APPENDIX A
GLOSSARY

A1 GLOSSARY

The following is a list of acronyms and terms used throughout this ~~Request for Proposal (RFP)~~Solicitation document.

Term	Description
A2A	**Application-to-Application -** Connectivity used to solve the problem of putting together a diverse set of application subsystems
Agent	Licensed salespersons that represent one or more health insurance companies and presents their products to consumers.
AIM	**Access for Infants and Mothers** – A DHCS low cost health program for pregnant women.
Alert Report	One of the MEDS, CDB or IEVS reports used to inform users of situations that may require action on their part.
ANSI	**American National Standards Institute** - Founded in 1918, ANSI is a voluntary organization composed of over 1,300 members that creates standards for the computer industry and for a wide range of technical areas, from electrical specifications to communications protocols.
ANSI ASC X12/ASC X12	The official designation of the U.S. national standards body for the development and maintenance of Electronic Data Interchange (EDI) standards.
ANSI 834	Benefit Enrollment and Maintenance Set (834) can be used by employers, unions, government agencies, associations or insurance agencies to enroll members to a payer. The payer is a healthcare organization that pays claims, administers insurance or benefit or product. Examples of payers include an insurance company, health care professional (HMO), preferred provider organization (PPO), government agency (Medicaid, Medicare etc.) or any organization that may be contracted by one of these former groups.
ANSI 835	Health Care Claim Payment/Advice Transaction Set (835) can be used to make a payment, send an Explanation of Benefits (EOB), send an Explanation of Payments (EOP) remittance advice, or make a payment and send an EOP remittance advice only from a health insurer to a health care provider either directly or via a financial institution.
ANSI 270	EDI Health Care Eligibility/Benefit Inquiry (270) is used to inquire about the health care benefits and eligibility associated with a subscriber or dependent.
ANSI 271	EDI Health Care Eligibility/Benefit Response (271) is used to respond to a request inquire about the health care benefits and eligibility associated with a subscriber or dependent.
ANSI 276	EDI Health Care Claim Status Request (276) This transaction set can

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	be used by a provider, recipient of health care products or services or their authorized agent to request the status of a health care claim.
ANSI 277	EDI Health Care Claim Status Notification (277) This transaction set can be used by a health care payer or authorized agent to notify a provider, recipient or authorized agent regarding the status of a health care claim or encounter, or to request additional information from the provider regarding a health care claim or encounter. This transaction set is not intended to replace the Health Care Claim Payment/Advice Transaction Set (835) and therefore, is not used for account payment posting. The notification is at a summary or service line detail level. The notification may be solicited or unsolicited.
API	**Application Programming Interface -** A source code based specification intended to be used as an interface by software components to communicate with each other.
Applicant	An individual who is seeking an eligibility determination to enroll in a QHP in the Exchange, to receive advance payments of the premium tax credit or cost-sharing reductions, or to receive benefits through other State health programs. In the context of a SHOP, the term applicant indicates an employer or employee.
APTC	**Advanced Premium Tax Credit** - Beginning in tax year 2014, the ACA creates a refundable tax credit (the "premium assistance credit") for eligible individuals and families who purchase health insurance through an exchange. Individuals eligible for the premium tax credit must have annual incomes between 100 and 400 percent of the federal poverty level (FPL); tax credits are also available for legal immigrants with incomes below 100 percent of the FPL and not eligible for Medicaid. The refundable premium tax credits are available for the purchase of health insurance coverage offered through health insurance Exchanges. The payment of this tax credit is made on an advance basis to an eligible individual of a QHP through an Exchange.
Assister	Includes, but is not limited to, Navigator, Broker and Agent that assist consumers with the application process.
Beneficiary	An individual enrolled in a health insurance plan who receives benefits through those policies.
BHP	Basic Health Program
Benefits	Medical services for which an insurance plan will pay, in full or in part.
BIC	**Benefits Identification Card** - An identification card that is issued to Medi-Cal beneficiaries as proof of their eligibility for the program. At the time of service, a provider verifies eligibility through the POS Network using the number and issue date on the BIC. It is generated by a DHCS vendor using a batch file from MEDS, this identification card is mailed to the customers address within a few days of determining presumptive or actual eligibility for services.

Term	Description
BPM	**Business Process Management** - A holistic management approach focused on aligning all aspects of an organization with the wants and needs of clients. It promotes business effectiveness and efficiency while striving for innovation, flexibility, and integration with technology.
BPMS	**Business Process Management System** – A suite of BPM components. Four critical components of a BPMS include Process Engine, Business Analytics, Content Management, and Collaboration Tools.
Business Rules Engine	**Business Rules Engine** - A software system that executes one or more business rules in a runtime production environment.
BRMS	**Business Rules Management System -** A software system used to define, deploy, execute, monitor and maintain the variety and complexity of decision logic that is used by operational systems within an organization or enterprise. This logic, also referred to as business rules, includes policies, requirements, and conditional statements that are used to determine the tactical actions that take place in applications and systems.
Broker	Licensed insurance salesperson who obtains quotes and plan from multiple sources information for clients.
C-IV	**The California Statewide Automated Welfare System (SAWS) Consortium-IV Joint Powers Authority** - entity that owns and operates the automated welfare system for 39 California Counties that form the Consortium.~~The automated welfare system that is used by the CIV Consortium.~~
CalFresh	California's name for the Food and Nutrition Services Supplemental Nutrition Program (SNAP) program
CalWIN	**The Statewide Automated Welfare System (SAWS) California Work Opportunity and Responsibility to Kids Information Network (CalWIN)** - The automated welfare system that is used by the Welfare Client Data System Consortium.
CalWORKS	**California Work Opportunity and Responsibility to Kids** - A welfare program that gives cash aid and services to eligible needy California families.
Capitation	A flat monthly fee that a health plan pays to a provider (doctor, hospital, lab, etc.) to take care of a patient's needs. Capitation is part of the provider-reimbursement mechanism.
CA-MMIS	**CA Medicaid Management Information System** - T~~t~~he system used to manage the Medicaid program and process Medi-Cal Claims in California.
CHIP	**Children's Health Insurance Program** - A joint State/federal program to provide health insurance to children in families who earn too much

Term	Description
	money to qualify for Medicaid, yet cannot afford to buy private insurance.
CHDP	**Child Health and Disability Prevention Program** - A preventive program that delivers periodic health assessments and services to low income children and youth in California.
CHDP Gateway	**Child Health and Disability Prevention Program Gateway** - The automated process used by CHDP providers to enroll applicants into presumptive eligibility which includes a web front end, income calculation table, MEDS interface and the POS device.
CIN	**Client Index Number** - The CIN, generated and controlled by the California Department of Health Services' Statewide Client Index, is the primary identifier for individuals who have applied for public benefits (CalWORKs, Food Stamps, Medi-Cal, etc.) and uniquely identifies a recipient across multiple programs.
Claim	A notice to the insurance company that a person received care covered by the plan. A claim also may be a request for payment and will state so.
Continuing coverage	Eligibility for State Health Care programs is re-determined on an annual basis. The year-long period of enrollment is considered continuing coverage as opposed to the two-month period of coverage granted through the presumptive eligibility.
Coverage	What the health plan does and does not pay for. Coverage includes almost everything mentioned in this booklet: benefits, deductibles, premiums, limitations, etc.
Deductible	A portion of the covered expenses (typically $100, $250 or $500) that an insured individual must pay before benefits are paid by the insurance plan. Deductibles are standard in many indemnity policies, and are usually based on a calendar year.
ELC	Exchange Life Cycle
Eligibility Determination	Eligibility determination is performed by authorized program staff or automated systems according to the rules of the program for which the applicant is applying, utilizing documentation presented by the applicant
Eligibility Verification	A provider is able to verify a Medi-Cal beneficiary's eligibility through the Point of Service network. The provider uses the beneficiary's BIC to validate coverage to ensure payment for covered care.
Eligible Employer-Sponsored Plan	The term 'eligible employer-sponsored plan' means, with respect to any employee, a group health plan or group health insurance coverage offered by an employer to the employee which is: • A governmental plan (within the meaning of section 2791(d)(8) of the Public Health Service Act), or

Term	Description
	• Any other plan or coverage offered in the small or large group market within a State. (State of WA EEI-16).
Enrollment	Registration or entry into a list (whether manual or automated) of individuals who are eligible for a health or social services program. An applicant is enrolled into a program after he or she has been determined to meet all of the eligibility requirements for the program. Enrollment may be performed only by an authorized entity.
ERA	**Exchange Reference Architecture** - CMS specified key architectural principles and guidelines that support the business of providing Medicaid and Exchange services. Included are IT principles, technology standards, IT governance, and identified areas where collaborative discussions are necessary to ensure the most effective and efficient environment for Medicaid and Exchange IT services.
ESB	**Enterprise Service Bus** - A method of allowing integration of enterprise applications services and services built on newer technologies (e.g. J2EE, .NET). The ESB acts as a middle layer communicating between the two architectures.
Essential Health Benefits	Individuals enrolling in QHPs must receive coverage that meets or exceeds the "Essential Health Benefits" standard. The Department of Health and Human Services will launch an effort this fall to collect public input on the Essential Health Benefits standard. Based on expectations in the ACA, that standard will offer robust coverage, including mental health and substance abuse services that are often excluded from commercial plans. It may also include some Medicaid-optional benefits that states have selected not to cover in order to make plans more affordable for certain populations.
File Clearance	The process used to determine whether an applicant is known to any of the health or social services programs whose eligibility data is maintained in MEDS.
HEDIS	**Healthcare Effectiveness Data and Information Sets** - is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service.
HIS	**The Health Information System** - HIS stores information relating to the name and type of plan, start date and stop date. It is loosely coupled to the MEDS system in that the only requirement for acceptance of a plan transaction is the existence of eligibility in a program during the same period. The purpose of this system is to provide a centralized source of all plan information.
HIPAA	**Health Insurance Portability and Accountability Act** - Allows persons to qualify immediately for comparable health insurance coverage when they change their employment or relationships. It also creates the authority to mandate the use of standards for the electronic exchange of health care data; to specify what medical and administrative code sets should be used within those standards; to

Term	Description
	require the use of national identification systems for health care patients, providers, payers (or plans), and employers (or sponsors); and to specify the types of measures required to protect the security and privacy of personally identifiable health care.
HL7	**Health Level 7** - HL7 and its members provide a framework (and related standards) for the exchange, integration, sharing, and retrieval of electronic health information. v2.x of the standards, which support clinical practice and the management, delivery, and evaluation of health services, are the most commonly used in the world.
IEVS	**Income and Eligibility Verification System** - Federally-mandated system under Social Security Act Title IV-A for TANF/CalWORKs, and Title XIX for the Medi-Cal only programs for the purpose of verifying eligibility and benefit amounts available under these programs. The databases used in the ongoing IEVS "match" include, but are not limited to: • Wage information from the State Wage Information Collection Agency • Unemployment/disability compensation benefits from the agencies administering those programs • Benefits/pensions/wage information from the Social Security Administration (SSA) • Internal Revenue Service (IRS)/Franchise Tax Board (FTB) unearned income data • Inter/intra-county duplicate benefit matches • Social Security number (SSN) verification information from SSA
Insurance affordability programs	Advance payments of the premium tax credit, cost-sharing reductions, Medicaid, CHIP, and the Basic Health Program.
Interoperability	Being able to accomplish end-user applications using different types of computer systems, operating systems, and application software, interconnected by different types of local and wide area networks. (James A. O'Brien and George M. Marakas)
Issuer	A health insurance issuer, qualified health plan issuer, etc. that offers health plans.
ISO	International Standards Organization
LEADER	**Los Angeles Eligibility, Automated Determination, Evaluation and Reporting (LEADER) System ~~Consortium~~** – The automated welfare system by Los Angeles County.
MAGI	**Modified Adjusted Gross Income** - Adjusted gross income (AGI), modified by adding back in any deductions for passive activity losses, tuition, fees, student loan interest paid, IRAs, half of self-employment tax, employer-paid adoption expenses, and domestic production activities.

Term	Description
MAGI-based Medicaid	Medicaid based services determined via the new MAGI process beginning 1/1/2014.
Managed Care Plan	A term that typically refers to an HMO, Point of Service, EPO, or PPO; any health plan with specific requirements, such as pre-authorization or second opinions, which enable the primary care physician to coordinate or manage all aspects of the patient's medical care.
MCO	**Managed Care Organization** - A health insurance company that provides healthcare networks and health plans.
MAXe2	**MAXe2** - A proprietary system used as the system of record for the Healthy Families Program (HFP), Access to Infants and Mothers Program (AIM) and the Single Point of Entry (SPE).
MEDS	**Medi-Cal Eligibility Data System** - A ~~MEDS is a~~ system that collects and retains eligibility data on individuals who apply for and/or become eligible for Medi-Cal. MEDS is a system of applications, networks, databases, people and procedures working together to support delivery of certain health and human services program benefits to Californians who qualify for those programs. The data maintained within the MEDS database originates from counties, State agencies, federal agencies, and non-governmental organizations such as health plans.
Medicaid	Medicaid is a federal health care program available to individuals and families that meet certain categorical, income, resources, citizenship and residency, and other requirements established under Title XIX of the Social Security Act. Medicaid funding is available to states that meet the applicable requirements of Title XIX and file a State Plan describing their program with the federal Department of Health and Human Services. The federal government and State governments each pay a portion of the cost of the program, with the proportion varying based on the per capita income of the residents of the State.
Medi-Cal	California's Medicaid program
Medi-Cal Bridge Program	A Bridge program is a program designed to help a Medi-Cal beneficiary transfer to another health care program when that individual no longer meets the eligibility requirements for Medi-Cal. For example, if a child is no longer eligible for Medi-Cal at annual re-determination due to excess income, the county will 'bridge' that application to the Healthy Families program for eligibility determination purposes.
Minimum Essential Coverage	The term 'minimum essential coverage' means any of the following: (A) Government sponsored programs–Coverage under– (i) the Medicare program under part A of title XVIII of the Social Security Act, (ii) the Medicaid program under title XIX of the Social Security Act, (iii) the CHIP program under title XXI of the Social Security Act, (iv) the TRICARE for Life program,

Term	Description
	(v) the veteran's health care program under chapter 17 of title 38, United States Code, or (vi) a health plan under section 2504(e) of title 22, United States Code (relating to Peace Corps volunteers). (B) Employer-sponsored plan–Coverage under an eligible employer-sponsored plan. (C) Plans in the individual market–Coverage under a health plan offered in the individual market within a State. (D) Grandfathered health plan–Coverage under a grandfathered health plan. (E) Other coverage–Such other health benefits coverage, such as a State health benefits risk pool, as the Secretary of Health and Human Services, in coordination with the Secretary, recognizes for purposes of this subsection. (State of WA EEI-16)
MIS/DSS	**DHCS' Management Information System/Decision Support System (MIS/DSS)** - a subsystem of the State's Medicaid Management Information System (CA-MMIS) and serves as the Medi-Cal Program's centralized and integrated data warehouse. The MIS/DSS contains both Medi-Cal Fee-for-Service claim and Managed Care encounter data, along with related beneficiary eligibility and provider information, within a highly sophisticated relational database coupled with leading-edge business intelligence data mining and reporting tools. The MIS/DSS is used primarily by DHCS staff and management in their efforts to more effectively and efficiently manage the Medi-Cal Program.
MITA	**Medicaid Information Technology Architecture** - With MITA, CMS is establishing a national framework of enabling technologies and processes that support improved administration for the Medicaid program and foster integrated business and IT transformation across the Medicaid enterprise.
MRMIP	**Major Risk Medical Insurance Program** – This program is administered by MRMIB.
NCQA	**National Committee of Quality Assurance** - The National Committee for Quality Assurance is a private, 501(c)(3) not-for-profit organization dedicated to improving health care quality.
Navigator	A function to help people who will get insurance through the Exchange, such as small businesses, self-employed or people who do not have access to insurance through their employers. They provide individuals and families with the information necessary to determine which health insurance option best fits their needs and then help them enroll in their plan of choice.
No Wrong Door	Ensures that a Customer who approaches the State for Health Assistance Programs is correctly directed to the program for which they are eligible.

Term	Description
Non-MAGI-based Medicaid	Medicaid based services whose eligibility requirements remain the same following the implementation of the new MAGI process beginning 1/1/2014. Process and consumers include: ▪ No income determination made by Medicaid agency ▪ SSI, Title IV-E recipients ▪ Individuals deemed to be receiving SSI ▪ Express Lane Agency income finding ▪ Eligibility on the basis of being blind or disabled or need for long-term care services ▪ Eligibility for Medicare cost sharing assistance ▪ Medically needy ▪ Individuals aged 65+
Open Enrollment	A specified period of time in which employees may change insurance plans and medical groups offered by their employer, without proof of insurability. Open enrollment usually occurs once a year.
PERM	**Payment Error Rate Measurement** - The PERM program measures improper payments in Medicaid and CHIP and produces error rates for each program.
PHI	**Protected Health Information** - The HIPAA Privacy Rule defines Protected Health Information as individually identifiable health information that is held or transmitted in any form or medium by a covered entity.
PICP	**Pre-Existing Condition Insurance Plan** – A program administered by MRMIB.
PII	**Personally Identifiable Information** - As defined by OMB (Memorandum M-07-16), refers to any information about an individual maintained by an agency, including (1) any information that can be used to distinguish or trace an individual's identity, such as name, Social Security Number, date and place of birth, mother's maiden name, or biometric records; and (2) any other information that is linked or linkable to an individual, such as medical, educational, financial, and employment information.
Premium	The money paid to an insurance company for coverage. Premiums are usually paid monthly and may be paid in part or in full by your employer.
Provider	A ~~A provider is a~~ physician, hospital, clinic or other individual or institution that has a valid provider agreement with DHCS to provide Medi-Cal services to program beneficiaries.
Qualified employee	Employees offered coverage through a SHOP by a qualified employer

Term	Description
Qualified employer	Employer that has been determined eligible to participate in a SHOP
QHP	**Qualified Health Plan** - Certified health insurance plans offered to consumers and small businesses purchasing coverage through the Exchange.
Re-determination	On an annual basis, a beneficiary's categorical, financial and other eligibility-related circumstances must be re-evaluated to determine whether the individual remains eligible for the program. This re-evaluation process is knows as the re-determination.
SaaS	**Software as a Service** - Aa software distribution model in which applications are hosted by a vendor or service provider and made available to customers over a network, typically the Internet.
SAWS	**Statewide Automated Welfare Systems** - SAWS is used to administer intake, eligibility determination and benefit calculation, re-determination, benefit issuance, case management, fair hearings, quality control, fraud and reporting for CalWORKs, Medi-Ca and SNAP programs. SAWS consists of three separate county consortia systems, CalWIN, C-IV and LEADER.
SCI	**Statewide Client Index** - A DHCS system that generates and controls CINs. It allows access to beneficiary information for file clearance purposes used by several state agencies and departments to establish identity information and assign and individual CINs.
Self-attestation	An option to provide information (e.g., income) required by an entity without providing the data via authoritative source (e.g., IRS tax return) or attestation via notary public. Self-attestation requires that you attest that the information you provide is accurate under the risk of perjury. Proposed CMS rules include that for APTC and CSR a head-of-household taxpayer can self-attest their income and household composition when IRS tax return data is not available or is significantly differs from available data.
Shared Services	Refers to the provision of a service by one part of an organization or group where that service had previously been found in more than one part of the organization or group. Thus the funding and resourcing of the service is shared and the providing department effectively becomes an internal service provider.
SHOP	**Small Business Health Options Program** - The component of the Exchange designed to allow small businesses to shop for and enroll their employees in qualified health plans.
SOA	**Service oriented architecture** - A method that allows differing services to communicate together through interfaces and messages. This is becoming more common in web based applications.

Term	Description
SOC	**Share-of-Cost** - The amount that a Medi-Cal beneficiary must pay or obligate each month for medical costs before Medi-Cal will pay for services rendered if the beneficiary earns more than the maintenance need permitted under Title XIX.
SSL	**Secure Socket Layer** - A protocol that provides secure communications over the internet for such things as email and web-browsing. Whenever personal data is being transmitted (e.g., making an online purchase), SSL is the method that should be used. Web pages that are using SSL have https:// at the beginning of their URL.
VETRO	The elements of an infrastructure for key service integration that includes: • A Validation (V) request; • An Enrichment (E) request which adds additional information from internal and external data sources; • Inbound and outbound data transformation (T) to transform inbound data to canonical format and outbound data to the external target format; • Configuration-*driven routing (R) to* dynamically route the request to the appropriate service/process; and • *Service Operation (O)*
Web Portal	A web portal or links page is a web site that functions as a point of access to information in the World Wide Web.
Whole case	In MEDS/CDB a set of Medi-Cal and/or CalFresh recipients identified by the same county code, county assigned serial number and family budget unit.
WS-BPEL	**Web Services - Business Process Execution Language** - An OASIS standard executable language for specifying actions within business processes with web services. Processes in BPEL export and import information by using web service interfaces exclusively.
WSDL	**Web Services Description Language -** An XML-based language that is used for describing the functionality offered by a Web service. A WSDL description of a web service (also referred to as a WSDL file) provides a machine-readable description of how the service can be called, what parameters it expects and what data structures it returns.
WS-I	**Web Services Interoperability -** Guidelines and tests for the interoperability of web services.
XML	eXtensible Markup Language - A set of rules for encoding documents in machine-readable form