

# GLOSSARY OF TERMS

## Glossary of Terms

Term	Definition
<b>Abuse</b>	<p>The infliction of injury, unreasonable confinement, intimidation, punishment, mental anguish, sexual abuse or exploitation on an individual. Types of abuse include (but are not necessarily limited to):</p> <ul style="list-style-type: none"> <li>(a) physical abuse (a physical act by an individual that may cause physical injury to another individual);</li> <li>(b) psychological abuse (an act, other than verbal, that may inflict emotional harm, invoke fear and/or humiliate, intimidate, degrade or demean an individual);</li> <li>(c) sexual abuse (an act or attempted act such as rape, incest, sexual molestation, sexual exploitation or sexual harassment and/or inappropriate or unwanted touching of an individual by another); and,</li> <li>(d) verbal abuse (using words to threaten, coerce, intimidate, degrade, demean, harass or humiliate an individual).</li> </ul>
<b>Access</b>	Individuals have access to home and community - based services and supports in their communities.
<b>Assessed Needs</b>	The level of supports an individual is determined to need through the completion of an comprehensive participant evaluation.
<b>Accessibility of Services</b>	The ability to get care and services when needed.
<b>Activities of Daily Living (ADL)</b>	Basic personal everyday activities that include bathing, dressing, transferring (e.g., from bed to chair), toileting, mobility and eating. The extent to which a person requires assistance to perform one or more ADLs often is a level of care criterion.
<b>Area Agency on Aging (AAA)</b>	Agencies established in each state under the provisions of the Federal Older Americans Act to meet the needs of persons age 60 and over in local communities.
<b>Assisted Living</b>	An assisted living facility provides residents personal care and other assistance as needed with ADLs and IADLs but does not provide round-the-clock skilled nursing services. Assisted living facilities generally provide less intensive care than nursing facilities and emphasize resident privacy and choice.
<b>Assurance</b>	The commitment by a state to operate a HCBS waiver program in accordance with statutory requirements. Approval of a new waiver is contingent on CMS determining that the program's design will result in meeting the assurances contained in 42 CFR §441.302. Renewal of a waiver is contingent on CMS finding that a waiver has been operated in accordance with the assurances and other Federal requirements.
<b>Attendant Care</b>	In-home personal assistance services such as help with bathing, dressing, meal preparation and housekeeping to live independently in the community.
<b>Backup</b>	Provision for alternative arrangements for the delivery of

	services that are critical to participant well being in the event that the provider responsible for furnishing the services fails or is unable to deliver them.
<b>Billing</b>	The request for payment by a provider from the state for services rendered to a Medicaid beneficiary.
<b>Caregiver</b>	A person who helps care for someone who is ill, has a disability, and/or has functional limitations and requires assistance. Informal caregivers are relatives, friends or others who volunteer their help. Paid caregivers provide services in exchange for payment for the services rendered.
<b>Case/Care Management</b>	A set of activities that are undertaken to ensure that the waiver participant receives appropriate and necessary services. Under a HCBS waiver, these activities may include (but are not necessarily limited to) assessment, service plan development, service plan implementation and service monitoring as well as assistance in accessing waiver, State plan, and other non-Medicaid services and resources. Case management sometimes is referred to as “service coordination,” or “support coordination.”
<b>Centers for Medicare &amp; Medicaid Services (CMS)</b>	The agency in the Department of Health and Human Services that is responsible for Federal administration of the Medicaid, Medicare, and State Children’s Health Insurance Program (SCHIP) programs. CMS was formerly known as the Health Care Financing Administration (HCFA).
<b>Chronic Illness</b>	A long-term or permanent illness (e.g., diabetes, arthritis) that may result in some type of disability for which assistance may be required on a continuing basis.
<b>Complaint</b>	The formal expression of dissatisfaction by a participant with the provision of a service or the performance of an entity in conducting other activities associated with the service.
<b>Continuous Improvement</b>	The utilization of systematically-complied data and quality information derived from discovery activities in order to engage in actions to secure better performance in the operation of a program.
<b>Continuous Quality Improvement</b>	A process which continually monitors program performance. When a quality problem is identified, CQI develops a revised approach to that problem and monitors implementation and success of the revised approach. The process includes involvement at all stages by all organizations, which are affected by the problem and/or involved in implementing the revised approach.
<b>Cost Neutrality</b>	The requirement that an HCBS waiver must be designed and operated so that the average cost per unduplicated participant of furnishing waiver services and other Medicaid benefits is no greater than the average cost per unduplicated individual of furnishing institutional services and other Medicaid benefits to institutionalized persons at the same level of care. Cost neutrality must be demonstrated prospectively in order for a new waiver or a waiver renewal to be approved. It also must be

	verified each year that the waiver is in effect (by the submission of the annual CMS 372(S) report).
<b>Countable Income or Resources</b>	The amount of income or resources that is left after the application of all financial eligibility methodologies and that is compared to the applicable income or resource standard for the purpose of determining Medicaid eligibility.
<b>Critical Incident (Event)</b>	An alleged, suspected, or actual occurrence of: <ul style="list-style-type: none"> <li>(a) abuse (including physical, sexual, verbal and psychological abuse);</li> <li>(b) mistreatment or neglect;</li> <li>(c) exploitation;</li> <li>(d) serious injury;</li> <li>(e) death other than by natural causes;</li> <li>(f) other events that cause harm to an individual; and,</li> <li>(g) events that serve as indicators of risk to participant health and welfare such as hospitalizations, medication errors, use of restraints or behavioral interventions.</li> </ul>
<b>Developmental Disability</b>	As provided in The Developmental Disabilities Assistance and Bill of Rights Act of 2000 (P.L. 106-402 – 42 USC §15002(8)(A)&(B)), the “term ‘developmental disability’ means a severe, chronic disability of an individual that: <ul style="list-style-type: none"> <li>(i) is attributable to a mental or physical impairment or combination of mental and physical impairments;</li> <li>(ii) is manifested before the individual attains age 22;</li> <li>(iii) is likely to continue indefinitely;</li> <li>(iv) results in substantial functional limitations in 3 or more of the following areas of major life activity: <ul style="list-style-type: none"> <li>(I) Self-care</li> <li>(II) Receptive and expressive language.</li> <li>(III) Learning.</li> <li>(IV) Mobility.</li> <li>(V) Self-direction.</li> <li>(VI) Capacity for independent living.</li> <li>(VII) Economic self-sufficiency; and</li> </ul> </li> <li>(v) Reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated.</li> </ul> <p>“An individual from birth to age 9, inclusive, who has a substantial developmental delay or specific congenital or acquired condition, may be considered to have a developmental disability without meeting 3 or more of the criteria ... if the individual, without services and supports, has a high probability of meeting those criteria later in life.”</p> <p>[N.B., The foregoing definition is not the same as the Medicaid specification of individuals who may receive ICF/MR services.</p>

	ICF/MR services are furnished to persons with mental retardation and other related conditions (see below). When a waiver targets individuals with developmental disabilities, a state should define its use of the term “developmental disability.”]
<b>Disability</b>	For Social Security purposes and as provided in §1614(a)(3) of the Act, disability means the inability of a person age 18 or older to engage in substantial gainful activity (work) by reason of any medically determinable physical or mental condition that can be expected to result in death or to last for a continuous period of not less than 12 months. In the case of children (persons age 17 and younger), the child must have a physical or mental condition that results in marked and severe functional limitations. The condition also must be expected to result in death or to last for a continuous period of not less than 12 months.
<b>Disabled</b>	As provided in §1905(a)(vii) of the Act, for Medicaid purposes the term “disabled” means persons under the age of 65 who have been determined to have a disability for Social Security purposes (as provided in §1614(a)(3) of the Act). A 209(b) state may use a more restrictive definition for “disability.”
<b>Discovery</b>	Engaging in activities to collect data about the conduct of processes, the delivery of services, and direct participant experiences in order to assess the ongoing implementation of a waiver, identifying both concerns as well as other opportunities for improvement. Examples of discovery activities include, but are not limited to, monitoring, complaint systems, incident management systems, and regular systematic reviews of critical processes such as participant-centered planning and level of care determinations. Discovery activities are usually designed to identify problems that may require remediation and sometimes lead to systemic changes/improvements.
<b>Duration (of services)</b>	The length of time that a service will be provided. A limit on the duration of services means that the service will no longer be provided after a specified period of time or, after a specified period of time, the necessity for the service is subject to review and reauthorization.
<b>Eligibility Determination</b>	Refers to the processes that are employed to ascertain whether an individual meets the requirements specified in the State plan to receive Medicaid benefits. Such requirements include the determination of whether a person is a member of an eligibility group specified in the State plan and meets the applicable income and resource standards associated with the group. Eligibility determination must be performed by the Medicaid agency or another agency specified in 42 CFR §431.10(c) with which the Medicaid agency has an agreement as provided in 42 CFR §431.10(d).
<b>Enrollment</b>	An informal term used to describe the processes that result in the entry of an individual into a program. Synonymous with the

	term Entrance.
<b>Entrance</b>	<p>The result of completing all processes that must be completed in order for an individual to begin to receive waiver services. A person may start to receive services when:</p> <ul style="list-style-type: none"> <li>(a) the person has been determined to meet applicable program eligibility criteria;</li> <li>(b) there has been a determination that the person is member of a target group that is included in the program;</li> <li>(c) there has been a determination that the person requires a level of care specified for the program;</li> <li>(d) the person has exercised freedom of choice and has elected to receive program services instead of institutional services; and,</li> <li>(e) a service plan has been developed that includes one or more program services. FFP is not available for the costs of services furnished to an individual until all of these steps have been completed. Entrance may be expedited by the preparation of an interim service plan.</li> </ul>
<b>Evaluation</b>	The processes that are undertaken to determine whether an individual requires the level of care specified for the program.
<b>Evidence</b>	Data or facts that support determining whether something is true or not true.
<b>Evidence-Based</b>	A broad term that is used to describe methods or practices that have been demonstrated (through formal research and systematic analysis of data) to secure specified outcomes efficiently and efficaciously.
<b>Exploitation</b>	An act of depriving, defrauding or otherwise obtaining the personal property of an individual by taking advantage of a person's disability or impairment.
<b>Fair Hearing</b>	The administrative procedure established in §1902(a)(3) of the Act and further specified in 42 CFR Subpart E (42 CFR §431.200 through §431.246) that affords individuals the statutory right and opportunity to appeal adverse decisions regarding Medicaid eligibility or benefits to an independent arbiter. An individual has the opportunity to request a Fair Hearing when denied eligibility, when eligibility is terminated, or when denied a covered benefit or service.
<b>Feasible Alternatives</b>	The types of services that may be available to an individual who is a candidate for entrance to the program (e.g., meets requirements for entrance such as the need for a level of care specified in the program). During the program entrance process, a person must be informed of the feasible alternatives under the program so that the person may exercise freedom of choice between waiver, other available programs and institutional services.
<b>Fee for Service</b>	A method of paying providers for services rendered to individuals. Under a fee-for-service system, the provider is paid for each discrete service rendered to an individual.

<b>Financial Accountability</b>	The assurance by a state that its claims for Federal financial participation in the costs of waiver services are based on state payments for waiver services that have been rendered to waiver participants, authorized in the service plan, and properly billed by qualified waiver providers in accordance with the approved waiver.
<b>Financial Eligibility</b>	In order to qualify for Medicaid, an individual must meet both categorical (e.g., have a disability) and financial eligibility requirements. Financial eligibility requirements vary state-to-state and by eligibility category. These requirements generally include limits on the amount of countable income (income standard) and the amount of countable resources (resource standard) an individual is allowed to have in order to qualify for coverage.
<b>Financial Management Services</b>	A support that is provided to waiver participants who direct some or all of their waiver services. This support may be furnished as a waiver service or conducted as an administrative activity. When used in conjunction with the Employer Authority, this support includes (but is not necessarily limited to) operating a payroll service for participant employed workers and making required payroll withholdings. When used in conjunction with the Budget Authority, this support includes (but is not necessarily limited to) paying invoices for waiver goods and services and tracking expenditures against the participant-directed budget.
<b>Fraud and Abuse</b>	In the context of provider billings for Medicaid services, <i>fraud</i> means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law. <i>Abuse</i> means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary costs to the Medicaid program. State plan requirements concerning fraud detection and investigation are located in 42 CFR §455.12 <i>et seq.</i>
<b>Free Choice of Provider</b>	As specified in §1902(a)(23) of the Act and 42 CFR §431.51, the right of a Medicaid beneficiary to obtain Medicaid services from any institution, agency, pharmacy, person, or organization that is:  (a) qualified to furnish the services; and (b) willing to furnish them to the beneficiary. Free choice of provider may be limited under a waiver granted under §1915(b) of the Act. §1915(c) of the Act (the statute

	authorizing the HCBS waiver program) does not grant the Secretary the authority to waive §1902(a)(23) of the Act.
<b>Freedom of Choice</b>	The right afforded an individual who is determined to be likely to require a level of care specified in a waiver to choose either institutional or home and community-based services, as provided in §1915(c)(2)(C) of the Act and in 42 CFR §441.302(d).
<b>Frequency (of services)</b>	How often a service will be furnished to a participant.
<b>Guardian</b>	A court-appointed person who has the legal responsibility for the care and management of an estate, minor or incapacitated person.
<b>Habilitation</b>	Services that are provided in order to assist an individual to acquire a variety of skills, including self-help, socialization and adaptive skills. Habilitation is aimed at raising the level of physical, mental, and social functioning of an individual. Habilitation is contrasted to rehabilitation which involves the restoration of function that a person has lost.
<b>HCBS</b>	Home and Community-Based Services
<b>Health Insuring Organization (HIO)</b>	An entity that provides for or arranges for the provision of care and contracts on a prepaid capitated risk basis to provide a comprehensive set of services.
<b>Health Insurance Portability and Accountability Act of 1996 (HIPAA)</b>	The Federal law (P.L. 104-191) that requires (among its other provisions) that each state's Medicaid management information system (MMIS) have the capacity to exchange data with the Medicare program and that contains "Administrative Simplification" provisions that require state Medicaid programs to use standard, national codes for electronic transactions related to the processing of health claims. HIPAA also mandates certain standards and practices with regard to the privacy of consumer health information. (A regulation to guarantee patients new rights and protections against the misuse or disclosure of their health records.
<b>Home</b>	Location, other than a hospital or other facility, where the patient or consumer receives care in a private residence.
<b>Home and Community-Based Service Waiver Programs (HCBS)</b>	Eligible participants receive care in their home and community in order to remain independent and close to family and friends.
<b>Home Health Aide</b>	A person who, under the supervision of a home health, assists elderly, ill or a person with a disability with household chores, bathing, personal care, and other daily living needs.
<b>Home Health Services</b>	As specified in 42 CFR §440.70, the provision of part-time or intermittent nursing care and home health aide services and, at a state's option, physical therapy, occupational therapy, speech pathology and audiology services, medical equipment, medical supplies, and appliances that are provided to Medicaid beneficiaries in their place of residence. Home health services are a mandatory Medicaid benefit. Home health services must

	be ordered by a physician under a plan of care that the physician reviews at least every sixty days.
<b>Homemaker Services</b>	The performance of general household tasks (e.g., meal preparation and routine household care) provided by a qualified homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home.
<b>Indicator</b>	A key quality characteristic that is measured, over time, in order to assess the performance, processes, and outcomes of service delivery components.
<b>Individual Budget Amount (IBA)</b>	As used in the CMS waiver application, the term “individual budget amount” means a prospectively-determined amount of funds that the state makes available for the provision of waiver services to a participant. The IBA may encompass all waiver services or a subset of waiver services. An IBA may serve as the basis for but is not necessarily synonymous with the term “participant-directed budget” when a waiver provides for the Budget Authority participant direction opportunity.
<b>Individual Cost Limit</b>	A limitation on the entrance of individuals to a waiver that is based on the comparison of the expected costs of HCBS waiver and State plan services to the expected costs of institutional and State plan services that the person would receive in lieu of participation in the waiver. When a state adopts an individual cost limit, the state denies entrance to the waiver when the expected cost of HCBS waiver and State plan services required by an individual exceeds the limit established by the state.
<b>Individual Risk Agreement (Contract)</b>	An agreement that outlines the risks and benefits to the participant of a particular course of action that might involve risk to the participant, the conditions under which the participant assumes responsibility for the agreed upon course of action, and the accountability trail for the decisions that are made. A risk agreement permits individuals to assume responsibility for their choices personally, through surrogate decision makers, or through planning team consensus.
<b>Information and Assistance in Support of Participant Direction</b>	Activities that are undertaken to assist a waiver participant to direct and manage his/her waiver services. Such activities might include assisting a participant in carrying out employer responsibilities under the Employer Authority or locating sources of waiver goods and services and managing the participant-directed budget. This support is furnished by individuals or entities that work on behalf of and under the direction of the person. These activities may be provided as a distinct waiver service, in conjunction with the provision of case management, as an administrative activity or using a combination of delivery methods. Also sometimes known as “supports brokerage” or “personal agent.”
<b>Informed Decisions</b>	Choices made by the participant and his/her Planning Team based on a clear explanation by the provider of alternatives available to the participant.

<b>Interagency Agreement</b>	A formal document that sets forth the responsibilities that are assumed by two or more governmental agencies in their pursuit of common goals and objectives. In the context of the HCBS waiver, the Medicaid agency may enter into an interagency agreement (or, alternatively, a Memorandum of Understanding or MOU) with another state agency to operate a waiver, provided that the Medicaid agency retains ultimate authority over the administration of the waiver.
<b>Institution</b>	In the context of the waiver application, a hospital, nursing facility or ICF/MR for which the state makes Medicaid payment under the State plan.
<b>Instrumental Activities of Daily Living (IADL)</b>	Activities related to independent living, including preparing meals, managing money, shopping for groceries or personal items, performing light or heavy housework, and communication. The extent to which a person requires assistance in performing IADLs is often assessed in conjunction with the evaluation of level of care.
<b>Intermediate Care Facility for the Mentally Retarded (ICF/MR)</b>	A public or private facility that provides health and habilitation services to individuals with mental retardation or related conditions (e.g., cerebral palsy). The ICF/MR benefit is an optional Medicaid service that is authorized in §1905(d) of the Act. ICFs/MR facilities have four or more beds and must provide active treatment to their residents.
<b>Legal Representative</b>	A person who has legal standing to make decisions on behalf of another person (e.g., a guardian who has been appointed by the court or an individual who has power of attorney granted by the person).
<b>Legally Responsible Individual</b>	A person who has a legal obligation under the provisions of state law to care for another person. Legal responsibility is defined by State law, and generally includes the parents (natural or adoptive) of minor children, legally-assigned caretaker relatives of minor children, and sometimes spouses.
<b>Level of Care</b>	The specification of the minimum amount of assistance that an individual must require in order to receive services in an institutional setting under the State plan.
<b>Limited English Proficient (LEP) Persons</b>	Individuals who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English may be limited English proficient (LEP) and eligible to receive language assistance in conjunction with a particular type of service, benefit, or encounter. Recipients of Federal assistance from HHS (including Medicaid) are required to provide language assistance to LEP persons under the HHS Office of Civil Rights guidelines that are included in Attachment D to these instructions.
<b>Live-In Caregiver</b>	An unrelated personal caregiver who resides in the same household as the waiver participant. For purposes of the waiver, a live-in caregiver does not include staff or personnel who reside with a participant or participants in a residence that is owned or leased by a provider of Medicaid services.

<b>Long-Term Care</b>	A variety of services that help people with health or personal needs and activities of daily living over a period of time. Long-term care can be provided at home, in the community, or in various types of facilities, including nursing homes and assisted living facilities.
<b>Managed care</b>	A method of organizing and financing the delivery of health care and other services that emphasizes cost-effectiveness and coordination of care. Managed care organizations receive a fixed amount of money per member per month (called a capitation); no matter how much care a member needs during that month. Managed care integrates the financing and delivery of appropriate services to covered individuals by means of: arrangements with selected providers to furnish an array of services to members; explicit criteria for the selection of health care providers; and financial incentives for members to use providers and procedures associated with the plan. Federal Medicaid managed care regulations are located in 42 CFR §438.
<b>Managed Care Organization (MCO)</b>	As defined in 42 CFR §438.2, an entity that has a comprehensive risk contract with the Medicaid agency and is: <ul style="list-style-type: none"> <li>(1) a Federally qualified Health Maintenance Organization (HMO) or</li> <li>(2) makes the services it provides to its Medicaid enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid recipients within the area served by the entity.</li> </ul>
<b>Measure</b>	A numeric value associated with an indicator. In the quality improvement context, a quality indicator describes the attributes of care or services related to quality. A measure is a way of quantifying attributes. For example, a quality indicator might be expressed as “eligibility is determined promptly.” A measure associated with this indicator could be “the average number of days to complete eligibility determination.”
<b>Measurement</b>	The systematic process of data collection, repeated over time or at a single point in time.
<b>Medicaid</b>	The joint Federal and state program to assist states in furnishing medical assistance to eligible needy persons. Federal law concerning the Medicaid program is located in Title XIX of the Act. Within broad national guidelines established by Federal statutes, regulations, and policies, each state: <ul style="list-style-type: none"> <li>(1) establishes its own eligibility standards;</li> <li>(2) determines the type, amount, duration, and scope of services</li> <li>(3) sets the rate of payment for services; and</li> <li>(4) administers its own program.</li> </ul>
<b>Medicaid Management Information System</b>	A CMS-approved information technology system that supports the operation of the Medicaid program. The MMIS includes the

<b>(MMIS)</b>	following types of sub-systems or files: recipient eligibility, Medicaid provider, claims processing, pricing, SURS, MARS, and potentially encounters processing. In Pennsylvania the MMIS system is PROMISE.
<b>Medical Assistance</b>	The term used in Title XIX of the Act to refer to the payment for items and services covered under a state's Medicaid program on behalf of Medicaid beneficiaries.
<b>Medical Assistance Unit</b>	The state government entity established in accordance with 42 CFR §431.11(b). The Medical Assistance Unit may be the same as the Medicaid agency or a subordinate division/unit within the Medicaid agency.
<b>Medically Necessary</b>	Services or supplies that are proper and needed for the diagnosis or treatment of a medical condition, are provided for the diagnosis, direct care, and treatment of the condition, and meet the standards of good medical practice.
<b>Medicare</b>	The Federally-administered health insurance program established in Title XVIII of the Act for persons age 65 and older and certain persons with disabilities under age 65. Medicare eligibility is determined by the Social Security Administration. Medicare has four parts: Part A (hospital insurance); Part B (optional medical insurance which covers physicians' services and outpatient care in part and which requires the payment of a monthly premium); Part C (managed care arrangements for the delivery of Medicare benefits); and, Part D (prescription drugs).
<b>Medication Administration</b>	The provision of a medication by a service provider to an individual who is not able to self-administer his/her own medications.
<b>Medication Error</b>	A mistake in medication administration that includes but is not necessarily limited to the following:  <ul style="list-style-type: none"> <li>(a) wrong medication (an individual receives and takes medication which is intended for another person, discontinued, or inappropriately labeled;</li> <li>(b) wrong dose (an individual receives the incorrect amount of medication);</li> <li>(c) wrong time (an individual receives medication dose at an incorrect time interval); and,</li> <li>(d) omission (missed dose) is when an individual does not receive a prescribed dose of medication, not including when an individual refuses to take medication.</li> </ul>
<b>Medication Management</b>	Processes and activities that are undertaken in order to ensure that the full range of medications that a person receives is appropriate. Medication management may include periodic review of medications to determine their necessity, to identify possible over medication, and to identify contraindicated medications.
<b>Mental Retardation</b>	A condition/disability that is manifested by:  <ul style="list-style-type: none"> <li>(1) significant sub-average intellectual functioning as measured</li> </ul>

	<p>on a standardized intelligence test;</p> <p>(2) significant deficits in adaptive behavior/functioning (e.g., daily living, communication and social skills); and,</p> <p>(3) on-set during the developmental period of life (prior to age 18).</p>
<b>Monitoring</b>	The ongoing oversight of the provision of programs and other services to determine that they are furnished according to the participant's service plan and effectively meet his/her needs, including assuring health and welfare. Monitoring activities may include (but are not limited to) telephone contact, observation, interviewing the participant and/or the participant's family (as appropriate) (in person or by phone), and/or interviewing service providers.
<b>Neglect</b>	The failure to provide an individual the reasonable care that s/he requires, including but not limited to food, clothing, shelter, medical care, personal hygiene, and protection from harm.
<b>Nursing Facility (NF)</b>	<p>Sometimes referred to as nursing homes. Nursing facility services for individuals age 21 and older are a mandatory Medicaid benefit. A state may provide nursing facility services to individuals under age 21 on an optional basis. Nursing facilities are institutions that primarily provide:</p> <ul style="list-style-type: none"> <li>• Skilled nursing care and related services for residents who require medical or nursing care;</li> <li>• Rehabilitation services for the rehabilitation of injured, disabled or sick persons; and/or</li> </ul> <p>Health-related care and services, on a regular basis, to individuals who because of their mental or physical condition require care and services, above the level of room and board, which can be made available to them only through institutional facilities.</p>
<b>Operating Agency</b>	A state agency other than the Medicaid agency that is responsible for the day-to-day operation and administration of a waiver. An operating agency conducts waiver operation and administration functions under an interagency agreement or memorandum of understanding with the Medicaid agency.
<b>Operation (Waiver)</b>	The constellation of administrative activities and processes that are necessary so that individuals may receive services through the waiver. Such activities may include functions such as payment rate determination, training and technical assistance, utilization management, and prior authorization.
<b>Ombudsman</b>	A representative of a public agency or a private nonprofit organization who is empowered under state law to investigate and resolve complaints made by or on behalf of individuals who receive services. Under the provisions of the Older Americans Act, each state has established a Long-Term Care Ombudsman Office to investigate and resolve complaints about services in nursing and certain other long-term care facilities. Some states have established similar programs for individuals with

	disabilities.
<b>Outcome</b>	The result of the performance (or nonperformance) of a function or process, including the provision of services.
<b>Outcome Indicator</b>	A key quality characteristic that is measured, over time, in order to assess whether the provision of services or the performance of activities resulted in the desired result.
<b>Participants</b>	Individuals who are enrolled in programs to receive HCBS services and supports.
<b>Participant-Centered</b>	A general term used to describe waiver processes and activities that are designed to address each participant's unique goals, preferences and needs.
<b>Participant-Directed Budget</b>	An amount of waiver funds that is under the control and direction of the waiver participant when a waiver makes available the Budget Authority participant direction opportunity. Sometimes called the "individual budget."
<b>Participant-Directed Service</b>	A waiver service that the state specifies may be directed by the participant using the Employer Authority, the Budget Authority or both.
<b>Participant Direction</b>	Provision of the opportunity for a waiver participant to exercise choice and control in identifying, accessing, and managing waiver services and other supports in accordance with their needs and personal preferences.
<b>Performance Assessment</b>	Involves the analysis and interpretation of performance measurement data to transform it into useful information for purposes of continuous performance improvement.
<b>Performance Measure</b>	A gauge used to assess the performance of a process or function of any organization. Quantitative or qualitative measures of the services that are delivered to individuals (process) or the end result of services (outcomes). Performance measures also can be used to assess other aspects of an individual or organization's performance such as access and availability of care, utilization of care, health plan stability, beneficiary characteristics, and other structural and operational aspect of health care services.
<b>Person-Centered Planning</b>	An assessment and service planning process is directed and led by the individual, with assistance as needed or desired from a representative or other persons of the individual's choosing. The process is designed to identify the strengths, capacities, preferences, needs, and desired outcomes of the individual. The process may include other persons, freely chosen by the individual, who are able to serve as important contributors to the process. The PCP process enables and assists the individual to identify and access a personalized mix of paid and non-paid services and supports that assist him/her to achieve personally defined outcomes in the community.
<b>Personal Care Services</b>	A range of human assistance provided to persons with disabilities and chronic conditions of all ages to enable them to accomplish tasks that they would normally do for themselves if they did not have a disability. Assistance may take the form of

	hands-on assistance or as cueing so that the person performs the task by him/herself. Such assistance most often relates to performance of activities of daily living (ADLs) and instrumental activities of daily living (IADLs), which includes assistance with daily activities such as eating, bathing, dressing, toileting, transferring, personal hygiene, light housework, medication management, etc. Personal care may be furnished in the home or outside the home. Also sometimes known as “personal assistance” or “attendant care.” Personal care is an optional State plan benefit (42 CFR §440.167) and is a waiver service that is recognized in §1915(c) of the Act.
<b>Persons Living With AIDS (PLWAs)</b>	Individuals who have Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) Infection
<b>Planning Team</b>	A group of people who help to support the participant in the community. The planning team is comprised of the participant, guardian (if applicable), Supports Coordinator and others as chosen by the participant or guardian (if applicable).
<b>Potential Participant</b>	A person who has selected HCBS services and is awaiting enrollment.
<b>Private Residence</b>	As used in the waiver application: <ul style="list-style-type: none"> <li>(1) The home that a waiver participant owns or rents in his or her own right or the home where a waiver participant resides with other family members or friends. A private residence is not a living arrangement that is owned or leased by a service provider; or,</li> <li>(2) The home of a caregiver who furnishes foster or respite care to a waiver participant</li> </ul>
<b>Process</b>	A goal-directed, interrelated series of actions, events, mechanisms, or steps.
<b>Process Improvement</b>	A methodology utilized to make improvements to a process through the use of continuous quality improvement methods.
<b>Process Indicator</b>	A gauge that measures a goal-directed interrelated series of actions, events, mechanisms, or steps.
<b>Provider</b>	A qualified individual or entity that undertakes to render Medicaid services to beneficiaries and has an agreement with the Medicaid agency. Supply HCBS services and supports.
<b>Provider Agreement</b>	The contract between the Medicaid agency and a service provider under which the provider or organization agrees to furnish services to Medicaid beneficiaries in compliance with state and Federal requirements. Federal regulations concerning provider agreements are located in 42 CFR §431.107.
<b>Provider-Managed Service</b>	A waiver service for which a provider is responsible for directing and managing in accordance with the service plan on behalf of a waiver participant. In the waiver application, a state may designate a service as provider managed, participant-directed or both.
<b>Quality Assurance</b>	The process of looking at how well a service is provided. The process may include formally reviewing the services furnished

	to a person or group of persons, identifying and correcting problems, and then checking to see if the problem was corrected.
<b>Quality Improvement</b>	The performance of discovery, remediation and quality improvement activities in order to ascertain whether the waiver meets the assurances, correct shortcomings, and pursue opportunities for improvement. Quality Improvement also is employed to address other areas of waiver performance.
<b>Quality Improvement Strategy (QIS)</b>	The document that is submitted with the waiver application that describes how the state will continually assess whether it operates the waiver in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and how it identifies opportunities for improvement. A QIS describes the processes of discovery, remediation and quality improvement activities; the frequency of those processes; the source and types of information gathered, analyzed, and utilized to measure performance; and key roles and responsibilities for managing quality. The QIS may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and extend beyond regulatory requirements. Updates to the QIS will be submitted with the annual waiver report.
<b>Quality Improvement Intervention</b>	An effort to enhance the extent to which service is safe, timely, effective, efficient, equitable, and participant-centered and results in the best possible outcomes. It can occur at the policy, delivery system, or microsystems levels (or all of these) and will enhance the way service delivery is structured, organized, and operationalized to ensure that participants receive service based on the best available evidence.
<b>Reevaluation</b>	The periodic but at least annual review of an individual's condition and service needs to determine whether the person continues to need a level of care specified in the waiver.
<b>Rehabilitation</b>	Services that have the purpose of improving/restoring a person's physical or mental functioning. Such services may include therapeutic services such as occupational and physical therapy services, as well as mental health services such as individual and group psychological therapies, psychosocial services, and addiction treatment services. Rehabilitative services may be provided at home, in the community or in long-term care facilities. Medicaid rehabilitation services, defined at 42 CFR §440.130(d), may be covered as an optional State plan benefit or as waiver services.
<b>Related Condition</b>	For the purpose of ICF/MR services and as provided in 42 CFR §435.1009, a person with related conditions is an individual who has a severe, chronic disability that meets all of the following conditions:  (a) It is attributable to-- (1) Cerebral palsy or epilepsy; or

	<p>(2) Any other condition, other than mental illness, found to be closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, and requires treatment or services similar to those required for these persons.</p> <p>(b) It is manifested before the person reaches age 22.</p> <p>(c) It is likely to continue indefinitely.</p> <p>(d) It results in substantial functional limitations in three or more of the following areas of major life activity:</p> <ol style="list-style-type: none"> <li>(1) self-care;</li> <li>(2) understanding and use of language;</li> <li>(3) learning;</li> <li>(4) mobility;</li> <li>(5) self-direction;</li> <li>(6) capacity for independent living.</li> </ol>
<b>Remediation</b>	<p>Activities designed to correct identified problems at the individual, provider or system level. Examples of individual level remediation include providing additional needed services when discovery activities indicate that an individual/participant has not received necessary services. Provider level remediation includes sanctioning a provider for failure to furnish services in accordance with state requirements. System-level remediation activities may include the correction of underlying waiver design problems.</p>
<b>Representative</b>	<p>A person who may act on behalf of another. A representative may be:</p> <ol style="list-style-type: none"> <li>(a) a legal representative (a court-appointed guardian, a parent of a minor child, or a spouse) or</li> <li>(b) an individual (family member or friend) selected by an adult to speak for and/or act on his/her behalf.</li> </ol>
<b>Request for Additional Information (RAI)</b>	<p>A formal, written document issued by CMS that identifies serious problems with a waiver request that potentially could cause CMS to disapprove the request. An RAI stops the 90-day clock. Once a state responds to the RAI, a new 90-day clock is started. During the second clock CMS may not issue an RAI — it must approve/disapprove the request.</p>
<b>Risk</b>	<p>Factors that, if unaddressed, might pose a high threat to an individual's health and welfare. These include:</p> <ol style="list-style-type: none"> <li>(a) health risk (medical conditions that require continuing care and treatment);</li> <li>(b) behavioral risk (behaviors or conditions that might cause harm to the person or others); and,</li> <li>(c) personal safety risk (e.g., safe evacuation).</li> </ol>
<b>Safeguard</b>	<p>Policies or procedures that are designed to prevent harm to an individual or to ensure that the application of a policy takes into account potentially adverse effects on a person.</p>
<b>Self-Administration</b>	<p>The administration of medications or other procedures by a</p>

	person without assistance.
<b>Serious Injury</b>	An injury that requires the provision of medical treatment beyond what is commonly considered first aid.
<b>Service Plan</b>	The written document that specifies the program and other services (regardless of funding source) along with any informal supports that are furnished to meet the needs of and to assist a program participant to remain in the community. The service plan must contain, at a minimum, the types of services to be furnished, the amount, the frequency and duration of each service, and the type of provider to furnish each service.
<b>Skilled Care</b>	A type of health care given when skilled nursing or rehabilitation staff is required to manage, observe, and evaluate your care.
<b>Skilled Nursing Care</b>	A level of health care that includes services that can only be performed safely and correctly by a licensed nurse (either a registered nurse or a licensed practical nurse).
<b>Skilled Nursing Facility (SNF)</b>	A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.
<b>Stakeholders</b>	Any individual with vested interest in OLTL programs and services.
<b>Supports Coordinator</b>	An individual that assists participants to gain access to needed services and supports, including medical, social, educational and other services, regardless of the funding source to which access is granted.
<b>Target Group</b>	A group of Medicaid beneficiaries who have similar needs, conditions or characteristics to whom a state elects to furnish waiver services. Common HCBS waiver target groups include older persons, individuals with physical disabilities, persons who have experienced a brain injury, and persons with developmental disabilities. A state must specify the target group(s) that it serves in the waiver.
<b>Targeted Case Management</b>	As provided in §1915(g) of the Act, optional State plan services that are furnished to assist Medicaid beneficiaries to gain access to needed medical, social, educational, and other services. TCM services may be furnished to target groups specified by the state on a statewide or less than statewide basis. Rules published in CMS-2237-IFC apply.
<b>Technology Dependent</b>	A person who needs both a medical device to compensate for the loss of a vital body function and substantial and ongoing nursing care to avert death or further disability.
<b>Telemedicine</b>	The use of communication equipment to link health care practitioners and patients in different locations. This technology is used by health care providers for many reasons, including increased cost efficiency, reduced transportation expenses, improved patient access to specialists and mental health providers, improved quality of care, and better communication among providers.
<b>Traumatic Brain Injury</b>	A sudden insult or damage by an external physical force to the

<b>(TBI)</b>	brain or its coverings, not of a degenerative, congenital or post operative nature, which is expected to last indefinitely and results in substantial functional limitation in major life activities.
<b>Trend</b>	Pattern of gradual change in a condition, output, or process, or an average or general tendency of a series of data points to move in a certain direction over time, represented by a line or curve on a graph.
<b>Unduplicated Participant</b>	A unique individual who receives waiver services at any point during a waiver year, regardless of the length of time that the person is enrolled in the waiver or the amount of waiver services that the person receives. A person who enters, exits, and then reenters the waiver is considered to be one unduplicated participant.
<b>Validation</b>	The process by which the integrity and correctness of data are established. Validation processes can occur immediately after a data item is collected or after a complete set of data is collected.
<b>Waiver Period</b>	The period of time that a waiver is in effect. In the case of a new waiver, the waiver period is three years. In the case of a renewal, the waiver period is five years.
<b>Waiver Year</b>	The 12-month period that begins on the date the waiver takes effect and the 12-month period following each subsequent anniversary date of the waiver.