

Speaking the Same Language: Criminal Justice, Health Care, and Information Technology, Second Edition

TERM	MEANING
42 CFR Part 2	The federal confidentiality regulations known collectively as 42 CFR Part 2 were enacted in the 1970s to address the stigma associated with substance use and the fear of prosecution that deterred some individuals from entering treatment. Part 2 stipulates that no substance use record may be used to initiate or substantiate criminal charges against a patient or to conduct any investigation of a patient, and it additionally enforces a limitation of scenarios in which court orders authorizing the disclosure of such records can be implemented. Part 2 permits the disclosure of patient information to health information organizations and other health information exchange organizations. The regulation requires patient consent for most disclosures by substance use treatment programs, although there are some exceptions. Patient consent is not permanent and patients specify the date on which consent expires. In addition, a patient can revoke consent at any time. However, consent from a patient referred by the criminal justice system may be made irrevocable for a period of time.
340B Drug Pricing	The 340B Drug Pricing program requires drug manufacturers to offer reduced prices to certain health care organizations, including Federally Qualified Health Centers, children's hospitals, Ryan White HIV/AIDS clinics, and other safety net providers. The program, established by section 340B of the Public Health Services Act in 1992, is designed to help these organizations reach greater numbers of patients and provide more comprehensive services.
1115 Waiver	Section 1115 of the Social Security Act allows the Secretary of Health and Human Services to waive certain federal statutory requirements, allowing states flexibility in pursuing Medicaid demonstration projects. In the past, states have used 1115 waivers to expand Medicaid eligibility to new populations, cover new services, and/or utilize alternative payment and delivery systems. 1115 demonstration projects are required to be budget neutral (not exceeding the estimated federal spending that would have occurred without the waiver), and can range in scope from comprehensive waivers that alter a state's entire program to more limited waivers that introduce new services for specific groups. For example, one recent 1115 waiver, California's 2010 "Bridge to Reform," expanded Medicaid eligibility to childless adults with income up to 138% of the Federal Poverty Level in anticipation of the 2014 implementation of the Affordable Care Act.



1332 Waiver	Section 1332 of the Affordable Care Act (ACA) allows states to apply for State Innovation Waivers that would take effect in 2017 and that would give states flexibility to pursue different health reform initiatives than the ones established by the ACA. Section 1332 allows for waivers of various ACA requirements, including provisions related to qualified health plans, federal advanced premium tax credits, and the shared responsibility requirement (also known as the individual mandate). 1332 waivers could allow states to receive the federal funding that would have been available through tax credits and cost-sharing reduction payments in order to fund reform efforts. Notably, policymakers in Vermont have considered applying for a 1332 waiver as part of the state's plan to create a statewide single payer health care system.
1915(b) Waiver	Section 1915(b) of the Social Security Act allows states to use managed care models in the Medicaid program. Through these waivers, states can pursue managed care systems that restrict the types of providers that beneficiaries can use, allow counties to act as enrollment brokers to help beneficiaries pick a managed care plan, and use the savings from the managed care system to provide additional services to Medicaid beneficiaries. States can also use these waivers to mandate that all Medicaid beneficiaries in the state or a particular geographic area participate in managed care.
1915(c) Waiver	Section 1915(c) of the Social Security Act allows states to provide long term care in home and community-based settings through the Medicaid program. These services can include case management, home health aides, and respite care.
AB 109	California Assembly Bill 109 (AB 109), signed into law by Governor Jerry Brown in 2011, authorized the state's Public Safety Realignment initiative. The law was a response to the U.S. Supreme Court's 2011 ruling in <i>Brown v. Plata</i> that the state would be required to reduce the population of its prisons to 137.5% of the system's total design capacity, which at the time meant a reduction of more than 30,000 prisoners. AB 109 redefined many low-level felonies as non-violent, non-serious, non-sex (N-3) offenses, and realigned the responsibility and funding for the supervision of individuals convicted of those offenses from the state Department of Corrections and Rehabilitation (CDCR) - which oversees the state prison system - to the counties. Newly convicted N-3 felons in California now serve sentences in county jails, in the community under county probation supervision, or through a combination of the two, when in the past they would have been sentenced to state prison. Certain individuals with N-3 sentences returning to the community from state prisons are also now supervised by county probation departments under a program called Post Release Community Supervision, when in the past they would have been supervised by CDCR's Division of Adult Parole. Community Corrections Partnerships in each county - comprised of executive leadership in corrections, the courts, and behavioral health services - are charged with planning and implementing the realignment process. Counties allocate the new funding they receive across departments, and are encouraged to seek innovative ways to supervise the AB 109 population.

Accountable Care Organization	Accountable care organizations (ACOs) are groups of doctors, hospitals, and other health care providers that coordinate care for patients in order to bend the health care cost curve. ACOs operate along the lines of the Health Maintenance Organization model of health care finance and delivery, working in a synchronized fashion to provide timely treatments that save costs, reduce duplication of services, and reduce medical errors. ACOs represent an effort to tie payment to quality. Early ACOs focused primarily on Medicare patients, but some ACOs have been formed to cover Medicaid and/or commercial health insurance patients as well.
Admissions, Discharges, and Transfers	Admissions, discharges, and transfers (referred to collectively as ADT) represent one of the most common types of health data sent between systems. Health Level Seven ADT messages carry patient demographic information and provide important information about trigger events (such as patient admissions, discharges, transfers, registrations, and updated demographic data). These trigger events cause ADT messages to flow out to different locations such as outpatient clinics or laboratories, depending on who needs that information.
Advanced Premium Tax Credit	The Affordable Care Act allows certain individuals and families with income between 100% and 400% of the Federal Poverty Level who are not eligible for Medicaid to receive federal tax credits to help purchase insurance through the Health Insurance Exchanges. These tax credits are known as advanced premium tax credits because they are available immediately to assist in paying health insurance premiums. The tax credits are available on a sliding scale depending on projected income, and are reconciled through the federal income tax reporting process.
Alternative Benefit Plan	The Affordable Care Act (ACA) requires that coverage for individuals gaining eligibility through the Medicaid expansion new adult group be provided through Alternative Benefit Plans (ABPs), which allow states flexibility in offering coverage. Through ABPs, states can choose to provide specific groups of Medicaid enrollees with “benchmark coverage” – the provision of benefits that are at a minimum equivalent to one of four statutorily defined coverage options, three of which are commercial insurance products. States can adopt different ABPs for different sub-populations or can adopt one plan for the entire Medicaid expansion population. The ACA requires that ABPs cover the ten categories of essential health benefits. Federal guidelines have stated that Medicaid ABPs must be compliant with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (see “Parity”).
Arraignment	Arraignment is a criminal proceeding in which a defendant is brought before a court, charges against the defendant are read, and the defendant is asked to enter a plea. When bail is available, it is typically set at arraignment. Most jurisdictions require that arraignment take place within a reasonable amount of time after arrest, typically 48 - 72 hours.
Bail	Bail is a form of property deposited or pledged to a court to persuade it to release a defendant from jail, on the understanding that the defendant will return for trial or forfeit the bail.
Beacon Community Program	The Beacon Community Cooperative Agreement Program supports 17 communities selected for their leadership in adopting secure and robust systems of electronic health records and health information exchanges. The Beacon communities focus on improving health, improving health care, and reducing health care costs, and provide support and guidance to other communities.

Benchmark	Benchmark is a term used to denote a minimum level of benefits that a health plan must provide. In the context of the commercial health insurance market, the term benchmark refers to the health plan that each state must select in order to define the minimum services offered by all individual and small group health plans within each category of essential health benefits defined by the Affordable Care Act. Within the context of Medicaid, benchmark refers to coverage based on one of four statutorily defined coverage options that are available to states in defining Alternative Benefit Plans.
Benefit Exclusion	Most health plans contain benefit exclusions, which outline conditions under which the plan will not pay for services. One typical benefit exclusion is for court-ordered services, such as alcohol dependence treatment, which may be part of a sentence for someone convicted of a crime. States have primary responsibility for regulating the insurance market, and vary with respect to the benefit exclusions that they allow. Similarly, benefit exclusions can vary by health plan.
Blue Button	Blue Button is a standard blue icon or “button” that appears on a health portal website. Patients may click the blue button to access their health information. Patients can download a variety of information in multiple formats, including text and PDF. Blue Button Plus is an initiative of the Standards and Interoperability Framework that gives consumers the ability to obtain, print, and/or share their health care records in both human-readable and machine-readable formats, and to send them where they choose.
Booking	Booking refers to the processes and procedures performed by law enforcement officers immediately following arrest. Booking procedures vary by law enforcement agency, but typically encompass the following activities: obtaining basic personal information, obtaining fingerprints, recording details of the alleged offense, and placing the arrested individual in a detention facility such as a police department holding facility or a local jail.
Bridge Medication	At release, many correctional institutions provide inmates with a supply of some or all of the medications that they were prescribed while incarcerated to prevent a lapse in treatment. Typically a supply of three to thirty days is provided at the time of release. In 1999, the U.S. Court of Appeals for the Ninth Circuit held in <i>Wakefield v. Thompson</i> that outgoing inmates who were receiving medication while incarcerated have a right to a sufficient supply of bridge medication to allow them the necessary time to obtain a new supply.
<i>Brown v. Plata</i>	The culmination of a series of lawsuits dating to the early 1990s, <i>Brown v. Plata</i> is a 2011 U.S. Supreme Court ruling upholding a Three-Judge Panel’s order that California reduce its prison population to 137.5% of design capacity over the course of two years. The court held that overcrowding had led to deficiencies in medical and mental health care services within the prisons that constituted a violation of prisoners’ Eighth Amendment protections against cruel and unusual punishment. California’s Public Safety Realignment initiative (see “AB 109”), which placed low-level felons under the responsibility of the counties rather than the state, was a response to the <i>Brown</i> decision.

Capitation	Capitation refers to a system of health care payment in which providers receive fixed or “capitated” payments for each of their patients per unit of time (usually a month) to provide an array of health care services. Capitated payments are typically employed in managed care models and are distinct from fee-for-service payments, in which providers are paid a fee for each service that they perform. There are many varieties of capitated payment structures. For example, managed care organizations may contract with primary care physicians to provide a range of services and pay a fixed, up-front “per member per month” (pmpm) fee based on the services they would be expected to provide. In this scenario, the physicians would be “at risk” financially, as they would bear any costs that surpassed their aggregate pmpm fees. In some capitated payment systems, capitation-receiving entities can enter into “sub-capitation” agreements with other entities to provide certain services for patients.
Center for Medicare and Medicaid Innovation	The Affordable Care Act added section 1115A to the Social Security Act, establishing the Center for Medicare and Medicaid Innovation (Innovation Center, or CMI) within the Centers for Medicare and Medicaid Services. Section 1115A allows the Secretary of Health and Human Services to waive certain federal statutory requirements in order to carry out demonstration projects through the Innovation Center. The Innovation Center is charged with testing and evaluating innovative health care payment and delivery models with the potential to lower costs and improve quality, and has \$10 billion at its disposal over a 10-year period to fund projects through open, competitive solicitations. The Transitions Clinic Network, a project designed to address the health care needs of Medicaid-eligible individuals with chronic conditions released from prison, received funding from the Innovation Center. The Transitions Clinic model uses community health workers to help recently released individuals navigate the health care system in an effort to reduce emergency room use, hospital admissions, and costs while improving health and access to health care.
Centers for Medicare and Medicaid Services	The Centers for Medicare and Medicaid Services (CMS) is the federal agency under the federal Department of Health and Human Services that administers the Medicare and Medicaid programs as well as the Children’s Health Insurance Program (CHIP).
Certified Electronic Health Record Technology	The HITECH Act of 2009 established the Medicare and Medicaid EHR Incentive Programs for providers and hospitals that adopt and “meaningfully use” electronic health records (EHRs) (that is, use EHRs in a clinically significant way in order to improve patient care). Meaningful Use is the set of objectives established by the Centers for Medicare and Medicaid Services (CMS) that an entity must achieve in order to receive incentive payments. CMS and ONC developed standards and a certification program to define the EHR systems that providers and hospitals could adopt in order to achieve Meaningful Use. Systems that meet the standards are designated “certified EHR technology” (CEHRT). Providers and hospitals that adopt CEHRT do not automatically achieve Meaningful Use; however, CEHRT guarantees a minimum level of functionality that can be used to meet the objectives of Meaningful Use.
Certified Public Expenditure	States must finance the non-federal portion of the Medicaid program through public state and local funding. (Money that flows to the states from other federal sources cannot be used for this obligation; similarly, private money generally cannot be used.) One way that states accomplish this is through certified public expenditures (CPEs). When state or local government entities spend money on the Medicaid program, they can certify that those expenditures meet federal requirements as CPEs. State Medicaid agencies can then use CPEs to draw down federal matching funds.

Clinical Document Architecture, Consolidated Clinical Document Architecture	Health Level Seven International developed the Clinical Document Architecture (CDA), an XML-based standard used for the exchange of electronic clinical documents. CDA is a flexible standard and is unique in that it can be read by the human eye or processed by a machine. Text, images, and multimedia can be included in a CDA document. Standardized groupings of data known as “templates” can be used within the CDA framework to build a great variety of clinical documents. CDA’s flexibility led to a proliferation of standards published by different groups, threatening interoperability. To address this problem, the Consolidated Clinical Document Architecture (CCDA) consolidated the existing guidelines into a single library of reusable CDA templates for nine frequently used document types: continuity of care documents (CCDs), consultation notes, diagnostic imaging reports, discharge summaries, history and physical notes, operative notes, procedure notes, progress notes, and unstructured documents. To attest for Meaningful Use Stage 2, providers need to send CCDA care summaries containing problem lists, medications, and medication allergies.
Consent Decree	A consent decree is a voluntary settlement between two parties procured as part of a court order. A consent decree differs from a judgment in that the defendant has some input in the terms of the decree and the terms of how to remedy the plaintiff’s grievances. Defendants accomplish this by negotiating with both the court and the plaintiff. In these instances, a defendant may settle without exposing many details publically. Reciprocally, a plaintiff is guaranteed the power of the courts in enforcing the settlement. This latter point is important because a consent decree, unlike a contract, has the force of judgment and as such can be enforced by the court merely on the motion of an aggrieved party (instead of requiring a new lawsuit), wherein it becomes the responsibility of the defendant to demonstrate compliance with the decree. Many jails are party to consent decrees. Consent decrees in this context can often change how health care is delivered in jails.
Continuity of Care Document	A Continuity of Care Document (CCD) is an electronic document that is used to share patient summary information according to specific interoperability standards. This specialized set of information includes the most commonly needed, pertinent information about a patient’s past and current health status in a form that can be shared among multiple computerized health information systems, including electronic health and medical record systems.
Co-pay	A co-pay is a payment that health insurance plans often require a patient to make upon receiving a service. It is a form of cost-sharing intended to discourage overuse of health care services.
Correctional Officer	A correctional officer is an employee of a jail, reformatory, or prison who is responsible for overseeing individuals who have been detained or incarcerated.
Costs Not Otherwise Matchable	Section 1115 of the Social Security Act allows the Secretary of Health and Human Services to waive certain federal statutory requirements, allowing states flexibility in pursuing Medicaid demonstration projects. Through section 1115, the Secretary can approve federal funding for costs not otherwise matchable (CNOM), or spending for services that are not otherwise covered through the Medicaid program. Although 1115 demonstration projects can include CNOM, overall spending must be budget neutral compared to what projected costs would be without a waiver.

Covered Entity	The HIPAA Privacy Rule applies only to covered entities. Covered entities are defined by the federal government as health care providers (any person or organization who furnishes, bills, or is paid for health care) that transmit information electronically in connection with transactions specified by the HIPAA Transactions Rule (such as submitting claims to a health plan); any individual or group health plan (with a few exceptions); and health care clearinghouses, which process data for other organizations.
Criminal Charge	Criminal charges are formal accusations of crimes, typically issued by a district attorney after reviewing a case brought forth by a law enforcement officer. Individuals who are charged with crimes proceed to arraignment unless charges are dismissed.
Crisis Intervention Team	Crisis intervention teams (CITs) are collaborations between local law enforcement agencies, mental health professionals, and patient advocates designed to improve interactions between law enforcement officers and people with mental health disorders. Although program structures vary, most programs train law enforcement officers to recognize and safely de-escalate mental health crises without the use of force. In some jurisdictions, mental health providers accompany law enforcement officers when dispatched to crisis scenes. Typically, patients are brought to health care facilities rather than entering the criminal justice system.
Current Procedural Terminology	Current Procedural Terminology (CPT) is a system of codes used to report medical procedures and services under public and private health insurance programs. The CPT code set is maintained by the American Medical Association's CPT Editorial Panel, which meets three times per year to discuss the use and revision of CPT coding in response to new and emerging medical procedures and technologies. CPT codes identify services that have been performed rather than medical, surgical, or psychiatric diagnoses.
CVX	CVX is a numerical code that identifies vaccines. ONC has adopted CVX as a standard for the entry of structured data regarding immunizations in certified EHR technology.
Data Segmentation	The term "data segmentation" refers to the process of sequestering from capture, access, or view certain data elements that are perceived by a legal entity, institution, organization, or individual as being undesirable to share. ONC has launched a data segmentation initiative with the goal of tagging portions of medical records with enough metadata to separate data into categories that better allow control of information exchange in accordance with patient privacy preferences. Data segmentation initiatives are under development for protected diagnoses such as HIV and for substance use treatment records.
Deductible	An insurance plan's deductible is the amount of money that the beneficiary is required to pay "out-of-pocket" over a given period of time - typically a year - before the insurance plan will pay for services.
Deliberate Indifference	As defined by the U.S. Supreme Court in <i>Estelle v. Gamble</i> , deliberate indifference to a jail or prison inmate's serious medical needs constitutes a violation of the Eighth Amendment's protection against cruel and unusual punishment. The court held that a jail or prison official acts with deliberate indifference only if he or she knows of and disregards an excessive risk to inmate health and safety.

Direct	<p>Direct is a project developed by the <i>Nationwide Health Information Network</i> (now the eHealth Exchange) that establishes standards and documentation to support simple scenarios of sending health-related information from one location to another using encrypted email protocols. A provider or organization that needs to securely send clinical information to another provider or health care organization manually “pushes” the information forward to the recipient. Direct is often referred to as secure e-mail. It is used for situations such as a provider sending a patient’s clinical snapshot to a specialist, or a hospital sending a recently discharged patient’s information to another provider. Direct encryption protocols ensure a high degree of discretionary protection for each transmission, which is coupled with the security strategy of sending information on a case-by-case basis without centralized storage. Providers can use Direct to meet the Meaningful Use Stage 2 core measure requirement for secure electronic messaging.</p>
Discharge Planning	<p>Discharge planning is the process of preparing an inmate for release and reentry into the community. Discharge planning is a standard practice in prisons, where inmates have predictable release schedules. Many jails use some form of discharge planning, but practices vary widely. Some jails provide comprehensive discharge planning that may include linkages to primary care, substance use or mental health treatment, housing, job training, assistance applying for health coverage and other benefits, and/or transportation vouchers. Some jails provide harm reduction counseling or pamphlets to help prevent drug overdose following release from custody. Most facilities provide a supply of bridge medications. Commonly, at the other end of the spectrum, inmates may be released without much preparation, possibly in the middle of the night. The multiple points at which a jail inmate or detainee may be released from jail – including after completing a sentence, after adjudication of charges, or after posting bail – complicates the discharge planning process.</p>
Diversion	<p>In the context of the criminal justice system, diversion refers to any program or service that “diverts” an individual away from the tradition criminal justice trajectory. Examples of diversion programs include Crisis Intervention Teams, which divert individuals with mental health disorders into treatment before the point of arrest; pretrial supervision, which diverts individuals unable to make bail out of incarceration while awaiting trial; and specialty courts, which allow nonviolent individuals with mental health disorders, substance use disorders, or other specific circumstances to receive treatment in the community under intensive court supervision in lieu of incarceration.</p>
eHealth Exchange	<p>Formerly known as the <i>Nationwide Health Information Network</i>, the eHealth Exchange is a collection of federal agencies and other organizations that develop standards and specifications for the secure exchange of health information. The eHealth Exchange was originally developed as an ONC product, and is now run by a nonprofit coalition called HealtheWay. Participating organizations agree to comply with standards in order to allow for interoperability.</p>

Electronic Medical Record, Electronic Health Record, Personal Health Record	An electronic medical record (EMR) refers to both a patient's computerized medical record and the software system used to create, modify, and secure a health care organization's complete patient records. The term is often used interchangeably with electronic health record (EHR), which performs identical functions but is thought to be better designed for the interoperable exchange of health information. Clinicians use these systems to access appropriately authorized portions of a patient's record and for adding or modifying information such as laboratory results, prescriptions, clinical interview data, and billing and diagnostic codes. While EMR and EHR systems generally are intended for use by health care practitioners and administrators, a similar record called the personal health record (PHR) lets patients confidentially and independently access their records outside a physician's office or a hospital. While all PHRs include some or all of the information generated by health care providers, some PHRs have added functionality for personal tasks like viewing recent test results, renewing prescriptions, scheduling appointments, and communicating with clinicians.
Electronic Medication Administration Record	An electronic medication administration record (eMAR) is a technology that automatically tracks medications from initial orders to final administration. An eMAR system typically features assistive technologies such as bar code readers, mobile devices, and/or smart carts for point of care delivery. Some jails use eMARs to great benefit as they provide precise inventory control and help prevent medication diversion (the use of prescription medication for recreational purposes).
Eligible Provider, Eligible Hospital	<p>Eligible Providers (EPs) and Eligible Hospitals (EHs) can qualify to receive incentive payments through the Medicare and Medicaid EHR Incentive programs established by the HITECH Act of 2009. A given provider cannot simultaneously qualify to receive payments for both the Medicare and the Medicaid EHR Incentive Programs. A Medicare EP can be a doctor of medicine or osteopathy, a doctor of dental surgery or dental medicine, a doctor of podiatry, a doctor of optometry, or a chiropractor. Besides the professional qualifications, a Medicare EP must furnish services which are reimbursed based on the Medicare physician fee schedule. A Medicaid EP can be a physician, a nurse practitioner, a certified midwife, a dentist, or a physician assistant (if he or she furnishes services in a Federally Qualified Health Center or Rural Health Clinic that is led by a physician assistant). A Medicaid EP must also have a patient volume of at least 30% Medicaid patients (20% Medicaid patients for pediatricians), or practice predominantly in a Federally Qualified Health Center or Rural Health Center and have a patient volume at least 30% attributable to needy individuals. Any patient who is enrolled in Medicaid, regardless of paid encounters, can be counted toward a provider's patient volume. A patient whose Medicaid status is suspended because of incarceration may be counted toward a provider's patient volume. As a result, some providers within jails could become Medicaid EPs.</p> <p>Unlike providers, a given hospital can simultaneously qualify to receive payments for both the Medicare and the Medicaid EHR Incentive Programs. Medicare EHs can be any of the following: hospitals defined in section 1886 of the Social Security Act, subsection (d) (which includes most acute care, general short-term hospitals); Critical Access Hospitals; or Medicare Advantage hospitals. Medicaid EHs can be any of the following: acute care hospitals (including Critical Access Hospitals and cancer hospitals) that have a patient volume that is at least 10% Medicaid patients; or children's hospitals.</p>

Essential Health Benefits	The Affordable Care Act (ACA) requires that all health plans in the individual and small group markets, as well as Medicaid Alternative Benefit plans, offer at minimum a set of basic covered services. These essential health benefits (EHBs) must include services within 10 broad categories: 1) ambulatory patient services, 2) emergency services, 3) hospitalization, 4) maternity and newborn care, 5) mental health and substance use disorder services (including behavioral health treatment), 6) prescription drugs, 7) rehabilitative and habilitative services, 8) laboratory services, 9) preventive and wellness services and chronic disease management, and 10) pediatric services (including oral and vision care). In accordance with the ACA, each state defines the minimum services that every individual and small group health insurance plan must cover within the EHB categories by selecting a benchmark insurance plan from several options within a given state. States select benchmark coverage for beneficiaries gaining coverage through Medicaid expansion through a similar process. Individual and small group health plans must provide EHB coverage whether or not they participate in Health Insurance Exchanges.
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<i>Estelle v. Gamble</i>, 429 U.S. 97	Decided by the U.S. Supreme Court in 1976, <i>Estelle v. Gamble</i> established the constitutional right to health care for people held in jails and prisons. The court established the criteria that deliberate indifference to an inmate's serious medical needs would constitute a violation of the Eighth Amendment's ban on cruel and unusual punishment. The cases that have followed <i>Estelle</i> have established three basic rights: the right to access to care, the right to care that is ordered, and the right to a professional medical judgment.
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Federal Financial Participation	States receive financial support from the federal government for Medicaid medical services and administrative expenditures through federal financial participation (FFP). Also known as the "federal match," states receive FFP at varying levels depending on the state and the type of expenditure. The FFP that states receive for medical services is determined by the Federal Medical Assistance Percentage, which varies by state. The FFP for administrative expenditures (obtained through the process of Medicaid Administrative Claiming) is the same for each state, but varies by category of expenditure, ranging from 50% to 90% of every dollar spent by the state.
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Federal Medical Assistance Percentage	The Federal Medical Assistance Percentage (FMAP) determines the federal government's share of a given state's Medicaid service expenditures. The FMAP, also known as the "federal matching rate," is determined by a formula that considers a state's per capita income compared to the national average. A lower-income state will receive a higher FMAP. Currently, states' FMAPs range from 50%, meaning that the federal government pays one dollar for every dollar spent by the state, to 74%, meaning that the federal government will spend nearly three dollars for every dollar spent by the state. In states that choose to expand Medicaid in accordance with the Affordable Care Act, Medicaid services for the newly eligible population can receive an enhanced FMAP of 100% from 2014 through 2016. By 2020 the enhanced FMAP will decrease to 90% and remain at that level thereafter.
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Federal Poverty Level	The Federal Poverty Level (FPL) is a guideline calculated annually by the Census Bureau for statistical purposes and to determine eligibility for certain state and federal programs. The Affordable Care Act gives states the option to expand Medicaid eligibility to individuals with income up to 138% of the FPL. The 2013 FPL (used to determine 2014 eligibility for Medicaid and advanced premium tax credits) is \$11,490 for an individual and \$23,550 for a family of four.
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Federally Qualified Health Center	Federally Qualified Health Centers (FQHCs) are community health centers that receive federal funding through the Health Center Program. FQHCs are consumer-directed and serve disproportionately low-income and uninsured populations, providing primary care and preventive services (often including dental care, mental health treatment, and substance use disorder treatment in addition to medical services) to millions of patients. FQHCs are expected to play a major role in providing services to the millions of patients newly eligible for coverage through the Affordable Care Act.
Fee-For-Service	In a fee-for-service (FFS) payment system, health care providers are reimbursed for each individual service they perform for patients. FFS is the traditional payment system for Medicare, Medicaid, and commercial health plans. Efforts to reduce health care costs and improve health care quality have increasingly moved away from FFS and toward the capitated payment systems frequently used in managed care models of health care finance and delivery.
Felony vs. Misdemeanor	Although definitions differ by state, in most jurisdictions in the United States, a felony is a more serious crime punishable by more than one year of incarceration, while a misdemeanor is a less serious crime punishable by up to one year of incarceration. People convicted of misdemeanors are often sentenced to incarceration in local jails or to alternatives to incarceration such as probation, whereas people convicted of felonies are usually sentenced to incarceration in prisons.
Global	The Global Justice Information Sharing Initiative (Global) is a coalition of law enforcement, public safety, and criminal justice organizations that serves as a federal advisory committee to the U.S. Attorney General on issues related to justice information sharing and integration. Global initiatives include creating standards such as the National Information Exchange Model for interoperable data, Global Reference Architecture for data transport, and Global Federated Identity and Privilege Management for privacy and security.
Global Federated Identity and Privilege Management	The Global Federated Identity and Privilege Management (GFIPM) program provides the justice community with a standards-based approach to information sharing. The GFIPM program uses the National Information Exchange Model to provide a standard set of data elements and attributes to identify users, describe their privileges, and authenticate them.
Global Reference Architecture	Global Reference Architecture (GRA) is an information sharing architecture that meets the requirements of the justice community. GRA is the electronic transport layer that delivers data specified by the National Information Exchange Model's Information Exchange Package Document (IEPD). GRA is an example of service oriented architecture (SOA), which implements clearly defined and independent functions known as services that deliver specific information. Websites such as Expedia.com rely on an SOA where users can select categories – such as flights, hotels or rental cars – and each category maps to a discrete service that delivers information from other locations as specified by the selected category/service.

Harm Reduction	Harm reduction is a public health strategy designed to minimize the negative consequences of drug use and other risky activities for individuals and communities. Harm reduction strategies generally do not focus on the prevention of drug use itself, but rather the prevention of negative outcomes associated with drug use, such as overdose and the spread of infectious disease. Harm reduction approaches that have proven effective include needle exchange programs, which provide injection drug users with sterile needles in order to prevent the spread of HIV, Hepatitis C, and other infectious diseases; and increased access to Naloxone, a drug that reverses opiate overdose.
Health and Human Services	The U.S. Department of Health and Human Services (HHS) is the federal cabinet-level department responsible for administering government health care programs. The Centers for Medicare and Medicaid Services, the Food and Drug Administration, and the Centers for Disease Control and Prevention are all agencies within HHS. HHS is the government department responsible for implementing the Affordable Care Act.
Health Home	Section 2703 of the Affordable Care Act created an option for states to provide coordinated care for Medicaid beneficiaries with chronic conditions by establishing Health Homes. Medicaid beneficiaries are eligible for Health Homes if they have two or more chronic conditions (including mental health disorders, substance use disorders, asthma, diabetes, heart disease, and obesity), have one chronic condition and are at risk for a second, or have one serious and persistent mental health condition. The model is designed to coordinate and integrate all primary care, hospital care, mental health services, substance use services, and ongoing social services and supports. States have some flexibility in designing their Health Home programs, and Health Home services include care management and care coordination, transitional care and follow up, and patient and family support.
Health Information Exchange	A Health Information Exchange (HIE) enables the electronic transfer of clinical information between different health care information systems while maintaining the meaning of the information being exchanged. The goal of HIE is to facilitate the access and retrieval of clinical data. HIE can include peer-to-peer messaging (sending patient information to specific providers) and/or allow providers to query for information about specific patients. The terms HIE, Health Information Organization, and Regional Health Information Organization are often used interchangeably, and organizations that implement HIE frequently use a permutation of these three terms within their names. ONC prefers to employ HIE as a verb (describing the act of exchanging health data) rather than as a noun (the organization that implements the HIE).
Health Information Organization, Regional Health Information Organization	Health Information Organizations (HIOs) are entities that provide information and assistance to health care providers planning to participate in health information exchange. HIOs work closely with and among the communities that they serve to develop and establish secure systems and processes for sharing electronic clinical information. A Regional Health Information Organization (RHIO) is an HIO that operates in a fixed geographic area.
Health Information Services Provider	A Health Information Services Provider (HISP) is an organization that manages security and transport for health information exchange among health care providers using Direct.

Health Insurance Health insurance is insurance that protects against the cost of health care. The term health insurance is commonly used to describe private (also known as commercial) health insurance products as well as publicly funded and administered programs that pay for health care. Private health insurance is organized into three main categories for purposes of federal and state regulations: large group health insurance, which is typically defined as employer-sponsored insurance for organizations with 51 or more employees; small group health insurance, which is typically defined as employer-sponsored insurance for organizations with 50 or fewer employees; and individual health insurance, which is health insurance purchased by individuals and families. Some large organizations, like labor unions and large employers, directly administer health insurance for their members or employees, while others purchase insurance through the commercial market. Public programs that pay for the costs of health care, such as Medicare and Medicaid, often contract with private health insurance companies to provide benefits for eligible populations.

Health Insurance Exchange The Affordable Care Act (ACA) established Health Insurance Exchanges, or Exchanges (also known as Health Insurance Marketplaces, or Marketplaces), to allow individuals and families to compare and purchase affordable qualified health plans. The ACA requires all 50 states to establish Exchanges; some states have established their own Exchanges, while some have opted to use an Exchange administered by the federal government. Certain individuals and families are eligible to receive federal advanced premium tax credits to assist in purchasing health insurance through the Exchanges. The ACA also requires the establishment in all 50 states of an Exchange for small businesses through the Small Business Health Options Program (SHOP). SHOP Exchanges allow employers to compare and choose health insurance options for their employees and choose how much to contribute toward employees' premiums. Some employers with fewer than 25 employees may qualify for tax credits to assist with premiums.

Health Level Seven International Health Level Seven International (HL7) is an all-volunteer, nonprofit organization that develops international standards for health care informatics that can be used interoperably among different health care entities. Hospitals and other health care provider organizations typically have many different computer systems for different tasks such as billing or patient tracking. Ideally, all of these systems would communicate or "interface" with each other when they receive new information; however, not all do. HL7 specifies a number of flexible standards, guidelines, and methodologies by which various health care systems can communicate with each other. Such data standards constitute a set of rules that allows information to be shared and processed in a uniform and consistent manner. These data standards are meant to allow health care organizations to easily share clinical information. HL7 messages are specified in Meaningful Use Stages 1 and 2 as the format for submitting immunization, syndromic surveillance, and lab data.

Health Plan Health plan (or health insurance plan) is a term that is used broadly to refer to organizations that pay for health care (whether through commercial health insurance products or through public benefit programs) as well as to health insurance products themselves. Health plans include commercial health insurance issuers (companies that sell insurance products in the large group, small group, and/or individual markets), health maintenance organizations, Medicare, Medicaid (including Medicaid managed care organizations), and the Veterans' health care program. Health plans are often referred to as health care payers.

HEDIS	The Healthcare Effectiveness Data and Information Set (HEDIS) is a widely used set of performance measures in the managed care industry. It is developed and maintained by the National Committee for Quality Assurance. HEDIS supports comparisons of health plan performance against other plans and against national benchmarks.
HIPAA	The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is the key federal law pertaining to the privacy and sharing of health information. The HIPAA Privacy Rule pertains to covered entities that use and disclose protected health information (PHI). A covered entity must obtain informed consent from a patient before disclosing PHI unless the disclosure falls under one of several exceptions for permitted uses. These exceptions include: disclosures to the patient; disclosures for treatment by any health care provider; the use of PHI for payment activities or health care operations; disclosures that are court orders; and disclosures to correctional institutions.
HITECH Act	The Health Information Technology for Economic and Clinical Health Act (HITECH Act) is legislation contained within the American Recovery and Reinvestment Act of 2009 that seeks to improve American health care delivery and patient care through a \$19.2 billion investment in the promotion of health information technology. The HITECH Act has been designed to provide health care providers with assistance and technical support for adopting new technology, to enable the coordination and alignment of new systems within and among states, and to assure that the health care workforce is properly trained and equipped to use electronic health record (EHR) systems. The HITECH Act established the Medicare and Medicaid EHR Incentive Programs to provide financial incentives for the adoption and Meaningful Use of certified EHR technology.
Inmate Exception	The Code of Federal Regulations defines an “inmate of a public institution” as an individual who is living in a public institution, except if he is in an institution for “a temporary period pending other arrangements appropriate to his needs.” Public institutions are defined as institutions that are “the responsibility of a governmental unit or over which a governmental unit exercises administrative control,” including jails and prisons (42 CFR section 435.1010). Section 1905(a) of the Social Security Act prohibits federal Medicaid funds, known as federal financial participation, from being used to pay for services for inmates of public institutions, even if they are otherwise eligible for Medicaid. This exclusion of federal financial participation is known as the inmate exception. Despite the inmate exception, Medicaid can reimburse a provider for services delivered to an inmate sent to a non-correctional medical facility if the inmate is an inpatient in that facility for greater than 24 hours. The Affordable Care Act did not make any changes to these longstanding federal Medicaid policies.
Inmate Management System	An inmate management system (IMS) (also known as a jail management system (JMS), inmate information system (IIS), or offender management system (OMS)) is a software suite designed to support a jail’s record-keeping, administrative, and supervisory needs. With several varieties of IMS software available from numerous vendors, common applications include booking, accounting, biometrics, document management, medical management, staff records, and scheduling. The medical capabilities of IMS systems are generally restricted to patient visit scheduling, the recording of inmates’ vitals, tracking physicians’ orders pertaining to prosthetics, tracking housing placements dependent upon medical needs, and tracking medication distribution assignments.

Institution for Mental Diseases	Section 1905(a) of the Social Security Act precludes the use of federal financial participation for services provided to a patient in an Institution for Mental Diseases (IMD). The Code of Federal Regulations defines an IMD as “a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases” (42 CFR section 435.1010). According to section 4390 of the State Medicaid Manual, a facility is “primarily engaged” in diagnosing, treating, or caring for persons with mental diseases if over 50% of the facility’s patients have been institutionalized for a mental disease. According to the Manual, the term “mental disease” includes diseases listed as mental disorders in the International Classification of Diseases, Ninth Revision (ICD-9) (except for mental retardation, senility, and organic brain syndrome), including alcoholism and other substance use disorders. Federal law prohibits Medicaid from paying for any services provided to an individual residing in an IMD, regardless of whether those services are provided in the IMD.
Intake	Intake is the set of processes and procedures used to newly admit an individual to jail or prison custody. Although processes vary by jail and by prison, intake typically involves the collection of personal information, the issue of standard clothing, and the completion of health, mental health, and security risk assessments. While booking generally refers to the process immediately following arrest, intake refers to a more comprehensive process that takes place after an individual has been initially booked.
Integrating the Healthcare Enterprise	Integrating the Healthcare Enterprise (IHE) is a project designed to advance the state of data integration in health care. IHE brings together medical professionals and the health care information and imaging systems industry to agree upon document standards and demonstrate standards-based methods of sharing information in support of optimal patient care.
International Classification of Diseases, Ninth Revision and Tenth Revision	The International Classification of Diseases, Ninth Revision (ICD-9) is a medical classification standard for the coding of diseases. ICD-9 assigns every known health condition a unique category and code, thereby providing a standardized numerical identity for diseases that can be used worldwide for morbidity and mortality statistics, reimbursement systems, and automated decision support. The International Classification of Diseases, Tenth Revision (ICD-10) is the successor to the ICD-9 standards. On October 1, 2014, the ICD-9 standards will be replaced by the ICD-10 standards. ONC has adopted ICD-9/ICD-10 as a standard for the entry of structured data for specifying diagnoses in certified EHR technology.
Interoperability	Interoperability describes the extent to which systems and devices can exchange data and interpret shared data. For two systems to be interoperable, they must be able to exchange data and subsequently present those data such that they can be understood by a user. A key goal of Meaningful Use is to promote interoperability in order to lower costs and improve care.

Jail vs. Prison	<p>Jails are typically county or city institutions that house inmates awaiting local trial and individuals convicted of misdemeanors who are serving short sentences, generally less than one year. Prisons, on the other hand, are state or federal facilities that usually incarcerate convicted felons serving sentences longer than one year. Compared with prison inmates, the health and legal status of people in jail are constantly in flux. For example, people entering jail are frequently intoxicated and some are experiencing drug or alcohol withdrawal. They may be injured, angry, fearful, remorseful, delusional, hallucinating, aggressive, and/or suicidal. They may have been taking psychotropic medication, which is abruptly stopped when they enter the jail. Time is required to assess, treat, and stabilize many incoming inmates. At any time, a jail inmate may be released on bail or charges could be dropped. By contrast, prison inmates are usually stable upon admission and have relatively fixed release dates that depend on their sentences.</p>
Keep-On-Person	<p>According to the National Commission on Correctional Health Care's Essential Standard P-D-02, keep-on-person (KOP) medication (also known as "self-medication") policies and procedures are required in correctional facilities. A KOP medication is one that a medically approved inmate can keep in his or her possession and self-administer as needed. In facilities that allow KOP medications, the responsible physician, in collaboration with the pharmacist, develops a list of all medications and related procedures that govern self-administration of medication. The most common example is nitroglycerine for treating angina. Medications that are routinely disallowed for KOP distribution include controlled substances, some psychotropic drugs, and prescription pain medications. KOP is distinct from directly observed therapy (DOT), which involves a health care worker dispensing medication to an inmate and generating a written record of the encounter.</p>
Logical Observation Identifiers Names and Codes	<p>Logical Observation Identifiers Names and Codes (LOINC) are a set of universal codes and names to identify laboratory and other clinical observations that facilitate exchange and pooling of results for clinical quality measures, outcomes management, and research. ONC has adopted LOINC as a standard for the entry of structured data for laboratory and clinical observation in certified EHR technology.</p>

Managed Care Managed care is a model of health care finance and delivery generally characterized by arrangements between managed care organizations (MCOs) and health care providers in which providers receive capitated payments in return for services provided to an MCO's patients. Managed care models are designed to limit the cost and improve the quality of health care by eliminating unnecessary care, focusing on preventive care, and improving care coordination. In general, access to providers is limited to providers who are in an MCO's contracted network. MCOs employ various techniques designed to improve care coordination and reduce costs. Such techniques include: the use of primary care providers (PCPs) as gatekeepers to the wider health care system, requiring patients to go through PCPs in order to access specialty care and other services; utilization review, which is the prospective, concurrent, or retrospective review of care provided to determine appropriateness and medical necessity; and prior authorization, a requirement of some insurers that services be specifically authorized in order for them to be reimbursed.

While there are many variations of managed care models, two of the most common are Health Maintenance Organizations (HMOs), in which care is provided almost entirely within an HMO's network of contracted providers; and Preferred Provider Organizations (PPOs), in which patients are able to access certain contracted providers at discounted rates but also have the option to pay more for providers outside a PPO's network. Managed care is usually associated with the private sector, but public programs such as Medicaid and Medicare also employ managed care models to deliver care to some eligible beneficiaries (see Medicaid Managed Care).

Master Patient Index A key issue concerning health information exchange (HIE) technology is ensuring that an individual patient is identified accurately across multiple electronic health record systems. Because there is no national unique identifier associated with health records, the health care industry currently establishes patient identity by using a master patient index (MPI) to perform probabilistic algorithms on demographic information to determine if health records from different sources represent the same individual. Once a match is made in the MPI, the health records associated with this identifier can be retrieved. Industry experience indicates that there is a false-negative error rate (i.e., records are overlooked) of roughly 8% to 10% in this process, and a small but non-zero false-positive rate (i.e., records returned are not the patient's). These rates may be even higher among criminal justice-involved populations, whose members frequently employ multiple aliases and addresses.

Meaningful Use The HITECH Act of 2009 outlined plans for the nationwide adoption of interoperable electronic health record (EHR) systems. It established the Medicare and Medicaid EHR Incentive Programs to provide financial incentives for providers and hospitals to adopt and “meaningfully use” EHRs (that is, use EHRs for clinically significant purposes in order to improve patient care). The Centers for Medicare and Medicaid Services (CMS) developed the Meaningful Use program to provide specific criteria that providers and hospitals must achieve in order to qualify for incentive payments. CMS divided Meaningful Use into three stages, each with its own series of requirements known as “objectives.” An example of a Stage 1 objective is the requirement that providers maintain active medication lists entered into EHRs as structured data. Stage 1 objectives, effective in 2011, focus on data capture and sharing. Stage 2 objectives, effective in 2014, focus on advancing clinical practices. Stage 3 objectives, which are planned for 2016, will focus on improved clinical outcomes.

In order for providers and hospitals to be considered Eligible Providers (EPs) or Eligible Hospitals (EHs) who are able to participate in Meaningful Use, they must meet certain minimum criteria related to the Medicare or Medicaid status of their patients. CMS and ONC developed standards and a certification program to define the EHR systems that EPs and EHs could adopt in order to achieve Meaningful Use. Systems that meet the standards are designated “certified EHR technology” (CEHRT). EPs and EHs must successfully demonstrate Meaningful Use through a process of “attestation” – the details of which vary for each stage of Meaningful Use. EPs and EHs that adopt CEHRT, meaningfully use the CEHRT, and successfully attest to Meaningful Use can receive incentive payments.

Medicaid Administrative Claiming In addition to the federal funding that states receive to support medical services, federal financial participation is also available to support state expenditures necessary for the administration of the Medicaid program. States seek federal reimbursement for these expenditures through Medicaid Administrative Claiming (MAC). States can submit claims for expenditures supporting a range of eligible activities, which include program eligibility determinations, the construction of information technology systems, and program planning and development. Most Medicaid administrative activities receive a 50% federal match, although some activities are eligible for higher matching rates. Each state’s single state agency is responsible for submitting claims, and the claiming process must be supported through a validated time study methodology in order to document employees’ time spent on eligible activities. Local government units that perform eligible Medicaid administrative activities, including but not limited to county health and human services departments, are potentially eligible to receive federal reimbursement. Each state has its own MAC process but, in general, state and local agencies can receive federal reimbursement for eligible Medicaid administrative activities performed by law enforcement and public safety personnel.

Medicaid Expansion	In accordance with the Affordable Care Act (ACA) and the Supreme Court’s 2012 decision in <i>National Federation of Independent Business v. Sebelius</i> , states have the option to expand Medicaid eligibility to all U.S. citizens and certain legal residents under the age of 65 with income up to 138% of the Federal Poverty Level. Known as the “new adult group” or the “Medicaid Expansion population,” the new coverage group will include many childless adults who were previously ineligible for Medicaid despite having low income. Prior to the ACA, individuals had to fall within one of several eligibility categories – for example, aged, blind, or disabled individuals – to be eligible for Medicaid. Individuals in the new adult group will receive coverage through state-defined Alternative Benefit Plans. Medicaid services for the new adult group will receive an enhanced Federal Medical Assistance Percentage (FMAP) of 100% from 2014 through 2016. By 2020, the enhanced FMAP will decrease to 90% and remain at that level thereafter.
Medicaid Managed Care	States can use managed care models to deliver benefits to Medicaid beneficiaries. One model of managed care that is common in the Medicaid program is primary care case management (PCCM), in which Medicaid agencies pay primary care providers (PCPs) supplemental fees to coordinate, monitor, and approve the services that patients receive, including specialty care and hospital care. In PCCM models, PCPs are typically paid on a fee-for-service basis for care provided in addition to the supplemental care management fees. States can also contract with managed care organizations (MCOs) to provide Medicaid benefits; states that do so generally pay capitated monthly fees to MCOs for each enrolled beneficiary. States can pursue Medicaid managed care systems through State Plan Amendments or through Medicaid waivers.
Medicaid Management Information System	Federal regulations require that each single state agency maintain a claims processing and information retrieval system known as a Medicaid Management Information System (MMIS). The primary function of an MMIS is the payment of Medicaid claims from health care providers. Many MMISs were developed decades ago on mainframe systems that are now difficult to maintain. In 2011, the Centers for Medicare and Medicaid Services offered to fund 90% of the cost for states to develop or enhance their MMISs by December 2015. This offer could allow states to include additional Medicaid status categories as part of their redesign (see “Medicaid Suspension vs. Termination”).
Medicaid Status: Eligibility, Enrollment, and Coverage	Individuals are eligible for Medicaid if they meet certain federal and state criteria in categories such as age and income. Individuals become enrolled in Medicaid once they have applied for the program and have been determined eligible by the state or local entity responsible for eligibility determinations. Coverage refers to the services that Medicaid will pay for if an enrolled beneficiary receives services delivered by a certified Medicaid provider. People in jail or prison cannot have Medicaid coverage because federal law prohibits federal financial participation from being used to pay for services for inmates (see “Inmate Exception”). However, people in jail or prison who are otherwise eligible for Medicaid retain their eligibility while in custody.

Medicaid Suspension vs. Termination	<p>Even though federal law only requires that federal financial participation cannot be used for services provided to inmates, many jurisdictions terminate Medicaid enrollment when a beneficiary is incarcerated in jail or prison. However, the federal government has urged states to suspend rather than terminate enrollment, thereby halting payments but allowing individuals to retain enrollment so that they would not need to re-apply upon release from custody. Suspension could allow formerly incarcerated individuals to access care immediately upon release. Many states' Medicaid Management Information Systems (MMIS) do not allow for distinctions between an active and suspended payment status, potentially limiting states' abilities to pursue Medicaid suspension as a policy. Federal funding opportunities for MMIS redesigns could represent an opportunity to introduce this capability and facilitate Medicaid suspension policies.</p>
Medicaid vs. Medicare	<p>Medicaid is a government program that pays for health care services for low-income individuals. It is jointly financed by the federal government and the states, and each state administers its own Medicaid program within broad federal guidelines. States are required to cover services for low-income individuals in several mandatory eligibility categories, including pregnant women, the blind, and the disabled, and have the option to cover additional populations. Federal law requires states to cover some mandatory services, such as hospital care and physician services, and allows states to cover additional optional services. Medicare is the federally financed and administered program that pays for health care services for individuals older than 65 and some disabled individuals. It covers hospital services, physician services, and prescription drugs. Individuals who are eligible for both Medicaid and Medicare are known as "dual-eligibles" and may qualify for special programs designed to improve care coordination and decrease costs.</p>
Medicaid Waiver	<p>Along with State Plan Amendments (SPAs), Medicaid waivers are one of the two ways that states can make changes to their Medicaid programs. States can submit requests to the Secretary of Health and Human Services to waive certain federal Medicaid requirements. For example, the Secretary can waive requirements of statewideness (the requirement that the Medicaid program be the same for beneficiaries throughout the state); comparability (the requirement that all beneficiaries have access to comparable services); and freedom of choice (the requirement that beneficiaries be able to choose services from any willing Medicaid provider). Medicaid waivers are referred to by the section of the Social Security Act that provides the waiver authority, and include 1115 waivers, 1915(b) waivers, and 1915(c) waivers. Unlike SPAs, waivers are generally limited to three or five year periods and they must be cost-neutral.</p>

Medical Necessity	Health care payers such as Medicare and commercial insurance plans use the criteria of medical necessity to determine whether or not to pay for care furnished by health care providers. Although definitions vary by payer, medical necessity is typically defined as care that a reasonable physician or other practitioner would provide to prevent, diagnose, or treat illness, disease, or injury in a clinically appropriate manner that is consistent with generally accepted standards of practice. In general, medical necessity is determined clinically by a physician or other health care provider; however, a health care payer may dispute the medical necessity of care provided and refuse to provide reimbursement. The federal government defines medical necessity criteria for Medicare, while states define medical necessity criteria for Medicaid.
Medication Assisted Treatment	Medication assisted treatment (MAT, also known as medication assisted therapy) is an evidence-based method of treating opioid and alcohol dependence using medication in combination with counseling. Medications used in MAT include methadone, a synthetic opioid that reduces the effects of opiate withdrawal and reduces opiate cravings; buprenorphine, a drug that reduces the effects of opiate withdrawal and produces milder euphoric effects than methadone; and naltrexone, a drug that reduces alcohol cravings and blocks the euphoric effects of opiates. Studies have found MAT to reduce drug use, disease, and criminal conduct among people with opiate and alcohol addictions. Some jails and prisons provide MAT, but the use of MAT in criminal justice settings is not widespread.
Metadata	Metadata is structured data that describes, explains, locates, or otherwise makes it easier to retrieve, use, or manage data. Metadata is often called “data about data” or “information about information.”
Middleware	Middleware software is generally used to interface disparate information technology systems or software components, allowing them to exchange data. A master patient index is an example of middleware. When a health information exchange (HIE) needs to locate a patient’s health record, it interfaces with an MPI. The MPI supports patient matching software and consolidates the results that the HIE requested and returns the results (a health record) to the HIE, thus effecting an exchange of data.
Modified Adjusted Gross Income	The Affordable Care Act (ACA) established a new method for determining income eligibility for Medicaid and for the advanced premium tax credits for insurance purchased through Health Insurance Exchanges. This new method, known as Modified Adjusted Gross Income (MAGI), simplifies existing eligibility determination criteria by taking into consideration only income and family size (certain Medicaid eligible individuals, including individuals who are eligible because they are aged, blind, or disabled, are exempt from using the MAGI methodology). The MAGI methodology applies a 5% income disregard to all individuals or families applying for coverage, raising the income eligibility threshold for Medicaid expansion coverage from 133% of the Federal Poverty Level (FPL) (as specified in the ACA) to an effective threshold of 138% FPL.
National Commission on Correctional Health Care	The National Commission on Correctional Health Care (NCCHC) is a nonprofit organization that establishes and publishes standards for health care in jails and prisons. NCCHC offers a voluntary accreditation service based on its standards.

National Crime Information Center	The National Crime Information Center (NCIC) is the central database maintained by the FBI's Criminal Justice Information Services Division for tracking crime-related information in the United States. The NCIC collects data from federal, state, and local law enforcement agencies. Reciprocally, law enforcement agencies nationwide can access relevant NCIC records, even in the field. The NCIC file for an individual includes a fingerprint classification system that is used by the criminal justice system to better establish the identity of an individual.
National Federation of Independent Business v. Sebelius	In 2012, in <i>National Federation of Independent Business v. Sebelius</i> , the U.S. Supreme Court upheld the constitutionality of the majority of the Affordable Care Act (ACA), including the shared responsibility requirement (also known as the individual mandate), which is the requirement that most Americans have health insurance. The court ruled that the ACA's Medicaid expansion provision, a requirement that all states expand Medicaid or risk losing existing federal Medicaid funding, was unconstitutional. The court ruled that the Medicaid expansion provision would be constitutional if states could choose not to expand Medicaid without risking federal funding for their existing Medicaid programs.
National Information Exchange Model	The National Information Exchange Model (NIEM) is an outgrowth of the Global Justice XML Data Model (GJXDM) project. NIEM is an XML-based data model that provides data components for describing universal objects such as people, locations, activities, and organizations. These basic data components are known as the NIEM-Core. NIEM also includes individual domains, such as emergency management, that contain domain-specific data components. Other NIEM domains, such as Health, are potentially supported. U.S. government agencies use NIEM as a model for data and software interoperability. To define data exchange, NIEM provides a specification called the Information Exchange Package Document (IEPD). This information package defines message type, structure, content, and the meaning of all the exchanged data (see "Global Reference Architecture"). In this way, users can achieve a common language of data transmission for their on-demand data exchange needs, without the high costs of developing and maintaining unique communication protocols.
ONC	The Office of the National Coordinator for Health Information Technology (ONC), formally located within the Office of the Secretary for the U.S. Department of Health and Human Services (HHS), is a federal entity designed to coordinate the nation's efforts for establishing a health information technology (HIT) infrastructure that supports the electronic exchange of health information. ONC promotes the goal of nationwide HIT as a means of increasing health care quality, lowering costs of treatment, ensuring the security of protected patient information, and increasing the ability of a range of health care providers to operate in a coordinated way. ONC has awarded grants to a variety of HIT-related projects from funding created by the HITECH Act of 2009. These include the Beacon Community Program and the State Health Information Exchange Program. The position of National Coordinator was created in 2004 through an Executive Order of former President George W. Bush, and legislatively mandated within the HITECH Act.

Open Enrollment	Open enrollment refers to the period of time defined by a given health plan when beneficiaries can newly enroll in coverage or change existing coverage. In general, people cannot apply for coverage outside of a health plan's open enrollment period, except in the case of a "qualifying event" such as a job loss, the birth or adoption of a child, marriage, or release from incarceration. Some health plans, notably Medicaid, allow for a continuous enrollment period for new applicants.
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Parity	In the context of health care, parity refers to requirements that coverage for mental health and substance use disorder services be offered by health plans in no more restrictive way than coverage for medical and surgical services. In the past, some health plans had imposed more severe restrictions – such as limits on the number of covered office visits, co-pay requirements, or limitations on care received outside of a plan's network – on mental health and substance use disorder services. The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 mandated parity in large group health plans. The Affordable Care Act extended those same requirements to health plans in the small group and individual markets, as well as to Medicaid Alternative Benefit Plans (through which Medicaid expansion populations will be covered) and Medicaid managed care organizations.
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Patient Protection and Affordable Care Act	<p>The Patient Protection and Affordable Care Act (Affordable Care Act, ACA) is a federal statute signed into law by President Barack Obama on March 23, 2010. The ACA is commonly known as the health care reform law and establishes numerous provisions, including:</p> <ul style="list-style-type: none"> • The state option to expand Medicaid eligibility to include all U.S. citizens and some legal residents under the age of 65 with income up to 138% of the Federal Poverty Level (FPL). • The creation in each state of a Health Insurance Exchange where people can compare and purchase qualified health plans. Individuals and families with income between 100% and 400% of FPL who are not eligible for Medicaid can receive federal advance premium tax credits to help pay for coverage purchased through the Exchanges. • The creation in each state of a Small Business Health Options Program (SHOP) Exchange, where employers can compare and select qualified health plan options for their employees. Some small businesses can receive tax credits to help pay for coverage purchased through the Exchanges. • Essential health benefits that health plans must provide. • Guaranteed issue for individual and group health insurance plans, which prevents health plans from denying coverage based on applicants' pre-existing medical conditions. • Partial community rating, which requires health plans to offer the same premium to all applicants of the same age and geographical location without regard to most pre-existing conditions (excluding tobacco use). • A shared responsibility requirement, commonly called the individual mandate, which requires that most people have minimal essential coverage. Forms of coverage that count as minimum essential coverage include most employer-sponsored health plans, Medicaid, Medicare, other public insurance programs, or individual coverage (including plans purchased through Health Insurance Exchanges). There are exemptions to the shared responsibility requirement for certain individuals, including individuals with very low income, incarcerated individuals, and individuals who are uninsured for less than three continuous months. • Bans on lifetime coverage caps.
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Pending Disposition	An individual who has been charged with an alleged crime but who has not yet been convicted is said to be pending disposition. Many individuals held in local jails are pending disposition; although they have not been convicted of a crime, they either have not been offered bail, have not been able to make bail, or have not been offered an alternative to incarceration. The Affordable Care Act allows individuals in jail pending disposition to enroll in qualified health plans through Health Insurance Exchanges, although coverage would be subject to the requirements of health plans. Medicaid coverage is not available for individuals in jail pending disposition because of the inmate exception (see “Inmate Exception”).
Premium	A premium is a payment that a customer makes to a health plan in return for coverage for health care services. Premiums are usually paid monthly.
Presumptive Eligibility	Presumptive eligibility (PE) is a process that states have used in the past to rapidly enroll pregnant women and children into Medicaid and provide them immediate coverage if their initially-reported income appears to qualify them for Medicaid. A full eligibility determination takes place later, but in the meantime beneficiaries can have access to Medicaid covered services. The Affordable Care Act allows hospitals to use PE for all Medicaid-eligible populations, including Medicaid expansion’s new adult coverage group. Under the new PE authority, hospitals can collect information regarding monthly income and family size and determine patients to be presumptively eligible for Medicaid based on that information and the state’s eligibility criteria. Hospitals have the authority to use PE for the Medicaid expansion population regardless of whether they use it for other Medicaid populations.
Pretrial	The term pretrial refers to the processes and events that occur at the “front end” of the criminal justice system – from initial contact with a law enforcement officer through final adjudication of charges – as well as to the period of time during which those processes and events occur. In general, defendants are either held in jail or released into the community during the pretrial period. Traditionally, after arrest an officer of the court (usually a judge or a magistrate) will decide whether to release an individual on his or her own recognizance without bail, release an individual on condition of bail, or hold an individual in jail without bail. These decisions are based on the perceived likelihood that the defendant will appear in court for trial and/or pose a risk to public safety. Increasingly, jurisdictions are using pretrial risk assessment tools to determine a defendant’s suitability for release, often in combination with pretrial supervision for some defendants who are released while awaiting trial.
Pretrial Risk Assessment	Pretrial risk assessment is the practice of using data, whether subjective or objective, to determine the likelihood that a defendant will fail to appear before court for trial or pose a risk to public safety if released from custody during the pretrial period. Jurisdictions are increasingly using statistically validated pretrial risk assessment tools based on objective data to make decisions about pretrial release. Risk assessment tools typically combine administrative data (for example, past arrest records) with data obtained through standardized defendant interviews, and classify defendants according to risk based on an actuarially sound methodology.

Pretrial Services	Many jurisdictions have established pretrial services agencies to make recommendations regarding pretrial release (often using pretrial risk assessment tools) and to supervise some released defendants in the community. Courts can condition a defendant's release on compliance with pretrial supervision, which may potentially include mandatory substance use disorder treatment. Some jurisdictions contract with nonprofit organizations to perform pretrial services, while others house pretrial services within probation departments or within the court system. Responsibilities vary by jurisdiction as well: Some agencies only make recommendations to the courts, whereas others perform intensive case management and supervision, connect defendants to services, remind defendants of court dates, make reports to the court, and implement sanctions.
Probation vs. Parole	Probation and parole are two forms of community supervision by the criminal justice system. An offender may be sentenced to probation in lieu of serving jail or prison time. Probation sentences usually involve strict guidelines to which offenders must adhere; violating conditions of probation can result in incarceration. Parole is a conditional release from prison. Parolees are individuals who have already served time in prison and are granted an early release, dependent upon certain conditions that must be met in order for the offender to avoid re-incarceration.
Protected Health Information	Protected health information (PHI), sometimes referred to as personal health information, is health information that is protected by the HIPAA Privacy Rule. The federal government defines PHI as information that is individually identifiable, is held or transmitted by a covered entity, and relates to an individual's past, present, or future health care.
Qualified Health Plan	As specified by the Affordable Care Act (ACA), a qualified health plan (QHP) is a health plan that is certified by and sold on a Health Insurance Exchange. QHPs must provide the ten essential health benefits and meet other ACA-mandated requirements. Individual health plans (for individuals and families) and small group health plans (for employers with 50 or fewer employees) can be certified as QHPs that can be offered on Exchanges (QHPs for small businesses are available through the Small Business Health Options Program (SHOP) Exchanges). Individuals and families with income between 100% and 400% of the Federal Poverty Level who are not eligible for Medicaid may qualify for advanced premium tax credits to assist in purchasing coverage through a QHP. Some small businesses may qualify for tax credits to assist in purchasing coverage.
Reentry	Reentry refers to the transition period between custody in jail or prison and the community. Resources are often available to facilitate the reentry process through discharge planning, which can help individuals find housing, health care, and employment. However, because of uncertain release times in jails, services often are not available to assist with reentry.
Regional Extension Center	The HITECH Act of 2009 authorized the creation of a Health Information Technology Extension program that included the establishment of Health Information Technology Regional Extension Centers (RECs). The HITECH Act provided \$677 million in funding to support a national system of RECs in order to service every geographic region of the United States. In total, 62 RECs were created nationwide. RECs were tasked with providing on-the-ground training and support services to individual and small-practice physicians, offering information and guidance about electronic health record (EHR) implementation, and giving technical support on an as-needed basis. These services have included working with vendors to help REC clients select certified EHR technology that can be used to achieve Meaningful Use in the Medicare and Medicaid EHR Incentive Programs.

Release on Own Recognizance	Individuals who have been arrested and charged with crimes can be released on their own recognizance (ROR, also referred to as “OR”) from jail, meaning that they formally attest that they will appear in court. ROR is not subject to bail.
RxNorm	RxNorm is a vocabulary used to communicate medication data. ONC has adopted RxNorm as a standard for the entry of structured data for specifying medication and medication allergies in certified EHR technology.
Sick Call	According to the National Commission on Correctional Health Care’s Essential Standard P-E-07, all incarcerated individuals request non-emergency medical, mental health, and dental attention through a clearly defined policy and procedure known as sick call. In general, patients submit oral or written requests for care that are triaged based on urgency and used to schedule time with clinical staff.
Single State Agency	Section 1902(a)(5) of the Social Security Act requires each state to designate a single state agency to administer the Medicaid state plan. The single state agency can also administer the Medicaid eligibility determination process, or eligibility determinations can be administered by the state or local agencies that administer eligibility determinations for other public assistance benefits such as the Supplemental Security Income program. Other programs, such as the federal Substance Abuse Prevention and Treatment Block Grant, also require the designation of single state agencies.
Small Business Health Options Program	The Small Business Health Options Program (SHOP) is an Affordable Care Act (ACA) initiative designed to allow small businesses to offer affordable health insurance to their employees. The ACA requires the establishment of a SHOP Exchange (also known as a SHOP Marketplace) in each state where employers with 50 or fewer employees can compare and choose health insurance options for their employees and choose how much to contribute toward employees’ premiums. Some employers with fewer than 25 employees may qualify for tax credits to help pay for coverage purchased through the Exchanges.
SNOMED-CT	The Systematized Nomenclature of Medicine – Clinical Terminology (SNOMED-CT) is a systematically organized set of medical terms that can be used to record and transmit clinical data. ONC has adopted SNOMED-CT as a standard for the entry of structured data for problem lists in certified EHR technology.
Specialty Court	A Specialty court, also known as a problem solving court, is a court dedicated entirely to one specific type of case, and combines treatment with intensive court supervision. Many jurisdictions have established drug courts, mental health courts, veterans’ courts, and other specialty courts to address the underlying causes of many non-violent felonies, and to offer community-based rehabilitation as an alternative to incarceration. The programs are usually collaborative, involving judges, prosecutors, public defenders, dedicated case managers, treatment providers, patient advocates, and other community stakeholders.
Standardized Codes and Vocabularies	Meaningful Use Stage 2 rules specify an array of standardized codes and vocabularies to be used to normalize data and promote data exchange. These standardized codes and vocabularies include: SNOMED-CT for problem lists; ICD-9/ICD-10 for diagnoses; LOINC for laboratory and other clinical observations; RxNorm for medication and medication allergies; and CVX for immunizations.

Standards and Interoperability Framework	The Standards and Interoperability (S&I) Framework is a collaborative community of providers, both private and public, that assists ONC in fulfilling its charge of enabling interoperability specifications to support national health outcomes and health care priorities. The S&I Framework currently supports multiple initiatives including data segmentation, transition of care, and Blue Button Plus.
State Health Information Exchange Cooperative Agreement Program	The State Health Information Exchange Cooperative Agreement Program was established under the HITECH Act of 2009 and is administered by ONC. The program is intended to build states' capacity for exchanging health information. Under this program, ONC has awarded a total of over \$540 million to 56 states, eligible territories, and qualified State Designated Entities.
State Plan	Section 1902(a) of the Social Security Act describes the requirements for the State Plan, a contract between a state and the federal government detailing the state's Medicaid program. Provisions in each State Plan include: groups of people covered, services provided, and administrative requirements.
State Plan Amendment	Along with Medicaid waivers, State Plan Amendments (SPAs) are one of the two ways that states can make changes to their Medicaid programs. States can submit amendments to the Centers for Medicare and Medicaid Services to change any aspects of their Medicaid programs that do not violate federal Medicaid requirements. For example, states can make changes to optional covered services through SPAs. Unlike waivers, SPAs can be permanent and do not have to be cost-neutral.
Structured Data	Data that resides in fixed fields within a record or file are referred to as structured data. Data in spreadsheets are an example of structured data. XML is also considered to be structured data. Even though XML files are not fixed in specific locations like traditional database records, they are nevertheless structured because the data are tagged and can be accurately identified.
Triple Aim	As defined by the Institute for Healthcare Improvement, the Triple Aim is the pursuit of three simultaneous goals: improving the health of the population, improving the experience of health care, and reducing per capita health care costs.
XML	XML stands for eXtensible Markup Language. To understand XML, it is useful to compare XML with HyperText Markup Language (HTML). Both XML and HTML are mark-up languages, meaning that they surround textual data with "tags." HTML tags tell web browsers how to display text. XML tags tell software applications information about the data (see "Metadata"). XML is extensible, allowing users to create their own tags. The extensibility of XML allows it to capture the complexity of health data. Because of its widespread acceptance, XML is often mentioned as a language well suited to achieve interoperability of health data. XML is an example of structured data.