DEFINITIONS

Capitation: A reimbursement system in which health care providers receive a fixed fee for every patient served, regardless of how many or how few services the patient uses.

Case Management: A technique used by third party payors and self-insured employers to monitor or coordinate treatment for specific diagnosis, particularly those involving high-cost or expensive services.

Certificate of Need (CON): State programs that regulate expenditures for the introduction or expansion of health facilities, institutional health services, and/or the purchase of major medical equipment.

Clawback: (or phase down state contribution) - Required state payment to Medicare to cover the cost of dual eligiblies for Medicare prescription drug coverage offered under Medicare Part-D.

Diagnostic-Related Group (DRG): This is a system in which the hospital receives a fixed fee for each type of medical procedure regardless of the hospital's cost of providing that service.

DSH payment: Disproportionate Share Hospital payment: source of funding/reimbursement from Medicaid to hospitals serving a disproportionate share of Medicaid and uninsured patients.

Dual Eligible: senior or disabled individual enrolled in both Medicaid and Medicare.

Early Periodic Screening, Diagnosis, and Treatment (EPSDT) – Medicaid disease prevention program for children.

Federal Medical Assistance Percentage (FMAP): The federal government share of state Medicaid expenditures. Often referred to as financial participation or the federal match rate. The FMAP for each of the 50 states is formula driven and based on per capita incomes. States having low per capita incomes receive a higher federal match.

Federal Poverty Level (FPL): Poverty measure determined by the federal government based on family size.

Fee-for-Service: The traditional way of billing for health care services. There is a separate charge for each patient visit and service provided.

Federal Fiscal Year (FFY): October 1 to September 30.

Gatekeeper: A component of an independent practice association HMO that requires its subscribers to see a primary physician before seeing a specialist.

Health Maintenance Organization/Federally Qualified (HMO/FQ): A public or private organization that contracts on a prepaid capitated risk basis to provide a comprehensive set of services and is federally qualified.

Health Maintenance Organization/State Plan Defined (HMO/SPD): A public or private organization that contracts on a prepaid capitated risk basis to provide a comprehensive set of services and is a state defined plan.

Home and Community Based Services Waiver: Enable states to disregard certain federal requirements to provide home and community based services to targeted populations who would otherwise require institutionalization(ICF/MR services, and skilled and intermediate care nursing facility services).

Limited Risk Plan: A managed care plan in which the state contracts directly with providers on a per patient basis for certain services, but continues to pay on the fee-for-service for all other care. The state shares the financial risk of providing medical services with the managed care organization.

Managed Care Organization (MCO): A system of care under which a predetermined number of patients are enrolled, for a pre-determined rate for all or part of their care. The most common categories are health maintenance organizations and primary care case management.

Management Service Organization: An organization formed by one or more physician groups to manage their medical practices.

Mandatory Services: Services required to be provided (by CMS) to Medicaid eligibles as a result of operating a Medicaid program.

Medicaid Managed Care: A system of care in which a state has moved all or part of its Medicaid recipients into a managed care system. The most common categories are health maintenance organizations and primary care case management.

Medicaid: A national entitlement health insurance program authorized by Title XIX of the Social Security Act in 1965 that is jointly funded by states and the federal government and operated by the individual states. It is designed to provide medical coverage for the poor and specific groups of uninsured. Eligibility is typically limited to low income children, pregnant women, elderly and individuals with disabilities. States are granted flexibility in designing their Medicaid programs, but must cover certain groups of individuals.

Medical Saving Accounts: Individual and/or family health funds similar to individual retirement accounts into which employers and employees make tax-deferred contributions.

Medically Needy: A state option that allows Medicaid eligibility to an individual that may qualify under a certain category, but not financially (has too much income or assets to qualify under categorically needy limits). The states allow the individual to reduce their income (by spending down monthly income on medically necessary services to the provider or Medicaid program) to the Medicaid income standard/requirement for the respective category in order to qualify for Medicaid.

Open Enrollment: One period of time each year when HMOs are required to take applications regardless of the applicants' pre-existing conditions.

Point-of-Service (POS): A POS plan covers the health care services provided to members who use the network. It is similar to an HMO in that it utilizes a primary care "gatekeeper".

Preferred Provider Organization (PPO): Type of health insurance program in which a group of doctors and hospitals provide a broad range of medical care to a predetermined group of subscribers for a predetermined fee. Under this plan, a third party negotiates discounted rates for services with specific providers. Its members, however, may use providers outside the network but are encouraged by financial incentives to seek care from within the network.

Prepaid Health Plan (PHP): An entity that either contracts on a prepaid, capitated risk basis to provide services that are not risk-comprehensive, or contracts on a non-risk basis. Additionally, some entities that are defined as HMOs are treated as PHPs through statutory exemption.

Presumptive Eligibility: a state option that allows eligible providers to pre-determine (expedite) eligibility (without verification) under Medicaid before/while Medicaid eligibility is being determined. Services are temporary, or until appropriate Medicaid applications are submitted and eligibility is determined by an individual state.

Primary Care Case Management (PCCM): Programs that use a provider who receives a small fee to manage the individual's care but reimburses on a fee-for-service basis. The primary care case manager is responsible for health care

utilization and access to service. This is a freedom of choice waiver program which can be authorized by the authority of 1915(b) of the Social Security Act.

Prior Authorization: approval required from state Medicaid programs before physicians can prescribe certain medications. Prior authorization has typically been used by Medicaid programs as a cost saving tool.

Provider Taxes: Broad-based taxes on specific health providers/facilities, such as hospitals or nursing homes; and services such as pharmaceutical services which are used to generate state Medicaid funds.

SSI: Includes Supplemental Security Income recipients (or aged, blind and disabled individuals in those states which apply more restrictive eligibility requirements).

Section 1634 State: State option that requires state to provide Medicaid coverage to all aged, blind, and disabled individuals that receive cash assistance through SSI.

Section 1915(b) Waivers: Provision of the Social Security Act that allows states to waive certain programmatic rules governing Medicaid. It is typically used in implementing managed care to implement provider choices. States have generally used one of the following two approaches; capitated or primary care management programs.

Section 1915(c) Home and Community Based Services (HCBS) Waiver: Typically used to allow a state to offer long-term care services in a community based setting as opposed to institutional care.

Section 1115 Waivers (Research and Demonstration projects): Provision of the Social Security Act that allows states, subject to CMS approval, to waive certain requirements of the Medicaid program, such as eligibility rules. These waivers can be used to create small-scale demonstration projects in order to test proposed broad changes in the Medicaid program.

States Health Insurance Program (SCHIP): Federal health insurance program for targeted low income children under the age of 19 (that do not qualify for Medicaid) authorized by Title XXI of the Social Security Act. The program is jointly funded by states and the federal government, and states receive an enhanced federal match rate. SCHIP is an entitlement program that is capped by the federal government.

T19: All mandatory eligibility groups, as described by Title XIX of the Social Security Act.

The Breast and Cervical Cancer Prevention and Treatment Act of 2000: Federal act that gives states the 'option' to provide breast and cervical cancer treatment services through the Medicaid program (new eligibility category) to certain women.

The Centers for Medicare and Medicaid Services (CMS-- formerly HCFA): A federal agency within the Department of Health and Human Services. It was created in 1977 to administer the Medicare and Medicaid programs -- two national health care programs with more that 72 million beneficiaries. While CMS mainly acts as a purchaser of health care services for the Medicare and Medicaid beneficiaries, it also:

- Assures that Medicare and Medicaid are properly administered by its contractors and state agencies;
- Establishes policies for the reimbursement of health care providers;
- Conducts research on the effectiveness of various methods of health care management, treatment, and financing; and
- Assesses the quality of health care facilities and services.

Utilization Review: Involves medical professionals who are outside the managed care organization reviewing and evaluating the activities and diagnoses of the individuals within the organization.

Waiver: The Secretary of the Department of Health and Human Services can waive certain Medicaid statutory requirements upon request in order to allow states flexibility in operating their Medicaid programs. Waivers are usually implemented to target specific services to specific groups, expand eligibility to new or different groups, implement a new delivery system, or provide a different service.