Director, in consultation with the Medicaid Medical Director, may consider authorizing services at his discretion on a case-by-case basis.

Member: Persons enrolled in the SMO.

Network: As used in the Contract, “network” may be defined as a group of participating providers linked through contractual arrangements to a SMO to supply a range of behavioral health care services. The term “provider network” may also be used.

Network Adequacy: Refers to the network of behavioral health care providers for a SMO (whether in- or out-of-network) that is sufficient in numbers and types of providers/facilities to ensure that all services are accessible to Members without unreasonable delay. Adequacy is determined by a number of factors, including, but not limited to, provider/patient ratios, geographic accessibility and travel distance, waiting times for appointments, and hours of provider operations.

Performance Measures: Specific operationally-defined performance indicators utilizing data to track performance and quality of care and to identify opportunities for improvement dimensions of care and service.

Plan of Care: Strategies designed to guide the development of an individual-specific plan to address the behavioral health and natural support needs of the Member. Care plans are intended to ensure optimal outcomes for individuals during the course of their care.

Prior Authorization: The process of determining medical necessity for specific services before they are rendered.

Prospective Review: Utilization review conducted prior to an admission or a course of treatment.

Protected Health Information (PHI): Individually-identifiable health information that is maintained or transmitted in any form or medium and for which conditions for disclosure are defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and 45 CFR 160 and 164.

PRTF: Psychiatric Residential Treatment Facility for individuals less than 21 years of age.

Qualified Service Provider: Any individual or entity that is engaged in the delivery of behavioral health care services that meets the credentialing standards of the SMO and all State licensing and regulatory requirements. It also applies to the delivery of Medicaid services, if certified by the Medicaid agency to participate in the Medicaid program.

QA/QI: Quality assurance/quality improvement.

QAO: Quality Assurance Officer.

Quality: As it pertains to external quality review, the degree to which a SMO increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics

and through the provision of health services that are consistent with current professional knowledge.

Quality Management (QM) – The ongoing process of assuring that the delivery of covered services is appropriate, timely, accessible, available, medically necessary, in keeping with established guidelines and standards, and reflective of the current state of medical and behavioral health knowledge.

Routine: Minimal to low risk of harm, such as absence of current suicidal ideation; substance use without significant episodes of potentially harmful behavior.

SAMHSA: Substance Abuse and Mental Health Services Administration.

Secure File Transfer Protocol (SFTP): Software protocol for transferring data files from one computer to another with added encryption.

Security Rule (45 CFR Parts 160 & 164): Part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which stipulates that covered entities must maintain reasonable and appropriate administrative, physical, and technical safeguards to protect the confidentiality, integrity, and availability.

Utilization Management (UM): Refers to the process of evaluation of medical necessity, appropriateness, and efficiency of health care services, procedures, and facilities. UM is inclusive of utilization review and service authorization.

Wraparound Agency: WAAs are the locus of accountability for developing a single plan of care and providing intensive care coordination for children within the CSoC needing such supports, with the goal of “one family, one plan of care, and one wraparound facilitator”.

Wraparound approach: Informed by the wraparound principles. When the principles of wraparound are purposefully applied to services or supports that are different from the full wraparound care coordination process (e.g., child welfare case work, day treatment, case management) we often refer to these services as adopting a wraparound *approach*.

Wraparound fidelity: How fully the wraparound process (whether it is for a family, in an organization, or in a whole system) adheres to the 10 principles and basic activities of the wraparound process. Can be measured using fidelity tools such as the *Wraparound Fidelity Index* or *Team Observation Measure*. Wraparound fidelity should not be considered synonymous with wraparound quality; a wraparound team or initiative that scores high on getting the basic wraparound “steps” done may still need improvements in the quality of its work.

Wraparound process: An intensive, team-based, individualized care planning and management process that follows a series of steps and considers a set of unique inputs to help children and their families realize a life that reflects their hopes and dreams.

Wraparound principles: A set of 10 statements that defines the wraparound philosophy and guides the activities of the wraparound process.

Wraparound staff positions: The range of staff assigned to implement the wraparound process on the child and family level. Wraparound staffing can range from one position such as a facilitator or care coordinator who is responsible for putting the process together for each family to a group of multiple staff persons that might include family support partners, youth partners and/or behavioral specialists. Wraparound staffing varies from site to site but all sites must have the capacity to have someone take on the primary role for putting the process together.

Wraparound teams: Also known as child and family teams, these are groups of people – chosen with the family and connected to them through natural, community, and formal support relationships – who develop and implement the family’s plan, address unmet needs, and work toward a collective team mission that reflects the family’s vision.



Glossary of Acronyms

ACT – Assertive Community Treatment
AD – Addictive Disorders
BC/DRP – Business Continuity and Disaster Recovery Plans
BH-MCO – Behavioral Health Managed Care Organization
BHSF/MVA – Bureau of Health Services Financing/Medical Vendor Administration, Department of Health and Hospitals
BESE – State Board of Elementary and Secondary Education
CAHSD – Capital Area Human Services District
CANS – Child and Adolescent Needs and Strengths assessment tool
CFT – Child and Family Team
CFR – Code of Federal Regulations
CIT – Crisis Intervention Team
CLSH – Central Louisiana State Hospital
CMS – Centers for Medicare & Medicaid Services
COB – Close of Business
COD – Co-occurring Disorders of Mental and Addictive Disorders
CSoc – Coordinated System of Care
DACTS – Dartmouth Assertive Community Treatment Scale
DCFS – Department of Children and Family Services
DHH – Department of Health and Hospitals
DHH-OBH – Department of Health and Hospitals-Office of Behavioral Health
DHH-OPH – Department of Health and Hospitals-Office of Public Health
DOE – Department of Education
EBD – Emotional Behavioral Disorders
EBP – Evidenced-Based Practices
ELMHS – Eastern Louisiana Mental Health System
EPSDT – Early and Periodic Screening, Diagnosis, and Treatment
FACT – Forensic Assertive Community Treatment
FFS – Fee-for-Service
FI – Fiscal Intermediary
FICA – Federal Insurance Contributions Act
FINS – Families in Need of services
FPHSA – Florida Parishes Human Services Authority
FSO – Family Support Organization
HEDIS – Healthcare Effectiveness Data and Information Set
HIPAA – Health Insurance Portability and Accountability Act
HMO – Health Maintenance Organization
ICM – Intensive Case Management
IT – Information Technology
JLCB – Joint Legislative Committee on the Budget
JPHSA – Jefferson Parish Human Services Authority

LAN – Local Area Network
LEA – Local Education Agency
LGE – Local Governing Entities
LMMIS – Louisiana Medicaid Management Information System
LOC – Level of Care
MH/BH – Mental Health/Behavioral Health
MHBG – Mental Health Block Grant
MHRIS – Mental Health Rehabilitation Services Information System
MHSD – Metropolitan Human Services District
MITA – Medicaid Information Technology Architecture
MST – Multisystemic Therapy
NCQA – National Committee for Quality Assurance
NGBRI – Not Guilty by Reason of Insanity
OBH – Office of Behavioral Health
OAAS – Office of Aging and Adult Services
OJJ – Office of Juvenile Justice
PA – Prior Authorization
PHI – Protected Health Information
PIHP – Prepaid Inpatient Health Plan
PRTF – Psychiatric Residential Treatment Facility
QM – Quality Management
QA/QI – Quality Assurance/Quality Improvement
RFP – Request for Proposal
RHC/FQHC – Rural Health Clinic/Federally Qualified Health Center
ROI – Return on Investment/also Release of Information-depends on context
SAMHSA – Substance Abuse and Mental Health Services Administration
SCLHSA – South Central Louisiana Human Services Authority
SED – Serious Emotional Disturbance
SFF – Secure Forensic Facility
SFTP – Secure File Transfer Protocol
SMI – Serious Mental Illness
SPOE – Single Point of Entry
TANF – Temporary Assistance for Needy Families
WAA – Wraparound Agency
WF – Wraparound Facilitation

References:

Louisiana Department of Health and Hospitals. (2010). Coordinated System of Care (CSoC) Community Application. From http://www.dcf.louisiana.gov/assets/docs/searchable/OS/CSoC/20110314_CSoCFirstPhase_RFA.pdf

Louisiana Department of Health and Hospitals. (2010). Request for Proposals Statewide Management Organization for the Louisiana Behavioral Health Partnership. From: http://new.dhh.louisiana.gov/assets/docs/contracts/305PUR-DHHRFP-SMO-OBH_STATEWIDE_MANAGEMENT_ORGANIZATION.pdf

Louisiana Department of Health and Hospitals. (2011). About the Louisiana Behavioral health Partnership. From: <http://new.dhh.louisiana.gov/index.cfm/page/453/n/213>

National Wraparound Initiative. (2011). Wraparound Implementation Guide. From: <http://www.nwi.pdx.edu/pdf/ImplementationGuide-AboutThisGuide.pdf>