Medicaid Glossary

Actuarially Sound—The federal statutory standard to which capitation payments made by state Medicaid programs under risk contracts to managed care organizations (MCOs) are held. See Capitation Payment, MCO, Risk Contract.

Amount, Duration, and Scope—The phrase used to describe the Medicaid program policy under which states are allowed to limit the items and services they cover within a statutory benefit category (e.g., physician, inpatient hospital, prescription drug). Each benefit category that a state covers must be sufficient in amount, duration, and scope to reasonably achieve its purpose.

AMP (Average Manufacturer Price)—The average price paid to a drug manufacturer in the U.S. by wholesalers for drugs distributed to retail pharmacies. Used in calculating the amount of the rebate participating manufacturers are required to pay on covered outpatient drugs purchased by state Medicaid programs.

Assets—See Resources.

Assignment—The Medicaid program policy under which hospitals, physicians, nursing facilities, and other providers that elect to participate in Medicaid must accept as payment in full the program's payment for an item or service delivered to a Medicaid beneficiary and may not "balance bill" or charge the beneficiary any additional amount. If the state's Medicaid program imposes nominal cost-sharing on certain categories of Medicaid beneficiaries for certain services, the providers of those services may seek payment of the allowable cost-sharing amounts directly from the beneficiary.

Beneficiary—An individual who is eligible for and enrolled in the Medicaid program in the state in which he or she resides. Millions of individuals are eligible for Medicaid but not enrolled and are therefore not program beneficiaries.

Best Price—The lowest price on a prescription drug available from a manufacturer to any wholesaler, retail pharmacy, provider, or managed care organization, subject to certain exceptions. Used in calculating the amount of the rebate participating manufacturers are required to pay on covered outpatient drugs (other than generic drugs) purchased by state Medicaid programs.

Boren Amendment—The requirement in federal Medicaid law from 1980 until 1997 that states pay for inpatient hospital and nursing facility services using rates that are "reasonable and adequate" to meet the costs that must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with federal and state quality and safety standards.

Capitation Payment—A payment made by a state Medicaid agency under a risk contract, generally to a managed care organization (MCO). The payment is made on a monthly basis at a fixed amount on behalf of each Medicaid beneficiary enrolled in the MCO. In exchange for the capitation payment, the MCO agrees to provide (or arrange for the provision of) services covered under the contract with the state Medicaid agency to enrolled Medicaid beneficiaries. See fee-for-service, MCO, Risk Contract.

Carve Out—The term used informally to describe the exclusion of certain services to which Medicaid beneficiaries are entitled from a risk contract between a state Medicaid agency and an MCO. A common "carve out" arrangement involves behavioral health services. In the case of those behavioral health services covered under the state's Medicaid plan that an MCO does not contract to provide, the state Medicaid agency may continue to pay for these services on a fee-for-service basis. In the alternative, it may enter into a risk contract with a behavioral health organization (BHO), a managed care entity specializing in such services. In either case, the services are "carved out" of the MCO contract. See Risk Contract.

Categorical Eligibility—A phrase describing Medicaid's policy of restricting eligibility to individuals in certain groups or categories, such as children, the aged, or individuals with disabilities. Certain categories of individuals—e.g., childless adults under 65 without disabilities—are generally ineligible for Medicaid

regardless of the extent of their impoverishment. Individuals who fall into approved categories must also satisfy financial eligibility requirements, including income and, in most cases, resource tests imposed by the states in which they reside. See Financial Eligibility.

Categorically Needy—A phrase describing certain groups of Medicaid beneficiaries who qualify for the basic mandatory package of Medicaid benefits. There are "categorically needy" groups that states participating in Medicaid are required to cover, such as pregnant women and infants with incomes at or below 133 percent of the Federal Poverty Level (FPL). There are also "categorically needy" groups that states may at their option cover, such as pregnant women and infants with incomes above 133 percent and up to 185 percent of the FPL. Unlike the "medically needy," "categorically needy" individuals may not "spend down" in order to qualify for Medicaid. See also Medically Needy, Spend Down.

Center for Medicaid and State Operations (CMSO)—The agency within the Centers for Medicare and Medicaid Services (CMS) with responsibility for administering Medicaid and the Children's Health Insurance Program (SCHIP).

Centers for Medicare and Medicaid Services (CMS)—The agency in the Department of Health and Human Services with responsibility for administering the Medicaid, Medicare, and State Children's Health Insurance programs at the federal level. Formerly known as the Health Care Financing Administration (HCFA).

Children's Health Insurance Program (SCHIP)—Enacted in the 1997 Balanced Budget Act as Title XXI of the Social Security Act, SCHIP is a federal-state matching program of health care coverage for uninsured low-income children. In contrast to Medicaid, SCHIP is a block grant to the states; eligible low-income children have no individual entitlement to a minimum package of health care benefits. Children who are eligible for Medicaid are not eligible for SCHIP. States have the option of administering SCHIP through their Medicaid programs or through a separate program (or a combination of both). The statutory federal matching rate for SCHIP services (on average, 70 percent) is higher than that for Medicaid (on average, 57 percent), but the federal allotment to each state for CHIP services is capped at a specified amount each year. Also referred to as the State Children's Health Insurance Program (SCHIP).

Civil Money Penalty (CMP)—An intermediate sanction (i.e., less drastic than exclusion from participation in the program) applied to participating providers and managed care plans that are found to have engaged in program fraud or have violated certain program requirements. Some CMP authorities are administered by the Centers for Medicare and Medicaid Services, others by the Office of Inspector General (OIG). See Exclusion, OIG.

Comparability—A rule of Medicaid benefits design that requires a state to offer services in the same amount, duration, and scope to one group of categorically needy individuals (e.g., poverty-related children) as it offers to another group of categorically needy individuals (e.g., elderly SSI recipients). See Amount, Duration, and Scope; Categorically Needy.

Continuous Eligibility—An option available to states under federal Medicaid law whereby children enrolled in Medicaid may remain eligible for a continuous period of 12 months, regardless of intervening changes in family income or status.

Copayment—A fixed dollar amount paid by a Medicaid beneficiary at the time of receiving a covered service from a participating provider. Copayments, like other forms of beneficiary cost-sharing (e.g., deductibles, coinsurance), may be imposed by state Medicaid programs only upon certain groups of beneficiaries, only with respect to certain services, and only in nominal amounts as specified in federal regulation.

Departmental Appeals Board (DAB)—The agency within the Department of Health and Human Services that adjudicates disputes between CMS and state Medicaid agencies regarding disallowances of federal matching payments and hears appeals of CMS or OIG decisions to impose civil money penalties or exclusions on providers. See Disallowance; Civil Money Penalties; Exclusions.

De-Linking—The informal term used to refer to breaking the historic link between eligibility for cash assistance under Aid to Families with Dependent Children (AFDC) and eligibility for Medicaid. The process of de-linking began in the mid-1980s with the enactment of optional eligibility groups of poverty-related pregnant women and children and continued with the repeal of the AFDC program in 1996 and the enactment of a new section 1931 eligibility group. See Poverty-Related, Section 1931.

Disallowance—A determination by CMS not to provide federal Medicaid matching payments to a state in connection with an expenditure made by the state's Medicaid program because the expenditure does not meet federal requirements for matching payments. States may appeal CMS disallowances to the Departmental Appeals Board (DAB) and to federal court. See Departmental Appeals Board.

Disregards—An informal term that relates to a state Medicaid program's methodology for counting income and resources in determining eligibility. For certain eligibility categories, such as poverty-related children or working disabled adults—states may disregard—that is, not count—certain income or resources in determining whether the individual meets its Medicaid income or resource standards. The effect of an income or resource disregard is to enable an individual to qualify for Medicaid even if his or her gross income or resources exceed the state's eligibility standard. See Methodology, Standard.

Disproportionate Share Hospital (DSH) Payments—Payments made by a state's Medicaid program to hospitals that the state designates as serving a "disproportionate share" of low-income or uninsured patients. These payments are in addition to the regular payments such hospitals receive for providing inpatient care to Medicaid beneficiaries. States have some discretion in determining which hospitals qualify for DSH payments and how much they receive. The amount of federal matching funds that a state can use to make payments to DSH hospitals in any given year is capped at an amount specified in the federal Medicaid statute.

Dual Eligibles—A term used to describe an individual who is eligible both for Medicare and for full Medicaid coverage, including nursing home services and prescription drugs, as well as for payment of Medicare premiums, deductibles, and co-insurance. Some Medicare beneficiaries are eligible for Medicaid payments for some or all of their Medicare premiums, deductibles, and co-insurance requirements, but not for Medicaid nursing home or prescription drug benefits. See Qualified Medicare Beneficiary, Specified Low-Income Medicare Beneficiary, and Qualifying Individual.

Drug Use Review (DUR)—The program of prospective and retrospective review of prescriptions paid for by a state Medicaid program that each state is required to conduct in order to ensure that prescriptions are appropriate, medically necessary, and not likely to result in adverse medical outcomes.

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services—One of the services that states are required to include in their basic benefits package for all Medicaid-eligible children under age 21. EPSDT services include periodic screenings to identify physical and mental conditions as well as vision, hearing, and dental problems. EPSDT services also include follow-up diagnostic and treatment services to correct conditions identified during a screening, without regard to whether the state Medicaid plan covers those services with respect to adult beneficiaries.

Enrollment Broker—The term used to describe an organization, usually a private entity, that contracts with a state Medicaid agency to inform Medicaid beneficiaries about, enroll them in, and disenroll them from MCOs and PCCMs participating in the state's Medicaid program.

Entitlement—A program that imposes a legal obligation on the federal government to any person, business, or unit of government that meets the criteria set in law. Federal spending in an entitlement program is controlled through the program's eligibility criteria and benefit and payment rules, not by the appropriation of a specific level of funding in advance. Entitlement programs such as Medicare and Medicaid are also referred to (for federal budget purposes) as "direct" or "mandatory" spending. Medicaid is both an individual entitlement and an entitlement to the states that elect to participate.

Error Rates—Refers to the percentage of Medicaid payments made by a state on the basis of erroneous Medicaid eligibility determinations. For this purpose, an error occurs when an individual who is not in fact eligible is incorrectly enrolled in the program and a payment is made on that individual's behalf to a provider or plan. States are subject to the loss of federal Medicaid matching funds if their "error rate"—i.e., their payments for services attributable to ineligible individuals—exceeds 3 percent of their total spending on Medicaid benefits. See Quality Control.

Estate Recovery—The requirement that state Medicaid programs seek to collect from the estate of a deceased Medicaid beneficiary the amounts paid on the individual's behalf for nursing facility services, home and community-based services, and related hospital and prescription drug services.

Exclusion—A sanction imposed upon providers or managed care plans for certain fraudulent conduct, usually by the Office of Inspector General (OIG) or a state Medicaid fraud control unit (MFCU). An excluded provider or plan may not receive Medicaid reimbursement during the period of exclusion, which varies with the nature and severity of the offense. See MFCU, OIG.

External Quality Review Organization (EQRO)—A private entity that conducts the required annual, external independent reviews of the quality and accessibility of services for which state Medicaid agencies have entered into risk contracts with Medicaid MCOs. See MCO, Risk Contract.

Fair Hearing—Because Medicaid is an entitlement, individuals have a statutory right to appeal denials or terminations of Medicaid benefits to an independent arbiter. The fair hearing is the administrative procedure that provides this independent review with respect to individuals who apply for Medicaid and are denied enrollment, individuals enrolled in Medicaid whose enrollment is terminated, and Medicaid beneficiaries who are denied a covered benefit or service.

Federal Financial Participation (FFP)—The technical term for federal Medicaid matching funds paid to states for allowable expenditures for Medicaid services or administrative costs. States receive FFP for expenditures for services at different rates, or FMAPs, depending on their per capita incomes. FFP for administrative expenditures also varies in its rate, depending upon the type of administrative cost. See FMAP.

Federal Poverty Level (FPL)—The federal government's working definition of poverty that is used as the reference point for the income standard for Medicaid eligibility for certain categories of beneficiaries. Adjusted annually for inflation and published by the Department of Health and Human Services in the form of Poverty Guidelines, the FPL in calendar year 2001 was $14,630 for a family of 3 in 48 contiguous States and the District of Columbia, $18,290 in Alaska, and $16,830 in Hawaii.

Federal Medical Assistance Percentage (FMAP)—The statutory term for the federal Medicaid matching rate—i.e., the share of the costs of Medicaid services or administration that the federal government bears. In the case of covered services, FMAP varies from 50 to 83 percent depending upon a state's per capita income; on average, across all states, the federal government pays at least 57 percent of the costs of Medicaid. FMAPs for administrative costs vary not by state, but by function. The general FMAP for administrative costs is 50 percent; some functions (e.g., survey and certification, fraud control units) qualify for enhanced FMAPs of 75 percent or more.

Federally Qualified Health Center (FQHC)—States are required to include services provided by FQHCs in their basic Medicaid benefits package. FQHC services are primary care and other ambulatory care services provided by community health centers and migrant health centers funded under section 330 of the Public Health Service Act, as well as by "look alike" clinics that meet the requirements for federal funding but do not actually receive federal grant funds. FQHC status also applies to health programs operated by Indian tribes and tribal organizations or by urban Indian organizations.

Fee-For-Service—A traditional method of paying for medical services under which doctors and hospitals are paid for each service they provide. Bills are either paid by the patient who then submits them to the insurance company or are submitted by the provider to the patient's insurance carrier for reimbursement.

Financial Eligibility—In order to qualify for Medicaid, an individual must meet both categorical and financial eligibility requirements. Financial eligibility requirements vary from state to state and from category to category, but they generally include limits on the amount of income and the amount of resources an individual is allowed to have in order to qualify for coverage.

Formulary—States that elect to cover prescription drugs in their Medicaid programs may limit the drug products covered through the use of a formulary, a listing of the specific drugs for which a state will make payment without prior authorization. States may exclude from their formularies specific drugs of manufacturers participating in the Medicaid rebate programs only if certain criteria are met and only if the excluded drug is made available through a prior authorization program.

Freedom of Choice—Refers to both the right of providers to choose whether or not to participate in the Medicaid program and the right of Medicaid beneficiaries to choose providers from among those participating. This right with respect to beneficiaries is commonly waived in states implementing Medicaid managed care. See Waivers.

Health Insurance Flexibility and Accountability (HIFA) Waivers—The term used by the Bush Administration to describe its demonstration initiative, using the section 1115 waiver authority, to encourage new comprehensive state approaches that will increase the number of individuals with health insurance coverage within current-level Medicaid and SCHIP resources. See Section 1115 Waivers.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)—The Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, which requires each state's Medicaid management information system (MMIS) to have the capacity to exchange data with the Medicare program and contains "Administrative Simplification" provisions that require state Medicaid programs to use standard, national codes for electronic transactions relating to the processing of health claims.

Home- and Community-Based Services (HCBS) Waiver—Also known as the "1915(c) waiver" after the enabling section in the Social Security Act, this waiver authorizes

the Secretary of HHS to allow a state Medicaid program to offer special services to beneficiaries at risk of institutionalization in a nursing facility or facility for the mentally retarded. These home and community-based services, which otherwise would not qualify for federal matching funds, include case management, homemaker/home health aide services, personal care services, adult day health services, habilitation services, and respite care. They also include, in the case of individuals with chronic mental illness, day treatment and partial hospitalization, psychosocial rehabilitation services, and clinic services.

Hyde Amendment—The provision in the annual Labor-HHS Appropriations bill that, as of FY 2001, prohibits the use of federal Medicaid matching funds for abortions except if the pregnancy is the result of an act of rape or incest or if the woman suffers from a condition that would, as certified by a physician, place the woman in danger of death unless the abortion is performed.

Institution for Mental Diseases (IMD)—A public or private facility with more than 16 beds that is "primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases." This includes not just hospitals for individuals with mental illness but also nursing homes or other long-term care facilities that primarily serve such individuals. Federal Medicaid matching funds are not allowable for the costs of any Medicaid covered services furnished to an individual under 65 years of age who resides in an IMD.

Intergovernmental Transfer (IGT)—The transfer of non-Federal public funds from a local government (or locally owned hospital or nursing facility) to the state Medicaid agency, or from another state agency (or state-owned hospital) to the State Medicaid agency, usually for the purpose of providing the state share of a Medicaid expenditure in order to draw down federal matching funds. Often used in connection with payments to DSH hospitals and UPL transactions. See DSH, UPL.

Intermediate Care Facility for the Mentally Retarded (ICF/MR)—A public or private facility, the primary purpose of which is to provide health or rehabilitative services to individuals with mental retardation or related conditions (e.g., cerebral palsy). State Medicaid programs may at their option cover services provided by ICFs/MR.

Katie Beckett Option—The popular name for the option available to states of making eligible for Medicaid children with disabilities who require the level of care provided in a hospital, nursing facility, or ICF/MR but can be cared for at home and would not otherwise qualify for Medicaid if not institutionalized.

"Look-Behind" Surveys—The informal term for a validation survey of nursing facilities participating in Medicaid conducted by CMS in order to ensure that the facilities meet quality requirements and that the surveys of these facilities conducted by state survey agencies are adequate.

Managed Care Entity (MCE)—The federal statutory term for a managed care plan participating in Medicaid. There are two types of MCEs: managed care organizations (MCOs) and primary care case managers (PCCMs). MCEs may be public or private.

Managed Care Organization (MCO)—An MCO is an entity that has entered into a risk contract with a state Medicaid agency to provide a specified package of benefits to Medicaid enrollees in exchange for an actuarially sound monthly capitation payment on behalf of each enrollee. See Actuarially Sound, Capitation Payment, Risk Contract.

Mandatory—State participation in the Medicaid program is voluntary. However, if a state elects to participate, as all do, the state must at a minimum offer coverage for certain services to certain populations. These eligibility groups and services are referred to as "mandatory" in order to distinguish them from the eligibility groups and services that a state may, at its option, cover with federal Medicaid matching funds. See Optional.

Means Testing—The policy of basing eligibility for benefits upon an individual's lack of means, as measured by his or her income or resources. Means testing by definition requires the disclosure of personal financial information by an applicant as a condition of eligibility. Medicaid and SCHIP are means-tested programs; Medicare is not.

Medicaid Fraud Control Unit (MFCU)—A state agency independent of the state Medicaid agency responsible for investigating and prosecuting fraud and patient neglect and abuse under state law.

Medical Assistance—The term used in the federal Medicaid statute (Title XIX of the Social Security Act) to refer to payment for items and services covered under a state's Medicaid program on behalf of individuals eligible for benefits.

Medically Needy—A term used to describe an optional Medicaid eligibility group made up of individuals who qualify for coverage because of high medical expenses, commonly hospital or nursing home care. These

individuals meet Medicaid's categorical requirements—i.e., they are children or parents or aged or individuals with disabilities—but their income is too high to enable them to qualify for "categorically needy" coverage. Instead, they qualify for coverage by "spending down"—i.e., reducing their income by their medical expenses. States that elect to cover the "medically needy" do not have to offer the same benefit package to them as they offer to the "categorically needy." See Categorically Needy, Spend-down.

Medicaid Management Information System (MMIS)—A state's computer systems for tracking Medicaid enrollment, claims processing, and payment information. The 1996 HIPAA legislation requires that each state's MMIS have the capacity to exchange data with Medicare. It also contains "Administrative Simplification" provisions that require state Medicaid programs to use standard, national codes for electronic transactions relating to the processing of health claims.

Medicare Buy-in—The informal term referring to the payment of Medicare Part B premiums on behalf of low-income Medicare beneficiaries who qualify for full Medicaid coverage (dual eligibles) or just for assistance with Medicare premiums and cost-sharing (Qualified Medicare Beneficiary, Specified Low-Income Beneficiaries, and Qualifying Individual).

Methodology—The rules that a state uses in counting an individual's income or resources in determining whether he or she meets its Medicaid eligibility standards. For certain eligibility categories, states have the flexibility to disregard some or all of an individual's income and resources in determining whether the individual qualifies for Medicaid. See Disregards, Standard.

Office for Civil Rights (OCR)—The agency within the Department of Health and Human Services with responsibility for monitoring and enforcing compliance with federal anti-discrimination laws by providers and managed care entities participating in Medicaid as well as state Medicaid agencies and their contractors.

Office of Inspector General (OIG)—The agency within the Department of Health and Human Services with responsibility for monitoring and enforcing compliance with federal fraud and abuse laws by providers and managed care entities participating in Medicaid.

Optional—The term used to describe Medicaid eligibility groups or service categories that states may cover if they so choose and for which they may receive federal Medicaid matching payments at their regular matching rate, or FMAP. About two thirds of all federal Medicaid funds are used to match the cost of optional services for mandatory or optional groups and all services for optional populations.

Outstationing—The placement of state or local Medicaid eligibility workers at locations other than welfare offices. State Medicaid agencies are required to outstation workers at DSH hospitals and FQHCs to accept Medicaid applications from poverty-related pregnant women and children.

Peer Review Organization (PRO)—An entity that, under contract with a state Medicaid agency, reviews the utilization or quality of services provided to Medicaid beneficiaries either by fee-for-service providers or managed care entities. PROs must meet federal performance standards. CMS recently renamed PROs "Quality Improvement Organizations."

Personal Needs Allowance (PNA)—In the case of a Medicaid beneficiary who is a resident of a nursing facility or ICF/MR, the amount of monthly income that he or she is allowed to keep for personal expenses like haircuts and laundry. The remainder of the beneficiary's monthly income is applied to the costs of care at the facility. The minimum PNA that a state must allow an institutionalized beneficiary is $30 per month.

Preadmission Screening and Annual Resident Review (PASARR)—The federal requirement that states must screen all individuals with mental illness or mental retardation prior to admission to a Medicaid nursing facility and review at least annually all residents with mental illness or mental retardation in such facilities, to determine whether the individual or resident requires the level of care provided by the facility.

Poverty-Level Groups—The popular term for eligibility groups, both mandatory and optional, for whom Medicaid income eligibility is determined on the basis of a percentage of the federal poverty level (FPL) (e.g., pregnant women and infants with family incomes at or below 133 percent of the FPL). See De-Linking, Federal Poverty Level.

Presumptive Eligibility—The option available to states to extend limited Medicaid coverage (with federal matching payments) to certain groups of individuals from the point a qualified provider determines that the individual's income does not exceed the eligibility threshold until a formal determination of eligibility is made by the state Medicaid agency. The groups to whom states may offer Medicaid coverage during a presumptive eligibility period are pregnant women, children, and women diagnosed with breast or cervical cancer.

Primary Care Case Manager (PCCM)—PCCMs are physicians, physician groups, or entities having arrangements with physicians that contract with state Medicaid agencies to coordinate and monitor the use of covered primary care services by enrolled beneficiaries. State Medicaid contracts with PCCMs tend to be less comprehensive in their coverage of benefits and involve less financial risk than those with MCOs.

Prior Authorization—A mechanism that state Medicaid agencies may at their option use to control use of covered items (such as durable medical equipment or prescription drugs) or services (such as inpatient hospital care). When an item or service is subject to prior authorization, the state Medicaid agency will not pay unless approval for the item or service is obtained in advance by the beneficiary's treating provider, either from state agency personnel or from a state fiscal agent or other contractor.

Program of All-Inclusive Care for the Elderly (PACE)—A benefit that states may at their option offer to Medicaid beneficiaries age 55 or older who have been determined to require the level of care provided by a nursing facility. Qualifying beneficiaries receive all Medicaid-covered services through the PACE provider in which they enroll. PACE providers must meet minimum federal standards and are paid on a capitation basis.

Provider Tax—A tax, fee, assessment, or other mandatory payment required of health care providers by a state. States may use revenues from provider taxes to pay the state share of Medicaid spending only under limited circumstances specified in federal Medicaid law.

Qualified Medicare Beneficiary (QMB)—A Medicare beneficiary with income or assets too high to qualify for full coverage under the Medicaid program as a dual eligible, but whose income is at or below 100 percent of the federal poverty line (FPL) and whose countable resources do not exceed $4000. QMBs are eligible to have Medicaid pay all of their Medicare cost-sharing requirements, including monthly premiums for Part B coverage, and all required deductibles and coinsurance (up to Medicaid payment amounts).

Qualifying Individual (QI)—Between January 1998 and December 2002, States are required to pay all or a portion of Medicare premiums on behalf of a limited number of Medicare beneficiaries known as "Qualifying Individuals," or QIs. Unlike other categories of low-income Medicare beneficiaries (e.g., dual eligibles, QMBs, and SLIMBs), QIs are not entitled to this assistance, but are enrolled on a first-come, first-served basis each year up to the limit established by each state's allotment of federal funds for this purpose. QIs have incomes from 120 to 175 percent of the federal poverty level (FPL) and countable resources of up to $4,000.

Quality Control (QC)—Also known as Medicaid Eligibility Quality Control (MEQC), quality control is the term applied to CMS's statutory duty to monitor state and local Medicaid eligibility determinations. States that are found to have made eligibility errors that result in payments on behalf of ineligible individuals that exceed 3 percent of a state's total Medicaid benefits payments are subject to reductions in federal matching funds.

Quality Improvement System for Managed Care (QISMC)—Standards and guidelines issued by CMS that direct managed care organizations to operate internal programs of quality assessment and performance improvement and collect and report data reflecting its performance. QISMC standards and guidelines are mandatory for Medicare+Choice plans but are optional for state Medicaid agencies to use in measuring and improving quality of Medicaid MCOs.

Rebate—The amounts paid by manufacturers to state Medicaid programs for outpatient prescription drugs purchased by the programs on behalf of eligible beneficiaries on a fee-for-service basis. Rebates are calculated on the basis of the average manufacturer price (AMP) for each drug and, in the case of brand name drugs, on the basis of the manufacturer's best price. A manufacturer must agree to pay rebates in order for federal Medicaid matching funds to be paid to states for the costs of the manufacturer's drug products. See Average Manufacturer Price, Best Price, Formulary.

Resources—Sometimes referred to as assets, resources are items of economic value that are not income. Resources include financial instruments such as savings accounts and certificates of deposit, personal property such as an automobile (above a specified value), and real estate (other than an individual's home). Some Medicaid eligibility groups must meet a resource test; others (at state option) are not subject to a resource test. In establishing a resource test, a state Medicaid program must specify both the resource standard (e.g., the amount of countable resources an individual may retain) and the resource methodology (e.g., which resources are counted and how are they valued).

Risk Contract—A contract between a state Medicaid agency and an MCO or other managed care entity (MCE) under which the entity agrees to provide, or arrange for the provision of, a specified set of services to enrolled beneficiaries in exchange for a fixed monthly capitation payment on behalf of each enrollee. By entering into such a contract, the MCO is assuming the financial risk of

providing covered health services to the enrolled population.

Rural Health Clinic (RHC)—States are required to include services provided by RHCs in their basic Medicaid benefits package. RHC services are ambulatory care services (including physicians' services and physician assistant and nurse practitioner services) furnished by an entity that is certified as a rural health clinic for Medicare purposes. An RHC must either be located in a rural area that is a federally-designated shortage area or be determined to be essential to the delivery of primary care services in the geographic area it serves.

Section 209(b) State—In amendments to the Social Security Act enacted in 1972, Congress created the Supplemental Security Income (SSI) program of cash assistance for low-income elderly and disabled individuals. Section 209(b) of those amendments allowed states the option of continuing to use their own eligibility criteria in determining Medicaid eligibility for the elderly and disabled rather than extending Medicaid coverage to all of those individuals who qualify for SSI benefits. As of 1998, eleven states had elected the "209(b)" option to apply their 1972 eligibility criteria to aged or disabled individuals receiving SSI benefits for purposes of determining Medicaid eligibility.

Section 1115 Waiver—Under section 1115 of the Social Security Act, the Secretary of HHS is authorized to waive compliance with many of the requirements of the Medicaid statute to enable states to demonstrate different approaches to "promoting the objectives of" the Medicaid program while continuing to receive federal Medicaid matching funds. In 2001, 19 states were operating Medicaid section 1115 waivers affecting some or all of their eligible populations and involving $27 billion in federal matching funds, or one fifth of all federal Medicaid spending that year. The waivers, which are granted (or renewed) for 5-year periods, are administered by CMS. See also Health Insurance Flexibility and Accountability Waivers.

Section 1902(r)(2) "Less Restrictive" Methodologies—Under section 1902(r)(2) of the Social Security Act, states have flexibility, in determining an individual's Medicaid eligibility, to use methodologies for counting income and resources that are less restrictive than those used in the cash assistance programs for families (TANF) or the elderly and disabled (SSI). Using these less restrictive methodologies, states may disregard some or all of an individual's income or resources in determining whether the individual meets the applicable eligibility standard (e.g., 100 percent of the federal poverty level). As a result, a state can under section 1902(r)(2) expand the numbers of individuals eligible for Medicaid without changing the eligibility standards.

Section 1915(b) Waiver—Under section 1915(b) of the Social Security Act, the Secretary of HHS is authorized to waive compliance with the "freedom of choice" and "statewideness" requirements of federal Medicaid law in order to allow states to operate mandatory managed care programs in all or portions of the state while continuing to receive federal Medicaid matching funds. The waivers, which are granted (or renewed) for 2-year periods, are administered by CMS.

Section 1931 Eligibility—Under section 1931 of the Social Security Act, states must extend Medicaid eligibility to parents (and older children) in families who meet the eligibility requirements that were in effect under their state's Aid to Families with Dependent Children (AFDC) program as of July 16, 1996. States have the option under section 1931 to raise the eligibility levels for these parents through the use of "less restrictive" income and resource methodologies (see de-linking).

Section 1932 State Plan Option—Under section 1932 of the Social Security Act, states may require Medicaid beneficiaries to enroll in managed care entities (MCEs) by submitting an approvable state plan amendment (SPA) to CMS. Unlike section 1915(b) or 1115 waivers, section 1932 SPAs need not be periodically renewed by CMS.

Single State Agency—The agency within state government designated as responsible for administration of the state Medicaid plan. The single state agency is not required to administer the entire Medicaid program; it may delegate most administrative functions to other state (or local) agencies or private contractors (or both). However, all final eligibility determinations must be made by state (or local) agency personnel.

Specified Low Income Medicare Beneficiary (SLMB)—A Medicare beneficiary with income or assets too high to qualify for full coverage under the Medicaid program as a dual eligible, but whose income is above 100 percent and not in excess of 120 percent of the federal poverty line (FPL) and whose countable resources do not exceed $4000. SLMBs, like QMBs are eligible to have Medicaid pay their Medicare monthly premiums, but unlike QMBs are not eligible for Medicaid payment for their Medicare cost-sharing obligations. See also Dual Eligible, Federal Poverty Level, and Qualified Medicare Beneficiary.

Spend-Down—For most Medicaid eligibility categories, having countable income above a specified amount will disqualify an individual from Medicaid. However, in some eligibility categories—most notably the "medically

needy"—individuals may qualify for Medicaid coverage even though their countable incomes are higher than the specified income standard by "spending down." Under this process, the medical expenses that an individual incurs during a specified period are deducted from the individual's income during that period. Once the individual's income has been reduced to a state-specified level by subtracting incurred medical expenses, the individual qualifies for Medicaid benefits for the remainder of the period. See Medically Needy.

Spousal Impoverishment—The term used to describe the set of eligibility rules that states are required to apply in the case where a Medicaid beneficiary resides in a nursing facility and his or her spouse remains in the community. The rules, which specify minimum amounts of income and resources each spouse is allowed to retain without jeopardizing the institutionalized spouse's eligibility for Medicaid benefits, are designed to prevent the impoverishment of the community spouse.

Standard—As used in the context of Medicaid eligibility determinations, the dollar amount of income or resources that an individual is allowed to have and qualify for Medicaid. For example, states must cover all pregnant women with family incomes at or below 133 percent of the federal poverty level (FPL), or $14,630 ($1,219 per month) for a family of 3 in 2001. In determining whether a pregnant woman meets this income standard, a state must count her income; the methodology that the state applies will determine what types of income are counted and what income (if any) is disregarded.

State Medicaid Plan—Under Title XIX of the Social Security Act, no federal Medicaid funds are available to a state unless it has submitted to the Secretary of HHS, and the Secretary has approved, its state Medicaid plan (and all amendments to the state plan). The state Medicaid plan must meet 64 federal statutory requirements.

State Plan Amendment (SPA)—A state that wishes to change its Medicaid eligibility criteria or its covered benefits or its provider reimbursement rates must amend its state Medicaid plan to reflect the proposed change. Similarly, states must conform their state plans to changes in federal Medicaid law. In either case, the state must submit a state plan amendment (SPA) to CMS for approval.

State Survey Agency—The state agency, usually the health department, that is designated by the state as having responsibility for ensuring the quality of public and private hospitals and nursing facilities (usually through licensure). The state survey agency is also responsible for conducting standard and, where necessary, extended surveys of nursing facilities to determine whether they meet the requirements for participation in Medicaid.

Statewideness—The requirement that states electing to participate in Medicaid must operate their programs throughout the state and may not exclude individuals residing in, or providers operating in, particular counties or municipalities. This requirement may be waived under section 1115, 1915(b), and 1915(c) waivers.

Supplemental Security Income (SSI)—A federal entitlement program that provides cash assistance to low-income aged, blind, and disabled individuals. Individuals receiving SSI benefits are eligible for Medicaid coverage in all states except "section 209(b)" states, which have opted to use their more restrictive 1972 criteria in determining Medicaid eligibility for SSI recipients. See Section 209(b).

Survey and Certification—The term for the process of surveying nursing facilities to determine whether they meet the requirements for participation in Medicaid (and Medicare). The process involves state survey agencies conducting inspections and CMS surveyors conducting "look behind" inspections. Facilities that do not meet the requirements are subject to various administrative sanctions, including civil money penalties; in extreme cases, a facility's participation in Medicaid may be terminated.

Temporary Assistance for Needy Families (TANF)—A block grant program that makes federal matching funds available to states for cash and other assistance to low-income families with children. TANF was established by the 1996 welfare law that repealed its predecessor, the Aid to Families with Dependent Children (AFDC) program. Prior to this repeal, states were required to extend Medicaid coverage to all families with children receiving AFDC benefits. States may but are not required to extend Medicaid coverage to all families receiving TANF benefits; states must, however, extend Medicaid to families with children who meet the eligibility criteria that states had in effect under their AFDC programs as of July 16, 1996.

Third Party Liability (TPL)—The term used by the Medicaid program to refer to another source of payment for covered services provided to a Medicaid beneficiary. For example, if a Medicaid beneficiary is also eligible for Medicare, the Medicare program is liable for the costs of that beneficiary's hospital and physician services, up to the limit of Medicare's coverage. From the Medicaid program's standpoint, Medicare is a liable third party. Other examples of TPL include private health insurance

coverage, automobile and other liability insurance, and medical child support.

Title XIX—Title XIX of the Social Security Act, 42 U.S.C. 1396 et seq., is the federal statute that authorizes the Medicaid program. Related titles of the Social Security Act are Title IV-A (TANF), Title IV-E (Foster Care and Adoption Assistance), Title V (MCH block grant), Title XVI (SSI), Title XVIII (Medicare), and Title XXI (SCHIP).

Transfer of Assets—Refers to the practice of disposing of countable resources such as savings, stocks, bonds, and other real or personal property for less than fair market value in order to qualify for Medicaid coverage. When such transfers occur, it is usually in connection with the anticipated or actual need for long-term nursing home care. Federal law limits (but does not entirely prohibit) such transfers.

Transitional Medical Assistance (TMA)—Refers to Medicaid coverage for families with children leaving welfare to become self-supporting through work. States are required to continue Medicaid benefits to families who lose their cash assistance due to an increase in earnings. The transitional coverage extends for up to 12 months as long as the family continues to report earnings.

Upper Payment Limit (UPL)—Limits set forth in CMS regulations on the amount of Medicaid payments a state may make to hospitals, nursing facilities, and other classes of providers and plans. Payments in excess of the UPLs do not qualify for federal Medicaid matching funds. The UPLs are generally are keyed to the amounts that can reasonably be estimated would be paid, in the aggregate, to the class of providers in question using Medicare payment rules. In the case of MCOs, the UPL is specific to each plan and is tied to the amounts that would have been paid under Medicaid on a fee-for-service basis.

Vaccines for Children (VFC) Program—A program under which the federal government, through the Centers for Disease Control and Prevention, purchases and distributes pediatric vaccines to states at no charge and the state in turn arranges for the immunization of Medicaid-eligible and uninsured children through public or private physicians, clinics, and other authorized providers.

Waivers—Various statutory authorities under which the Secretary of HHS may, upon the request of a state, allow the state to receive federal Medicaid matching funds for its expenditures even though it is no longer in compliance with certain requirements or limitations of the federal Medicaid statute. In the case of program waivers such as the 1915(c) waiver for home- and community-based services, states may receive federal matching funds for services for which federal matching funds are not otherwise available. In the case of demonstration waivers such as the section 1115 waivers, states may receive federal matching funds for covering certain categories of individuals for which federal matching funds are not otherwise available. Under Section 1915(b) waivers, states may restrict the choice of providers that Medicaid beneficiaries would otherwise have.