

# **Expanded Glossary of Medicaid Terms** As They Relate to Public Health



## Introduction

Successful partnerships between state public health and Medicaid agencies can achieve significant improvements in population health for vulnerable populations, as well as reduce healthcare spending. However, public health professionals may not be familiar with Medicaid policy levers, programmatic rules, and opportunities for collaboration. The Association of State and Territorial Health Officials (ASTHO) seeks to address these gaps by providing public health professionals with the necessary understanding and language to communicate effectively with their Medicaid colleagues.

This glossary lists terms commonly used by Medicaid professionals in order to facilitate communication and understanding among other public health professionals. Terms with a particular relevance to public health or that represent “hot button” issues to Medicaid partners have expanded discussion and links to provide further context.

These terms were compiled and adapted from information provided by the Health Policy Institute of Ohio and the American Academy of Family Physicians. The original document can be found [here](#). To look for a specific term and its corresponding page number, please see the [index](#).

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## A

### **Accountable Care Organization (ACO)**

A group of healthcare providers that provides coordinated care and care management to improve the quality of patient care and control costs. In this provider group, payments are tied to the achievement of healthcare quality goals and outcomes that result in cost savings. An ACO is one type of managed care organization; however, an ACO patient is not required to stay in-network for care.

#### **Community-Based and Provider-Controlled Organizations**

- ACOs are community-based and provider-controlled organizations that may become important components in the healthcare delivery system.
- ACOs are often based on hospital systems that have management agreements with insurers and health maintenance organizations.
- ACOs are based in part on the “carrot and stick” model. Financial incentives motivate providers to improve the quality of patient care and receive a portion of shared savings (the carrot). In some types of ACOs, providers can choose to be at risk of losing money (the stick) if they want to pursue a higher reward. Others can enter ACO agreements without risk.

#### **Origins in Medicare**

- ACOs started as demonstrations by Medicare, and the concept is expanding into Medicaid and private payers.
- The movement toward accountable care has spread across the healthcare system: private payers continue to enter new ACO arrangements with providers in all parts of the country, and many states that have relied on Medicaid managed care plans are moving to or considering ACOs through these private plans.
- Accountable care in Medicaid involves considering which performance measures are appropriate and navigating shared savings complications related to the federal-state Medicaid funding structure, program scope and state authority, and potential antitrust issues.
- Some states are implementing accountable care reforms through direct reforms in their contracts with both specific providers and regional groups.

#### **Medicaid Reform Efforts: Targeting Improved Care and Cost Control at the Community Level**

- States can use multiple mechanisms to move toward accountable care for their Medicaid populations, including patient-centered medical homes, episode-based payments, and patient-level accountable care payment reforms. These mechanisms can be sequential and synergistic.<sup>1,2</sup>

### **Actuary**

A business professional who analyzes the financial consequences of risk. Actuaries use mathematics, statistics, and financial theory to study uncertain future events, especially those of concern to insurance and pension programs. They evaluate the likelihood of those events and design creative ways to reduce their likelihood and decrease the impact of adverse events that actually do occur.

### Capitation Rates

An actuary takes the total cost of delivering covered services, trends them forward to the current year, and divides this by the projected member months to establish a cost per member per month. The state pays the Medicaid managed care organization (MCO) that capitation rate times the number of enrolled members (e.g., per member per month). The MCO is then obligated to serve those patients and cover administrative costs incurred. If the rate is set too high, the state and federal governments will incur excessive costs. If the rate is set too low, the MCO will suffer financial losses and could deteriorate in quality or withdraw from the market.

### Financial and Operational Advice

Actuaries serve an important role in both the fee-for-service and managed care environments, and they are particularly critical in Medicaid's movement to managed care. They serve as advisors in many financial situations, and setting the capitation rate is an essential element of their work. They use analytics and judgment to help predict future cost and operational trends that are essential in managing the program.<sup>3</sup>

### Adverse Selection

When less-healthy people disproportionately enroll in a risk pool and healthier people do not participate. People with a higher-than-average risk of needing healthcare or with greater health needs are more likely than healthier people to seek health insurance. However, Medicaid and other health insurers try to maintain risk pools of people whose health, on average, is the same as that of the general population.

### All Savings Claimed Are Not the Same

A [study by the RAND Corporation](#) examines whether substituting a health maintenance organization (HMO)—a type of managed care organization (MCO)—for traditional fee-for-service (FFS) Medicaid insurance reduces the cost of children's healthcare through adverse selection. The researchers found that selection can substantially bias estimates of HMO impact. In other words, estimates of HMO savings in reduced expenditures were impacted significantly by HMOs' ability to attract patients that were in better health than those in FFS.<sup>4</sup>

### Managing Adverse Selection

In the Medicaid managed care world, Medicaid strives to have competition among managed care providers with freedom of choice for patients. If individual HMOs are able to attract recipients who are healthier (and thus likely to incur less cost), they are able to increase their profit margins (the difference between what they are paid for a patient's care and what that care actually costs). Medicaid and its actuaries must take this into account as a critical success factor for administering a managed care system. If the actuaries do not carefully manage adjustments in rates or patient risk pools, some MCOs will make disproportionate profits and others will suffer losses. A MCO with losses may attempt reduce costs by limiting care provided or investing less in services that contribute to overall care quality, or they may fail altogether, causing disruption in patient care.

## **Affordable Care Act (ACA)**

The healthcare reform law (the Patient Protection and Affordable Care Act) enacted in March 2010, often referred to as “Obamacare.” ACA’s principal goal is to improve access to the traditional healthcare system via expansion of affordable health insurance options. ACA also implemented a number of other reforms aimed at improving healthcare quality and efficiency, preventing chronic disease and improving health, improving transparency and consumer protections for patients, and building the healthcare workforce.<sup>5</sup>

### **Preventive Service Mandates**

- ACA expands access to primary and secondary prevention services such as immunizations and regular disease screening.
- Health insurance plans are now required to provide preventive health services to plan members without charging a copayment or coinsurance if certified as an A or B rating by the U.S. Preventive Services Task Force.
- ACA requires free provision of FDA-approved contraceptive methods.

### **Provisions with Direct Implications for Public Health**

- ACA is designed to realign and encourage collaboration between the public health and healthcare systems. For example, ACA requires nonprofit hospitals to create community health needs assessments and community health improvement plans as part of their community benefit requirements. Both require nonprofit hospitals to involve public health agencies in these development efforts.

### **Prevention and Public Health Fund**

- ACA also directly influences public health by creating the Prevention and Public Health Fund, the nation’s first mandatory funding for public health, and the first National Prevention Strategy, a sweeping development program that focuses on individual behavioral choices and the social determinants of health.<sup>6,7</sup>

## **Aged, Blind, Disabled (ABD)**

A Medicaid designation that assists poor individuals who are 65 or older, blind, or disabled with their medical expenses. The eligibility flows from designation by the Social Security Administration as a Supplemental Security Income beneficiary.

### **Role of Dual Eligibles in ABD**

Some individuals are dually eligible for Medicaid and Medicare. In these cases, Medicare pays for patients’ care and Medicaid pays their health insurance premiums and copayments. Medicaid is also required to pay for prescriptions not covered under Medicare Part D. This is a complex program covering the most expensive and medically fragile eligibility group.

### Highest Cost Group

ABDs typically constitute Medicaid's highest-cost patients. The overlap of insurance coverage between Medicaid and Medicare can complicate the design and implementation of programs to serve this eligibility group. (See also [Dual Eligibles](#).)<sup>8</sup>

## B

### Behavioral Health

A term that encompasses both mental health and substance abuse services. Medicaid plans typically cover the following behavioral health services:

- Psychiatric hospital visits.
- Case management.
- Day treatment.
- Psychosocial rehabilitation.
- Psychiatric evaluation and testing.
- Medication management.
- Individual, group, and family therapy.
- Inpatient detoxification.
- Methadone maintenance.
- Smoking and tobacco cessation services.

### Medicaid and Mental Health Services

Medicaid is the single largest payer for mental health services in the U.S., and is playing an increasingly larger role in reimbursing substance use disorder services. Individuals with behavioral health disorders often experience other physical health comorbidities—in 2007, nearly 12 million U.S. emergency department visits involved individuals with a mental disorder, substance abuse problem, or both.<sup>9</sup> In fact, there is an approximate 15-20 year life expectancy gap between individuals with mental illness and those in general population.<sup>10</sup>

### Mandates Do Not Ensure Access

All plans offered in the health insurance marketplaces created by the Affordable Care Act (ACA) must cover mental health and substance services as essential health benefits. Further, ACA extended federal mental health parity protections. As a result, HHS estimates that 32.1 million Americans will gain access to coverage that includes mental health and/or substance abuse disorder benefits that complies with federal parity requirements, while an additional 30.4 million Americans who already have some coverage will now benefit from the full federal parity protections.<sup>11</sup> However, increased coverage does not ensure access: in 2014, an estimated 96.5 million Americans lived in areas with mental health provider shortages.<sup>12</sup> Further, despite requirements for providing a comprehensive set of services and sweeping increases in eligibility for Medicaid programs, state budget constraints and lack of enrolled providers are seen as barriers to effectively implementing the services.<sup>13</sup> Mental health providers are

considering innovations such as telepsychiatry (off-site psychiatrists and psychiatric advance practice nurses) to meet this demand.<sup>14,15</sup>

### **Bundled Payments**

Use of a single payment for all services related to a treatment or condition, possibly spanning multiple providers in multiple settings. Bundled payments can also be referred to as case rates, episode-based payment, or package pricing.

#### **Providers Assume Financial Risk**

In a bundled payment arrangement, providers assume financial risk for the cost of services, as well as costs associated with preventable complications. The state Medicaid agency or other payer then compensates the provider based on the expected costs for clinically defined episodes (e.g., total knee or hip replacement surgeries) that may involve several practitioner types, care settings, and services or procedures over time. Bundled payment arrangements can also include requirements for reporting clear quality metrics focused on desired clinical outcomes that providers must achieve to maximize their payment.

#### **Reduced Cost and Improved Care**

This payment system is relatively new and is used both prospectively and retrospectively by public and private plans. There is some evidence that it can improve care and reduce costs in procedures that have a clearly defined scope of service and time of treatment, such as total joint replacement.<sup>16</sup>

## **C**

### **Capitation**

A method of payment for health services in which an individual or institutional provider is paid a fixed amount for each person served regardless of the amount and intensity of services provided to each person in a set period of time. This capitation rate is often expressed in per member per month (PMPM) units.<sup>17</sup>

#### **Typical Services Provided**

When a primary care provider signs a capitation agreement, it includes a list of specific services that must be provided to patients in the contract, for example:

- Preventive, diagnostic, and treatment services.
- Injections, immunizations, and medications administered in the office.
- Outpatient laboratory tests done either in the office or at a designated laboratory.
- Health education and counseling services performed in the office.
- Routine vision and hearing screening.<sup>18</sup>

### How Rates are Set

An actuary takes the total cost of delivering the covered services costs, trends them forward to the current year, and divides them by the projected member months to establish a cost PMPM. The managed care organization (MCO) is paid that capitation times the number of enrolled members, and is obligated to serve those patients and cover administrative costs and obligations.<sup>19</sup>

### Importance of Appropriate Rate Setting

If the rates are set too high, Medicaid will incur unnecessary cost. If they are set too low, the MCO's margins will be too small or it could suffer losses, resulting in the business' failure or withdrawal from the market. Thus, appropriate rate setting is important for the fiscal viability of MCOs in order to maintain care access for patients.<sup>20</sup>

### Care Coordination

How interdisciplinary healthcare professionals work with patients to ensure that patients' health needs are being met and that the right provider is delivering the right care at the right time. The concept typically applies to Medicaid managed care and Medicaid health homes.

### Services and Characteristics

The patient, caregivers, and providers work together to develop a care plan and ensure that all parties understand their responsibilities in its execution. These parties aim to:

- Identify all barriers that affect the patient's ability to adhere to treatments.
- Obtain the appropriate team of professional providers.
- Help the patient navigate provider systems and insurance.
- Ensure that the patient's electronic health record reflects appropriate and current information.
- Facilitate communication between all individuals tasked with the patient's care.
- Follow up with the patient periodically to ensure that care goals are current and being met.

### Reimbursement

Often, large groups or physicians involved in primary care network models and Medicaid medical home programs receive an additional capitation payment for care coordination and case management. Case managers perform their duties in office during visits with the provider and/or staff. In managed care organizations, case managers are typically employees or contractors who perform these functions and typically do additional outreach.<sup>21</sup>

### Carve-Out

A service or population not covered in a health insurance contract. It is usually reimbursed according to a different arrangement or rate formula than those services specified under the contract umbrella. Services or populations that are sometimes included in a carve-out arrangement in Medicaid contracts are behavioral health services, foster care children, or individuals with serious mental illness.

### General Provisions

A carve-out program excludes certain services—typically, from a managed care capitation agreement—and may focus on one disease or population in depth with separate healthcare arrangements. Services



or populations that are “carved out” are covered through a contract with a separate set of providers or directly administered by Medicaid.<sup>22</sup>

### Public Health Significance

Public health agencies are sometimes the only providers of specific services, and Medicaid may pay these agencies under contract to care for carve-out populations. These services can include administrative services, cancer detection, and newborn metabolic disease detection. In these cases, Medicaid may remove the services from the capitation paid to managed care organizations so that the unique relationship with public health agencies can continue.

### Case Management

A process where a health plan identifies covered individuals with specific healthcare needs (usually for individuals who need high-cost or extensive services or who have a specific diagnosis) and devises and carries out a coordinated treatment plan. (See also [Care Coordination](#).)

### Characteristics of Successful Programs

Successful case management programs have the following characteristics:<sup>23</sup>

- *Targeted populations.* Case management is most critical for patients who are at substantial risk of hospitalization in the coming year.
- *In-person contact.* Although many providers rely on contact with patients by telephone, the most successful case management programs are reported to average nearly one in-person contact per patient per month during the patients’ first year in the program.
- *Close interaction between care coordinators and primary care physicians.* The strength of this relationship relies on the opportunity for face-to-face interaction and having a care coordinator work with all of a given physician’s patients.
- *Provider access to timely information.* It is important for providers and care coordinators to have access to information on hospital admissions, emergency room visits, and other acute care episodes very soon after they occur in order to help prevent readmissions.
- *Services tailored to patients.* Case management should ultimately help patients manage their own healthcare, especially by teaching them how to take their medications properly. Patients also often need social supports (e.g., help with daily living activities, transportation, or overcoming isolation), so successful care coordination often has staff who could arrange for those services.
- *Appropriate staffing.* Successful case management often relies heavily on registered nurses to deliver the bulk of interventions, with assistance from social workers for some patients.

### Types of Organizations Using Case Management

In Medicaid, there are two main service delivery options that use case management: the Medicaid managed care organization model, where the techniques are used with capitation, and the enhanced primary care case management (PCCM) program, where the state contracts with case management agencies. Examples of PCCM are found in Oklahoma, North Carolina, Alabama, among other states.<sup>24</sup>

### **Categorically Needy**

Medicaid's eligibility pathway for individuals who can be covered. There are more than 25 eligibility categories organized into five broad groups: children, pregnant women, adults with dependent children, individuals with disabilities, and the elderly. Prior to the Affordable Care Act (ACA), childless adults who did not fall into those groups could not qualify for Medicaid; however, with expansion of Medicaid, this has changed in certain states.

### **Medicaid Expansion Through ACA**

ACA simplifies Medicaid eligibility, expanding coverage to all adults up to 138 percent of the federal poverty level (133% + 5% income disregard), if a state decides to expand eligibility.

- Thirty-one states and the District of Columbia have chosen to expand Medicaid, leaving 19 states that have not adopted expansion.<sup>25</sup>

### **Expansion and Public Health**

Medicaid expansion is generally positive for community health because it:

- Provides health insurance, including preventive care services, to uninsured individuals.
- Provides funding to hospitals and other providers that are obligated to provide care regardless of ability to pay.
- Financially helps localities that provide subsidies for uninsured care that are otherwise subsidized locally.
- May assist public health financially by funding patients for services currently not reimbursed and relieving the funding burden for those services.<sup>26,27</sup>

### **Centers for Medicare and Medicaid Services (CMS)**

The federal agency within HHS that directs the Medicare, Medicaid, and Children's Health Insurance Program (under Titles XVIII and XIX of the Social Security Act). Formerly the Health Care Financing Administration, CMS and state Medicaid programs partner to provide financing and management of services to Medicaid-eligible beneficiaries. That relationship is formalized in the "state plan," which provides details of eligible beneficiaries covered, services provided, how they are paid, and how stakeholders share costs.<sup>28</sup>

### **Children's Health Insurance Program (CHIP)**

Enacted in 1997, CHIP is a federal-state program that provides healthcare coverage for uninsured low-income children who are not eligible for Medicaid. Eligibility is calculated based on income and family size, and accepted income levels vary by state. States have the option of administering CHIP through their Medicaid programs, through a separate program, or through a combination of both.

### **CHIP Matching**

The federal government matches state spending for CHIP. Federal CHIP funds are capped; however, the federal matching rate for state CHIP is typically higher than the normal Medicaid program (i.e., a state with a 50% Medicaid federal Medical assistance percentage has an "enhanced" CHIP matching rate of 65%).<sup>29</sup>

### CHIP Coverage

Covering roughly 5 million children, CHIP 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 percent to 19 percent, largely due to increases in Medicaid and state CHIP coverage.<sup>30</sup>

### Comparability of Services

A requirement in the Federal Code of Regulations that medical assistance available to any eligible and categorically needy individual “shall not be less in amount, duration, or scope than the medical assistance made available to any other individual.”<sup>31</sup> This requirement assures that the services provided to categorically eligible Medicaid beneficiaries are comparable to those provided to the medically needy (*See also* Medically Needy). Second, it ensures that Medicaid-covered services are provided in the same amount and scope across the range of all individuals who are categorically eligible for Medicaid.<sup>32</sup>

### Cost-Sharing

States can limit state Medicaid program costs by establishing cost-sharing requirements, in which Medicaid enrollees must pay premiums, enrollment fees, or copayments, and thereby share the costs of their care. Cost-sharing can also be called out-of-pocket spending. Cost-sharing requirements depend on income levels (e.g., individuals over 100% of the federal poverty level). Copayments are a type of cost-sharing arrangement where an individual pays a fixed dollar amount at the time of receiving a covered healthcare service from a participating provider. The required fee varies depending on the service and provider and is limited to nominal or minimal amounts. Copayments have also been used in a number of Section 1115 waivers to expand Medicaid, such as the Healthy Michigan and Pennsylvania plans.<sup>33</sup>

### Limitations

States may impose cost-sharing among Medicaid enrollees for both inpatient and outpatient services, but cost-sharing cannot be imposed for emergency services, family planning services, pregnancy-related services, or children’s preventive services. Generally, out-of-pocket costs apply to all Medicaid enrollees except those specifically exempted by law. Exempted groups include children, terminally ill individuals, and individuals residing in institutions. Because Medicaid covers particularly low-income and often very sick patients, services cannot be withheld for failure to pay, but enrollees may be held liable for unpaid copayments.

### Alternative Copayments

States have the option to establish alternative out-of-pocket costs that are targeted at certain groups of Medicaid enrollees with income above 100 percent of the federal poverty level. Alternative out-of-pocket costs may be higher than nominal charges, depending on the type of service, and are capped at 5 percent of a family’s income. In addition, Medicaid enrollees may be denied services for nonpayment of alternative copayments.<sup>34</sup>

### Crowd-Out

A phenomenon whereby new public programs or expansions of existing public programs designed to extend coverage to uninsured individuals prompt some privately insured persons to drop their private coverage and take advantage of the expanded public subsidy.

### Evidence from Wisconsin

In order to predict outcomes of Affordable Care Act (ACA) expansions, researchers used administrative and survey data to estimate the number of individuals who were newly eligible for Wisconsin's expansion of Medicaid eligibility prior to ACA. They found that after the expansion of eligibility for public coverage, approximately 20 percent of new enrollees previously had access to private insurance at the time of their enrollment, with only 8 percent dropping this coverage. These results mean that the remaining 12 percent of enrollees had both public and private insurance. Given constraints on public resources, this finding has financial implications for state budgets and public health spending.<sup>35</sup>

## D

### Deductible

A set amount of medical expenses that a patient must pay before being eligible for benefits under an insurance program. As with other types of cost-sharing, states may impose these charges on Medicaid beneficiaries on non-emergency services with similar exemptions to other cost-sharing mechanisms. (See also [Cost-Sharing](#).) Services cannot be withheld for failure to pay. Deductibles are limited to nominal amounts in Medicaid programs. For example, in 2013, the maximum deductible was \$2.65 and the maximum managed care copayment was \$4.00. These rules limit the utility for use of deductibles and copayments being used to curb utilization, as with private insurance plans.<sup>36</sup>

### Diagnostic-Related Group (DRG)

In 1982, Congress mandated the creation of a prospective payment system known as diagnostic-related groups (DRGs) to control hospital costs. The system is administered for Medicare through CMS. Variations on the concept are used extensively by Medicaid and private insurers.

This system is a per-case reimbursement mechanism under which inpatient admission cases are divided into relatively homogeneous categories. Under this prospective payment system, hospitals are paid a fixed fee for each case in a given category, regardless of the actual costs.<sup>37,38</sup>

### Benefits of a DRG

Because insurers pay hospitals a flat rate per case for inpatient hospital care, efficient hospitals are rewarded and inefficient hospitals have an incentive to become more efficient. Payment by DRGs encourages access to care, rewards efficiency, improves transparency, and improves fairness by paying similarly across hospitals for similar care. Payment by DRGs also simplifies the payment process, encourages administrative efficiency, and bases payments on patient acuity and hospital resources rather than length of stay. However, there can be concerns about hospitals prematurely discharging patients, selecting low-cost patients, and increasing admissions in a DRG system. The World Health Organization recommends including quality and monitoring measures to protect against this.<sup>39</sup>

## **Disease Management**

A process of identifying targeted patient populations (e.g., patients with asthma or diabetes) and delivering the most efficient, effective combination of resources, interventions, or pharmaceuticals to treat or prevent a disease. Patient education and self-care are significant components of disease management.

### **Disease Management Organization**

A disease management organization is an entity that provides a service to managed care organizations and other health insuring organizations to manage services for people with specific and often chronic diseases. This type of service is believed to deliver a higher quality of care at more reasonable price than alternative, presumably more fragmented, care. This industry is expanding rapidly because of the promise of lower healthcare costs, better outcomes, and increased productivity. In the 1990s, disease management commonly tackled diabetes, asthma, and heart failure. Today, the largest disease management companies, such as American Healthways, CorSolutions, Health Dialog Services, and Lifemasters Support Self Care, offer to manage as many as 120 diseases or conditions. Typically, they include musculoskeletal or low back pain, depression, and severe chronic pain.

### **Disease Management as a Population Health Strategy**

Disease management is a population health strategy, as well as an approach to personal health. It may reduce healthcare costs and/or improve quality of life for individuals by preventing or minimizing the effects of (usually, chronic) disease through patient education and skill-building, enabling a sense of control over life (despite symptoms of disease), and integrating care.<sup>40, 41, 42</sup>

## **Disproportionate Share Hospital Program (DSH)**

A federal program that aims to increase healthcare access for the poor. Hospitals that treat a disproportionate number of Medicaid and other indigent patients qualify for higher Medicaid payments based on the hospital's estimated uncompensated cost of services to the uninsured or those who cannot afford to pay.

### **Helping Hospitals Serve the Poor**

DSH was implemented by Congress largely to help mitigate the impact of changes in reimbursement from the "reasonable cost" standard. There was concern that hospitals who provided large amounts of uncompensated care to uninsured or underinsured patients would be hurt by the shift to diagnostic-related groups.

### **Funding Is Capped by State and in Total**

The amount of DSH funds is capped by state and is subject to a complex formula that accounts for many factors related to uncompensated care, including a look back at individual hospitals to ensure that they qualified for the payments. The state must perform a DSH audit each year and is subject to "claw backs," or fund repayment, if found to be in error. DSH is a significant issue for state Medicaid agencies and hospitals. The funds are large (over \$11.9 billion in fiscal year 2014), and Medicaid has significant discretion in how the funds are distributed within the federal rules.<sup>43</sup>

### Medicaid Expansion's Unanticipated Consequences

In anticipation of expanded public and private healthcare coverage, the Affordable Care Act called for a reduction of DSH allocations each year through fiscal year 2020.<sup>44</sup> When many states chose not to expand their Medicaid eligibility, the number of uninsured patients did not decrease as dramatically as expected. Thus, the DSH reduction impacted state Medicaid budgets as they still had a higher uninsured population, leaving them with less funding for hospital care, their most expensive program, and for their most vulnerable safety net hospitals—those caring for the poor.<sup>45,46</sup>

### Dual-Eligible

A person who is eligible for two health insurance plans, often referring to a Medicare beneficiary who also qualifies for Medicaid benefits.

### Cost-Sharing for Patients Enrolled in Both Medicaid and Medicare

Medicare pays for the patient's care, and Medicaid pays his or her health insurance premiums and copayments. Medicaid is also required to pay for prescriptions not covered under Medicare Part D and any other services normally covered by Medicaid but not Medicare. This is a complex program covering the most expensive and medically fragile eligibility group. Dually-eligible individuals make up 14 percent of Medicaid enrollment, yet account for approximately 36 percent of Medicaid expenditures.<sup>47</sup>

### Program is Complex and Expensive

Dually-eligible patients tend to be the most vulnerable and often sickest adults; their care has historically been expensive, totaling \$294 billion in 2011.<sup>48</sup> A major challenge for the dual-eligible population is coordination between Medicare and Medicaid. This challenge arises from communication barriers between Medicare and Medicaid programs, given the complex and overlapping payment mechanisms for covering services for these vulnerable patients, which also varies by state.<sup>49</sup> To address these issues, the Affordable Care Act created the Medicare-Medicaid Coordination Office in the Center for Medicare & Medicaid Innovation to improve care coordination and quality for this population.

## E

### Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT)

This benefit is designed to provide comprehensive and preventive healthcare services for children under the age of 21 who are enrolled in Medicaid. EPSDT requires states to assess a health needs among all eligible children 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 costlier. States must perform medical, vision, hearing, and dental checkups according to standardized schedules, called a "periodicity schedule" (see Table 1). 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.

**Table 1: EPSDT Benefit<sup>50</sup>**

Early	Assessing and identifying problems early.
Periodic	Checking children’s health at periodic, age-appropriate intervals.
Screening	Providing physical, mental, developmental, dental, hearing, vision, and other screening tests to detect potential problems.
Diagnostic	Performing diagnostic tests to follow up when a risk is identified.
Treatment	Controlling, correcting, or reducing health problems found.

### State Title V Agencies’ Roles in the EPSDT Program

Federal EPSDT rules call for coordination with state maternal and child health (MCH) agencies who receive Title V block grants to create written state MCH-Medicaid agreements that provide for maximum utilization of Title V-supported services. These agreements aim to improve children’s health and reimburse Title V providers for services rendered, even if such services are provided free of charge to low-income uninsured families. These payment mechanisms can include reimbursement for costs, capitation payments, or prospective interagency transfers with retrospective adjustments.<sup>51</sup>

### Role of Public Health Agencies

Additional opportunities for public health participation include:

- Administrating EPSDT services in public health clinics.
- Quality monitoring.
- Tracking participation.
- Developing and monitoring EPSDT screening rates and data collection tools.
- Managed care activities, such as reviewing records and monitoring the adequacy of screens.

### Electronic Health Record (EHR)

An individual’s health record that has been digitized and stored electronically that can be shared with different clinicians, including laboratories and specialists, and the patient. The record contains the patient’s medical history and key administrative clinical data. EHRs can also support other care-related activities, such as evidence-based decision support, quality improvement, and reporting.<sup>52</sup>

### Benefits of EHRs

By storing health information electronically through EHR systems, healthcare providers can improve patient care by supporting provider decisionmaking with clinical alerts and reminders, safeguard against potential adverse events, share information quickly with other providers, and correctly order tests and prescriptions. Although EHRs show significant promise for improving patient care overall, barriers to successful uptake and utilization include provider resistance and limited ability to exchange data across health systems (i.e., limited interoperability).<sup>53</sup>

### Medicaid’s Role in Promoting EHRs

The American Recovery and Reinvestment Act of 2011 included the creation of the Medicare and Medicaid EHR Incentive Programs. These programs created incentives for providers and hospitals to adopt and meaningfully use EHRs. Standards for what counted as “meaningful use” were defined by the Office of the National Coordinator for Health Information Technology (ONC), and the incentives used a

staged approach to move providers from simply recording data electronically to focusing on patient outcomes via EHRs in later stages. Based on data from ONC, EHR adoption nearly doubled among physicians and more than tripled among hospitals between 2009 and 2013.<sup>54</sup>

## F

### **Federal Medical Assistance Percentage (FMAP)**

The statutory term for the federal Medicaid matching rate (i.e., the share of Medicaid costs that the federal government bears for a specific state). Changes in the FMAP can have a big impact on state general fund budgets. CMS can also provide a higher match for specific services, such as tobacco cessation quitlines, in order to help support services that enhance health outcomes.

#### [How Rates Are Set for Federal Share of Medicaid](#)

The Social Security Act requires the HHS secretary to calculate and publish the FMAPs each year. Section 1905(b) of the Social Security Act specifies the formula for calculating FMAP, which varies from 50 to 83 percent, depending on a state's demographic and economic factors. Under Section 2105(b) of the Social Security Act, the Children's Health Insurance Program receives an enhanced FMAP.<sup>55</sup>

### **Federal Poverty Level (FPL)**

Annually updated guidelines established by HHS to determine eligibility for various federal and state programs. In 2016, the FPL for a family of four was a household income of \$24,300 or less. The impact of varying levels of FPL on Medicaid is demonstrated as follows: states use modified adjusted gross income to calculate income eligibility regardless of whether or not they have expanded Medicaid.<sup>56</sup>

#### [Using a 100 Percent FPL Income Limit](#)

Many states use 100 percent of FPL as a primary income limit for qualifying for Medicaid as adults; however, that is not a statutory requirement, and some states are more restrictive.

#### [Using a 133 Percent FPL Income Limit](#)

States that opted to expand Medicaid under the Affordable Care Act use 133 percent FPL as the income limit to expand Medicaid to adults. States that expanded Medicaid ignore five percentage points of income, so individuals under 138 percent of poverty level may qualify for services. In addition, in some states, children and pregnant women under 133 percent FPL qualify for Medicaid, and in other states, parents or childless adults can qualify for Medicaid with income under this level.

#### [Using a 135 Percent FPL Income Limit](#)

Individuals with incomes under 135 percent FPL who are on Medicare can be eligible for other Medicare Savings Programs. One of these programs is the Qualifying Individual program, which pays the beneficiary's monthly Part B premium. The income limit for another Medicare Savings Program, Specified Low-Income Medicare Beneficiary, is 120 percent of FPL; however, the program provides the same benefit—payment of the monthly Part B premium. In addition, 135 percent FPL is the income limit



to qualify for Medicare Part D's Extra Help full subsidy, which pays premiums and deductibles under the Medicare Part D Prescription Drug Plan and provides reduced per prescription copayments.

#### Using a 150 Percent FPL Income Limit

Medicare Part D's Extra Help partial subsidy, which provides reduced premiums and deductibles and reduced per prescription copayments, uses a 150 percent FPL income limit. In addition, 150 percent FPL (for two people) is also the limit used for the "minimum monthly maintenance needs allowance" for individuals whose spouses are in Medicaid-paid nursing homes. However, this amount, is not increased to the 150 percent of current year's FPL until July 1 of that year.<sup>57</sup>

### Federal Waivers

The Social Security Act authorizes multiple waiver and demonstration authorities to allow states flexibility in operating their Medicaid programs. Each authority has a distinct purpose and distinct rules. Waivers give CMS and the HHS secretary the ability to approve innovations and strategies that improve care and reduce costs. Typically, these strategies must demonstrate cost neutrality and other project reporting requirements. There are many examples of health departments partnering with Medicaid through such waivers.

#### Section 1115 Research and Demonstration Project Waivers

Section 1115 of the Social Security Act gives the HHS secretary broad authority to approve projects that test policy innovations likely to further the Medicaid program's objectives. Several states are using Section 1115 waivers to create Delivery System Reform Incentive Programs to undertake payment and delivery system reform and other improvements.<sup>58</sup>

#### Section 1915(b) Managed Care/Freedom of Choice Waivers

Section 1915(b) of the Social Security Act gives the HHS secretary authority to grant waivers that allow states to implement managed care delivery systems, allow a county or local government to act as a choice counselor to help individuals pick managed care plans, use savings that a state gets from a managed care delivery to provide additional services, or otherwise limit individuals' choice of provider under Medicaid.

#### Section 1915(c) Home and Community-Based Services Waivers

Section 1915(c) of the Social Security Act grants the HHS 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.<sup>59</sup>

### Federally Qualified Health Center (FQHC)

A health center in a medically underserved area or one that serves a population eligible to receive favored Medicare and Medicaid reimbursement. In addition to serving a medically underserved area or population, an FQHC must offer services to all persons regardless of their ability to pay, establish a sliding fee discount program, provide comprehensive primary care services, and be community-based. FQHCs provide direct reimbursement to nurse practitioners, physician assistants, and certified nurse midwives.

### FQHC Look-Alikes

FQHCs qualify for specific reimbursement systems under Medicare and Medicaid and receive federal Health Center Program grant money. Health centers receive FQHC status and funding by submitting applications to open HRSA funding opportunity announcements. When there are no open funding opportunities available or if they choose not to pursue the FQHC designation, health centers may apply for the “look-alike” designation, which is a non-competitive process and is open for continuous review. FQHC look-alike organizations operate and provide services consistent with the applicable requirements for FQHCs, and they are eligible for enhanced Medicaid reimbursement and access to the [340B drug pricing program](#) in the same manner as FQHCs.<sup>60</sup>

### Community Health Centers

FQHCs are sometimes referred to as [Community Health Centers](#) (CHCs). A CHC is an ambulatory healthcare program that usually serves a catchment area that has scarce or nonexistent health services or a population with special needs.<sup>61</sup> Partnerships between CHCs and public health agencies can be fruitful in addressing the health and social needs of the underserved populations that both types of organizations serve.<sup>62</sup>

### Fee-for-Service (FFS)

A traditional method of paying for medical services whereby doctors and hospitals are paid for each service they provide. Bills are either paid by the patient, who then submits them to an insurance company for reimbursement, or they are submitted by the provider to the patient’s insurance carrier for reimbursement. Some state Medicaid agencies still pay providers in a FFS arrangement, rather than managed care.

### FFS Rewards Volume, Not Quality or Prevention

FFS payments incentivize spending, as providers are reimbursed more for delivering a higher quantity of services or for delivering higher-cost items and services. Further, FFS does not align financial incentives between different providers. FFS does not encourage low-cost, high-value services such as preventive screenings or patient education, since providers may choose to provide services that cost more for financial growth. The combined incentives from FFS encourage high-cost services and discourage low-cost, high-value services; therefore, FFS drives up costs and potentially lowers the value of care.<sup>63,64</sup>

### Formulary—see [Preferred Drug List](#)

## G

### General Fund

A state’s primary account to cover ongoing operating expenses or governmental functions. The general fund includes all of the state’s financial resources that are not included in special revenue, debt service, capital projects, or permanent funds. In state fiscal year 2014, the average state government used 18

percent of its general fund for Medicaid expenses, ranging from 6 percent in Alaska to 44 percent in New Hampshire.<sup>65</sup>

### **Graduate Medical Education (GME) Payments**

Governmental payments made to teaching hospitals and associated ambulatory settings that provide an educational environment for training resident physicians.

#### **Purpose of the GME Payment**

Residents are physicians who have graduated from medical school and are currently completing several years of supervised training in a particular area of expertise, such as family medicine or surgery. This phase of their training is called GME. Hands-on experience in clinical settings is critical to educating these physicians; however, hospitals that train residents incur real and significant costs beyond those customarily associated with providing patient care. The Medicare program makes explicit payments to teaching hospitals for a portion of these added training costs through direct GME payments.

Teaching hospitals' added direct GME costs include residents' stipends and fringe benefits, salaries and fringe benefits for the faculty who supervise residents, and allocated institutional overhead costs, such as maintenance and electricity. Other direct costs may include the cost of clerical personnel who work exclusively in the GME administrative office. Medicare does not make payments related to medical students' clinical education.<sup>66,67</sup>

#### **Medicaid GME**

Second to Medicare, Medicaid is the largest explicit payer of GME. Medicare has explicit rules on funding GME, but Medicaid programs are not subject to a federal obligation to participate. Most, but not all, states provide Medicaid GME payments. The amount of Medicaid GME payments is difficult to quantify precisely. This is due in part to the fact that teaching hospitals may also receive Medicaid disproportionate share payments, and it is challenging to differentiate them from Medicaid GME payments. In addition, states that include Medicaid GME payments in their managed care organization (MCO) rates may find it difficult to separately identify these payments or to determine the actual value.

Assuming these limitations, total Medicaid GME payments in fiscal year 2012 by the states and the District of Columbia reached an estimated \$3.87 billion.<sup>68</sup> These payments reflect the following:

- Payments made under Medicaid fee-for-service (\$2.32 billion).
- Payments made directly (explicitly) to teaching programs under managed care (\$1.29 billion).
- Payments (implicitly) recognized and included in capitated rates to MCOs (\$264 million).

## **H**

### **Health Homes**

The Affordable Care Act created an optional Medicaid state plan benefit that states can use to establish health homes that coordinate care for Medicaid beneficiaries with chronic conditions. Health homes are

expected to operate under a “whole-person” philosophy, similar to the patient-centered medical homes model (See also [Patient-Centered Medical Home](#)). Health homes’ providers deliver comprehensive care management, care coordination, health promotion, comprehensive transitional care and follow-up, patient and family support, and referrals to community and social support services.<sup>69</sup> Whereas patient-centered medical homes typically serve all populations across the lifespan, states can focus their health homes on a specific population, such as individuals with serious mental illness (e.g., New York), or those with chronic disease (e.g., Maine).<sup>70, 71</sup>

## **Health Information Exchange (HIE)**

Securely transmitting healthcare-related data among facilities, health information organizations, and government agencies, according to national standards.

### **Goals of HIE**

A primary goal of electronic HIE is to improve the speed, quality, safety, and cost-effectiveness of patient care by sharing health information between all members of a patient’s care team, as appropriate. Timely sharing of vital patient information can better inform decisionmaking at the point of care, allow providers to avoid readmissions and medication errors, improve diagnosis accuracy, and reduce duplicate testing. However, in addition to improving individual patient care, HIE can allow health insurers, public health agencies, and other institutions to analyze trends in utilization and patient outcomes to improve population health and create system-level efficiencies.

### **Types of HIE**

Directed HIE offers secure point-to-point communication, supported by the [Direct Project’s specifications](#) or other industry approaches to secure messaging. Query-based HIE refers to “pull” transactions, or query through an HIE entity, which allows a user to submit a request for patient information and ask the HIE entity to discover and provide any records it may have about the patient in accordance with policies governing patient consent and data-use agreements between exchange users.<sup>72</sup>

## **Health Information Technology (HIT)**

The hardware and software that enables healthcare providers to securely share electronic medical information to help them manage patient care. HIT is an all-encompassing term to cover a range of technological and policy efforts to improve patient care and reduce costs through the use of technology.

### **Examples of HIT Application**

HIT includes using electronic health records (EHRs) instead of paper medical records to maintain patient health information. HIT also includes electronic prescribing or utilizing electronic systems to submit and transfer prescriptions. Patients and providers might also engage in secure messaging, using a communication method similar to email to share information with one another.<sup>73</sup>

### **Governmental Support for HIT**

At the federal level, the Office of the National Coordinator for Health Information Technology leads efforts to promote HIT adoption and use across the nation. Medicaid also encourages HIT adoption by funding provider EHRs and establishing health information exchanges between providers. (See also [Health Information Exchange](#) and [Electronic Health Record](#).)

## **Health Insurance Exchange**

A competitive insurance marketplace that offers affordable and qualified health benefit plans. Exchanges offer a choice of health plans that meet certain benefits and cost standards. The exchanges can set standards beyond those required by the federal government, accept bids, and negotiate contracts with insurers. Under the Affordable Care Act (ACA), states must offer exchanges for both individual coverage and small business health options. States may establish their own state-based marketplaces, participate in a state-federal partnership marketplace, or participate in a federally facilitated exchange (i.e., hosted by Healthcare.gov).<sup>74</sup>

### **Health Insurance Exchange Navigators**

Health insurance exchanges are required to contract with professional associations and local organizations to provide exchange navigator services. These services include providing education and information about qualified health plans that is culturally and linguistically appropriate; distributing fair and impartial information about enrollment; facilitating enrollment in health plans; and providing referrals for any enrollee with a grievance, complaint, or question regarding a health plan.

### **Health Insurance Exchange Plans**

In order to be certified as a Qualified Health Plan, the plan must offer the essential health benefits, cost-sharing limits, and market reforms outlined in ACA. Under these plans, certain low-income populations also receive subsidies to purchase exchange coverage. The health insurance exchanges established under ACA must offer four levels of coverage (bronze, silver, gold, and platinum plans) based on the plan's actuarial value.<sup>75</sup>

## **Health Insurance Portability & Accountability Act (HIPAA)**

A federal law passed by Congress in 1996 that provides consumers with various health insurance coverage and patient privacy protections. The HIPAA security rules were established to protect patient privacy by strictly enforcing confidentiality for medical records and other individually identifiable health information provided to health plans, doctors, hospitals, and other healthcare providers.<sup>76</sup>

## **Health Maintenance Organization (HMO)**

A health insurance plan that provides a coordinated array of preventive and treatment services for a fixed capitated payment per month. HMOs provide services through a panel of healthcare providers. Enrollees receive medically necessary services regardless of whether the cost of those services exceeds the premium paid on the enrollees' behalf.<sup>77</sup>

### **Comparison to Preferred Provider Organizations (PPO)**

HMOs and PPOs are both types of managed care organizations. (See [Managed Care Organization](#).) Unlike PPOs, HMOs often require enrollees to have a designated primary care provider to authorize treatment or access to a specialist. Further, HMOs offer no out-of-network insurance coverage, requiring patients to pay the full cost in those cases. HMO premiums are also typically lower than those among PPOs.

### **Health Professional Shortage Area (HPSA)**

Geographic areas or populations within certain geographic areas (e.g., low-income or Medicaid-eligible populations) that lack sufficient healthcare providers to meet the healthcare needs of the area or population. The Health Resources and Services Administration designates HPSAs based on primary care, dental care, mental health, and medically underserved areas/populations. As of 2014, there were 6,100 federally-designated primary care HPSAs, 4,900 dental HPSAs, and 4,000 mental health HPSAs across the United States.<sup>78</sup> Providers in HPSAs receive a 10 percent bonus payment for Medicare-covered services.

#### **Federal Qualifications**

To receive a HPSA designation, the specified population-to-provider ratio must be more than 3,500 individuals per physician, or 3,000 individuals per physician in “high needs” areas or populations. Further, healthcare resources in neighboring areas must be determined to be unavailable due to distance, overutilization, or other barriers to access.<sup>79</sup>

### **Health Resources and Services Administration (HRSA)**

An agency of the Department of Health and Human Services. HRSA is the primary federal agency responsible for improving health equity and access to healthcare services for people who are uninsured, isolated, or medically vulnerable. It is also the federal agency responsible for administering Federally Qualified Health Centers and the Ryan White Program for HIV.<sup>80</sup>

### **Home and Community-Based Services (HCBS)**

Services provided in an individual’s home or a setting in the community, such as adult day services, senior centers, at-home meal delivery, transportation services, respite care, housekeeping, case management, and companion services. These services are primarily designed to help older people and people with disabilities or mental illnesses remain in their homes for as long as possible. (See also [Long-Term Care](#).)<sup>81</sup>

#### **Benefits of HCBS**

In-home care is well received by patients, and studies indicate that it can be less costly than inpatient care. In addition, most people want to stay in their home as opposed to receiving nursing home care. In 2014, state Medicaid programs spent more than \$118 billion on long-term care, \$49.8 billion of this on nursing home facilities, making them the second costliest long-term care program.<sup>82</sup>

It is generally accepted that in-home care is less costly than in a nursing home and can allow seniors or individuals with disabilities to retain their independence for an improved quality of life. Although few studies document absolute cost savings, academic research has consistently found much lower average costs per individual for HCBS compared with institutional long-term care. Overall, findings illustrate that diverting and transitioning individuals from nursing home care to HCBS lowers healthcare costs. These potential savings and the clear preference by patients for in-home care make HCBS an attractive offering for state policymakers.

### Section 1915(c) Home and Community-Based Waivers

Through 1915(c) waivers, states may allow long-term care services in home and community-based settings through Medicaid. This can include both medical and non-medical services, such as case management, home health aides, personal care, habilitation, and respite care. States also have the flexibility to propose additional types of services that can help patients remain in non-institutional settings.<sup>83</sup>

### Hospice

A facility or program designed to care for patients in the terminal phase of an illness, which typically serves patients with less than six months to live. Hospice focuses on caring, not curing, and in most cases provides care in the patient's home. Patients can also receive hospice care in freestanding hospice centers, hospitals, nursing homes, and other long-term care facilities. Hospice services are available to all patients, regardless of age or illness. Hospice care is covered under Medicare, Medicaid, most private insurance plans, health management organizations, and other managed care organizations.<sup>84</sup>

## I

### Individuals with Disabilities Education Act (IDEA)

A U.S. federal law that governs how states and public agencies provide early intervention, special education, and related services to children with disabilities. As a condition of accepting funds under IDEA, public schools must provide special education and any additional services necessary for children with disabilities to benefit from a public education. Generally, federal IDEA funds are only able to finance a portion of these costs. Medicaid can help public school systems cover the health-related services that IDEA requires, as well as related administrative activities (e.g., outreach for Medicaid enrollment purposes, medical care coordination, and monitoring). States' uses of these funds have varied, prompting the federal government to tighten the rules.<sup>85</sup>

### Intergovernmental Transfers (IGTs)

Exchanges of public funds between different levels of government. IGTs are a common feature in state finance. The transfers may take place from one level of government to another (e.g., counties to states) or within the same level of government (e.g., from a state university hospital to the state Medicaid agency). In the early 1990s, many states began to use IGTs as a way to leverage federal Medicaid dollars to continue or expand service coverage or to pay higher reimbursement rates to providers. In this way, states can use county or state expenditures to generate a federal match to support Medicaid services.<sup>86</sup>

### IGTs Provide State Share in Medicaid

IGTs are used in "creative" ways to help states fill budget gaps and maintain services by increasing the federal share of total spending in times of budgetary shortfalls. However, there are continuing disputes between states and CMS, as states try to maximize federal funds and CMS attempts to monitor state financing practices and close loopholes.

IGTs between state and local health departments that are used to maximize Medicaid revenue for public health are legal. The federal Medicaid statute explicitly recognizes the legitimacy of IGTs involving tax revenues. [Section 1903\(w\)\(6\)\(A\)](#) of the Social Security Act specifies, "The Secretary may not restrict States' use of funds where such funds are derived from State or local taxes (or funds appropriated to State university teaching hospitals) transferred from or certified by units of government within a State as the non-Federal share of expenditures under this title, regardless of whether the unit of government is also a health care provider."<sup>87</sup> This provision has allowed many creative financing arrangements that benefit public health.

## K

### **Katie Beckett Waivers**

A Medicaid eligibility program for children with certain long-term disabilities or complex medical needs that covers healthcare services and supports through home-based care rather than in an institutional setting. Children on this waiver program receive a level of care that used to only be found in a hospital or skilled nursing facility. Thanks to recent technological and delivery advances, families can now sometimes provide that care with additional supports under this program. The Medicaid provision is named after a girl who remained institutionalized at a hospital solely to continue Medicaid coverage. Before the provision's enactment, Medicaid would only cover her required services in an institutional setting.<sup>88</sup>

## L

### **Long-Term Care (LTC)**

The continuum of healthcare, personal care, and social services that support individuals living with chronic health conditions that affect their ability to perform activities of daily living. LTC encompasses both medical and non-medical care that can be provided at home, in the community, in assisted living facilities, or in nursing homes. Although acute medical care may be focused on restorative or rehabilitative activities, LTC may sometimes aim to prevent deterioration and provide social support and adjustment.<sup>89</sup>

Unlike Medicare, Medicaid does pay for custodial care in nursing homes and at home and is the primary payer for LTC services and support to individuals who are elderly or disabled. Medicaid currently finances nearly 34 percent of all home healthcare and 43 percent of the nation's nursing home spending. Medicaid is projected to grow an average 7.5 percent per year primarily due to the aging U.S. population.<sup>90, 91</sup>



### **Long-Term Care Facility**

A long-term care facility provides rehabilitative, restorative, and/or ongoing skilled nursing care to patients or residents in need of assistance with activities of daily living, such as bathing, dressing, or eating. Long-term care facilities include nursing homes, rehabilitation facilities, inpatient behavioral health facilities, and long-term chronic care hospitals.<sup>92</sup>

## **M**

### **Managed Care Organizations (MCOs)**

Healthcare systems that integrate the financing and delivery of appropriate services to covered individuals. MCOs arrange with selected providers to furnish a comprehensive set of healthcare services. Health maintenance organizations (HMOs) and preferred provider organizations (PPOs) are two examples of MCOs.<sup>93</sup>

#### **MCO Business Model**

Under the MCO full-risk business model, the state or other payer pays the MCO a capitated amount for each enrolled participant each month, known as per member per month (PMPM) payments. The MCO must provide a contracted set of services through a health network of medical, hospital, and other healthcare providers for that capitated amount. If the MCO's costs exceed the PMPM payment, they must incur the loss. However, if aggregate expenditures are lower than the total income, the health plan makes a profit.

Reasonable profits are essential to MCOs' success. Without sufficient margins they will be unable to remain in the market or provide services beyond the minimum required by their contracts. MCOs are businesses with a set of rewards for their leadership and shareholders that require cost containment and financial performance as factors critical to their success and ability to make a return on equity. Even nonprofit MCOs must be sensitive to this requirement in order to be financially successful.

#### **Critical Success Factors in the MCO Model**

Within this framework of business goals, a successful MCO must also be responsive to the National Committee for Quality Assurance metrics that are critical for accreditation, which is highly desired by health plans. These include standards that are by nature aligned with public health goals, such as including preventive health screenings. States also build these types of quality metrics into managed care contracts. Business success under a capitated arrangement also depends on how successfully an MCO promotes health, prevents injury, and efficiently returns an enrollee to health—all of which may be included as contractual requirements and standards.

#### **Mandatory Managed Care**

Over time, state Medicaid programs have migrated toward capitated HMO alternatives as the preferred strategy to improve access and accountability, reduce costs, and 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 Waivers or Section 1115 of the Social Security Act Managed Care Demonstration Waivers. (See also [Federal Waivers](#).) Approximately 80 percent of Medicaid enrollees are now served through managed care delivery systems.<sup>94</sup>

## Medicaid

A means-tested health insurance program that provides medical benefits to qualified indigent or low-income persons in need of health and medical care. Funding is shared by the state and federal government. The program is subject to broad federal standards, but states determine their own eligibility standards, including the type, amount, duration, and scope of benefits covered; the rate of payment for services; and the administration methods. (See also [State Medicaid and CHIP Plan](#).)

### Medicaid and Public Health Perspectives

Medicaid and public health departments have very different organizational missions, cultures, and business models. Generally, public health mission statements focus on promoting community and overall population health. Medicaid, on the other hand, focuses primarily on Medicaid-eligible populations and the provision of effectively and efficiently purchasing services.

The public health enterprise is multifaceted and varies from state to state. Some public health agencies provide minimal clinical services and emphasize regulatory oversight and support of health promotion and health safety activities. Others provide substantial direct clinical services and are integral providers in their communities' healthcare systems. Conversely, Medicaid is much more focused on buying healthcare services in a cost-effective manner, and does not view all costs equally. State policymakers give special attention to the costs affecting the state share paid by the Medicaid agency. (See also [Federal Medical Assistance Percentage](#).)

### Medicaid Impact on State Budgets

Medicaid is typically the largest non-educational item in a state's general fund budget.<sup>95</sup> This level of funding draws intense focus from state policymakers, who are faced with the realities of balancing the state budget and seeking cost-efficiencies that can affect other state agencies, including public health departments. A critical measure of efficiency for state policymakers is the level of generated state savings and revenue, which can be directed to other state priorities, and not just reduced total spending.<sup>96</sup>

## Medical Loss Ratio (MLR)

The percentage of consumers' premium dollars that an insurance company spends on medical care and healthcare quality improvement efforts, as opposed to administrative costs or profits. The Affordable Care Act requires insurers in the large group market to have a MLR of at least 85 percent and insurers in the small group and individual markets to have a MLR of at least 80 percent. If an insurance company does not meet the MLR standard, the insurer is required to provide a rebate to its members.<sup>97</sup> This policy aims to increase transparency and allow consumers to make informed decisions regarding which health plans provide the most value for their premium dollar.

### **Medical Necessity**

Accepted healthcare services that are appropriate to the treatment of a disease, condition, illness, or injury, and that are consistent with applicable professional and/or legal standards of care. Medical necessity refers to services and supplies that are neither more nor less than what the patient requires. Decisions on what constitutes medical necessity must be conducted by the treating physician on a case-by-case basis, should not be determined by a payer, and should be available for peer review.<sup>98</sup>

Beyond screening and preventive services under the Early and Periodic Screening, Diagnosis, and Treatment Program, all Medicaid-funded services must be medically necessary. (See [Early and Periodic Screening, Diagnosis and Treatment Program](#).) Although the definition's wording may differ from state to state, numerous courts have emphasized that state procedures that interfere with a treating physician's professional judgment concerning medically necessary treatment violate the Medicaid Act.<sup>99</sup>

### **Medically Needy**

An optional state program that allows states to extend Medicaid eligibility to additional beneficiaries whose assets or income are too high to qualify for Medicaid under income-based or other categorically needy groups. This option allows medically needy individuals 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 threshold allowed by that state's Medicaid plan.

States may also allow families to qualify as medically needy if they pay 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.<sup>100</sup> However, some states restrict eligibility for their medically needy programs to only cover children and pregnant women.

### **Medicare**

A federally funded health insurance plan that provides hospital, surgical, and medical benefits to individuals over 65, individuals with certain disabilities, and individuals with end-stage renal disease.

#### **Medicare Structure**

- Medicare Part A covers basic inpatient hospital care and skilled nursing facilities, as well as some hospice care if the beneficiary meets certain conditions.
- Medicare Part B provides medical insurance benefits for physicians' professional services and outpatient care. Part B also helps cover services and supplies that are not covered under Part A, such as physical therapy or home health, if they are medically necessary.
- Medicare Part C (also called Medicare Advantage Plan) allows beneficiaries to combine their coverage under Parts A and B through private insurance companies.
- Medicare Part D helps cover prescription drugs and is available to everyone with Medicare through private insurance companies. Enrollment is optional, and beneficiaries pay a monthly premium for a drug plan of their choosing.<sup>101</sup>

## P

### **Pay-for-Performance (P4P)**

A healthcare payment system that seeks to improve care quality, value, and efficiency over time. In P4P, providers have financial incentives for meeting or exceeding quality and cost benchmarks. Some systems also penalize providers who do not meet the established benchmarks.<sup>102</sup>

#### **Contrast to Fee-for-Service (FFS)**

This system is often presented as an alternative payment structure to FFS, which incentivizes providers to increase the quantity or volume of care delivered. For example, a FFS model may pay hospitals for each patient admission; however, P4P would monitor the rate of returning patients and reward lower hospital readmissions.

#### **Quality Measurements**

CMS has established a number of P4P demonstration projects to evaluate different approaches. Generally, the quality measures used in P4P can be assorted into the following categories:<sup>103</sup>

- Process measurements, which monitor healthcare activities that are demonstrated to contribute to positive health outcomes (e.g., whether providers engage in patient counseling).
- Outcome measurements, which reflect the effect of the care (e.g., laboratory test results, total cost savings, and readmissions).
- Patient experience measurements, which assess patient satisfaction and are largely based on the patient's perception of their care (e.g., may reflect facility cleanliness or the providers' professionalism and communication).
- Structural measurements, which relate to the facilities, workforce, and equipment (e.g., tracking the adoption of health information technology).

### **Patient-Centered Medical Home (PCMH)**

Also commonly known as a "medical home" or "primary care medical home," this delivery model is a team-based approach to providing comprehensive primary care that facilitates partnerships between individual patients, their primary providers, specialists, and, when appropriate, the patient's family and community supports. Coordinated care is facilitated by registries, information technology, health information exchanges, evidence-based medicine, clinical decision support tools, and other means to assure that patients receive individualized care when and where they need it in a culturally and linguistically appropriate manner. The medical home mode is characterized by a whole person orientation and active patient participation.<sup>104, 105</sup>

### **Pharmacy Benefit Manager (PBM)**

A third-party administrator who manages drug benefit coverage between pharmacies, drug makers, payers, and health plan members in order to maximize drug effectiveness and contain costs. PBMs operate under contracts with managed care organizations, private insurance, and government programs. These companies leverage their large purchasing power to negotiate prices with pharmacies

and drug makers, to conduct drug utilization reviews, and to manage pharmacy network contracts for the health plan.<sup>106</sup>

### **Preferred Drug List (PDL)**

A list of the prescription drugs that a health plan or other payer covers. PDLs are also known as drug formularies. The prescription drugs that are included on a PDL are selected for their safety, clinical effectiveness, and cost. Typically, preferred drugs are generic formulations or were successfully included in price negotiations between pharmaceutical companies and Medicaid. Preferred drugs are recommended as first-choice drugs for Medicaid beneficiaries. If a prescription drug has a non-preferred status, the state Medicaid plan must issue prior authorization. New drugs are classified as non-preferred until a state's annual review, unless the Food and Drug Administration has given it priority status.<sup>107</sup>

### **Presumptive Eligibility**

Under presumptive eligibility, individuals can receive immediate outpatient services for a limited time through Medicaid while their applications are still pending.

### **Beneficiaries**

States can authorize qualified entities and hospitals to screen pregnant women for prenatal care coverage, with program eligibility based on a medically verified pregnancy and the woman's statement of her family's gross monthly income. In some states, qualified entities may also screen children who may be eligible for Medicaid or Children's Health Insurance Program (CHIP) enrollment.<sup>108</sup>

### **Qualified Entities**

In accordance with federal requirements, only organizations that receive funding under one of the following programs can be a qualified Medicaid presumptive eligibility provider:<sup>109</sup>

- Federal community or migrant health programs.<sup>110</sup>
- Title V Maternal and Child Health Block Grant.
- Title V of the Indian Health Improvement Act.
- Title XIX (Medicaid) or Title XXI (CHIP) for prenatal services.
- The Indian Health Service or a health program operated by a tribe or tribal organization under the Indian Self-Determination Act.

### **Primary Care Case Management (PCCM)**

A system of care in which a primary care provider (PCP) is responsible for approving and monitoring enrolled Medicaid beneficiaries' care, such as by authorizing visits to specialists or emergency department visits. PCCMs receive a monthly case management fee, typically \$3 per beneficiary per month, in addition to fee-for-service (FFS) reimbursements. This is a Freedom of Choice Waiver program, under the authority of section 1915(b) of the Social Security Act.<sup>111</sup>

### **History and Evolution**

States began enrolling beneficiaries in their PCCM programs in the mid-1980s to increase access and reduce inappropriate emergency department and other high cost care. These early programs operated more like a traditional FFS Medicaid arrangements than a risk-based plan, and their managed care

organization (MCO) contracts were considered to be the predominant managed care system. However, that emphasis has been shifting in states that are experiencing a decrease in contractors as MCOs choose to exit Medicaid managed care. PCCM models today now focus more on better managing the quality of care and increasing provider accountability.<sup>112</sup>

### **Primary Care Case Manager**

A member of a patient's primary care team who coordinates care across settings and help patients navigate the healthcare system. The primary care case manager assesses patient care needs, monitors care plans, provides education and counseling, communicates information to various clinicians, and connects patients to community resources. These individuals operate in both clinical and nonclinical arenas and may also be referred to as care coordinators or patient navigators.<sup>113</sup>

### **Primary Care Provider (PCP)**

A physician selected by or assigned to a patient who provides comprehensive general care and monitors the patient's access to other medical services and specialists. Often, PCPs serve as a patient's first point of entry into the healthcare system. PCPs are typically family medicine, internal medicine, geriatric, or pediatric physicians, although PCPs may also be nurse practitioners, clinical nurse specialists, or physician assistants.<sup>114</sup>

### **Prior Authorization**

A requirement imposed by a health plan or third party administrator that a provider must justify the need for delivering a particular service in order to receive reimbursement. Prior authorization typically evaluates an individual's eligibility, coverage, and medical needs. (See also [Utilization Review](#).) It may apply to all services or only to those that are potentially expensive or overused.<sup>115</sup>

### **Provider**

A person or organization that manages and delivers health-related clinical or support services. The term may also refer to a person or organization who furnishes, bills, or is paid for health or medical care.<sup>116</sup>

### **Provider Tax**

A state tax, mandatory payment, or fee of which at least 85 percent of the burden falls on healthcare providers. The federal government has specified 19 classes of healthcare providers that may fall under a provider tax; however, the providers most often taxed are nursing facilities, hospitals, and managed care organizations.<sup>117</sup>

### **Purpose and Rationale**

Healthcare provider taxes are common among states and help finance the state share of Medicaid, thereby increasing the federal medical assistance percentage. (See also [Federal Medical Assistance Percentage](#).) Many states then use the combined provider tax revenue and increased federal assistance to increase Medicaid reimbursement rates to the providers subjected to the tax. This tax therefore increases Medicaid funding without using additional state funds. In 2015-2016, 49 states and the District of Columbia utilized some type of Medicaid-related provider tax or fee. (Alaska was the only state not using provider taxes during this time.)

### Federal Restrictions

Federal law and regulations limit a state's ability to use provider taxes to fund its state share of Medicaid expenditures. Provider taxes cannot exceed 25 percent of the state/non-federal share of Medicaid expenditures, and the state cannot provide a guarantee to providers that the taxes will be returned to them. Further, a provider tax must be broad-based (imposed upon all providers within the specified class) and uniform (with an equal rate among all providers in the class).

## R

### 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]."<sup>118</sup> 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.<sup>119</sup>

### Risk-Based Plans

When a health plan receives a fixed fee payment per member per month and assumes part of the financial risk of cost overruns for a specified package of services. Payments are predicted based on an estimate of the expected costs to treat a particular condition or patient population. If actual expenditures exceed the fixed payments, the insurer is responsible for absorbing the loss, and that loss is passed on to the providers in some, although not all, models.<sup>120</sup>

Over half of all Medicaid beneficiaries are enrolled in managed care organizations rather than fee-for-service programs, and nearly all states have some Medicaid managed care programs. Major Medicaid managed care models include risk-based plans. (See also [Health Maintenance Organizations](#) and [Managed Care Organizations](#).)

### Rural Health Clinic

A public or private hospital, clinic, or physician practice certified by the federal government as being in compliance with the Rural Health Clinics Act.<sup>121</sup> The practice must be located in a medically underserved area or a Health Professional Shortage Area and use at least one physician assistant, nurse practitioner, or certified nurse midwife on-site at least 50 percent of the time to deliver services to rural populations. A physician must also be available to supervise the team.

Designation as a rural health clinic brings several advantages, including Medicaid reimbursement and drug purchasing availability similar to Federally Qualified Health Centers (FQHC). (See also [Federally Qualified Health Center](#).) Although FQHCs provide dental health, mental health, substance abuse, and

enabling services, rural health clinics differ in that they are only required to provide outpatient primary care and basic laboratory services.<sup>122</sup> Rural health clinics are required to have formal arrangements with at least one hospital to provide medically necessary services beyond those available on-site. Visiting nursing services are also provided in certified home health agency shortage areas.

### **Rural Health Network**

Refers to any variety of organizational arrangements to link rural healthcare providers in order to pool resources and collaborate to achieve common objectives. Networks may or may not be the result of formal agreements, and the scope, structure, and objectives vary among networks and are tailored to the local community's needs.

#### **Purpose and Common Activities**

Common objectives include pooling financial resources, establishing joint ventures in health information technology development, setting up group purchasing, facilitating legislative and regulatory advocacy, and developing educational resources and programs.<sup>123</sup>

#### **Network Structures**

Rural health networks are classified according to their membership. In a horizontal network, all of the organizations represent a singular type of provider and serve similar markets (e.g., an all-hospital network). Vertical networks consist of organizations with different purposes in different markets (e.g., in a network composed of a hospital, an ambulatory care provider, a nursing home, and a public health unit).

## **S**

### **Safety Net**

Providers and institutions that provide low-cost or free medical care to medically needy, low-income, uninsured, or otherwise vulnerable populations regardless of a patient's ability to pay. Core safety net providers include public hospitals, community health centers, and local health departments, as well as some HIV/AIDS and school-based clinics or ambulatory care sites. Medicaid is the largest revenue source for most of these providers.<sup>124</sup>

### **State Medicaid and Children's Health Insurance Plan (CHIP)**

A comprehensive statement that describes the scope and nature of a state's Medicaid and CHIP programs, including administration, eligibility categories for beneficiaries, and covered healthcare services. Under [Section 1902 of the Social Security Act](#), states are required to write a plan and obtain approval from HHS.<sup>125</sup>

#### **Provisions**

This state plan describes how the state will abide by federal rules and requirements in order to receive matching funds for its program activities. The state plan describes who is eligible for Medicaid, what



services are provided, how providers will be reimbursed, and how the state will administer the program.<sup>126</sup> It also must describe how beneficiaries and advocates can review and obtain copies of all current policies and rules governing program operation.

### State Plan Amendments (SPAs)

A SPA is a formal change to the state plan programs or policies that the state submits to CMS for review and approval. States also submit SPAs to request permissible program changes, make corrections, or update the Medicaid or CHIP state plan with new information. Typically, SPAs are reviewed by different entities with state Medicaid programs for approval. Once submitted, CMS reviews SPAs on a rolling basis every quarter.<sup>127</sup>

### Statewide Coverage

States must put their Medicaid and CHIP plans into effect in all political subdivisions of the state. States cannot limit healthcare services available under the state plan to a specific geographic location or fail to provide a covered service in a particular area. To comply with this requirement, state Medicaid and CHIP programs must provide all medically necessary healthcare services available under the state plan without regard to the county of residence of the beneficiary who is seeking healthcare services.

### Supplemental Security Income (SSI)

Federally funded cash assistance programs for individuals who are blind, disabled, or over age 65 and who have little or no income. SSI assists with basic needs, such as food, clothing, and shelter. Once eligible for SSI, these individuals are also eligible for Medicaid and supplemental nutrition assistance in most states. The program is administered by the Social Security Administration; however, unlike Social Security benefits, SSI is not based on prior work history. SSI benefit amounts do vary based on income, living arrangements, and other factors.<sup>128</sup>

## T

### Transfer of Assets

Individuals are only eligible for Medicaid coverage after reducing their personal assets to minimum levels, which vary from state to state and also vary with marital status. An individual must personally pay the bills for home care, nursing facilities, and other healthcare costs until his or her 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 before they apply for Medicaid. However, Medicaid rules severely restrict such transfers.

Provisions of Section 1917(c) of the Social Security Act apply when assets are transferred on behalf of individuals who are in long-term care facilities or who receive home and community-based waiver services.<sup>129</sup> States can review an individual's financial information up to 36 months prior to the date the individual was institutionalized or applied for Medicaid to find assets that were transferred, gifted, or sold for less than they were worth. If states find an asset transfer for less than fair market value within

that time period, the state must withhold payment for nursing facility care and certain other long-term care services for a penalty period. If the assets are transferred back to the individual, the state can remove the penalty.<sup>130</sup>

## U

### **Uncompensated Care**

Services provided by physicians and hospitals for which no payment is received from either the patient or a third party insurer. Uncompensated care refers to services for which hospitals anticipated but never received payment, which is often the result of patients' lack of insurance coverage and their inability to pay the full cost out of pocket. Data on hospitals' uncompensated care also typically include financial assistance or charity services provided to patients in need for which hospitals did not expect to receive payment. However, uncompensated care does not include budget gaps due to low Medicare or Medicaid reimbursement rates.<sup>131</sup>

### **Upper Payment Limit (UPL)**

A rule stating that aggregate Medicaid payments to specific groups of providers cannot exceed the rate that would have been paid under Medicare for the same services. Because state Medicaid reimbursement rates are often lower than the federal Medicare rates, states can receive supplemental UPL payments that comprise the difference in Medicaid and Medicare amounts. State Medicaid agencies calculate these supplemental federal matching funds based on a hospital or nursing facility's volume of fee-for-service care, and they are an important source of revenue for many safety net hospitals that provide care for a large number of Medicaid enrollees (See also [Safety Net](#)).<sup>132</sup>

### **Utilization**

Patterns regarding how much healthcare or specific treatment a population uses, which types of services it accesses, and how often it accesses them. Stakeholders can examine utilization in terms of a single service or a type of service (e.g., inpatient hospital care, physician visits, or prescription drug claims) or in a rate per unit of population over a given period of time. Utilization data are often used to measure a population's access to healthcare, since utilization reflects the successful connection between patients and providers.<sup>133</sup> Utilization data also can be used to track shifting demographic trends that affect changing demand for services (e.g., the aging of a population).

### **Utilization Review**

The critical assessment of how necessary, efficient, and appropriate an individual's medical treatment plan is (also sometimes referred to as utilization management). Typically, an insurer or third party administrator will conduct utilization reviews, either retrospectively or concurrent with the patient's care, and compare requests for service against treatment guidelines.<sup>134</sup> Generally, the insurer or administration conducts utilization reviews to monitor the quality of care or to control cost. Reviews evaluate whether a treatment is medically necessary and investigate whether it is too invasive or expensive.

### Medicaid drug utilization review (DUR)

The DUR program is one such model of utilization review. Under this program, state Medicaid agencies use electronic monitoring systems to screen prescription drug claims, tracking incorrect dosages or duration of treatment, drug allergies, or therapeutic duplication. DUR also retrospectively evaluates patterns of prescription drug claims to identify potential fraud and abuse or medically unnecessary care.<sup>135</sup>

## V

### Value-Based Purchasing (VBP)

A payment reform that offers financial incentives to hospitals and other providers based upon their performance against a defined set of quality measures.<sup>136</sup> Payment is determined by the quality, not the quantity, of provided services. Section 3001 of the Affordable Care Act authorized inpatient hospital value-based purchasing to be utilized in Medicare, and requires similar programs within skilled nursing facilities, home health agencies, and ambulatory surgical centers (*See also [Pay for Performance](#).*)<sup>137</sup>

Although VBP relies upon performance-based payments, effective reform also requires transparency among hospitals and healthcare providers and accurate public reporting. This allows purchasers, payers, and consumers to make decisions based on both quality and cost, rather than cost alone. As consumer demand shifts toward high-value treatments and providers, hospitals and healthcare systems will be pressured to focus on quality in order to remain economically viable.<sup>138</sup>

## Acronyms

Acronym	Definition
<b>ABD</b>	Aged, Blind, Disabled
<b>ACA</b>	Affordable Care Act (i.e., Patient Protection and Affordable Care Act)
<b>ACO</b>	Accountable Care Organization
<b>CHC</b>	Community Health Center
<b>CHIP</b>	Children’s Health Insurance Program
<b>CMMI</b>	Center for Medicare and Medicaid Innovation
<b>CMS</b>	Centers for Medicare and Medicaid Services
<b>DRG</b>	Diagnostic Related Group
<b>DSH</b>	Disproportionate Share Hospital Program
<b>DUR</b>	Drug Utilization Review
<b>EHR</b>	Electronic Health Record
<b>EPSDT</b>	Early and Periodic Screening, Diagnosis, and Treatment Program
<b>FFS</b>	Fee-for-Service
<b>FMAP</b>	Federal Medical Assistance Percentage
<b>FPL</b>	Federal Poverty Level
<b>FQHC</b>	Federally Qualified Health Center
<b>GME</b>	Graduate Medical Education
<b>HCBS</b>	Home and Community-Based Services
<b>HHS</b>	Department of Health and Human Services
<b>HIE</b>	Health Information Exchange
<b>HIT</b>	Health Information Technology
<b>HIPAA</b>	Health Insurance Portability and Accountability Act
<b>HMO</b>	Health Maintenance Organization
<b>HPSA</b>	Health Professional Shortage Area
<b>HRSA</b>	Health Resources and Services Administration
<b>IDEA</b>	Individuals with Disabilities Education Act
<b>IGT</b>	Intergovernmental Transfers
<b>LTC</b>	Long-Term Care
<b>LTCF</b>	Long-Term Care Facility
<b>MAGI</b>	Modified Adjusted Gross Income
<b>MCO</b>	Managed Care Organization
<b>MLR</b>	Medical Loss Ratio
<b>MPE</b>	Medicaid Presumptive Eligibility
<b>NCQA</b>	National Committee for Quality Assurance
<b>ONC</b>	Office of the National Coordinator for Health Information Technology
<b>P4P</b>	Pay-for-Performance
<b>PBM</b>	Pharmacy Benefit Manager
<b>PCCM</b>	Primary Care Case Management
<b>PCMH</b>	Patient-Centered Medical Home

<b>PCP</b>	Primary Care Provider
<b>PDL</b>	Preferred Drug List
<b>PMPM</b>	Per Member Per Month
<b>SLMB</b>	Specified Low-Income Medicare Beneficiary
<b>SMI</b>	Serious Mental Illness
<b>SPA</b>	State Plan Amendment
<b>SSI</b>	Supplemental Security Income
<b>UPL</b>	Upper Payment Limit
<b>VBP</b>	Value-Based Purchasing

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