GLOSSARY OF TERMS

Action – The denial or limited Authorization of a requested service, including the type, level or provider of service; reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment of a service; or failure to provide services or act in a timely manner as required by law or contract.

Acute Inpatient Care – Care provided to persons sufficiently ill or disabled requiring:

1. Constant availability of medical supervision by attending Provider or other medical staff
2. Constant availability of licensed nursing personnel
3. Availability of other diagnostic or therapeutic services and equipment available only in a hospital setting to ensure proper medical management by the Provider

Ambulatory Care – Health services provided on an outpatient basis. While many inpatients may be ambulatory, the term ambulatory care usually implies that the patient has come to a location other than his/her home to receive services and has departed the same day. Examples include chemotherapy and physical therapy.

Ambulatory Surgical Facility – A facility licensed by the state where it is located, equipped and operated mainly to provide for surgeries and obstetrical deliveries, and allows patients to leave the facility the same day surgery or delivery occurs.

Ancillary Services – Health services ordered by a Provider, including but not limited to laboratory services, radiology services, and physical therapy.

Appeal – An oral or written request by a Member or Member's personal representative received at Molina Healthcare for review of an action.

Apple Health Family (AHF) – A health insurance program for eligible Medicaid recipients under Title XIX of the SSA.

Apple Health Family Blind-Disabled (AHBD) - A health insurance program for eligible Medicaid recipients under Title XIX of the SSA.

Apple Health for Kids (AHPREM) – A federal/state funded health insurance program authorized by Title XXI of the SSA and administered HCA.

Authorization – Approval obtained by Providers from Molina Healthcare for designated service before the service is rendered. Used interchangeably with preauthorization or prior Authorization.

Average Length of Stay (ALOS) – Measure of hospital utilization calculated by dividing total patient days incurred by the number of admissions/discharges during the period.

Capitation – A prospective payment based on a certain rate per person paid on a monthly basis for a specific range of health care service.

Centers for Medicare & Medicaid Services (CMS) – A federal agency within the U.S. Department of Health and Human Services. CMS administers Medicare, Medicaid, and AHP programs.

Children With Special Health Care Needs (CSHCN) – Children identified by HCA as meeting the federal guidelines under Title V of the Social Security Act (SSA). Any child (birth

to 18 years of age) with a health or developmental problem requiring more than the usual pediatric health care.

Claim – A request for payment for the provision of Covered Services prepared on a CMS-1500 form, UB-04, or successor, submitted electronically or by mail.

Coordination of Benefits (COB) – Applies when a person is covered under more than one group medical plan. The plans coordinate with each other to avoid duplicate payments for the same medical services.

Complaint – Any written or oral expression of dissatisfaction.

Community Service Office (CSO) – An office under the direction of DSHS that administers social and health services and determines eligibility for benefits at the local community level.

Core Provider Agreement – A basic contract that HCA holds with medical Providers serving HCA clients. The Provider agreement outlines and defines terms of participation in the Medicaid program.

Covered Services – Medically necessary services included in the state contract. Covered services change periodically as mandated by federal or state legislation.

Credentialing – The verification of applicable licenses, certifications, and experience to assure that Provider status be extended only to professional, competent Providers who continually meet the qualifications, standards, and requirements established by Molina Healthcare.

Current Procedural Terminology (CPT) Codes – American Medical Association (AMA) approved standard coding for billing of procedural services performed.

Delivery System – The mechanism by which health care is delivered to a patient. Examples include, but are not limited to, hospitals, Providers' offices and home health care.

Denied Claims Review – The process for Providers to request a review of a denied claim.

Discharge Planning – Process of screening eligible candidates for continuing care following treatment in an acute care facility, and assisting in planning, scheduling and arranging for that care.

Durable Medical Equipment (DME) – Equipment used repeatedly or used primarily and customarily for medical purposes rather than convenience or comfort. It also is equipment that is appropriate for use in the home and prescribed by a Provider.

Dual Coverage – When a Member is enrolled with two Molina Healthcare plans at the same time.

Electronic Data Interchange (EDI) – The electronic exchange of information between two or more organizations.

Early Periodic Screening Diagnosis and Treatment Program (EPSDT) – A package of services in a preventive (well child) exam covered by Medicaid as defined in the SSA section 1905 (R). Services covered by Medicaid include a complete health history and developmental assessment, an unclothed physical exam, immunizations, laboratory tests, health education and anticipatory guidance, and screenings for: vision, dental, substance abuse, mental health and hearing, as well as any medically necessary services found during the EPSDT exam.

Emergency Care – The provision of medically necessary services required for the immediate attention to evaluate or stabilize a Medical Emergency (See definition below).

Expedited Appeal – An oral or written request by a Member or Member's personal representative received by Molina Healthcare requesting an expedited reconsideration of an action when taking the time for a standard resolution could seriously jeopardize the Member's life, health or ability to attain, maintain, or regain maximum function; or would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the appeal.

Expedited Grievance – A grievance where delay in resolution would jeopardize the Member's life or materially jeopardize the Member's health.

Federally Qualified Health Center (FQHC) – A facility that is:

1. Receiving grants under section 329, 330, or 340 of the Public Health Services Act; or
2. Receiving such grants based on the recommendation of HCA within the Public Health Service, as determined by the Secretary to meet the requirements for receiving such a grant; or
3. A tribe or tribal organization operating outpatient health programs or facilities under the Indian Self Determination Act (PL93-638).

Fee-for-Service (FFS) – FFS is a term Molina Healthcare uses to describe a method of reimbursement based upon billing for a specific number of units of services rendered to a Member. FFS is also the term HCA uses when a client, not Apple Health Family eligible, is able to go to any medical Provider who will accept the Services Card.

Grievance – An oral or written expression of dissatisfaction by a Member, or representative on behalf of a Member, about any matter other than an action received at Molina Healthcare.

HCA – Health Care Authority

Health Plan Employer Data and Information Set (HEDIS) – Set of standardized measures developed by NCQA. Originally HEDIS was designed to address private employers' needs as purchasers of health care. It has since been adapted for use by public purchasers, regulators and consumers. HEDIS is used for quality improvement activities, health management systems, Provider profiling efforts, an element of NCQA accreditation, and as a basis of consumer report cards for managed care organizations.

Hearing – An outside hearing conducted by HCA available to all Apple Health Members. The Member presents their appeal to an Administrative Law Judge.

HIPAA – Health Insurance Portability and Accountability Act

Independent Practice Association (IPA) – A legal entity, the Members of which are independent Providers who contract with the IPA for the purpose of having the IPA contract with one or more health plans.

Independent Review Organization (IRO) – A review process by a state-contracted independent third party.

Integrated Provider Network Database (IPND) – A database developed in partnership by HCA to provide verified and integrated Provider network information for all health plans serving Apple Health via the Internet and an internal user interface.

Medicaid – The state and federally funded medical program created under Title XIX of the SSA.

Medical Emergency – Circumstances which a reasonably prudent person would regard as the unexpected onset of sudden or acute illness or injury requiring immediate medical care such that the Member's life or health would have been jeopardized had the care been delayed.

Medical Records – A confidential document containing written documentation related to the provision of physical, social and mental health services to a Member.

Medically Necessary Services – Services reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause suffering or pain, result in illness or infirmity, threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, and there is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the Member requesting the service. Course of treatment may include mere observation or, where appropriate, no treatment at all. Medically Necessary Services shall include, but not be limited to, diagnostic, therapeutic, and preventive services generally and customarily provided in the service area.

Medicare – The federal government health insurance program for certain aged or disabled clients under Titles II and XVIII of the SSA. Medicare has two parts:

A) Part A covers the Medicare inpatient hospital, post-hospital skilled nursing facility care, home health services, and hospice care.

B) Part B is the supplementary medical insurance benefit (SMIB) covering the Medicare Provider's services, outpatient hospital care, outpatient physical therapy and speech pathology services, home health care, and other health services and supplies not covered under Part A of Medicare.

Member – A current or previous Member of Molina Healthcare.

NCQA – National Committee for Quality Assurance

Participating Provider – A Provider that has a written agreement with Molina Healthcare to provide services to Members under the terms of their agreement.

Provider Group – A partnership, association, corporation, or other group of Providers.

Physician Incentive Plan – Any compensation arrangement between a health plan and a Provider or Provider group that may directly or indirectly have the effect of reducing or limiting services to Members under the terms of the agreement.

Preventive Care – Health care emphasizing priorities for prevention, early detection, and early treatment of conditions, generally including routine physical examination and immunization.

Primary Care Provider (PCP) – A participating Provider responsible for supervising, coordinating, and providing primary health care to Members, initiating referrals for specialist care, and maintaining the continuity of Member care. PCPs include, but are not limited to; Pediatricians, Family Providers, General Providers, Internists, Provider Assistants (under the supervision of a Provider), or Advanced Registered Nurse Practitioners (ARNP), as designated by Molina Healthcare.

ProviderOne Services Card (Services Card) - Each Member who is eligible for Apple Health will receive his or her own Services Card. Each person has a different ProviderOne client number that stays with him or her for life.

Quality Improvement Program (QIP) – A formal set of activities provided to assure the quality of clinical and non-clinical services. QIP includes quality assessment and corrective actions taken to remedy any deficiencies identified through the assessment process.

Remittance Advice (RA) – Written explanation of processed claims.

Referral – The practice of sending a patient to another Provider for services or consultation which the referring Provider is not prepared or qualified to provide.

Rural Health Clinic (RHC) – A clinic, located in a rural area, designated by the Department of Health as an area having either a shortage of personal health services or a shortage of primary medical care. These clinics are entitled to receive enhanced payments for services provided to enrolled Members.

Service Area – A geographic area serviced by Molina Healthcare, designated and approved by HCA.

Specialist – Any licensed Provider, who practices in a specialty field such as Cardiology, Dermatology, Oncology, Ophthalmology, Radiology, etc.

Supplemental Security Income (SSI) – A federal cash program for aged, blind, or disabled persons, administered by the SSA. Clients eligible to receive SSI are not eligible for AHF or AHPREM.

Sub-Contract – A written agreement between a health plan and a participating Provider, or between a participating Provider and another sub-contractor, to perform all or a portion of the duties and obligations a plan is required to perform pursuant to the agreement.

Tertiary Care – Care requiring high-level intensive, diagnostic and treatment capabilities for adults and/or children, typically administered at highly specialized medical centers.

Third Party Liability (TPL) – A company or entity other than Molina Healthcare liable for payment of health care services rendered to Members. Molina Healthcare will pay claims for covered benefits and pursue a refund from the third party when liability is determined.

Title V – The portion of the federal SSA that authorizes grants to states for the care of CSHCN.

Title XIX – The portion of the federal SSA that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid.

Title XXI – The portion of the federal SSA that authorizes grants to states for AHPREM.

Transitional Healthcare Services – Means a set of actions designed to ensure coordination and continuity of care as enrollees transfer between different locations of different levels of care within the same locations. Transitional Healthcare Services are intended to prevent secondary health conditions or complications, re-institutionalization, and recidivism following substance use disorder treatment.

Utilization Management (UM) – The process of evaluating and determining the coverage for and the appropriateness of medical care services, as well as providing assistance to a clinician or

patient in cooperation with other parties, to ensure appropriate use of resources. UM includes prior Authorization, concurrent review, retrospective review, discharge planning and case management.

Washington Administration Code (WAC) – Codified rules of the State of Washington.