# MEDICAID: Glossary of Terms

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**Capitation** – a method of payment for health services in which a practitioner or hospital is pre-paid a fixed, per capita amount to cover a specific period of time for each person served, regardless of the actual number or nature of services provided to each person.

**Care coordination**, considered a managed care term, refers to primary care and coordination of health care services for all members of a Medicaid managed care plan. Care coordination procedures must meet state requirements and must do the following:

1. Ensure that each enrollee has an ongoing source of primary care appropriate to his or her needs, and a person or entity formally designated as primarily responsible for coordinating the health care services furnished to the enrollee.
2. Coordinate the services the managed care plan furnishes to the enrollee with the services the enrollee receives from any other managed care plan.
3. Share with other managed care plans serving the enrollee with special health care needs the results of its identification and assessment of that enrollee's needs to prevent duplication of those activities.
4. Ensure that in the process of coordinating care, each enrollee's privacy is protected.

If the State requires managed care organizations to produce a treatment plan for enrollees with special health care needs who are determined through assessment to need a course of treatment or regular care monitoring, the treatment plan must be developed by the enrollee's primary care provider with enrollee participation, and in consultation with any specialists caring for the enrollee. For enrollees with special health care needs determined through an assessment by appropriate health care professionals to need a course of treatment or regular care monitoring, each managed care plan must have a mechanism in place to allow enrollees to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the enrollee's condition and identified needs.

**Case management** is a method designed to accommodate the specific health services needed by an individual through a coordinated effort to achieve the desired health outcome in a cost effective manner. It is the process by which patients with specific diagnosis or requiring high-cost or extensive services are managed by a physician or nurse or designated health professional. The monitoring and coordination of treatment rendered by physician case managers includes coordinating designated components of health care, such as appropriate referral to consultants, specialists, hospitals, ancillary providers and services. Case management is intended to ensure continuity of services and accessibility to overcome rigidity, fragmented services, and the mis-utilization of facilities and resources. It also attempts to match the appropriate intensity of services with the patient's needs over time. Case managers handle each case individually, identifying the most cost-effective treatments for extremely resource-intensive conditions, such as accidents, AIDS, cancer, major trauma, prematurity, and strokes.

**Categorical eligibility.** Medicaid eligibility is based on defined indicators of financial need by families with children and pregnant women, and to persons who are aged, blind, or disabled. Persons not falling into these categories cannot qualify, no matter how low their income. The Medicaid statute defines over 50 distinct population groups as potentially eligible, including those for which coverage is mandatory in all states and those that may be covered at a state's

option. The scope of covered services that states must provide to the categorically needy is much broader than the minimum scope of services for other groups receiving Medicaid benefits. States generally have broad discretion in determining which groups their Medicaid programs will cover and the financial criteria for Medicaid eligibility. To be eligible for Federal funds, however, States are *required* to provide Medicaid coverage for certain individuals who receive Federally assisted income-maintenance payments, as well as for related groups not receiving cash payments. In addition to the Medicaid program, most States have additional "State-only" programs to provide medical assistance for specified poor persons who do not qualify for Medicaid. Federal funds are *not* provided for State-only programs.

**Comparability of services.** The "comparability" requirement provides that medical assistance available to any eligible individual "shall not be less in amount, duration, or scope than the medical assistance made available to any other individual. This requirement ensures equity of health care in two ways. First, it assures that the services provided to individuals who are categorically eligible for Medicaid are comparable to those provided to the medically needy. Second, it also ensures that services are comparable among individuals within the group of beneficiaries who are categorically eligible for Medicaid.

**Disease management** is a strategy of delivery health care services using interdisciplinary clinical teams, continuous analysis of relevant data, and cost-effective technology to improve the health outcomes of patients with specific diseases. It includes self-care management techniques, patient education, and provider training. Disease management provides individualized care plans based on clinical guidelines to manage individuals with treatable chronic diseases.

A **disease management organization** is an entity that provides a service to managed care organizations and other health insuring organizations to manage people with specific diseases; often chronic ones. The claim is that this type of service provides higher quality of care at more reasonable price than alternative, presumably more fragmented, care.

**Due process for Medicaid beneficiaries.** Medicaid agencies must inform applicants and beneficiaries of the right to request a hearing, the method to obtain a hearing, and the ability to be represented by an attorney or other representative. A fair hearing must be available to any individual whose application is denied or is not acted upon in a reasonably prompt manner. A hearing is also available when a state Medicaid agency seeks to deny, terminate, or suspend services.

**Dual eligible.** The term "dual eligible" refers to the almost 7.5 million low-income older individuals or younger persons with disabilities who are enrolled in both Medicaid and Medicare. About two thirds (5.9 million) of dual eligibles are age 65 and over, while the remaining one-third are disabled younger persons. More than 1.5 million dual eligibles are nursing home residents. Most dual eligibles qualify for full Medicaid benefits. State Medicaid programs are required by federal law to cover the dual eligibles with incomes up to 73% of poverty ($579 per month for an individual in 2005).

**Disproportionate share hospital (DSH) payments.** Federal Medicaid DSH payments, authorized by Congress in the 1980s and directed to hospitals that serve a large number of

Medicaid and low-income patients with special needs, are allocated among states in amounts set forth as ceilings in federal statutes.

**Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT)** is designed to improve primary health benefits for Medicaid children with emphasis on preventive care. EPSDT requires states to assess a child's health needs for all eligible children under age 21 through initial and periodic examinations and evaluations to assure that health problems are diagnosed and treated before the problem becomes more complex and the treatment more costly. States must perform medical, vision, hearing, and dental check-ups according to standardized schedules, called a "periodicity schedule." By statute, states must consult with recognized medical organizations to determine the appropriate scheduling to ensure timely EPSDT treatment, generally within an outer limit of six months after the request for screening services.

**Enhanced federal (FMAP) reimbursement.** The "enhanced FMAP", for a fiscal year, is equal to the federal medical assistance percentage for the state increased by a number of percentage points equal to 30 percent of the number of percentage points by which (1) such federal medical assistance percentage for the state, is less than (2) 100 percent; but in no case shall the enhanced FMAP for a state exceed 85 percent. The "Enhanced Federal Medical Assistance Percentages" are for use in the State Children's Health Insurance Program, and in the Medicaid program for certain children for expenditures for medical assistance described in sections 1905(u)(2) and 1905(u)(3) of the Act.

**Federal block grant.** Under the current system of federal funding to states, states are responsible for implementing more than 300 separate programs related to welfare, food stamps, housing and job training. These programs are administered by different agencies at the federal level and are subject to extensive, complicated rules and regulations, which often conflict across program lines. These so-called ‘block grants’ offer states an opportunity to develop programs and policies based on local needs rather than a one-size-fits-all federal perspective. States are given greater flexibility to use funds based on their own priorities and to design programs and allocate resources as they determine to be appropriate. Administrative, planning, fiscal and other types of reporting requirements are kept to the minimum amount necessary to ensure that national goals are being accomplished. The level of funding in each of the block grants is based on past individual state expenditures. In some cases the program growth rate may be reduced and in others the funding level may be capped. Some of the block grants have provisions for contingency or "rainy day" funds or loans.

**Federal financial participation (Federal Medical Assistance Percentage)**. Medicaid is a federal-state partnership insofar as Medicaid is authorized under federal law and is administered by each state. Federal funding is available to state Medicaid programs for the provision of health care services and various administrative functions. The amount of federal funding available to a state is referred to as federal financial participation (FFP) and is determined by comparing a state's per capita income to the national average. The FFP for any state will range from 50-83%, depending on this per capita income formula. The Federal Medical Assistance Percentages (FMAPs) are used in determining the amount of Federal matching funds for State expenditures for assistance payments for certain social services, and State medical and medical insurance

expenditures. The Social Security Act requires the Secretary of Health and Human Services to calculate and publish the FMAPs each year.

**Federal waivers.** The Social Security Act authorizes multiple waiver and demonstration authorities to allow states flexibility in operating Medicaid programs. Each authority has a distinct purpose, and distinct requirements.

- <u>Section 1115 Research & Demonstration Projects</u> provide the Secretary of Health and Human Services broad authority to approve projects that test policy innovations likely to further the objectives of the Medicaid program.
- <u>Section 1915(b) Managed Care/Freedom of Choice Waivers</u> provide the Secretary authority to grant waivers that allow states to implement managed care delivery systems, or otherwise limit individuals' choice of provider under Medicaid.
- <u>Section 1915(c) Home and Community-Based Services Waivers</u> provide the Secretary authority to waive Medicaid provisions in order to allow long-term care services to be delivered in community settings. This program is the Medicaid alternative to providing comprehensive long-term services in institutional settings.

**Intergovernmental transfers (IGTs)** are exchanges of public funds between different levels of government and are a common feature in state finance. In the early 1990s, many states began to use IGTs as a way to leverage federal Medicaid dollars to continue or expand coverage of services or to pay higher reimbursement rates to providers. The transfer of funds may take place from one level of government to another (i.e., counties to states) or within the same level of government (i.e., from a state university hospital to the state Medicaid agency). Thus, states can use county or state expenditures to generate a federal match to support Medicaid services.

**Mandatory managed care.** Over time, state Medicaid programs have migrated toward capitated HMO alternatives as the preferred strategy to not only improve access and accountability and reduce costs, but also achieve budget predictability. Many states chose to build upon voluntary managed care programs by enrolling beneficiaries on a mandatory basis into capitated managed care programs under 1915(b) freedom of choice or Section 1115 of the Social Security Act managed care demonstration waivers.

**Medicaid payment for graduate medical education (GME).** Second to Medicare, Medicaid is the largest explicit payer of GME, providing teaching hospitals between $2.5 and $2.7 billion in 2002, amounts slightly higher than the $2.3 to $2.4 billion estimate of total Medicaid GME payments in 1998. Of the 46 states and DC that made GME payments under their Medicaid FFS programs, the majority of states (24) and DC recognize and reimburse for both direct graduate medical education (DGME) and indirect medical education (IME) costs.

- <u>DGME payments</u> are designed to reimburse teaching hospitals for Medicaid's share of the costs of salaries and fringe benefits paid to medical residents, interns and supervising faculty, malpractice insurance for residents and administrative expenses. These expenses are typically borne by the teaching hospital utilizing the resident.
- <u>IME costs</u> are a substantial, but difficult to define, element of the hospital costs of resident training. These expenses are related to the higher costs associated with training, such as additional diagnostic tests ordered by residents learning how to make diagnoses, higher staffing ratios, and the higher percentage of patients in teaching hospitals with

complex conditions that necessitate costly treatment. Typically, IME is paid as an add-on to a teaching hospital's per diem payment for care of Medicaid inpatients.

**Medical necessity.** All Medicaid-funded services must be medically necessary. While the wording of the definition may differ from state to state, numerous courts have concluded that the determination of what treatment is medically necessary must be consistent with accepted standards of medical practice and must be made by the beneficiary's treating physician. The importance of the treating physician or other health care professionals in determining what treatment is medically necessary is clear from the legislative history of the Medicaid Act. Relying upon this legislative history, numerous courts have emphasized that state procedures that interfere with a treating physician's professional judgment concerning medically necessary treatment violate the Medicaid Act.

**Medically needy.** The option to have a "medically needy" program allows states to extend Medicaid eligibility to additional qualified persons who may have too much income to qualify under the mandatory or optional categorically needy groups. This option allows them to "spend down" to Medicaid eligibility by incurring medical and/or remedial care expenses to offset their excess income, thereby reducing it to a level below the maximum allowed by that State's Medicaid plan. States may also allow families to establish eligibility as medically needy by paying monthly premiums to the State in an amount equal to the difference between family income (reduced by unpaid expenses, if any, incurred for medical care in previous months) and the income eligibility standard.

**Medicare Modernization Act (MMA).** In 2003, President Bush signed into law the Medicare Prescription Drug Improvement and Modernization Act (P.L. 108-173). This landmark legislation provides seniors and individuals with disabilities with a prescription drug benefit, more choices, and better benefits under Medicare.

**Presumptive eligibility.** Medicaid Presumptive Eligibility (MPE) is for pregnant women. Under MPE, pregnant women can get immediate outpatient services for a limited time. Eligibility is based on a medically verified pregnancy and the pregnant woman's statement of her family's gross monthly income. Only qualified providers can determine eligibility for the MPE program. In accordance with federal requirements, only organizations that receive funding under one of the following programs can be a MPE provider.

- Federal community or migrant health programs (Section 329, 330 or 340 of the Public Health Service Act)
- Title V Maternal and Child Health Block Grant
- Title V of the Indian Health Improvement Act
- Title XIX (Medicaid) or Title XXI (SCHIP) for prenatal services
- The Indian Health Service or a health program operated by a tribe or tribal organization under the Indian self-determination

**Primary care case management (PCCM)** means a system under which a primary care provider is responsible for approving and monitoring the care of enrolled Medicaid beneficiaries, typically for a small case management fee in addition to fee-for-service reimbursement for service. A case management fee of $3 per person per month is the most common fee although some states pay

more and some less. This is a Freedom of Choice Waiver program, under the authority of section 1915(b) of the Social Security Act.
States began enrolling beneficiaries in their PCCM programs by the mid-1980s to increase access and reduce inappropriate emergency room and other high cost care. Early PCCM programs were more like traditional fee-for-service Medicaid than their managed care counterpart, risk-based programs. Some states developed PCCM as a stepping stone to risk-based managed care, and therefore considered their Managed Care Organization (MCO) contracts as the predominant managed care system. That emphasis has been shifting, however, in those states that are experiencing a decrease in contractors as MCOs choose to exit Medicaid managed care. As PCCM programs have matured, state goals have changed from simply expanding access to better management of the quality of care provided.

**Primary care case manager** means a physician, a physician group practice, an entity that employs or arranges with physicians to furnish primary care case management services or, at state option, any of the following: physician assistant, nurse practitioner, certified nurse-midwife.

**Provider tax.** The use of state taxes on health care providers became a common practice among states to raise the state share (and thus increase federal matching payments) for making Medicaid payments by the early 1990s, Congress in 1991 banned states' use of provider donations and imposed restrictions on provider taxes. Under federal law and regulations, a state's ability to use provider-specific taxes to fund their state share of Medicaid expenditures is limited. Those taxes cannot generally exceed 25% of the state (or non-federal) share of Medicaid expenditures, and the state cannot provide a guarantee to the providers that the taxes will be returned to them.

**Reasonable standards.** According to the Medicaid Act, "[a] State plan for medical assistance must...include reasonable standards...for determining eligibility for and the extent of medical assistance under the plan which...is consistent with the objectives of this [Act]." Many courts applying this standard have concluded that states cannot exclude medically necessary services from coverage when this exclusion would result in a denial of all treatment for a particular medical condition. Exclusions of treatment from coverage based upon non-medical criteria violate the reasonable standards requirement of the Medicaid Act.

**Risk based plans.** Over half of all Medicaid beneficiaries are enrolled in managed care organizations rather than fee-for-service programs. Nearly all states have some Medicaid managed care programs. Major Medicaid managed care models include *risk-based plans.* Under a risk-based plan, a health provider is paid a fixed monthly fee per enrollee and assumes the financial risk for the delivery of a specified package of services.

**The State Children's Health Insurance Program (SCHIP)** was enacted in 1997 to provide a capped amount of federal matching funds to states for coverage of children and some parents with incomes too high to qualify for Medicaid, but for whom private health insurance was either unavailable or unaffordable. Covering roughly 5 million children, SCHIP has played an important role in reducing the number of uninsured children in America. Between 1996 and 2002, the uninsured rate among low-income children dropped from 23% to 19%, largely due to increased in Medicaid and SCHIP coverage.

**State Medicaid plan.** Each state must develop a state plan that describes Medicaid program administration, eligibility categories, and services provided. The plan must identify the required and optional health care services available through Medicaid. It also must describe how beneficiaries and advocates can review and obtain copies of all current policies and rules governing program operation.

**State-wideness provision.** A state Medicaid plan "shall be in effect in all political subdivisions of the state." States cannot limit health care services available under the state plan to a specific geographic location or simply fail to provide a covered service in a particular area. To comply with this requirement, state Medicaid programs must provide all medically necessary health care services available under the state plan without regard to the county of residence of the beneficiary who is seeking health care services.

**Supplemental security income (SSI)** is a federal income supplement program funded by general tax revenues (not Social Security taxes). It is designed to help aged, blind, and disabled people, who have little or no income; and provide cash to meet basic needs for food, clothing, and shelter. People who receive SSI because of disability or because they are 65 years of age or older are automatically eligible for Medicaid in 39 states.

**Transfer of assets.** One is only eligible for Medicaid when their assets are reduced to minimum levels which vary from state to state and also with marital status. One must personally pay the bills for home care, nursing facility and other costs until their assets are reduced to Medicaid levels. To avoid spending all of their money on nursing facility costs before Medicaid coverage is used, many people give their assets away to children and other relatives, then they apply for Medicaid. Medicaid rules severely restrict such transfers. Provisions of Section 1917(c) of the Social Security Act (U.S. Code Reference 42 U.S.C. 1396p(c)) apply when assets are transferred by individuals in long-term care facilities or receiving home and community-based waiver services, or by their spouses, or someone else acting on their behalf. At state option, these provisions can also apply to various other eligibility groups. States can "look back" to find transfers of assets for 36 months prior to the date the individual is institutionalized or, if later, the date he or she applies for Medicaid. If a transfer of assets for less than fair market value is found, the State must withhold payment for nursing facility care (and certain other long-term care services) for a period of time referred to as the penalty period.

**Upper payment limit.** Often key to the effective use of IGTs is a state's upper payment limit (UPL). Although IGTs relate to what qualifies as the state share of Medicaid, UPLs have to do with the amounts state Medicaid programs can pay to providers for covered services. The UPL rule states that aggregate Medicaid payments to specific groups of providers cannot exceed a reasonable estimate of what would have been paid under Medicare payment principles.