



People First Waiver Glossary of Terms

Definitions of words and concepts related to the People First Waiver

This glossary is intended to help people understand some of the terms that appear in the materials produced by the design teams over the course of the summer 2011.

1115 Waiver: 1115 waivers are research and demonstration waivers. They give states the flexibility to demonstrate and evaluate new policies or approaches to providing services that have not been implemented on a large scale. Budget neutrality must be maintained (the costs of the waiver can't be larger than the costs that would exist without the waiver). The title of the 1115 waiver is based on Section 1115 of the Social Security Act. This section gives the secretary of the US Department of Health and Human Services the authority to allow states to conduct demonstration projects that can assist in promoting the objectives of the Medicaid statute.

5.07 Plan: New York State Mental Hygiene Law (§ 5.07) requires the Office of Alcoholism and Substance Abuse Services (OASAS), the Office of Mental Health (OMH), and the Office for People With Developmental Disabilities (OPWDD) to produce a long-range plan or an annual update to the long-range plan every October and an interim report on the plan/update in February. Common features of each plan include: public input, system overview, destinations, goals, and outcomes. Because the section of law containing this mandated planning is numbered 5.07, the plan is often referred to as the "5.07 Plan." (See: http://www.omh.state.ny.us/omhweb/iocc/mental_hygiene507_plans.html.)

Accountable Care Organization (ACO): A model that was formally introduced into health reform through the federal Patient Protection and Affordable Care Act (PPACA), and will officially become part of Medicare through the Medicare Shared Savings program in 2012. An ACO is group of health care providers that give coordinated care and chronic disease management, and thereby improve the quality of care people get. The organization's payment is tied to achieving health care quality goals and outcomes that result in cost savings. ACOs create incentives for health care providers to work together to treat an individual across care settings—including doctor's offices, hospitals, and long-term care facilities. Because providers receive a share of the savings beyond a predetermined threshold level, steps that achieve better outcomes with less resource use—such as care coordination services and wellness programs—result in greater provider reimbursement. (For further information, see: <http://www.healthcare.gov/news/factsheets/accountablecare03312011a.html> and <http://www.acolearningnetwork.org>.) *This definition was provided by NYSARC, Inc.'s 1115 Waiver Terminology Guide, which can be found at: <http://blog.nysarc.org/2011/08/10/understanding-the-1115-waiver-terminology-guide/>.*



Adverse Selection: When referring to insurance, adverse selection is the tendency of high-risk individuals to enroll in insurance while low-risk individuals do not enroll. The Patient Protection and Affordable Care Act attempts to prevent or mitigate adverse selection by requiring that all individuals obtain health insurance.

Aging and Disability Resource Center (ADRC): Aging and Disability Resource Centers (ADRCs) are federal programs supported by the United States Administration on Aging (AoA) and operated by individual states. ADRCs help people of all ages, disabilities, and income levels by improving access to long-term care services and supports through single points of entry, efficient use of care options, and maximization of available services. In New York State, ADRCs are administered by the New York State Office for the Aging (NYSOFA) and operated at the county level. (For further information, see: http://www.nhpf.org/library/background-papers/BP81_ADRCs_11-19-10.pdf.)

Affordable Care Act (ACA): A common abbreviated reference to the federal Patient Protection and Affordable Care Act (PPACA) described below.

Americans with Disabilities Act (ADA): A federal law that guarantees the rights of individuals with disabilities by making it unlawful to discriminate against individuals with disabilities or people who are perceived to have a disability. The law also requires accessibility and reasonable accommodation in certain settings (work, public facilities, transportation, and telecommunications). The ADA was signed into law on July 26, 1990, by President George H. W. Bush and later amended with changes effective January 1, 2009. (For further information, see: <http://www.ada.gov/cguide.htm> and http://en.wikipedia.org/wiki/Americans_with_Disabilities_Act_of_1990.)

Behavioral Health Organization (BHO): The New York State Medicaid Redesign Team (MRT) has proposed the establishment of behavioral health organizations to manage behavioral health services. BHOs “oversee regional performance improvement initiatives that will work with hospitals and community providers to enhance hospital/detox discharge planning and outpatient follow up services in ways that should improve aftercare and reduce avoidable ER [emergency room] and hospital readmissions.” (For further information, see: <http://www.nyaprs.org/e-news-bulletins/2011/2011-09-01-NYAPRS-NYS-Medicaid-Redesign-Update.cfm>.)

Budget Authority: The authority to select and manage one’s individual budget for supports and services. Individual budgets are a key element in self-direction. (For further information, see: <http://www.bc.edu/schools/gssw/nrcpds/tools/handbook.html>.)

Capitation Payment: A payment methodology where providers of service are paid a contracted rate for each individual for whom care is provided. It is referred to as a “per member per



month” rate. The capitation payment will be received as long as the provider meets its quality and service expectations, regardless of the specific number or nature of services provided to any given individual.

Care Coordination: Planning for and management of the provision of services. Care coordination often involves marshalling personnel and other resources to carry out all the activities related to the services offered to individuals (For further information, see: [http://www.ncbi.nlm.nih.gov/books/NBK44012/.](http://www.ncbi.nlm.nih.gov/books/NBK44012/))

COMPASS: is an OPWDD initiative that recognizes provider agencies that have progressed beyond minimal regulatory compliance, and achieved excellence in service delivery. COMPASS agencies engage their entire organization by encouraging board members, management, staff, and service recipients to work together in a person-centered environment with the goal of promoting and achieving valued outcomes for people. Upon admission, the Division of Quality Management (DQM) suspends all routine survey activity at the agency, (with the exception of ICF surveys and Willowbrook visits.) The new COMPASS agency assumes the task of surveying its own programs to determine regulatory compliance. Thereafter, new COMPASS agencies submit a written status report to DQM on a semi-annual basis. On an annual basis, DQM conducts a visit to each COMPASS agency. There currently are seven agencies with COMPASS status.

(For further information, see: [http://www.opwdd.ny.gov/hp_about_compass.jsp.](http://www.opwdd.ny.gov/hp_about_compass.jsp))

Comprehensive Care Entity: An organization that coordinates care for a person and either provides or arranges for the provision of the full range of services needed by the individual it serves, including developmental disabilities services, long-term care services, and health care services. Such an entity need not be the direct service provider for all services required by every individual, but would have the capacity to deliver a broad menu of services to meet the full spectrum of service needs.

Consolidated Supports and Services (CSS): Consolidated Supports and Services (CSS) is an OPWDD service option in the 1915 (c) waiver that is used to create individualized services for people with developmental disabilities through person-controlled, portable budgets. (For further information, see: [http://www.opwdd.ny.gov/hp_services_css.jsp.](http://www.opwdd.ny.gov/hp_services_css.jsp))

Continuum of Care: A full range of flexible and effectively linked services, from institutional care to home-based/community-based care. (For further information, see: *21st Century: A new vision for health care*, McGill University Health Centre [Montreal: 1997], [http://toolkit.cfpc.ca/en/glossary.php.](http://toolkit.cfpc.ca/en/glossary.php))

Continuum of Services: An integrated and seamless system of graduated settings, services, service providers, and service levels that can meet the needs of individuals as they change over



time. (For further information, see: *Achieving Improved Measurement*, Canadian Council on Health Services Accreditation [Ottawa: 2002] Glossary, <http://toolkit.cfpc.ca/en/glossary.php>.)

Council on Quality and Leadership (CQL): A national organization that works with public and private organizations with a commitment to person-centered services and supports by defining, measuring, and improving quality. CQL offers technical assistance, training, and support for organizations that seek to move from theory to practice in achieving person-centered outcomes for those they support. CQL offers an accreditation program based on personal outcome measures and continuous quality improvement. Three NYSARC chapters have CQL accreditation: Chemung, Franklin-Hamilton, and Montgomery. (For further information, see: <http://thecouncil.org>.)

Developmental Disabilities Individual Support and Care Coordination Organization (DISCO): Nonprofit organizations that function as fiscal intermediaries and provide individualized supports and services in addition to care coordination to individuals with developmental disabilities and/or their families. DISCOs will be equipped to serve individuals with all levels of need by providing supports and services directly or indirectly through sub-contracts with provider agencies. The creation of DISCOs has been recommended by the People First Waiver fiscal sustainability design team to fulfill key roles of the recommended financial platform. (For further information, see the work of the People First Waiver design teams: http://www.opwdd.ny.gov/2011_waiver.)

Developmental Disability Services Offices (DDSO): Regional offices of the New York State Office for People with Developmental Disabilities (OPWDD) through which individuals with developmental disabilities and their families can access supports and services. DDSO locations include: Bernard M. Fineson (in Queens), Brooklyn, Broome, Capital District, Central New York, Finger Lakes, Hudson Valley, Long Island, Metro NY (in Manhattan and the Bronx), Staten Island, Sunmount (in northern New York), Taconic, and Western NY. (For further information, see: http://www.opwdd.ny.gov/document/hp_contacts.jsp.)

Dual Eligibles / Integrating Care for Dual Eligible Individuals: Individuals who are eligible for both Medicaid and Medicare are a significant focus of both federal and state policy makers, and care integration is a potential area for achieving cost savings and improved health outcomes. The number of people with developmental disabilities who are dual eligible has grown significantly in recent years and is estimated to include approximately 60% of all adults served by OPWDD. Recently, the federal Centers for Medicare & Medicaid Services (CMS) opened a Medicare-Medicaid Coordination Office. That office awarded contracts to 15 states including New York for dual eligible demonstration projects. Under the State Demonstrations to Integrate Care for Dual Eligible Individuals initiative, selected states will be awarded up to \$1 million to design strategies for implementing person-centered models that fully coordinate primary, acute, behavioral, and long-term supports and services for dual eligible individuals. After



federal review of the proposals, CMS will work with states to implement the plans that hold the most promise. (For further information, see: <http://www.cms.gov/medicare-medicaid-coordination/>.) *This definition was provided by NYSARC, Inc.'s 1115 Waiver Terminology Guide, which can be found at: <http://blog.nysarc.org/2011/08/10/understanding-the-1115-waiver-terminology-guide/>.*

Employer Authority: A key feature of self-directed services which gives individuals the authority to hire, manage, and fire workers.

Equitable Resource Allocation: The designation of the amount of service funding needed to appropriately address an individual's service needs. An equitable resource allocation ensures that Medicaid funding for services is available to individuals according to their level of need.

Fee-for-Service Payments (FSS): A system in which the provider receives reimbursement directly for the expense related to delivering each covered service after the expense has been incurred (For further information, see <http://www.nhpf.org/library/other/InsuranceGlossary.pdf>.)

Fiscal Intermediary: One role of a care coordination entity in which it receives capitation payments, manages funds and payment of claims, and conducts reimbursement reviews and medical coverage reviews. This role is different from that of fiscal intermediaries in the CSS program. (See "Consolidated Supports and Services (CMS)" above.)

Global Budgets: A global budget is a fixed maximum expenditure, typically set by government, for a defined set of services. The size of the budget may be set by an assessment of projected needs or determined relative to an objective metric (a percentage of payments made in a prior period). In the health care field, institutional providers such as hospitals may be given individual budgets each year and be required to work within them.

(For further info, see:

http://www.mass.gov/Eeohhs2/docs/dhcfp/pc/2009_03_13_Global_Budgets_final-C5.pdf) *This definition was provided by NYSARC, Inc.'s 1115 Waiver Terminology Guide, which can be found at: <http://blog.nysarc.org/2011/08/10/understanding-the-1115-waiver-terminology-guide/>.*

Health Home: "Person-centered systems of care that facilitate access to and coordination of the full array of primary and acute physical health services, behavioral health care, and long-term community-based services and supports. The health home model of service delivery expands on the traditional medical home models that many states have developed in their Medicaid programs, by building additional linkages and enhancing coordination and integration of medical and behavioral health care to better meet the needs of people with multiple chronic illnesses. The model aims to improve health care quality and clinical outcomes as well as the



patient care experience, while also reducing per capita costs through more cost-effective care.” (For further information, see: www.kff.org/medicaid/upload/8136.pdf.)

Health Home (New York): The federal Affordable Care Act included provisions for establishing enhanced Medicaid federal financial participation for certain health care services that are delivered consistent with the precepts of a health home. New York State has filed a Medicaid State Plan Amendment to establish health Homes. Health home services support the provision of coordinated, comprehensive medical and behavioral health care to patients with chronic conditions through care coordination and integration that assures access to appropriate services, improves health outcomes, reduces preventable hospitalizations and emergency room visits, promotes use of health information technology (HIT), and avoids unnecessary care. (For further information, see: <http://www.health.ny.gov/funding/rfp/1106211121/> and <https://www.cms.gov/smdl/downloads/SMD10024.pdf>.)

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Independent Living Centers: “Private, nonprofit, consumer controlled, community-based organizations that provide information, services, and advocacy by and for persons with all types of disabilities. They help individuals with disabilities achieve their maximum potential within their families and communities. Independent living centers provide a strong advocacy voice on national, state, and local issues. They work to assure access to housing, employment, transportation, communities, recreational facilities, and health and social services.” (For further information, see: http://www.southshoreelderservices.com/?page_id=231.)

Individualized Budget: A budget that is designed for individuals who choose to self-direct their services and reflects the costs of various supports included in the individual’s service plan. (For further information, see: <http://www.nasdds.org/pdf/IBExecutiveSummary.pdf>.)

Informed Choice: When someone has made an informed choice, it means “he or she has made a decision based on a good understanding of the options available and a good understanding of how that decision may affect his or her life. A person can make an informed choice on his/her own or may ask family members, friends, or others for assistance if the person needs help making a good decision. Informed choices can be about everyday things like what to wear, or big life changing things like where to live, what kind of work to do, or who to be friends with. These decisions can also be about what kinds of services or supports someone wants or needs, and where and how to get them. When making an informed choice, a person should understand the possible risks involved and what can be done to reduce the risks. A person should also realize that his/her ability or desire to make choices may change over time, or may be different for different kinds of decisions. Personal choices should be respected and supported by the people involved in the person’s life.” *As articulated by OPWDD’s Informed*



Choice Workgroup 2009-10 (For further information, see: http://www.opwdd.ny.gov/2011_waiver/images/access_and_choice_072911_powerpoint.pdf.)

Insurance Exchange: The Affordable Care Act directs states to set up insurance exchanges by 2014. These exchanges will be a one-stop shop for insurance where individuals can browse private insurance options and select the best plan. Individuals will have the opportunity to find insurance in a manner similar to online shopping. (For further information, see: <http://www.nhpf.org/library/other/InsuranceGlossary.pdf>.)

Long-Term Care: A range of services and supports that help people meet health or personal needs over a long period of time. “Most long-term care is not medical care, but rather assistance with the basic personal tasks of everyday life, sometimes called ‘Activities of Daily Living,’ such as: bathing, dressing, using the toilet, transferring (to or from bed or chair), caring for incontinence, eating. Other common long-term care services and supports are assistance to complete what are called instrumental activities of daily living. These are household and other tasks that you may do every day, such as: housework, preparing and cleaning up after meals, taking medication, shopping for groceries or clothes, using the telephone or other communication devices, managing money, caring of pets, responding to emergency alerts such as fire alarms.” Habilitation services are long-term care services that are designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully” in community settings. (For further information, see: http://www.longtermcare.gov/LTC/Main_Site/Understanding/Definition/Index.aspx.)

Long-Term Care Entity: An organization that provides a variety of clinical and non-clinical services such as long-term therapies, developmental disabilities services, home health personal care, and residential services, with a focus on helping individuals function at their highest level of independence.

Managed Care: Managed care generally refers to a system of health care services in which organizations (managed care organizations) coordinate the access and delivery of services to ensure desired positive outcomes, while controlling costs. Risk-based managed care describes care from organizations that provide or contract to provide specified health care services for a defined population for a fixed, prepaid price where the organizations are at financial risk to deliver the services for the fixed price. It can be considered “hands-on health insurance” because it combines the responsibility for paying for a defined set of health services with an active program to control the costs associated with providing those services, while ensuring quality and access. Managed care is intended to eliminate redundant facilities and services and to reduce costs. Health education and preventive medicine are emphasized. Doctors and other health care providers make a profit by providing only the services necessary in treating patients and by maintaining plan members’ health. Traditional fee-for-service providers profit instead when people are sick and use health services, and thus have less incentive to keep people



healthy. (For further information, see: Mosby's Medical Dictionary, 8th edition, and <http://aspe.hhs.gov/Progsys/Forum/basics.htm#definiti>.)

Managed Care Organization (MCO): An organization that receives a fixed sum of money to pay for the expenses related to providing identified benefits and services to a defined population of enrollees. (For further information, see “Developmental Disabilities Individual Support and Care Coordination Organization (DISCO)” above.)

Medicaid: Medicaid is “a joint federal and state program that helps with medical costs for some people with limited income and resources. (For further information, see: <http://www.medicare.gov/Glossary/m.html> and www.cms.gov.)

Medicaid Managed Long-Term Care (MLTC): An alternative approach to fee-for-service funding in which states pay health insurers a fixed monthly fee for each Medicaid patient’s long-term care. The insurers use the lump sum to cover all of a patient’s long-term care costs. (For more information, see: <http://www.kaiserhealthnews.org/Stories/2011/February/21/medicaid-managed-long-term-care.aspx>.)

Medicaid Redesign Team (MRT): A team of doctors, government officials, advocates, and other representatives of the health care system in New York tasked by Governor Andrew Cuomo to find ways to reduce costs and increase quality and efficiency in the Medicaid program for the 2011-12 fiscal year. (For more information, see: http://www.health.state.ny.us/health_care/medicaid/redesign/.)

Medicare: Medicare is “the federal health insurance program for people who are age 65 or older, certain younger people with disabilities, and people with end-stage renal disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD).” (For more information, see: <http://www.medicare.gov/Glossary/m.html>.)

Network: “A group of physicians, hospitals, and other providers that contract with a particular health care plan to provide services to the plan’s enrollees at negotiated rates.” (For more information, see: <http://www.nhpf.org/library/other/InsuranceGlossary.pdf>.)

No Wrong Door: A concept that ensures individuals access to any and all of the services they need within the full health and human service system regardless of where (at which particular service agency) they begin seeking assistance. In a no wrong door system, different agencies work with each other “to integrate access to those services through a single, standardized entry process that is administered and overseen by a coordinating entity.” When there are no wrong doors, there are no barriers to entry. As a result of information sharing and collaboration, different agencies will gain the ability to direct individuals to the right place to meet their needs



(For more information, see: <http://www.adrc-tae.org/tikisearchresults.php?words=no+wrong+door.>)

Patient Protection and Affordable Care Act (PPACA): A federal statute signed into law by President Barack Obama on March 23, 2010. The law mandates comprehensive health insurance reforms that will hold insurance companies more accountable, lower health care costs, guarantee more health care choices, and enhance the quality of health care for all Americans. (For more information, see: <http://www.healthcare.gov/law/about/index.html>, <http://www.kff.org/healthreform/upload/8061.pdf>.)

Program for the All Inclusive Care for the Elderly (PACE): “A special type of health plan that provides all the care and services covered by Medicare and Medicaid as well as additional medically necessary care and services based on your needs as determined by an interdisciplinary team. PACE serves frail older adults who need nursing home services but are capable of living in the community. PACE combines medical, social, and long-term care services and prescription drug coverage.” (For further information, see: <http://www.medicare.gov/Glossary/p.html>.)

Person-Centered Planning: An ongoing process used to help people with disabilities plan for their future. “In person-centered planning, groups of people focus on an individual and that person’s vision of what they would like to do in the future. This person-centered team meets to identify opportunities for the focus person to develop personal relationships, participate in their community, increase control over their own lives, and develop the skills and abilities needed to achieve these goals.” (For further information, see: <http://www.pacer.org/tatra/resources/personal.asp>.)

Per Member Per Month (PMPM): See “Capitation Payment” above.

Pilot Project: A trial project that will be conducted during the first phase of the People First Waiver to test and demonstrate planned reforms within the developmental disability service system. The results of the pilot projects will guide implementation of the final system reforms.

Quality Improvement, Continuous Quality Improvement: These terms imply an approach to quality management that goes beyond basic standards compliance and looks at internal systems that are built into programs that result in quality outcomes. Critical to most quality improvement efforts are careful measurement and feedback loops that lead to management intervention and program improvement. (For further information, see: <http://www2.ancor.org/issues/medicaid/CMS%20Inventory%20Report.pdf>.)
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Safety Net Pool: “This is a term frequently used in connection with 1115 waivers wherein the federal government agrees to provide federal Medicaid revenue to cover costs delineated by the state in its “safety net pool.” Another term used in this regard is “costs not otherwise matchable (CNOM). In the case of New York’s OPWDD 1115 waiver proposal, the assumption is that the state will define a safety net pool that will be used to continue to capture the revenue that is now associated with developmental centers and other state-operated Medicaid billings that generate Medicaid revenue in excess of the costs associated with the delivery of those services.” (For further information, see: <http://www.naph.org/Main-Menu-Category/Publications/Safety-Net-Financing/medicaidsection1115demonstrationprojectsfinancing.aspx?FT=.pdf>. *This definition was provided by NYSARC Inc.’s 1115 Waiver Terminology Guide, which can be found at: <http://blog.nysarc.org/2011/08/10/understanding-the-1115-waiver-terminology-guide/>.*)

Single Entry Point: A service system in which a single entity is charged with determining service eligibility and resource allocation to ensure that high-risk individuals receive priority. Single entry point also refers to a unified, integrated data system that allows access to different entities in order to ensure that individuals and families do not have to go through unnecessary or redundant procedures.

Social Security Act: The Social Security Act was passed by Congress as part of President Franklin D. Roosevelt’s New Deal. “The act was an attempt to limit what were seen as dangers in the modern American life, including old age, poverty, unemployment, and the burdens of widows and fatherless children. By signing this act on August 14, 1935, President Roosevelt became the first president to advocate federal assistance for the elderly.” (For further information, see: <http://www.socialsecurity.gov/history/index.html>.)