# GLOSSARY

**Adjunct Services** – Services provided by the FQHC on weekends, state legal holidays, and between the hours of 5 p.m. and 8 a.m. Monday through Friday.

**Bureau of Health Services Financing (BHSF)** – The Bureau within the Department of Health and Hospitals responsible for the administration of the Louisiana Medicaid Program.

**Change in Scope** – an addition, removal and relocation of service sites and the addition or deletion of specialty and non-primary services that were not included in the baseline rate calculation.

**CMS** – The Center for Medicare and Medicaid Services **(**Formerly known as Health Care Financing Administration-HCFA) is the federal agency in DHHS responsible for administering the Medicaid Program and overseeing and monitoring of the State's Medicaid Program.

**Department of Health and Hospitals (DHH)** – The state agency responsible for administering the Medicaid Program and health and related services including public health, mental health, developmental disabilities, and alcohol and substance abuse services. In this manual the use of the word "department" will mean DHH.

**Department of Health and Human Services (DHHS)** – The federal agency responsible for administering the Medicaid Program and public health programs.

**Encounter –** A face-to-face visit with a physician, physician assistant, nurse practitioner, nurse midwife, visiting nurse, clinical psychologist, clinical social worker, or any other State plan approved ambulatory provider during which an FQHC core or other ambulatory service is rendered. Multiple medical encounters with more than one health care practitioner or with the same health care practitioner, which take place on the same day at a single location, constitute a single visit, except for cases in which the recipient, subsequent to the first encounter, suffers illness or injury requiring additional diagnosis or treatment.

**Enrollment** – A determination made by DHH that a provider agency meets the necessary requirements to participate as a provider of Medicaid or other DHH-funded services. This is also referred to as provider enrollment.

**Federally Qualified Health Center** – An entity receiving a grant under Section 330 of the Public Health Service Act; is receiving funding from such grant under a contract with the recipients of a grant and meets the requirements to receive a grant under Section 330 of the PHS Act; is not receiving a grant under Section 330 of the PHS Act but determined by the Secretary of DHHS to meet the requirements for receiving a grant based on the recommendation of the HRSA; is operating as an outpatient health program or facility of a tribe or tribal organization

under the Indian Self Determination Act or an urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act as of October 1, 1991.

**Fiscal Intermediary** – Is the private fiscal agent with which DHH contracts to operate the Medicaid Management Information System. It processes Title XIX claims for Medicaid services provided under the Medicaid Assistance Program, issues appropriate payment and provides assistance to providers on claims.

**Health Professional Shortage Area –** An urban or rural area, population group, or public or nonprofit private medical facility which the Secretary of DHHS determines has a shortage of health professionals.

**Health Resources Services Administration (HRSA)** – An office within the Department of Health and Human Services whose mission is to improve access to healthcare services for the uninsured, isolated, or medically vulnerable through leadership and financial support.

**Medicaid** – A federal-state financed entitlement program which provides medical services primarily to low-income individuals under a State Plan approved under Title XIX of the Social Security Act.

**Medically Underserved Area –** Areas designated by HRSA as having too few primary care providers, high infant mortality, high poverty and/or high elderly population.

**Medically Underserved Population** – Areas designated by HRSA as having high infant mortality, high poverty, and/or high elderly population.

**Medicare** – The health insurance program for the aged and disabled under Title XVIII of the Social Security Act.

**Medicaid Management Information System (MMIS)** – The computerized claims processing and information retrieval system for the Medicaid Program. This system is an organized method of payment for claims for all Medicaid covered services. It includes all Medicaid providers and eligible recipients.

**Prospective Payment System (PPS)** – Method of reimbursement in which payment is made on a predetermined, fixed amount. Section 1902(bb) of the Social Security Act describes the methodology used to determine the PPS for FQHCs.

**Provider Enrollment** – Another term for enrollment.

**Secretary** – The Secretary of the Department of Health and Hospitals or any official to whom (s)he has delegated the pertinent authority.

**Satellite Clinics** – Separate clinics of the primary FQHC.

**Service site** – Any center which provides primary health care services to a geographic service area or population.

**Trade Areas** – Counties in the states of Texas, Arkansas, and Mississippi that physically share a border with Louisiana.