Glossary of Terms

Affordable Care Act (ACA) - The comprehensive health care reform law enacted in March 2010. The law was enacted in two parts: The Patient Protection and Affordable Care Act was signed into law on March 23, 2010 and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name "Affordable Care Act" is used to refer to the final, amended version of the law.

Care Management – Care Management means a set of individualized, person-centered, goal-oriented, culturally relevant services to assure that a beneficiary receives needed services in a supportive, effective, efficient, timely and cost-effective manner.

Care Manager - an appropriately qualified professional who is a beneficiary's designated accountable point of contact for Care Management services.

Certified Nursing Assistant (CNA) - A person who assists patients with healthcare needs and cares for a patient who is ill or recovering from a surgery or disease. CNAs' duties are assigned by a registered professional nurse. Sometimes they provide activities of daily living services and bedside care, including basic nursing procedures under the supervision of a registered nurse.

Community Mental Health Center (CMHC) – Community based non-profit organizations that provide mental health and substance abuse prevention and treatment services.

Community Support Program (CSP) - This program provides case management services and supportive assistance to individuals in order to attain the goals of their behavioral health treatment plan, as well as access to medical, social, educational and other services essential to meeting basic human needs. Approximately 5,100 clients are in RI's Community Support Programs throughout 7 Community Mental Health Centers. This program is administered by the Department of BHDDH.

Comprehensive Functional Needs Assessment (CFNA)– A multi-dimensional, interdisciplinary process to determine actionable risk factors and beneficiaries' strength-based needs and preferences based on their medical, psychological, and functional capabilities. The CFNA is the basis of the beneficiary-specific Interdisciplinary Care Plan (ICP).

Connect Care Choice Community Partners (CCCCP) - a Coordinating Care Entity (CCE) which offers a community health team to those individuals who are actively engaged with a RI EOHHS-certified Patient Centered Medical Home practice.

Coordinating Care Entity (CCE) - an organization which acts to coordinate the care of Medicaid members in the Fee for Service delivery system. CCEs can provide services such as care management, community health teams, and peer mentoring.

Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH)- the Department responsible for assuring access to quality services and supports for Rhode Islanders with developmental disabilities, mental health and substance abuse issues, and chronic long-term medical and psychiatric conditions; and for advancing the State's mission to address and erase the stigma attached to these disabilities as well as planning for the development of new services and prevention activities.

Duals/Dual Eligibles - People who qualify for both Medicare and Medicaid

Durable Medical Equipment (DME) - any medical equipment used in the home to aid in a better quality of living.

Fee For Service Medicaid (FFS) - The Medicaid Program pays claims directly to providers for services rendered. There is no health plan involved. Providers must sign up to participate in the Program.

Home and Community Based Services (HCBS) are provided in the community for individuals who are eligible for Long Term Services and Supports. These services can include Homemaker/ CNA services, Environmental modifications, Special medical equipment, Meals on Wheels, Personal Emergency Response Systems, Case Management, Senior Companion, Assisted Living, Personal care services, Self-directed care, Respite, and Minor home modifications.

Integrated Care Initiative (ICI) - the Rhode Island Integrated Care Initiative includes two phases. Phase I of the ICI coordinates Medicaid-covered benefits to Medicaid-only adults eligible for LTSS and to Medicare-Medicaid eligible Beneficiaries (MMEs) or 'Duals'. Phase II will consist of a Three-way Contract between CMS, the State and an MCO where all Medicare and Medicaid benefits will be provided through the MCO.

Interdisciplinary Care Plan (ICP) - a written plan developed for beneficiaries eligible for LTSS or otherwise determined to be at high risk. The ICP is done in collaboration with the beneficiary; the beneficiary's family, guardian or other caregivers and the primary care provider (PCP).

Interdisciplinary Care Team (ICT) - a team of professionals and para-professionals that collaborate, in person and/or through other means, with beneficiaries to develop and implement an Interdisciplinary Care Plan or Wellness Plan that meets the beneficiaries' medical, behavioral, long term care and supports, and social needs.

Long Term Services and Supports (LTSS) - a range of medical, social, or rehabilitation services a person may need over months or years in order to improve or maintain function or health. Medicaid Long Term Services and Supports can include Home and Community-Based Services, Preventive Services, and Nursing Home Care. The type of services a person receives depends on level of care needs. Eligibility is determined after a member submits a long term care application to the Department of Human Services (DHS) Long Term Care.

Managed Care Organization (MCO) – A Health Plan that contracts with the state to provide most/all Medicaid benefits to members in exchange for a monthly payment from the state. Like a commercial health plan, MCOs contract with a large network of service providers to ensure access for their members. For the Rhody Health Options program Rhode Island contracts with Neighborhood Health Plan of Rhode Island.

Medicare-Medicaid Plan (MMP) - a health plan under contract with CMS and the State to provide fully integrated Medicare and Medicaid benefits under the Integrated Care Initiative. The MMP integrates the provision of primary care, acute care, behavioral health care, and long-term care services and supports through Care Management strategies focused on the person's needs.

Money Follows the Person (MFP) – RI was awarded a 5 year (2011-2016) federally funded MFP Demonstration Grant. The MFP demonstration grant is designed to assist the state in balancing their long-term care system by assisting Medicaid enrollee's transition from institutions to the community of their choice where they will receive long term services and supports (LTSS). Rhode Island utilizes the states existing nursing home transition program to implement requirements set forth under this Demonstration Program - a federally funded grant to support efforts by state Medicaid programs to give people with disabilities greater choice about where they live and receive long-term services and supports (LTSS).

Neighborhood Health Plan of Rhode Island (NHPRI) - a nonprofit managed care organization (MCO) that contracts with EOHHS to administer the RIte Care, Rhody Health Partners, Medicaid Expansion and Rhody Health Options programs.

Nursing Home Transition Program (NHTP) - a program for elders and adults with disabilities which will help to assess if they can safely live at home or in another community setting. NHTP includes discharge planning, implementation, identifying need for and arrangement of services and equipment and home modifications.

Ombudsman Program – An independent, conflict-free entity that will assist Enrollees in accessing their care, understanding and exercising their rights and responsibilities, and appealing adverse decisions made by their health care providers.

PACE/Program of All-Inclusive Care for the Elderly - serves individuals who are age 55 or older, certified by the state to need nursing home care; Individuals must be able to live safely in the community at the time of enrollment and live in a PACE service area. While all PACE participants must be certified to need nursing home care to enroll in PACE, only about 7 percent of PACE participants nationally reside in a nursing home. If a PACE enrollee needs nursing home care, the PACE program pays for it and continues to coordinate the enrollee's care. The PACE program in Rhode Island is a three-way partnership between the Federal government, the State of Rhode Island, and the PACE organization of Rhode Island (PORI).

Peer Navigator – An individual, typically a trained para-professional, who is responsible for helping Medicaid members navigate the delivery system across their local community.

Prescription Drug Plan (PDP)- a stand-alone prescription drug plan for Medicare members with Part D

Rhody Health Options (RHO) - a managed care plan, currently administered by Neighborhood Health Plan of Rhode Island (NHPRI), is intended to coordinate care for Medicare/Medicaid eligible individuals (MMEs)and Medicaid members receiving long term services and supports. . Previously Medicaid members who also qualified for Medicare would have been in the Medicaid Fee for Service (FFS) system.

Self-Direction (also Consumer Direction) – The ability for an Enrollee to direct his/her own services through the consumer-directed personal assistance option.

The Centers for Medicare and Medicaid Services (CMS) – A component of the Department of Health and Human Services, CMS oversees and administers the Medicare and Medicaid programs. In Phase II of the Integrated Care Initiative CMS and the State of RI will contract with Neighborhood Health Plan to provide both Medicare and Medicaid benefits to eligible individuals.