Colorado Department of
Health Care Policy and Financing

Solicitation #:
HCPFRFPKC13PBMS

Pharmacy Benefit Management System (PBMS)
Request for Proposals

Appendix F – PBMS Glossary of Terms and Abbreviations

APPENDIX F – GLOSSARY OF TERMS AND ABBREVIATIONS

Term/Acronym	Definition
340B	The pricing that is available to pharmacies that participate in the Federal Public Health Service's 340B Drug Pricing Program as described in 42 U.S.C. Section 256b (2011).
ACA (Affordable Care Act)	A shortened reference to the Patient Protection and Affordable Care Act, Pub. L. No. 111-148. The Patient Protection and Affordable Care Act, Pub. L. No. 111-148, enacted March 23, 2010, and the Health Care and Education Reconciliation Act of 2010 enacted March 30, 2010, (together referred to as the Affordable Care Act).
ACA Provider Screening Rules	Refers to rules implemented and published in the Federal Register (42 CFR Parts 405, 424, 447 et al) on February 2, 1011. This Rule implemented provisions of the Patient Protection and Affordable Care Act (ACA) Section 6401 specifying procedures under which enrollment and screening is conducted for providers of medical or other services and suppliers in the Medicare program, providers in the Medicaid program, and providers in the Children's Health Insurance Program (CHIP), as well as additional rules for termination, and payment suspension in cases of fraud.
ACC (Accountable Care Collaborative)	A new Medicaid program established to improve clients' health care and reduce costs. It is a patient-centered approach to managing the care of Medicaid members administered by the Department through contracted regional vendors.
ACP Address Confidentiality Program	The Colorado Address Confidentiality Program (ACP) provides survivors of domestic violence, sexual offenses or stalking/harassment with a means to prevent abusers and potential abusers from locating them through public records. The goal of the ACP is to help survivors stay safe by protecting their location. This program is administered by the Colorado Department of Personnel & Administration, and the laws governing the program are located at §24-30-2101, C.R.S.

Term/Acronym	Definition
ACO (Accountable Care Organization)	An organization of health care providers that agree to be accountable for the quality, cost, and overall care of Medicare beneficiaries who are enrolled in the traditional fee-for-service program.
ADA (Americans with Disabilities Act)	The Americans with Disabilities Act (ADA) gives civil rights protections to individuals with disabilities that are like those provided to individuals on the basis of race, sex, national origin, and religion. It guarantees equal opportunity for individuals with disabilities in employment, public accommodations, transportation, State and local government services, and telecommunications.
Adjudicated Claim	A submitted claim that has been processed with a resulting status of either paid or denied.
Affiliates	Any person, firm, corporation (including, without limitation, service corporation and professional corporation), partnership (including, without limitation, general partnership, limited partnership and limited liability partnership), limited liability company, joint venture, business trust, association or other entity that now or in the future directly or indirectly controls, is controlled by, or is under common control with the Contractor.
ANSI (American National Standards Institute)	A private nonprofit organization that oversees the development of voluntary consensus standards for products, services, and processes in the United States. These standards ensure that the characteristics and performance of products are consistent, that people use the same definitions and terms, and that products are tested the same way.
APCD (All Payer Claims Database)	Databases created to track health care delivery across carriers, facilities, and providers to identify important trends and track costs.
APD (Advanced Planning Document)	A document required by CMS for states to complete and submit for review and prior approval in order to receive enhanced federal funding for Medicaid Information Technology (IT) system(s) projects related to eligibility and enrollment functions.

Term/Acronym	Definition
APR-DRG (All Patient Refined Diagnosis Related Groups)	The All Patient Refined Diagnosis Related Groups (APR-DRGs) expand the basic DRG structure by adding two sets of subclasses to each base APR-DRG. Each subclass set consists of four subclasses: one addresses patient differences relating to severity of illness and the other addresses differences in risk of mortality. Severity of illness is defined as the extent of physiologic decompensation or organ system loss of function. Risk of mortality is defined as the likelihood of dying.
ARRA (American Recovery and Reinvestment Act of 2009)	The primary objective for ARRA was to save and create jobs almost immediately in response to the late-2000s recession. Secondary objectives were to provide temporary relief programs for those most impacted by the recession and invest in infrastructure, education, health, and "green" energy. The Act included direct spending in infrastructure, education, health, and energy, federal tax incentives, and expansion of unemployment benefits and other social welfare provisions. The Act also included many items not directly related to immediate economic recovery such as long-term spending projects (e.g., a study of the effectiveness of medical treatments) and other items specifically included by Congress.
Authorization	Official approval for action taken for, or on behalf of, a Medicaid client. This approval is only valid if the client is eligible on the date(s) of service for the applicable claim.
Authorized Prescribers	Physician, osteopath, dentist, nurse, physician assistant, optometrist, naturopath, podiatrist, pharmacist, nurses with prescriptive authority, or other person authorized to prescribe drugs.
Average Acquisition Cost (AAC)	The average acquisition cost for like drugs grouped by Generic Code Number (GCN). For GCNs with both generic and brand drugs, the Department shall determine two separate AAC rates for the GCN. One AAC rate shall be based on the average acquisition cost for all generic drugs while the other shall be based on the average acquisition cost for all brand drugs.

Term/Acronym	Definition
ALOS (Average Length of Stay)	The arithmetic mean experienced by a patient in the inpatient hospital setting within a chosen DRG.
BENDEX (Beneficiary Data Exchange)	A file containing data from CMS regarding persons receiving benefits from the Social Security Administration.
BHO (Behavioral Health Organization)	An organization that provides mental health services for a client for a set fee per month (a managed care payment).
BIDS System (Bid Information and Distribution System)	The Colorado procurement information system designed to notify interested contractors of the State of Colorado's intent to purchase goods or services competitively. These notifications are termed "solicitations".
BIDM (Business Intelligence and Data Management)	The term used to refer to the RFP that will replace the current decision support system, data warehouse, and SDAC. It is also used as an umbrella term that includes Business Intelligence and Analytics Services (comprised of an ETL tool, data warehouse, OLAP / Modeling, and data mining), Reporting (comprised of user-defined, MARs, and SUR reporting), and ACC Program Analytics Support Services. From an operational perspective, this RFP also uses this term to describe the support services required as part of the BIDM Contract.
BME (Board of Medical Examiners)	Exists at both the state and national level to conduct assessments of health care professionals. The Colorado BME provides and verifies licenses for medical professionals.
BPM (Business Process Model)	The activity of representing business processes of an enterprise, so that the current process may be analyzed and improved.
“Break the Glass” functionality	The practice of enabling a licensed practitioner to view a patient’s medical record, or a portion thereof, under emergency circumstances.

Term/Acronym	Definition
BUS (Benefits Utilization Services)	A Case Management system for Home and Community Based Long Term Care clients and Nursing Facilities developed by the Department.
Business Analyst	A resource responsible for requirements gathering and problem definition staff for Configuration and Customization activities.
Business Day	Any day in which the Department is open and conducting business, but shall not include weekend days or any day on which one of the Department's holidays are observed (see Holiday Schedule).
Business Intelligence and Analytics	Interactive software-based tools intended to help decision makers compile useful information from a combination of raw data, documents, and personal knowledge, or business models to identify and solve problems, make decisions and better manage outcomes. Typical components include ETL tool(s), data warehouse, OLAP / Modeling, and data mining.
Capitation	A payment arrangement for health care service providers, such as managed care entities. It pays an entity a set amount for each enrolled person assigned to them, per period of time, whether or not that person seeks care.
CASE (Computer-Aided Software Engineering)	Methods for the development of information systems together with automated tools that can be used in the software development process.
CBMS (Colorado Benefits Management System)	The single integrated system for determining eligibility and calculating benefits for 14 major welfare programs, including Medicaid, SNAP, TANF, and more than 80 subprograms.
CBT (Computer-Based Training)	A type of education in which the individual learns by executing special training programs on a computer. CBT is an effective training method because it enables students to practice using the application as they learn.

Term/Acronym	Definition
CCD (Continuity of Care Document)	The CCD is a joint effort of Health Level Seven International (HL7) and American Society for Testing and Materials (ASTM). CCD fosters interoperability of clinical data by allowing physicians to send electronic medical information to other providers without loss of meaning and enabling improvement of patient care. CCD is an implementation guide for sharing Continuity of Care Record patient summary data using the HL7 Version 3 Clinical Document Architecture (CDA), Release 2. CCD establishes a rich set of templates representing the typical Sections of a summary record, and expresses these templates as constraints on CDA. These same templates for vital signs, family history, plan of care, and so on can then be reused in other CDA document types, establishing interoperability across a wide range of clinical use cases.
CDHS (Colorado Department of Human Services)	Assists struggling Colorado families who need food, cash, and energy assistance to provide for their families; families in need of safe and affordable child care; children at risk of abuse or neglect; families who struggle to provide care for their adult children with developmental disabilities; youth who have violated the law and need structure and guidance to grow into responsible and compassionate adults; Coloradoans who need effective treatment for mental illness or substance abuse issues; and families who need resources to care for their elderly parents or nursing home care for their veteran parents.
CDT (Code on Dental Procedures and Nomenclature)	The CDT Code was named as a HIPAA standard code set to achieve uniformity, consistency and specificity in accurately reporting dental treatment and process dental claims. Code review and revision is conducted annually, with each version effective January 1. CDT is also referred to as "Current Dental Terminology".
CFR (Code of Federal Regulations)	The codification of the general and permanent rules and regulations (sometimes called administrative law) published in the Federal Register by the executive departments and agencies of the Federal government of the United States. The CFR is divided into 50 titles that represent broad areas subject to Federal regulation.

Term/Acronym	Definition
Change Management/Change Management Process	A process that facilitates the organized planning, development, and execution of modifications and enhancements to the System that supports the Colorado Medical Assistance program. The primary goals are to support the process of changes with minimal disruption to services and to enable traceability of the change(s). This process ensures that changes to a system are introduced in a controlled and coordinated manner, and reduces the possibility that unnecessary changes will be introduced to a system without proper planning.
Change Request	A document detailing the addition or modification to the agreed-upon Deliverables and/or associated functionality for a system. It is a critical component of the Change Management Process, and states what needs to be accomplished rather than how the change will be executed.
CHP+ (Child Health Plan Plus)	A low-cost health insurance for Colorado's uninsured children and pregnant women. CHP+ is public health insurance for children and pregnant women who earn too much to qualify for Medicaid, but cannot afford private health insurance.
CIIS (Colorado Immunization Information System)	A confidential, population-based, computerized system that collects and disseminates consolidated immunization information for Coloradans of all ages. CIIS enables any immunization provider in Colorado to electronically track immunizations a person has received, thereby maintaining an ongoing and complete record to ensure that the person receives all recommended shots in a timely manner.

Term/Acronym	Definition
Claim	A bill for services that is appropriate for the provider type and type of service(s), whether submitted as a paper claim or electronically, and identified by a unique Transaction Control Number (TCN). A single claim is defined as a billing comprised of a single beneficiary with the same date of service (or range of dates for service), submitted by a single billing provider which may include a drug or compounded medication, or one or more service(s) or document(s). Note: lack of capitalization of Claim in its use in this RFP is intentional for readability purposes. Offerors shall not assume that any reference that has not been capitalized is meant to imply anything other then this definition.
Clean Claim	1. A claim that does not contain any defect(s) requiring the Contractor to investigate or develop prior to adjudication. Clean claims shall be filed within the timely filing period (see Social Security Act 1842 (c)(2)(B); http://www.ssa.gov/OP Home/ssact/title18/1842.htm). 2. A clean claim is defined by CMS as a claim that has no defect, impropriety, or special circumstance, including incomplete documentation that delays timely payment. The required elements for a clean claim shall be complete, legible and accurate. 3. A claim that can be processed without obtaining additional information from the provider of the service or from a third party. 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.
Client	A person who has been determined eligible for Medicaid or Child Health Plan Plus. See also Recipient.
Client Service Plan	A plan of service for clients under one of the HCBS waiver programs within the Colorado Medical Assistance program. The service plan lays out the client need, and specifies the number and types of services allowed for the client, consistent with the waiver's covered services. Services are delivered and coordinated in conjunction with the client service plan.

Term/Acronym	Definition
CM (Case Management)	The facilitation of treatment plans to assure the appropriate services are provided to clients.
CM (Compliance Manager)	A named role for required Key Personnel.
CMAP (Colorado Medical Assistance program) Web Portal	Colorado's Provider Web Portal is a secured Web site that is used to submit and retrieve Provider transactions and/or reports. The Web Portal offers a centralized database that is secure and available only to the authorized health care providers through secure Internet connections. In addition, the Web Portal stores historical claims and client and provider data.
CMS (Centers for Medicare & Medicaid Services)	A federal agency within the United States Department of Health and Human Services (DHHS) that administers the Medicare program and works in partnership with state governments to administer Medicaid, the State Children's Health Insurance Program (SCHIP), and health insurance portability standards. In addition to these programs, CMS has other responsibilities, including the administrative simplification standards from the Health Insurance Portability and Accountability Act of 1996 (HIPAA), quality standards in long-term care facilities through its survey and certification process, and clinical laboratory quality standards under the Clinical Laboratory Improvement Amendments.
COB (Coordination of Benefits)	A provision establishing an order in which health care plans pay their claims, and permitting secondary plans to reduce their benefits so that the combined benefits of all plans do not exceed total allowable expenses.
COFRS (Colorado Financial Reporting System)	A financial information system that maintains the official accounting records for the State of Colorado government. With nearly 3,000 users statewide, it handles approximately $9 billion in transactions per year. Most financial transactions for the State are processed directly in COFRS. All financial activity for the State is eventually recorded in COFRS, even if it was first processed in a specialized accounting system operated by a state agency.

Term/Acronym	Definition
COHBE (Colorado Health Benefits Exchange)	A marketplace for Coloradans to shop for and purchase health insurance based on quality and price. The Exchange is scheduled to launch in October 2013.
COLA	Cost of Living Adjustment
Colorado Medical Assistance program	Provides access to Colorado residents who meet enrollment criteria for health care through a network of established providers. All references to the Medical Assistance program include Medicaid, CHP+, and State-only health care programs.
Colorado Registry and Attestation	Colorado's State Level Registry that supports HITECH and is making available incentive payments to eligible Medicaid providers that adopt and successfully demonstrate Meaningful Use (MU) of a certified Electronic Health Records (EHR) technology for allowable costs associated with the implementation, operation, and maintenance of this technology. See also SLR.
COMMIT (Colorado Medicaid Management Innovation and Transformation project)	A project to obtain Core MMIS and Supporting Services, PBMS, and BIDM for the implementation and operations of a state-of-the-art, certifiable Medicaid Management Information System (MMIS) to support Colorado's Medicaid, Children's Health Plan Plus (CHP+) programs, and other health benefit programs. The services and associated software will support the enrollment and management of providers, management of certain member functions, adjudication and payment of valid health care claims, and other subsidiary Work.
Configurable/Configuration	Modification of PBMS or System functionality, which does not require development changes to the software. Configurable software is typically rules-based and can be modified by non-technical (i.e., non-programmer/developer) staff.
Contract	The agreement that is entered into as a result of this procurement.

Term/Acronym	Definition
Contractor	The Offeror selected as a result of this procurement to complete the Work contained in the Contract. The individual or entity solely responsible for completion of all Work to be performed in the Contract, regardless of whether Subcontractors are used.
Contract Amendment	Any written alteration in the specification, delivery point, rate of delivery, contract period, price, quantity, or other contract provisions of any existing contract, whether accomplished by unilateral action in accordance with a contract provision, or by mutual action of the parties to the contract. It shall include bilateral actions, such as change orders, administrative changes, notices of termination, and notices of the exercise of a contract option.
Co-payment	Client's financial responsibility for a service, procedure, or prescription assigned by Medicaid.
Core MMIS	A collection of services that fulfills, at a minimum, the federal requirements specified in Part 11 of the State Medicaid Manual (CMS Publication 45), program directives and memos, policy statements, and the like that serve as the basis for CMS certification and is compliant with HIPAA requirements, as modified. This component is traditionally referred to as the claims payment engine, which is the system used to supply claims payment services to the Department; See also MMIS.
CORHIO (Colorado Regional Health Information Organization)	A nonprofit organization dedicated to improving health care for all Coloradans through health information exchange by helping doctors, hospitals and other health care providers connect their computer-based patient record systems to a protected statewide network that is used to securely share information for patient care (called the health information exchange). This allows health care professionals to access up-to-date patient information, which helps them provide better quality care and allows information to be shared in a more protected way than paper-based files, faxes and mail.

Term/Acronym	Definition
COS (Category of Service)	The Medicaid Act identifies numerous categories of medical services for which federal reimbursement is allowed. These categories of services do not describe specific medical treatments or procedures. Rather, they identify broad types of services.
Cost Allocation Plan	State's Medicaid Cost Allocation Plan.
COTS (Commercial Off-The-Shelf)	A product that is sold in substantial quantities in the commercial marketplace that does not require additional technical (software or hardware) development or Customization for general use.
COUP (Client Over-utilization Program)	A program that restricts a patient to filling all of his or her prescriptions at one pharmacy. The purpose of this program is to control duplicate and inappropriate drug therapies. Any Medicaid recipient who receives narcotic prescriptions from two (2) or more physicians and utilizes two (2) or more pharmacies are candidates for this program. Medicaid histories are reviewed so that recipients with certain diagnoses including cancer are excluded from this program. See also Lock-In Program.
CPT (Current Procedural Terminology)	A code set maintained by the American Medical Association through the CPT Editorial Panel. It describes medical, surgical, and diagnostic services and is designed to communicate uniform information about medical services and procedures among physicians, coders, patients, accreditation organizations, and payers for administrative, financial, and analytical purposes.
CRM (Customer Relationship Management)	A software or system used the Contractor to primarily manage interactions with providers. It involves using technology to organize, automate, and synchronize customer service and technical support.
Customization	Any modification, alteration, or extension to software requiring changes to the existing source code for such software to achieve new or modified functionality. Customization requires dedicated technical staff (i.e., programmer/developer).

Term/Acronym	Definition
CY (Calendar Year)	The calendar year begins on the New Year's Day (January 1) of the given calendar system and ends on the day before the following New Year's Day (December 31).
Dashboard	A subset of information delivery that includes the ability to publish formal, web-based reports with intuitive displays of information. It has an easy to read, often single page, real-time user interface, showing a graphical presentation of the current status (snapshot) and historical trends of an organization's Key Performance Indicators (KPIs) to enable instantaneous and informed decisions to be made at a glance.
Data Cleansing	See also data cleaning, data scrubbing. The process of detecting and correcting (or removing) corrupt or inaccurate data from a record set, table, or database. Primarily used in databases, the term refers to identifying incomplete, inaccurate, or irrelevant parts of the data and then replacing, modifying, or deleting the 'dirty' data.
Data Dictionary	Also referred to as a metadata repository, a data dictionary is a centralized repository of information about data such as meaning, valid values, relationships to other data, origin, usage, and format.
Data Mart	An access layer of the data warehouse environment that provides data to the users. A data mart is a subset of the data warehouse that is usually oriented to a specific business line or team. A data warehouse environment may have multiple data marts.
Data Mining	The process of sorting/filtering through large amounts of data and picking out patterns of relevant information.
Database Refactoring	A change(s) to a database schema that improves its design while retaining both its behavioral and informational semantics. Database refactoring is conceptually more difficult than a code refactoring; code refactoring only needs to maintain behavioral semantics while database refactoring must also maintain informational semantics.

Term/Acronym	Definition
Data Virtualization	The process of abstracting disparate systems (databases, applications, file repositories, websites, data services contractors, etc.) through a single data access layer (which may include several data access mechanisms) to enable data access to a single source, serialization, format, or structure.
DDI (Design, Development, and Implementation)	The Work on the COMMIT project and the Work defined under the Contract after planning that includes collaboration between the Department and the Contractor to identify, design, develop and implement technical or business services.
Defect	An error, flaw, mistake, failure, or fault in a computer program or system that produces an incorrect or unexpected result that differs from an agreed-to specification, or causes it to behave in unintended ways that differ from an agreed-to specification; See also see Error and Discrepancy.
Deliverables	Items identified in the Contract to be delivered by the Contractor to the Department, including Work products throughout the term of the Contract that may or may not be tied to a payment.
Department	The Colorado Department of Health Care Policy and Financing, a department of the government of the State of Colorado; See also HCPF.
Designee	A duly authorized representative of a person holding a superior position.
DHHS (U.S. Department of Health and Human Services)	A Cabinet department of the United States government with the goal of protecting the health of all Americans and providing essential human services.
Dimension Table	A set of companion tables to a fact table in a data warehouse. Dimension tables contain descriptive attributes or fields that are typically textual fields or discrete numbers that behave like text. These attributes are designed to serve two critical purposes: query constraining/filtering and query result set labeling.

Term/Acronym	Definition
Discrepancy	An error, flaw, mistake, failure, or fault in a computer program or system that produces an incorrect or unexpected result that differs from an agreed-to specification, or causes it to behave in unintended ways that differ from an agreed-to specification; See also see Error and Defect.
Dispute Process	The established process for the Contractor or the Department to follow to resolve all debates or disagreements between the Department and Contractor.
DME (Durable Medical Equipment)	Durable Medical Equipment: Medical equipment used in the home to aid in a better quality of living.
DOS (Date of Service)	The calendar date on which a specific medical service is performed.
Drug Rebate System	The Drug Rebate System ensures compliance with the Centers for Medicare & Medicaid Services (CMS) Drug Rebate program, established under OBRA 90 and the Supplemental Rebate program established by the Department. Under the Drug Rebate Program, Colorado Medicaid recovers cash rebates from the drug manufacturers whose products are used by Colorado Medicaid clients. The Drug Rebate System tracks pharmacy and medical claims for drugs and invoices drug manufacturers using drug information and rebate amounts specified by CMS and/or the Department.
DRG	A diagnosis-related group (DRG) is a system to classify hospital cases.
Drill Across	Data analysis across dimensions.
Drill Down	To move from summary information to detailed data by focusing on a specific criteria.

Term/Acronym	Definition
Drill Up	Data analysis that is associated to a parent attribute.
DSL (Data Staging Layer)	An intermediate storage area between the data sources and the data warehouse (DW) or Data mart (DM). It is usually temporary, and its contents are typically erased after the DW/DM has been loaded successfully.
DSS (Decision Support System)	See Business Intelligence and Analytics.
DUR (Drug Utilization Review)	A program designed to measure and assess the proper use of outpatient drugs in the Medicaid program. The Primary objective of the DUR functions is to improve the quality of care and to assist with containing health care cost. Prospective DUR is a function within the Pharmacy point-of-sale (POS) system that assists pharmacy providers in screening selected drugs categories for clinically important potential drug therapy problems before the prescription is dispensed to the recipient. The retrospective DUR function screens after the prescription has been dispensed to the recipient.
DW (Data Warehouse)	A database used for reporting and analysis. The data stored in the warehouse are uploaded from various operational systems and other data sources such as such as the immunization registry, vital statistics, and national reference data.
EAI (Enterprise Application Integration)	The collection of technologies and services that enable integration of systems and applications across the enterprise.
EAPG (Enhanced Ambulatory Patient Groups)	Enhanced Ambulatory Patient Groups (EAPG) system software version 3.7 is to classify and calculate reimbursement for outpatient hospital services. The Enhanced Ambulatory Patient Groups used in the EAPG system categorize the amount and type of resources used in various outpatient visits.

Term/Acronym	Definition
ED	An Emergency Department of a hospital.
EDI (Electronic Data Interchange)	The structured transmission of data between organizations by electronic means, which is used to transfer electronic documents or business data from one computer system to another computer system (i.e., from one trading partner to another trading partner without human intervention).
EDMS (Electronic Document Management System)	Software that manages documents for electronic publishing. The system supports a large variety of document formats and provides extensive access control and searching capabilities across LANs and WANs.
Effective Date	The date on which the Colorado State Controller or his or her Designee signs the Contract.
EH (Eligible Hospital)	Refers to eligible hospitals under the meaningful use incentive program coordinated through the Office of the National Coordinator for Health Information Technology (ONC) to meet the system capability requirements for Stage 1 of the Meaningful Use incentive program. The objective of the program is to utilize the EHR to improve quality, safety, and effectiveness of patient-centered care.
EHR (Electronic Health Record)	An electronic health record (EHR) is an evolving concept defined as a systematic collection of electronic health information about individual patients or populations. It is a record in digital format that is theoretically capable of being shared across different health care settings. In some cases this sharing can occur by way of network-connected enterprise-wide information systems and other information networks or exchanges. EHRs may include a range of data, including demographics, medical history, medication and allergies, immunization status, laboratory test results, radiology images, vital signs, personal stats like age and weight, and billing information.
EFT (Electronic Funds Transfer)	Also known as direct deposit.

Term/Acronym	Definition
EMR (Electronic Medical Record)	An electronic medical record (EMR) is a computerized medical record created in an organization that delivers care, such as a hospital or physician's office. Electronic medical records tend to be a part of a local stand-alone health information system that allows storage, retrieval and modification of records.
Encounter	A claim submitted by a Managed Care Entity for reporting purposes only. Encounters are not Billable Claims, but may create a financial transaction for the managed care plan. Note: lack of capitalization of Encounter in its use in this RFP is intentional for readability purposes. Offerors shall not assume that any reference that has not been capitalized is meant to imply anything other then this definition.
Encounter Data	Data collected to track use of provider services by managed care health plan enrollees that are used to develop cost profiles of a particular group of enrollees and then to guide decisions about or provide justification for the maintenance or adjustment of premiums.
Enhancement	Functional changes or performance improvements that require Configuration or Customization to the System. Enhancements follow a formal Change Management Process that will be established through the Change Management Plan following Contract award.
Enrolled Provider	A provider whose enrollment status is active and has billed a claim within the past twelve (12) calendar months.
EP (Eligible Professional)	Refers to eligible professionals under the meaningful use incentive program coordinated through the Office of the National Coordinator for Health Information Technology (ONC) to meet the system capability requirements for Stage 1 of the Meaningful Use incentive program. The objective of the program is to utilize the EHR to improve quality, safety, and effectiveness of patient-centered care.
EOB (Explanation of Benefits)	A statement sent by a health insurance company to covered individuals explaining what medical treatment and/or services were paid for on their behalf

Term/Acronym	Definition
EOMB (Explanation of Medical Benefits)	See Explanation of Benefits (EOB).
Episodes of Care	Refers to a health problem from its first encounter with a health care provider through the completion of the last encounter related to the problem, typically encompassing the patient's reason for the encounter, the diagnosis code, and the resulting therapeutic intervention(s).
EPSDT (Early Periodic Screening, Diagnosis, and Treatment)	Federal Medicaid requirement that the State's Medicaid agency cover services, products, or procedures for Medicaid recipients under 21 years of age if the service is medically necessary health care to correct or improve a defect, physical, or mental illness, or a condition (health problem) identified through a screening examination (which includes any evaluation by a physician or other licensed clinician).
EPLS (Excluded Party List System)	An EPLS is an electronic, web-based system that identifies those parties excluded from receiving Federal contracts, certain subcontracts, and certain types of Federal financial and nonfinancial assistance and benefits. The EPLS keeps its user community aware of administrative and statutory exclusions across the entire government, and individuals barred from entering the United States. The user is able to search, view, and download both current and archived exclusions.
Error	A flaw, mistake, failure, or fault in a computer program or system that produces an incorrect or unexpected result that differs from an agreed-to specification, or causes it to behave in unintended ways that differs from an agreed-to specification; See also see Defect and Discrepancy.
ESB (Enterprise Service Bus)	A software architecture model used for designing and implementing the interaction and communication between mutually interacting software applications in service-oriented architecture (SOA).

Term/Acronym	Definition
ETL (Extract, Transform, and Load)	A database and data warehousing process used to extract data from outside sources (one or more systems), transform it to fit operational needs (cleansing/modification), and load it into the end target (database, operational data store, data mart, or data warehouse).
Evaluation Committee	A committee that will be created before the opening of submitted proposals in order to conduct reviews of the proposals. The committee will evaluate proposals based on content and will ensure the fair and impartial treatment of all Offerors.
EVS (Eligibility Verification System)	A real time, online system that provides timely and accurate information regarding a recipient's eligibility for services.
FA (Fiscal Agent)	An entity that acts on behalf of the State Medicaid agency in respect to Core MMIS and Supporting Services claims processing, provider enrollment and relations, utilization review, and other functions; synonymous with Fiscal Intermediary.
FAO (Fiscal Agent Operations)	All contractual activities and responsibilities associated with the Fiscal Agent who is contracted by the Department to process and maintain the Core MMIS and Supporting Services (e.g., provider enrollment and relations, utilization review).
Fact Table	A data warehouse component that contains the measurements, metrics or facts of a business process. Fact tables contain the content of the data warehouse and store different types of measures like additive, non-additive, and semi additive measures. For example, "average monthly claims processed" is a measurement that could be stored in a fact table.
FDA (Food and Drug Administration)	Agency under the United States Department of Health and Human Services responsible for regulating food, dietary supplements, drugs, biological medical products, blood products, medical devices, radiation-emitting devices, veterinary products, and cosmetics in the United States.

Term/Acronym	Definition
FEIN (Federal Employer Identification Number)	A unique nine-digit number assigned by the Internal Revenue Service (IRS) to business entities operating in the United States for the purposes of identification.
FFP (Federal Financial Participation)	Federal matching funds for State expenditures for assistance payments for certain social services, and State medical and medical insurance expenditures.
FFS (Fee-For-Service)	A payment model where services are unbundled and paid for separately. In health care, it gives an incentive for physicians to provide more treatments because payment is dependent on the quantity of care, rather than quality of care.
Formulary	A list of name brand and generic drugs covered by a specific health care plan.
Fraud	An intentional deception or misrepresentation that could result in the payment of an unauthorized benefit.
Fraud and Abuse Detection System	A system designed to identify patterns and trends in claims data that are indicative of fraud and abuse.
FSSP (Family Support Services Program)	The Family Support Services Program (FSSP) assists families with costs beyond those normally experienced by other families, to avoid or delay costly out of home placements and reduce stress. Family Support provides funding to address disability related needs, as well as information, support and resource coordination. Eligibility for FSSP is not income based.
FTE	Full Time Equivalent
FUL (Federal Upper Limit)	Maximum allowable cost established by CMS and the U.S. Department of Health and Human Services for certain prescribed drugs.

Term/Acronym	Definition
FY (Fiscal Year)	A period used for calculating annual ("yearly") financial statements in businesses and other organizations. Colorado's fiscal year begins on July 1st, and ends on June 30; See also State Fiscal Year.
GCN (Generic Code Number)	Number use to group together all products that have the same following elements: ingredient, strength, dosage form, and route of administration.
GIS (Geographic Information System)	A system designed to capture, store, manipulate, analyze, manage, and present all types of geographical data. GIS is the merging of cartography, statistical analysis, and database technology. Typical functions of a GIS include: viewing / exploring data, creating data (the dataset is extended), editing data (the dataset is modified), storing data, integrating data from other datasets, transforming data, analyzing data, querying data, and creating maps.
GNUP (Guaranteed Net Unit Price)	The WAC minus all applicable rebates. Often referred to as "Net Cost".
GSN (Generic Sequence Number)	Unique identifier for a product/formulation that is specific to its agent, dosage form/strength, and route of administration. It is not unique across manufacturers and/or package sizes, and is used to group generically equivalent pharmaceutical products.
HCBS (Home and Community Based Services)	The federal designation for 1915 (i) waiver for alternatives to institutionalization waiver programs, administered by DHCPF.
(HCPCS) Health Care Common Procedure Coding System /Current Procedural Terminology (CPT)	A standardized coding system used to describe the items and services provided in health care, comprised of three levels. The first level is comprised of the American Medical Association's Current Procedural Terminology (CPT), which is numeric. CPT differs from ICD coding in that it identifies services rendered rather than the diagnosis.
HCPF (Health Care Policy and Financing)	The Colorado Department of Health Care Policy and Financing, a department of the government of the State of Colorado; See also "Department".

Term/Acronym	Definition
Health Benefit Plan (HBP)	A health care plan provided by the Department that include offering a standard set of services, which includes hospital and outpatient care, mental health, prevention, well-child care, and maternity care. The use of this term throughout the COMMIT RFP components includes Managed Care Entities and the Department's Accountable Care Collaborative, where applicable.
HEDIS (Healthcare Effectiveness Data and Information Set)	A tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. HEDIS consists of 75 measures across 8 domains of care. Because so many plans collect HEDIS data, and because the measures are so specifically defined, HEDIS makes it possible to compare the performance of health plans on an "apples-to-apples" basis.
HHS (Health and Human Services)	The Department of Health and Human Services (HHS) is the United States government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves.
HIBI (Health Insurance Buy-In)	The Health Insurance Buy-In (HIBI) program pays the Medicaid client's portion of commercial health insurance premiums when it would be cost-effective for Medicaid to do so. HIBI currently has approximately 450 active clients and pays approximately $97,000 per month in premiums, deductibles, coinsurance, and co-pays.
HIE (Health Information Exchange)	The mobilization of health care information electronically across organizations within a region, community or hospital system that provides the capability to electronically move clinical information among disparate health care information systems while maintaining the meaning of the information being exchanged. The goal of HIE is to facilitate access to and retrieval of clinical data to provide safer and more timely, efficient, effective, and equitable patient-centered care.

Term/Acronym	Definition
HIPAA (The Health Insurance Portability and Accountability Act of 1996)	Title I of HIPAA protects health insurance coverage for workers and their families when they change or lose their jobs. Title II of HIPAA, known as the Administrative Simplification (AS) provisions, requires the establishment of national standards for electronic health care transactions and national identifiers for providers, health insurance plans, and employers to address the security and privacy of health data. The standards are meant to improve the efficiency and effectiveness of the nation's health care system by encouraging the widespread use of electronic data interchange in the U.S. health care system.
HIT (Health Information Technology)	Provides the umbrella framework to describe the comprehensive management of health information across computerized systems and its secure exchange between consumers, providers, government and quality entities, and insurers. Health information technology (HIT) is increasingly viewed as the most promising tool for improving the overall quality, safety and efficiency of the health delivery system.
HITECH (Health Information Technology for Economic and Clinical Health Act)	The Health Information Technology for Economic and Clinical Health Act was enacted under Title XIII of the American Recovery and Reinvestment Act of 2009 (Pub.L. 111-5). Under the HITECH Act, the United States Department of Health and Human Services is spending $25.9 billion to promote and expand the adoption of health information technology to lay the foundation for health care reform.
HMO (Health Maintenance Organization)	A health care system that assumes both the financial risk associated with providing comprehensive medical services (insurance and service risk) and the responsibility for health care delivery in a particular geographic area to HMO members, in return for a fixed, prepaid fee. Financial risk may be shared with the providers participating in the HMO. See also MCO.

Term/Acronym	Definition
Holiday Schedule	The Department observes all holidays listed in C.R.S. 24-11-101(1) which are not considered to be business days. State Holiday Schedule: New Years Day, Martin Luther King Day, President's Day, Memorial Day, Independence Day, Labor Day, Columbus Day, Veteran's Day, Thanksgiving Day, and Christmas Day. Martin Luther King Day, Columbus Day, and Veteran's Day are not considered holidays under the Contract and the Contractor is expected to perform Work under the Contract during those days. State holidays require electronic transactions to be available.
IADL (Instrumental Activities of Daily Living)	A term used in health care to refer to daily self-care activities within an individual's place of residence, in outdoor environments, or both. Health professionals routinely refer to the ability or inability to perform ADLs as a measurement of the functional status of a person, particularly in regards to people with disabilities and the elderly.
ICD-9-CM (International Classification of Diseases, 9th Revision, Clinical modification)	Standardized nomenclature to describe medical diagnoses that are required for billing.
ICD-10-CM (International Classification of Diseases, 10th Revision, Clinical modification)	The Tenth Revision (ICD-10) differs from the Ninth Revision (ICD-9) in several ways although the overall content is similar: First, ICD-10 is printed in a three-volume set compared with ICD-9's two-volume set. Second, ICD-10 has alphanumeric categories rather than numeric categories. Third, some chapters have been rearranged, some titles have changed, and conditions have been regrouped. Fourth, ICD-10 has almost twice as many categories as ICD-9. Fifth, some fairly minor changes have been made in the coding rules for mortality.
ICF/ID (Intermediate Care Facilities for Persons with Intellectual Disabilities)	A disability benefit that is offered through Medicaid funding for "institutions" (which consisted of 4 or more beds) for individuals with mental retardation or developmental disabilities (MR/DD), the Act states these facilities providing for the MR/DD population must provide adequate "active treatment," currently defined by Secretary of the U.S. Department of Health and Human Services.

Term/Acronym	Definition
Implementation Contract Stage	Refers to the design, development, and implementation activities related to initial Contract Stage.
Informal Providers	Non-traditional provider types that bill for services rendered in the Colorado Medical Assistance program (e.g., taxi drivers).
Interoperability	The ability to exchange and use information (usually in a large heterogeneous network made up of several local area networks). Interoperable systems reflect the ability of software and hardware on multiple machines from multiple contractors to communicate.
IVR (Interactive Voice Response)	A technology that allows a computer to interact with humans through the use of voice and Dual-tone multi-frequency (DTMF) tones input via keypad.
IV&V (Independent Verification & Validation)	Processes and products to ensure adherence to Contract requirements and sound engineering practices to meet the Department objectives, specifically to produce a product on schedule and at budget.
KPIs (Key Performance Indicators)	Historical trends based on pre-defined performance criteria that organizations use to measure performance. Key performance indicators are established based on business or program drivers and organizational goals.
Key Personnel	The position or positions that are specifically designated as such in the Contract.
Labor Category	A grouping of similar skills, knowledge, ability, experience and education of the labor to be provided. Labor Categories are provided in each RFPs Appendix F – Pricing Schedule to designate hourly labor rates per category.
Legacy System	The old method, technology, computer system or application that will be replaced when converted into a new method, technology, system or application. The use of this term refers to the Department's current PDCS, DSS, and MMIS and supporting systems.

Term/Acronym	Definition
LEIE/MED (List of Excluded Individuals & Entities / Medicare Exclusion Database)	**List of Excluded Individuals & Entities** OIG's List of Excluded Individuals/Entities (LEIE) provides information to the health care industry, patients and the public regarding individuals and entities currently excluded from participation in Medicare, Medicaid and all other Federal health care programs. Individuals and entities who have been reinstated are removed from the LEIE. **Medicare Exclusion Database** The Medicare Exclusion Database (MED) is the CMS repository and distributor of all the OIG sanction data that is updated monthly. The data in the MED application is used to deny claims submitted from excluded providers.
LMS (Learning Management System)	A software application that allows for the administration, documentation, tracking, delivery, and reporting of online training or education programs.
LOC (Level of Care)	The intensity of medical care being provided by the physician or health care facility.
Lock-In Program	A program that restricts a patient to filling all of his or her prescriptions at one pharmacy. The purpose of this program is to control duplicate and inappropriate drug therapies. Any Medicaid recipient who receives narcotic prescriptions from two (2) or more physicians and utilizes two (2) or more pharmacies are candidates for this program. Medicaid histories are reviewed so that recipients with certain diagnoses including cancer are excluded from lock-in. See also Client Over-utilization Program (COUP).
LTC (Long-Term Care)	A variety of services that help meet both the medical and non-medical needs of people with a chronic illness or disability who cannot care for themselves for long periods of time.
LTSS (Long-Term Services and Supports)	A Medicaid program allowing for the coverage of Long Term Care Services such as Institutional Care and Home and Community Based Long Term Services and Supports.

Term/Acronym	Definition
Maintenance	Routine activities required to sustain normal operations of the PBMS, the PBMS Operations and the System, including COTS utilized by the Contractor under this Contract and the upkeep of servers and software patches. These activities are not considered Enhancements requested by the Department and do not require a formal SDLC process. See also System Maintenance.
Maintenance Drug	Drugs furnished to an individual with a chronic illness or condition. The Department designates drugs as maintenance drugs based on therapeutic value, clinical consultation with practitioners, and applicable CMS guidelines.
MARS (Management and Administrative Reporting Subsystem)	A financial reporting and analytical system that provides reports necessary for CMS certification, ongoing administrative reporting and program management.
MCO (Managed Care Organization)	Entities that serve Medicare or Medicaid beneficiaries on a risk basis through a network of employed or affiliated providers, formerly referred to as HMOs. See also HMO.
MCE (Managed Care Entity)	An entity that supports the administration of a variety of different managed care service delivery models, including full-risk managed care payment, primary care managed care payment, primary care case management, managed care agreements, preferred provider organization (PPO) agreements, Prepaid Health Plan (PHP) agreements, vendor contracting arrangements, Accountable Care Organization (ACO), Intermediary Service Organizations (ISO), and utilization-controlled fee-for-service arrangements. This also includes Prepaid Inpatient Health Plans (PIHP), Prepaid Ambulatory Health Plans (PAHP), Managed Care Organizations (MCO), and Primary Care Case Management (PCCM).
Meaningful Use (MU)	Meaningful use is a qualification to receive federal funding for health information technology, specifically, the use of electronic health records. There are three stages to MU over the next five years.

Term/Acronym	Definition
MECT (Medicaid Enterprise Certification Toolkit)	Created by CMS to assist states in all phases of the MMIS Certification life cycle (including the PBMS and BIDM functions). The main component of the MECT is the 20 checklists across the 6 business areas.
Medicaid	Medical assistance program authorized under Title XIX of the Social Security Act. The program provides health care coverage to low-income families with children, pregnant women, disabled people, and the elderly.
Medicaid Enterprise	The organizing logic for business processes and information technology infrastructure reflecting the integration and standardization requirements of the Colorado Medical Assistance program's operating model, which includes the MMIS, BIDM, and PBMS.
Medically Necessary	A service that meets any of the following conditions: treatment that is consistent with the recipient's diagnosis or condition; recognized as the prevailing standard or current practice among the provider's peer groups; rendered in response to a life-threatening condition to treat an injury, illness or infection; used to treat a condition that could result in physical or mental disability; care for a mother and child through the maternity period; used to achieve a level of physical or mental function which is consistent with prevailing community standards; a preventative service.
Medicare	A health insurance program for the aged and disabled under Title XVIII of the Social Security Act.
Medicare Buy-In	A procedure whereby the Department pays a monthly premium to the Social Security Administration on behalf of eligible medical assistance clients, enrolling them in the Medicare Part B program.
Milestone	A significant point, event, or achievement that reflects progress toward completion of a process, phase, or project.
MITA (Medicaid Information Technology Architecture)	A national initiative intended to foster integrated business and IT transformation across the Medicaid enterprise to improve the administration of the Medicaid program.

Term/Acronym	Definition
MMIS (Medicaid Management Information System)	An automated mechanized claims processing and information retrieval system for Medicaid required by the federal government; See also Core MMIS.
Modern System	A flexible, responsive, and automated claims and transaction processing system and a modular information management and retrieval system that enhances the State's program management, claims processing, and reporting capabilities.
MSIS (Medicaid Statistical Information System) or T-MSIS.	Under the Balanced Budget Act of 1997, as of 1/1/99, it is mandatory that States report Medicaid data through the Medicaid Statistical Information System (MSIS) system. This system requires the States to submit raw eligibility and claims data to the Centers for Medicare & Medicaid Services (CMS). MSIS data is used by CMS to produce Medicaid program characteristics and utilization information. MSIS data is made available to States and other federal agencies in order to gain greater insight into the Medicaid program. The MSIS State Summary data mart consists of enrollment, demographic, and claim information for each Medicaid fiscal year. The information is stored in a data cube and is viewed using Cognos PowerPlay Web.
MSQ	Medical Services Questionnaire
NABP (National Association of Board of Pharmacies)	An independent, international, and impartial association that assists its member boards and jurisdictions in developing, implementing, and enforcing uniform pharmacy standards for the purpose of protecting the public health.
NCCI (National Correct Coding Initiative)	The Patient Protection and Affordable Care Act (Healthcare Reform) required State Medicaid programs to incorporate national correct coding initiative (NCCI) methodologies into their claims processing systems by October 1, 2010.
NCPDP (National Council for Prescription Drug Programs)	An entity that creates and promotes standards for the transfer of data to and from the pharmacy services sector of the health care industry.

Term/Acronym	Definition
NDDF (National Drug Data File)	A commercially available private industry drug database used by both private industry and government agencies.
NDC (National Drug Code)	An eleven-digit code assigned to each drug. The first five numbers indicate the labeler code, the next four numbers indicate the drug and strength, and the remaining two numbers indicate the package size.
NEMT (Non-Emergency Medicaid Transportation)	Non-Emergency Medicaid Transportation (NEMT) services are available to Medicaid clients who are eligible for transportation services to routine (scheduled appointments) and urgent (client needs to get to doctor as soon as possible) medical appointments.
NLR (National Level Repository)	A repository and system which tracks and stores information on providers' meaningful use to electronic health records, allowing CMS to determine appropriate Health Information Technology for Economic and Clinical Health Act incentive payments for Medicare and Medicaid programs.
NMEH (National Medicaid EDI HIPAA)	The National Medicaid EDI Health care (NMEH) Workgroup is a vehicle for state collaboration in response to the original HIPAA mandates. NMEH was created by CMS, NASMD, and the S-TAG; it gives Medicaid a voice in standards organizations.
NPI (National Provider Identifier)	A unique 10-digit identification number issued to health care providers in the United States by the Centers for Medicare & Medicaid Services (CMS). The NPI has replaced the unique provider identification number (UPIN) as the required identifier for Medicare services, and is used by other payers, including commercial health care insurers.
NPPES (National Plan and Provider Enumeration System)	The system that uniquely identifies a health care provider (as defined at 45 CFR 160.103) and assigns it an NPI. The system is designed with the future capability to also enumerate health plans once the Secretary has adopted a standard unique health identifier for health plans.
NPS (National Provider System)	The administrative system that supports a national provider registry.

Term/Acronym	Definition
NUBC (National Uniform Billing Committee)	A committee comprised of major national provider and payer organizations in order to develop a single billing form and standard data sets that could be used nationwide by institutional providers and payers for handling diagnosis codes within health care claims.
OBC (Orange Book Code)	Identifies the therapeutic equivalency ratings assigned to each approved prescription product according to the FDA's Approved Drug Products with Therapeutic Equivalence Evaluations.
OBRA (Omnibus Budget Reconciliation Act)	Federal legislation defines Medicaid drug coverage requirements and drug rebate rules.
OCR (Optical Character Recognition)	The mechanical or electronic conversion of scanned images of handwritten, typewritten or printed text into machine-encoded text for the purpose of electronically searching, storing more compactly, on-line display, and text mining.
ODS (Operational Data Store)	A database designed to integrate data from multiple sources for additional operations on the data. The resulting data is passed back to operational systems for further operations and to the data warehouse for reporting.
Offeror	Any individual or entity that submits a proposal, or intends to submit a proposal, in response to this procurement.
OIG (Office of Inspector General)	A government agency created to protect the integrity of the Department of Health and Human Services (DHHS) against fraud, waste and abuse by improving the efficiency of the HHS programs.
OIT (Governor's Office of Information Technology)	A state agency responsible for the operation and delivery of information and communications technology (ICT) services and innovation across all Executive Branch agencies in the State of Colorado.

Term/Acronym	Definition
OLAP (Online Analytical Processing)	Tools that enable users to interactively analyze multidimensional queries and resulting data from multiple perspectives. OLAP consists of three basic analytical operations: consolidation (roll-up), drill-down, and slicing and dicing.
ONC (Office of the National Coordinator)	A Federal entity charged with coordination of nationwide efforts to implement and use the most advanced health information technology and the electronic exchange of health information. The ONC is a resource to the entire health system to support the adoption of health information technology and the promotion of nationwide heath information exchange to improve health care.
Open Source Software	Software that incorporates or has embedded in it any source, object or other software code subject to an "open source", "copyleft" or other similar type of license terms (including, without limitation, any GNU General Public License, Library General Public License, Lesser General Public License, Mozilla License, Berkeley Software Distribution License, Open Source Initiative License, MIT license, Apache license, and the like).
Operational Start Date	Date that the Department authorizes the Contractor to begin fulfilling its operations and maintenance obligations under the Contract.
OTC (Over The Counter)	Drugs/medications that may be sold directly to a consumer without a prescription from a healthcare professional, as compared to prescription drugs, which may be sold only to consumers possessing a valid prescription.
Other Personnel	Individuals and Subcontractors, in addition to Key Personnel, assigned to positions to complete tasks associated with the Statement of Work.
PA (Prior Authorization)	A requirement mandating that a provider must obtain approval to perform a service(s) or prescribe a specific medication. Without prior approval, Medicaid may not provide coverage or pay for a medication. The prior authorization is the record of the approved prior authorization request (PAR); See PAR.

Term/Acronym	Definition
PACE (Program of All-Inclusive Care for the Elderly)	Comprehensive health services for individuals age 55 and over who are categorized as "nursing home eligible" by their state's Medicaid program. Services include primary and specialty medical care, nursing, social services, therapies (occupational, physical, speech, recreation, etc.), pharmaceuticals, day health center services, home care, health-related transportation, minor modification to the home to accommodate disabilities, and anything else the program determines is medically necessary to maximize a member's health.
PAHP (Prepaid Ambulatory Health Plan)	An entity that provides medical services to enrollees that does not require an overnight hospital stay. These entities provide services under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State plan payment rates; (2) Does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees; and (3) Does not have a comprehensive risk contract.
PAR (Prior Authorization Request)	A request submitted to a health plan for review, accompanied by the necessary supporting clinical documentation for a service(s) or medication, prior to performing the service(s) or dispensing the medication.
PASRR (Preadmission Screening and Resident Review)	Preadmission Screening and Resident Review (PASRR) is a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care. PASRR requires that 1) all applicants to a Medicaid-certified nursing facility be evaluated for mental illness and/or intellectual disability; 2) be offered the most appropriate setting for their needs (in the community, a nursing facility, or acute care settings); and 3) receive the services they need in those settings.
PBMS (Pharmacy Benefit Management System)	The term used to refer to the RFP and resulting system that will replace the current pharmacy benefits management system.

Term/Acronym	Definition
PCCM (Primary Care Case Management)	A physician, physician group practice or an entity that employs or arranges with physicians to provide primary care case management services. A PCCM program is a system under which a Primary Care Physician (PCP) contracts with the Department to provide case management services which includes location, coordination and monitoring of primary health care services.
PCMP (Primary Care Medical Providers)	Health care providers that typically act as the principal point of consultation for patients within a health care system and coordinate other specialists that the patient may need. Such professionals can be primary care physicians, such as general practitioners or family physicians. Depending on the nature of the health condition, patients may then be referred for secondary or tertiary care. See also PCP/PCPP.
PCP/PCPP (Primary Care Physician; Primary Care Physician Program)	A physician or program that provides both the first contact for a person with an undiagnosed health concern as well as continuing care of varied medical conditions, not limited by cause, organ system, or diagnosis. See also PCMP.
PDL (Preferred Drug List)	A formal published list of specific prescription drug products by brand and generic name, usually divided into two separate categories: “preferred” and “non-preferred.”
PERM (Payment Error Rate Measurement)	The PERM program measures improper payments in Medicaid and CHP+ and produces error rates for each program. The error rates are based on reviews of the fee-for-service (FFS), managed care, and eligibility components of Medicaid and CHP+ in the fiscal year (FY) under review.
PETI (Post-Eligibility Treatment of Income)	A program for Nursing Facilities to provide services that are not a Medicaid benefit if they are medically necessary and the client has a patient payment amount.
Pharmacy Benefit Plan	A plan defined by the Department based on factors such as client eligibility, location, and third party coverage. Each Plan will have a specific set of pharmacy benefits.

Term/Acronym	Definition
PHI (Protected Health Information)/PII (Personal Identity Information)	Under HIPAA, PHI includes any individually identifiable health information. Identifiable refers not only to data that is explicitly linked to a particular individual (that's identified information). It also includes health information with data items, which reasonably could be expected to allow individual identification.
PHP (Prepaid Health Plan)	A program established to allow recipients to enroll in Health Maintenance Organizations (HMOs) as an alternative to the fee-for-service program. The program is intended to encourage the development of more efficient delivery of care, reduce inflationary costs, improve the access to and continuity of medical services, and reduce the administrative costs by allowing PHPs to assume the costs of administration and utilization controls for health services provided to their members.
PHR (Personal Health Record)	Related health data and care information maintained by the patient. This stands in contrast with the more widely used electronic medical record, which is operated by institutions (such as a hospital) and contains data entered by clinicians or billing data to support insurance claims. PHRs provide a complete and accurate summary of an individual's medical history online, which may include patient-reported outcome data, lab results, data from devices such as wireless electronic weighing scales, or collected passively from a smartphone.
PI (Program Integrity)	Activities performed by the Department's Program Integrity (PI) Section or other entity concerning monitoring the utilization habits and patterns of both members and providers of the Colorado Medical Assistance program to create a culture where there are consistent incentives to provide better health outcomes within a context that avoids over- or underutilization of services.
PMPM (Per Member/Per Month)	Per Member Per Month is a standard unit of measure for capitation payments that payers provide to providers, both hospitals and physicians. These payments also include ancillary service use.

Term/Acronym	Definition
POS (Point of Sale)	Claims processing system capable of adjudicating claims on-line in real time.
Power User	A user within an organization who has the ability to use advanced features of software programs, which are beyond the abilities of "normal" users, but is not necessarily capable of programming and system administration. In enterprise software systems, this title may go to an individual who is not a programmer, but who is a specialist in a business process or area.
Predictive Modeling	The process by which a model is created or chosen to try to best predict the probability of an outcome. This technique assists with forecasting and trend analysis.
Prescription	A written, faxed, or oral order, as required by the Board of Pharmacy, from a practitioner for a certain drug, medical supply, device or service.
Prime Contractor	The Offeror selected as a result of this procurement to complete the Work contained in the Contract. The individual or entity solely responsible for completion of all Work to be performed in the Contract, regardless of whether Subcontractors are used. See Contractor.
Problem(s)	A defect, Operational issue, or situation regarded as unwelcome or harmful and needing to be dealt with and overcome.
Procurement	The act of procuring a service and the process (RFP planning, development or evaluation) or planning activities for an upcoming solicitation.
Production	The system hardware and software environment designated to the final stage in the release process, which serves the end-users/clients.
Pro-DUR (Prospective Drug Utilization Review)	The provision of certain information, on-line, to authorized providers prior to filling a prescription.

Term/Acronym	Definition
Proprietary Contractor Material	Confidential material, knowledge, or information that the contracted parties wish to share with one another for certain purposes, but wish to restrict access to or by third parties.
Provider	Individual or entity furnishing medical, mental health, dental or pharmacy services.
Provider Enrollment	A completed capture and verification of provider demographic, licensure, disclosure information, and an executed provider participation agreement. This includes a Billable Provider Revalidation.
Provider Enrollment Tool	The Provider Enrollment Tool is a product of Implementation Stage I: Online Provider Enrollment activities as described in the Core MMIS & Supporting Services RFP (HCPFRFPKC13COREMMIS). The purpose of Online Provider Tool is so that all providers are enrolled, re-enrolled, and validated through an automated, Web Based application. This process supports the Provider Re-enrollment/validation process that is required by ACA Provider Screening Rule.
Provider Preventable Conditions	Regulations per the June 30, 2011, CMS final rule implementing the requirements of Section 2702 of the ACA defined conditions known as "health-care acquired conditions" (HCAC) for which federal payments to states are prohibited under Section 1903 of the Social Security Act. Provider Preventable Conditions (PPC) include HCAC and other preventable conditions as defined by CMS that must be identified for non-payment by States.
Provider Revalidation	A completed evaluation verifying that a provider meets Federal and State conditions for participation. See ACA Provider Screening Rule.
Provider Screening	An evaluation that verifies that a provider meets the legal requirements in order to be reimbursed for services provided under the Medicaid or Children's Health Insurance Program, without limitations. The specific requirements for each Billable Provider Screening vary based on whether the provider's risk category is "limited," "moderate," or "high." See ACA Provider Screening Rule.

Term/Acronym	Definition
QA (Quality Assurance)	The planned and systematic activities implemented in a quality system so that quality requirements for a product or service will be fulfilled.
Quarterly Milestone Review Period	During Contract negotiations, the Department and its Contractor will agree on all quarterly Milestones for each Project Phase within each Contract Stage. At that time, both parties will agree on the review schedule, as well as all Milestone acceptance criteria.
QMB (Qualified Medicare Beneficiaries)	The Qualified Medicare Beneficiaries (QMB) program covers Medicare cost sharing requirements for certain low-income Medicare beneficiaries. This includes Medicare monthly premiums for Parts A & B, Medicare deductibles, and Medicare co-insurance.
RAC (Recovery Audit Contractors)	The Recovery Audit Contractor (RAC) program was created through the Medicare Modernization Act of 2003 (MMA) to identify and recover improper Medicare payments paid to health care providers under fee-for-service (FFS) Medicare plans. The United States Department of Health and Human Services (DHHS) is required by law to make the program permanent for all states by January 1, 2010 under Section 302 of the Tax Relief and Health Care Act of 2006.
RAI (Resident Assessment Instrument)	Tool used by Long-Term Care facilities to assess and determine a patient's eligibility for services and to assist in the care planning and management of the patient.
RCCO (Regional Care Collaborative Organization)	The RCCO connects Medicaid clients to Medicaid providers and also helps Medicaid clients find community and social services in their area. The RCCO helps providers to communicate with Medicaid clients and with each other, so Medicaid clients receive coordinated care. A RCCO will also help Medicaid clients get the right care when they are returning home from the hospital or a nursing facility, by providing the support needed for a quick recovery. A RCCO helps with other care transitions too, like moving from children's health services to adult health services, or moving from a hospital to nursing care.

Term/Acronym	Definition
Recipient	A person who has been determined eligible for Medicaid or Child Health Plan Plus. See also Client.
Retro-DUR (Retrospective Drug Utilization Review)	A retrospective review of provider dispensing patterns and client use of drugs.
RFP (Request for Proposal)	An invitation presented for suppliers/contractors, often through a bidding process, to submit a proposal on a specific commodity or service. The RFP is issued at an early stage in a procurement process, and the process brings structure to the procurement decision and is meant to allow the risks and benefits to be identified clearly up front.
RTM (Requirements Traceability Matrix)	A document that compares any two baselined documents that require a many-to-many relationship to determine the completeness of the relationship.
Sanction	Penalty for noncompliance with laws, rules, and policies regarding Medicaid, which may include withholding payment from a provider or terminating Medicaid enrollment.
Scorecard	A management tool used to compare actual results to business targets or goals.
SDAC (Statewide Data Analytics Contractor)	The individual or entity responsible for providing secure electronic access to clinically actionable data to the Regional Care Collaborative Organizations (RCCOs) and Primary Care Medical Providers (PCMPs) to help meet the goals of the Accountable Care Collaborative (ACC).
SDLC (Systems Development Life Cycle)	A process of creating or altering information systems, and the models and methodologies that are used to develop these systems. The methodologies form the framework for planning and controlling the creation of an information system.
Services	Services to be delivered by Contractor pursuant to the official Contract documents.

Term/Acronym	Definition
SFY (State Fiscal Year)	The twelve (12) month period beginning on July 1st of a year and ending on June 30th of the following year; See also Fiscal Year.
Shall	Indicates a mandatory requirement or condition to be met by the specified individual, Contractor, or other entity.
SIS (Support Intensity Scale)	The Support Intensity Scale (SIS) is a tool used by some of the Home and Community Based Services (HCBS) waiver programs to evaluate the severity of the client's condition.
SLS (Supported Living Services)	State Supported Living Services (SLS) provide a variety of services, such as personal care (like eating, bathing and dressing) or homemaking needs, employment or other day type services, accessing his or her community, help with decision-making, assistive technology, home modification, professional therapies, transportation, and twenty-four emergency assistance. Supported Living Services are not intended to meet all needs, they are used to supplement already available supports for adults who either can live independently with limited supports or, if they need extensive support, are principally supported from other sources, such as the family.
SLR (State Level Registry)	Provides a mechanism for eligible Medicaid providers that adopt and successfully demonstrate Meaningful Use (MU) of a certified Electronic Health Records (EHR) technology to apply for available incentive payments to for allowable costs associated with the implementation, operation, and maintenance of this technology. See also Colorado Registration and Attestation.
SMAC (State Maximum Allowable Cost)	The maximum allowable cost that the State will pay for certain multisource drug products.
SME (Subject Matter Expert)	A person who is an expert in a particular area or topic.

Term/Acronym	Definition
SMHP (State Medicaid HIT Plan)	A documented plan that provides State Medicaid Agencies (SMAs) and CMS with a common understanding of the activities the SMA will be engaged in over the next 5 years relative to implementing Section 4201 Medicaid provisions of the American Recovery and Reinvestment Act (ARRA).
SNAP (Supplemental Nutrition Assistance Program)	Formerly known as the Food Stamp Program, it provides financial assistance for purchasing food to low- and no-income people living in the U.S. It is a federal aid program, administered by the U.S. Department of Agriculture, though benefits are distributed by individual U.S. states.
SOA (Service Oriented Architecture)	Represents software architecture comprised of interoperable, discoverable, and potentially reusable services.
SNF (Skilled Nursing Facility)	Places of residence for people who require constant nursing care and have significant deficiencies with activities of daily living. Nursing aides and skilled nurses are usually available 24 hours a day.
Software	A set of programs, procedures, algorithms and its documentation concerned with the operation of a data processing system. Program software performs the function of the program it implements, either by directly providing instructions to the computer hardware or by serving as input to another piece of software.
SOO (Statement of Objective)	States the overall explanation of objectives for this procurement.
SOW (Statement of Work)	The tasks and activities the Contractor is required to perform to fulfill its obligations under the Contract, including the performance of any services and delivery of any goods. See "Work."
SPAL	Service Plan Authorization Limits

Term/Acronym	Definition
SPSL	Service Plan Spending Limits
Specification(s)	A detailed, exact statement of particulars such as a statement prescribing materials, dimensions, and quality of Work.
SS-A (State Self-Assessment)	A structured method used to document a state's current Medicaid business enterprise by aligning a state's business areas to the MITA business areas and business processes. The self-assessment also allows states to determine business maturity, which allows them to shape the future of their Medicaid enterprise.
SSO (Single Sign-On)	An access control feature of software applications that allows a user to log in once and gain access to all associated applications, without being prompted to log in for each. This applies to all associated systems and/or applications provided by the Offeror for the COMMIT project.
Star Schema	The simplest style of data warehouse schema that is most effective for handing simpler queries. Star schemas typically consist of one or more fact tables that reference one or more dimension tables. Also called star-join schema, data cube, or multi-dimensional schema.
Start-Up Period	The period from the Effective Date of the Contract up to the start of DDI.
Stratified Random Sample	A random sample drawn after dividing the studied population into several non-overlapping subgroups or strata based on significant characteristics; sub-samples are then drawn separately from each of the strata. For example, the population of providers might be stratified by zip/specialty before random sampling.
Subcontractor	Any person or entity undertaking part of the Work under the terms of the Master Contract, by virtue of agreement with the Prime Contractor. The Department must approve all subcontractors, in writing, prior to any agreement(s) with the Prime Contractor.

Term/Acronym	Definition
Supplemental Drug Rebate	Payment from a pharmaceutical manufacturer, which is negotiated by the state to provide rebates greater than those provided through federal rebate rates.
Supporting Services	Activities or functions required for successful completion of the project.
SURS (Surveillance and Utilization Review Subsystem)	Utilization review for Medicaid Programs to identify program policy inconsistencies and potential fraud or provider abuse by identifying aberrant billing patterns.
System	Refers to the collection of software products, technical, and/or automated functions within the PBMS.
System Integrator	An enterprise that specializes in implementing, planning, coordinating, scheduling, testing, improving and maintaining computing operation.
System Maintenance	Routine activities required to sustain normal operations of the PBMS Operations and the System, including COTS utilized by the Contractor under this Contract and the upkeep of servers and software patches. These activities are not considered Enhancements requested by the Department and do not require a formal SDLC process. See also Maintenance.
TANF (Temporary Assistance for Needy Families)	Formerly known as the welfare program, it is a Federal assistance program that provides cash assistance to indigent American families with dependent children through the United States Department of Health and Human Services.
TCN (Transaction Control Number)	The Transaction Control Number (TCN) is the unique claim identifier used by the current System.
Technical Proposal	The competitive bid document in which an Offeror proposes how its system will meet the processing requirements for Colorado programs and agencies.

Term/Acronym	Definition
Technology Stack	A technology stack comprises the layers of components or services that are used to provide a software solution or application. Technology stacks are often articulated as a list of technologies, such as "J2EE with Java Server Faces running against a SQL Server database" or as a diagram.
Text Mining	The process of deriving high quality data/information from text.
TPL (Third Party Liability)	An entity that is, or may be, liable to pay all or part of the medical cost of care for a Medicaid client.
TRAILS	The system used by the Colorado Department of Human Services to track foster care clients. TRAILS foster care data are fed into CBMS. Foster care eligibility are then fed with other CBMS eligibility data into the System.
Transmittals	An official document from the Department authorizing the Contractor to perform a specific function that is considered within the Contractor's Scope-of-Work during the Implementation Contract Stage and PBMS Operations. The Transmittal document, workflow, and time frame for the Contractor to implement will be established through the Change Management Plan following Contract award. These requests will not include changes requiring a formal SDLC.
UAT (User Acceptance Testing)	The process to obtain confirmation that a system meets mutually agreed-upon requirements. Typically completed by the customer, UAT is one of the final stages of a project and often occurs before the customer accepts the new system.
ULTC (Uniform Long Term Care)	The ULTC 100.2 is the current client needs assessment tool form used to evaluate whether long term care is appropriate for any given client or potential client.

Term/Acronym	Definition
UM (Utilization Management)	The evaluation of the appropriateness, medical need and efficiency of health care services procedures and facilities according to established criteria or guidelines and under the provisions of an applicable health benefits plan. Typically it includes new activities or decisions based upon the analysis of a case. Utilization management applies to proactive procedures, including discharge planning, concurrent planning, pre-certification and clinical case appeals. It also covers proactive processes, such as concurrent clinical reviews and peer reviews, as well as appeals introduced by the provider, payer or patient.
URA (Unit Rebate Amount)	The amount used to calculate the amount paid by a manufacturer for each unit of a given drug that is being invoiced for federal rebate.
Vendor	A general term to describe an entity that is paid to provide services and/or goods.
Visualization	Any technique used to create images, diagrams, or animations to communicate a message.
WAC (Wholesale Acquisition Cost)	With respect to a drug or biological, the manufacturer's list price for the drug or biological to wholesalers or direct purchasers in the United States, not including prompt pay or other discounts, rebates or reductions in price, for the most recent month for which the information is available, as reported in wholesale price guides or other publications of drug or biological pricing data.
Warm Hand-Off	A call center technique that ensures that if a caller must be transferred, they are passed from one person to another person without being placed on hold or speaking to an automated system.
Warranty Period	The first year of the Ongoing PBMS Operations, beginning on the date of which the System becomes operational and terminating 365 days later.

Term/Acronym	Definition
Web Portal	A secure Internet website that contains forms and other information specific to the system and provides the Medical Assistance program enterprise a consistent look and feel for the various applications.
Work	The tasks and activities the Contractor is required to perform to fulfill its obligations under the Contract, including the performance of any services and delivery of any goods. See "Statement of Work".