March, 2007

CATALYST CENTER

IMPROVING FINANCING OF CARE for Children & Youth WITH SPECIAL HEALTH CARE NEEDS

Medicaid as a Second Language: A Slightly Irreverent Guide to Common Medicaid Terms, Acronyms and Abbreviations

Introduction

This guide is designed for policymakers, advocates, legislators, consumers, family members, and providers – in short, for anyone interested in financing care for children and youth with special health care needs at the state level, and in particular through the Medicaid program.

Medicaid has its own language, one that can be daunting to outsiders. There are mysterious combinations of numbers and letters that refer to legislation, familiar terms that may have unfamiliar meanings (crowd-out, respite, health-based payment), and dozens of abbreviations used as shorthand to describe programs and agencies. And then there are the acronyms – S-CHIP, FMAP, TEFRA, COBRA; it's likely that some state also has a ZEBRA.

While it's not necessary to be fluent in this language to discuss state policy, it helps to have some familiarity with these terms, or at least a place to go to look them up. In the hopes of providing a useful start, the Catalyst Center has adapted definitions without shame from other glossaries and updated or added to them to create *Medicaid as a Second Language.*

Boston University School of Public Health • Health and Disability Working Group
715 Albany Street, Boston, MA 02118 • Tel: 617-638-1930 • Fax: 617-638-1931 • http://www.hdwg.org/catalyst/index.php

We start with an overview of some of the basic structural features of Medicaid, and follow with a glossary of terms commonly used in the Medicaid program.

Medicaid: The Lay of the Land

The Medicaid program was established by Title XIX (19) of the Social Security Act in 1965, to provide coverage for health care and health-related services to low-income and other specific categories of individuals. Since it was developed, the Medicaid program has evolved in many ways. It is a national program, overseen by the federal government, but administered by states, with significant state latitude for decision-making about eligibility and coverage.

Mandatory and Optional Benefits

All states must cover Mandatory Medicaid benefits, which include:

- Inpatient hospital services (except institutions for mental disease)
- Outpatient services including those delivered by federally qualified health centers and rural health centers
- Laboratory and x-ray services
- Pediatric and family nurse practitioner services
- Nursing facility services for beneficiaries age 21 and older
- EPSDT services
- Family planning services and supplies
- Physician services
- Medical and surgical services of a dentist
- Home health services (to those eligible for nursing facility care)
- Nurse/Midwife services
- Pregnancy-related services
- 60 days postpartum pregnancy-related services

States may choose to offer a range of Optional Medicaid benefits. Examples include:

- Prescription drugs
- Optometry services
- Psychologist services
- Private duty nursing
- Physical, occupational and speech therapy
- Audiology services
- Dental services
- Prosthetics
- Eyeglasses
- Rehabilitation services
- Personal care services

Eligibility Categories

The most common Medicaid eligibility categories include:

- Pregnant women and infants;
- Children aged 1 to 18, including children in the child welfare system;
- Caretaker relatives of dependent children;
- Adults and children with disabilities who meet SSI standards or state disability standards (see 209b states below);
- People over the age of 64; and
- People who are blind.

States may choose to cover other groups also, such as people living with HIV; the working disabled; or uninsured women under 65 who screen positive for breast or cervical cancer or precursor conditions. In all cases, the individuals within each category must meet "low-income" eligibility criteria.

Waivers

A waiver is permission from the federal government for a state to disregard one or more of the federal rules governing the Medicaid programs under specific conditions. For example, federal rules state that benefits must be comparable for all Medicaid beneficiaries – a state can not offer certain benefits to one group of people but deny them to another group. However, states can request that this rule be waived if they can demonstrate that certain

benefits might help a specific group of people live in the community instead of an institution. Waivers must be approved by the Centers for Medicare & Medicaid Services, the federal agency that oversees the Medicaid program.

1915(b) Waiver
A waiver that addresses the federal rule that Medicaid beneficiaries must have "freedom of choice" of provider. It allows a state to restrict Medicaid beneficiaries' choice of providers by assigning recipients to a primary care case manager or by enrolling recipients in a Managed Care Organization (MCO).

1915(c) or Home and Community-Based Service (HCBS) Waivers
These waiver programs waive the federal Medicaid requirement that all beneficiaries receive comparable benefits for specific groups of individuals who qualify for institutional care under the Medicaid program. HCBS waivers allow states to offer benefits that Medicaid does not normally cover for most beneficiaries such as specialized home health services, personal assistance, adaptive equipment, assistive technology, home modifications, case management, respite care and family support services.

A single state may have multiple HCBS waivers targeting different populations — those with spinal cord injuries or developmental disabilities, for example.

Waiver programs can also expand the income eligibility for Medicaid. HCBS waivers must demonstrate that the cost of providing services under the waiver are no higher than the cost of providing services without the waiver.

As a result, the waiver application must include the number of people that can be enrolled in the waiver, also known as the number of waiver "slots." Multiple HCBS waivers may exist within a state targeting different populations such as people with spinal cord injuries, developmental disabilities, HIV, medically fragile children, etc.

1115 Research and Demonstration Waivers
Section 1115 of the Social Security Act allows the Secretary of Health and Human Services to waive multiple program rules and authorize demonstration projects likely to promote the objectives of the Medicaid program. These waiver programs are intended to demonstrate a policy or approach that has not previously been demonstrated on a widespread basis. Many states have used 1115 waiver authority to expand Medicaid eligibility to new populations or people at higher income levels, while also mandating enrollment in Medicaid managed care. Other1115 waivers have introduced new services or new means of service delivery, such as the Cash and Counseling demonstration projects that provide adults and children with disabilities a cash budget and counseling to purchase their own long term support services. 1115 waivers are generally approved for 5-year periods, but states may submit renewal requests. They must be budget neutral over the life of the project, and the projects must be evaluated.

Alpha-Numeric Soup: Common Medicaid Terms

209(b) states: In 209(b) states, SSI does *not* confer automatic Medicaid eligibility – people with disabilities must submit a separate application for Medicaid benefits and are generally required to meet stricter income, asset or disability criteria. The 209(b) states are CT, HI, IL, IN, MN, MO, NH, ND, OH, OK and VA.

Activities of Daily Living (ADLs)
ADLs include bathing, dressing, eating, mobility, transferring, toileting and grooming. The need for assistance with ADLs is often part of the criteria to qualify medically for institutional or community-based long term care services.

Applied Behavioral Analysis (ABA) Therapy
A treatment for children with autism spectrum disorders that uses intensive, highly repetitive teaching to modify behavior.

Assets
Money and property. Most health benefits administered by

Medicaid programs have "asset tests," a maximum amount of money, property, or goods a person can own to qualify for health care benefits.

Balanced Budget Act (BBA)
Federal legislation passed in 1997 designed to balance the federal budget by 2002. The BBA includes many reforms to both the Medicare and Medicaid programs, including a relaxation of rules that require states to obtain a waiver in order to implement mandatory managed care programs for certain Medicaid beneficiaries.

Capitation
A fixed sum that an insurer pays to a health plan or provider for each person served, usually on a monthly basis and regardless of the extent of services used. The capitation payment may cover all or part of the individual's benefits, depending on the agreement that is negotiated between the insurer and the health plan.

Centers for Medicare & Medicaid Services (CMS)
(Formerly HCFA, the Health Care Financing Administration.) The federal agency that administers Medicare and oversees the states' administration of Medicaid.

COBRA
The Consolidated Omnibus Budget Reconciliation Act of 1986, which requires most employers to permit workers who leave employment to purchase continued coverage for themselves and their dependents in the employer health plan *but wholly at their own expense* for 18 months. If employees file an application for SSA disability they may receive another 11 months of coverage under COBRA.

Consumer-Directed Care
Care for an adult or child with disabilities that is directed by that individual or his or her family, who may decide how limited funds, services, or other resources are used and who may choose to hire or direct personal care staff. May also be called Family-Directed Care. This use of the term "consumer-directed" should not be confused with its use to describe low-cost, high-deductible health plans.

Co-Payment
A specified dollar amount that an insured individual must pay out-of-pocket for covered services at the time they are rendered. Also called a co-pay.

Cost-Sharing
The portion of medical expenses that patients themselves are required to pay. Cost-sharing can include premiums, deductibles, coinsurance and co-payments. As a general rule, cost-sharing in Medicaid programs is limited because beneficiaries have very low incomes.

Crowd-Out
A concern that when public programs are created or expanded to offer health insurance coverage, people with private coverage may switch to public coverage. This can happen if employers reduce or drop their private insurance options for employees or if individuals drop their more expensive private coverage to enroll in less expensive public programs.

Deductible
A fixed amount that an individual must pay for medical care, usually each year, before his or her health insurance coverage begins.

Disease Management
The use of research-based care management protocols that provide guidelines for how individuals with specific diagnoses will receive services. The care management protocols are intended to improve quality of care and also promote efficiency in service delivery. Patient and family education are important elements in many disease management programs.

Durable Medical Equipment (DME)
Health-related equipment that is not disposable, such as wheelchairs, walkers, or oxygen concentrators.

Early Intervention (EI)
Developmental services provided to children between birth and age 3 who have, or in states with broad eligibility are at risk of, developmental delay. State Early Intervention programs can receive federal education funds to subsidize these services.

Early Periodic Screening, Diagnosis, and Treatment (EPSDT)
Medicaid benefits and services for children and youth under 21; designed to assure preventive treatment and to promote early diagnosis and treatment of identified health needs. Under EPSDT, Medicaid programs must pay for medically necessary services such as dental care, eyeglasses, hearing aids, special therapy, etc., without cost-sharing, even if they are not ordinarily covered by the Medicaid program.

Family-Directed Care
See Consumer-Directed Care.

Family Opportunity Act (FOA)
Federal legislation that gives states the option of providing Medicaid coverage to children who meet the disability standard used in the Supplemental Security Income (SSI) program, but who are over the income limit for SSI. Under the FOA, Medicaid benefits are made available to disabled children in middle-income families whose employer-sponsored health insurance does not offer the equipment, home health, mental health, transportation and specialized services that Medicaid offers. The FOA also amends Title V of the Social Security Act (Maternal and Child Health Services) to provide appropriations for the MCHB Division of Services for Children with Special Health Care Needs to develop Family-to-Family Health Information Centers in each of the fifty states.

Federal Match (FMAP)
The Federal Medical Assistance Percentage (FMAP) is the percentage that the federal government pays to states for certain program expenses, including Medicaid services and the

administration of the Medicaid program. The FMAP ranges from 50%-76%, with a higher federal match going to those states with a lower per capita income.

Federal Poverty Level (FPL)
The threshold used as a basis for determining eligibility for many public benefits programs, including Medicaid. The current FPL chart is available on the Web at http://aspe.hhs.gov/poverty/.

Fee-For-Service (FFS)
A payment system in which an insurer pays the provider directly for each medical service after it is provided. The financial incentive in this system is to provide lots of services because each service is paid for. FFS payment is distinguished from capitation payment, where an insurer or provider is paid a set amount for a package of services for a given individual, regardless of how many services that individual uses.

Federal Financial Participation (FFP)
The funds that the federal government pays as a match for the state funds expended for Medicaid services. Only services recognized as covered services by the federal government are eligible to receive FFP.

Formulary
A list of prescription drugs covered by Medicaid, a private insurance plan or an HMO.

General Assistance (GA), General Relief (GR), Temporary Disability Assistance (TDA), or **Home Relief (HR)**
Welfare payments -- and often medical assistance -- provided to low-income, unemployed, incapacitated and/or disabled childless adults who have not yet been determined disabled through the SSA disability determination process.

Home and Community Based Services (HCBS) Waivers
See 1915c waivers.

Health-Based Payment
A reimbursement strategy that pays health plans a higher capitation rate for members with complex medical needs, including individuals with disabilities. Health-based payment provides an incentive for plans to provide good quality care to individuals with costly care needs, as opposed to limiting care to avoid financial risk.

Health Maintenance Organization (HMO)
A type of health insurance plan that delivers a pre-defined set of health benefits to enrolled members. The HMO typically is paid a capitation rate from a payer or employer for a group of enrollees and provides the covered health services through a network of providers that contract with the HMO.

Instrumental Activities of Daily Living (IADLs)
IADLs include meal preparation, medication management and administration, money management, communication (such as use of the telephone), transportation, employment and sometimes, laundry and other household chores. The ability to perform IADLs is often used as part of the criteria to qualify for long-term care and support services.

Integrated Delivery Model
Health service programs, often developed for a particular target population, that provide multiple types of services, such as medical care, mental health care, family support services or school-based services, through a single system or provider.

Intermediate Care Facility (ICF)
A facility that provides health and related services above the level of basic custodial care but below the level of care available in a hospital or skilled nursing facility.

Intermediate Care Facility for the Mentally Retarded (ICF/MR)
An ICF as described above that serves people with mental retardation. Federal regulations specify that these institutions must provide "active treatment."

Katie Beckett Waiver
See TEFRA State Plan Option for Severely Disabled Children.

Long-Term Care
Health, and in some cases, custodial and social support services, including respite, home and personal care, for people with chronic conditions, disabilities, or mental illness. Services can be provided in community-based or institutional settings.

Managed Care
A system that manages health care delivery in order to control costs and/or coordinate health services. Managed care usually relies on a primary care provider to serve as a gatekeeper to other services.

Managed Care Organizations (MCOs)
Health insurance plans that offer managed care products as described above. MCOs can include HMOs, but may also include health plans that are not officially licensed as HMOs.

Mandatory Managed Care Enrollment
A managed health care program in which Medicaid beneficiaries are required to enroll. People may be required to enroll in two or more managed care plans, a single PCCM program, or a choice of managed care plan or PCCM program.

Medicaid Buy-In Program
Medicaid buy-in programs allow families who meet certain eligibility criteria (often disability-related) but who are over-income to purchase Medicaid benefits to cover services that are not covered or are covered inadequately by employer-sponsored insurance plans.

Medically Needy
A category of Medicaid eligibility for individuals who are eligible for Medicaid by virtue of being aged, blind, disabled, or members of families with dependent children, but who have incomes and/or assets above the financial eligibility criteria for Medicaid. These individuals may deduct incurred medical expenses from their original "excess" income to become poor enough to qualify for

Medicaid. Participants in the medically needy programs generally have one, three, or six months to spend down their "excess" medical expenses, based on the state's rules.

Pay for Performance (PFP)
A reimbursement strategy that pays health care providers according to how well they meet certain quality standards.

Personal Care Assistance
Services designed to help an individual with a disability perform activities of daily living at home or in the workplace. "PCA" generally refers to a Personal Care Attendant who provides these services.

Premium
The amount of money paid to a health plan to provide coverage for an individual or family over a specified time period.

Premium Assistance
The payment of all or part of an individual's or family's monthly private health insurance premium, usually by a public program such as Title V or Medicaid.

Primary Care Case Management (PCCM)
Many states offer PCCM programs, in which Medicaid contracts with a preferred network of primary care providers who in turn provide primary care, care coordination and referral services for their enrolled members. Most PCCM providers are reimbursed through fee-for-service, but may receive a nominal monthly payment per enrolled member for care coordination or may receive an enhanced visit fee.

Real Choice Systems Change Grants
Grants awarded by the Centers for Medicare & Medicaid Services to enhance home and community-based services and supports, thereby averting institutional placement of individuals of all ages who have disabilities.

Reinsurance
A contract in which an insurer is itself insured, wholly or in part, against risk. Some state Medicaid programs offer to reinsure their managed care plans against extraordinarily high risks.

Respite Care
Temporary, short-term relief for a family caregiver. Respite care may be provided by a family member, a friend or a paid employee and may involve care of a child or an adult with disabilities.

Risk Adjustment
The adjustment of premiums to compensate health plans or providers for the increased risks associated with demographic attributes (e.g. age) or special health needs of their clients.

Serious Emotional Disturbance (SED)
Diagnosable mental health disorder in a child or adolescent that severely disrupts daily functioning in the home, school, or community.

Spend-Down
The process by which medically needy individuals — those who are eligible for Medicaid based on a medical condition but whose incomes exceed Medicaid's income limits — gain eligibility for Medicaid by using their "excess" income to pay medical bills.

State Children's Health Insurance Program (SCHIP)
A program established in 1997 to provide health assistance to uninsured, low-income children either through expanded eligibility for state Medicaid programs or through separate state programs. In most states, SCHIP programs expand health care coverage to children in families with incomes up to 200% of the FPL, but in some states it is as high as 350% of the FPL; in others it is lower than 200% . SCHIP programs may charge nominal premiums, and some programs also cover the uninsured parents of uninsured children.

State Plan/State Plan Amendment
A state's Medicaid program plan, which must be approved by the federal government, spells out the state's Medicaid eligibility criteria, covered services, methods of administration, and fiscal and quality controls. If a state wants to change its menu of covered services or Medicaid eligibility criteria, it must submit a state plan amendment or waiver request to the federal government.

State Supplementary Payments (SSPs)
Extra state payments added to federal SSI payments; states may choose to offer this through its State Plan Amendment.

Supplemental Security Income (SSI)
A federal program for low income individuals with disabilities or over the age of 64 that pays cash benefits of up to $603/month (2006). SSI disability status also confers Medicaid eligibility in all but 11 states. See 209(b) States

Take-Up Rate
The number of people who accept or "take up" a benefit for which they are eligible.

Temporary Assistance to Needy Families (TANF)
A federal block grant program designed to help welfare recipients find work, TANF replaced Aid to Families with Dependent Children in 1996. Most people who receive TANF benefits also receive Medicaid benefits.

Take-Up Rate
The number of people who accept or 'take-up' a benefit for which they are eligible.

Targeted Case Management
The provision of case management services to specific groups of Medicaid beneficiaries; designed to provide beneficiaries with needed services while promoting the cost-effective use of community resources.

Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA)
Federal tax legislation passed during the Reagan administration that included a Medicaid coverage option for children with severe disabilities.

TEFRA State Plan Option for Severely Disabled Children
The TEFRA state plan option allows states to provide Medicaid coverage to disabled children in their homes rather than in institutions. The TEFRA state plan option is also known as the Katie Beckett waiver or option, after the child who's mother advocated strongly for the legislation. To qualify for TEFRA, a child must meet both SSI disability criteria and institutional level of care criteria. However, children who live in institutions or receive extended care in institutions are not eligible for TEFRA benefits. In determining eligibility for TEFRA, the family's income is not counted, allowing middle-income children who are severely disabled to receive Medicaid benefits. The estimated cost of care for the child in the home can not exceed the estimated cost of institutional care.

Title XIX, Title 19, T-19
Shorthand for the Medicaid program, referring to Title 19 of the Social Security Act.

Title XXI
Shorthand for the State Child Health Insurance Program (SCHIP).

Wraparound
Services that are not included in a typical health insurance benefit package, but that enhance a child's functional status or overall well-being, or that facilitate access to care. Wraparound services may include family support, respite care and adaptive technologies.

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Medicaid as a Second Language: A Slightly Irreverent Guide to Common Medicaid Terms, Acronyms and Abbreviations, a publication of the Catalyst Center: Improving Financing of Care for Children and Youth with Special Health Care Needs, March, 2007. The Catalyst Center is funded by the Maternal and Child Health Bureau of the Health Services and Resources Administration, U.S. Department of Health and Human Services, under grant #U41MCO4494.

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