

Commonly Used Terms:

A, B, C, D, E, F, G, H, I, J, K, L, M, N, O, P, Q, R, S, T, U, V, W, X, Y, Z

A

Affordable Care Act (ACA) – The health care reform law enacted in March 2010. The law was enacted in two parts: the Patient Protection and Affordable Care Act was signed into law on March 23, 2010 and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name —Affordable Care Act is used to refer to the final, amended version of the law.

Aged, Blind, Disabled (ABD) – A Medicaid designation that assists with medical expenses for poor individuals who are age 65 years or older, blind or disabled (disability as classified by the Social Security Administration for an adult or child)

Allowed Amount – Maximum amount on which payment is based for covered health care services. This may be called “eligible expense,” “payment allowance” or “negotiated rate.” If your provider participates with Kentucky Medicaid and/or your managed care organization, they agree to accept the allow amount as payment in full, minus any co-pays you must pay.

Appeal – The process you can utilize to have a decision heard by a third party when you don't agree with a Medicaid decision. With Medicaid, you must file an appeal stating why you think the denial of your coverage or a specific service is incorrect.

Attending physician – The physician providing specialized or general medical care to a member.

Auto assignment – Process that automatically assigns a member to a managed care organization (MCO) if the member does not select an MCO within the allotted 30 day time frame.

B

Behavioral health care – Assessment and treatment of mental and psychoactive substance abuse disorders. In Medicaid, many behavioral health services are covered. Medicaid plans typically covered psychiatric hospital visits, case management, day treatment, psychiatric evaluation and testing, individual, group and family therapy, inpatient detoxification.

Beneficiary—An individual who is eligible for and enrolled in the Medicaid program in the state in which he or she resides. They may also be referred to as a Medicaid recipient or member.

Benefit – Health care service that a Medicaid member receives for the treatment of illness, injury, or other conditions allowed by the State.

Benefit level – Limit or amount of services a person is able to receive based on that person's Medicaid coverage.

Billed amount – The amount of money requested for payment by a provider for a particular service rendered.

Cabinet – Cabinet means the Cabinet for Health and Family Services.

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

1. Ensure that each enrollee has an ongoing source of primary care appropriate to his or her needs, and a person or entity formally designated as primarily responsible for coordinating the health care services furnished to the enrollee.
2. Coordinate the services the managed care plan furnishes to the enrollee with the services the enrollee receives from any other managed care plan.
3. Share with other managed care plans serving the enrollee with special health care needs the results of its identification and assessment of that enrollee's needs to prevent duplication of those activities.
4. Ensure that in the process of coordinating care, each enrollee's privacy is protected. If the State requires managed care organizations to produce a treatment plan for enrollees with special health care needs who are determined through assessment to need a course of treatment or regular care monitoring, the treatment plan must be developed by the enrollee's primary care provider with enrollee participation, and in consultation with any specialists caring for the enrollee. For enrollees with special health care needs determined through an assessment by appropriate health care professionals to need a course of treatment or regular care monitoring, each managed care plan must have a mechanism in place to allow enrollees to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the enrollee's condition and identified needs.

Care Plan – Written documentation of decisions made in advance of care provided, based on a Comprehensive Assessment of a Member's needs, preference and abilities, regarding how services will be provided. This includes establishing objectives with the Member and determining the most appropriate types, timing and supplier(s) of services. This is an ongoing activity as long as care is provided.

Case manager – An experienced professional who works with Medicaid recipients and providers to coordinate all necessary services to provide the recipient with a plan of medically necessary and appropriate health care.

Case Management – A process where Medicaid, or the MCO, identifies covered individuals with specific health care 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.

Centers for Medicare and Medicaid Services (CMS) – The federal agency within the Department of Health and Human Services that directs the Medicare and Medicaid programs (Titles XVIII and XIX of the Social Security Act). www.cms.gov

Children's Health Insurance Program (CHIP) – Enacted in 1997, CHIP is a federal-state program that provides health care coverage for uninsured low-income children who are not eligible for Medicaid. States have the option of administering CHIP through their Medicaid programs or through a separate program (or a combination of both). The federal government matches state spending for CHIP but federal CHIP funds are capped.

Co-payment, co-pay —A fixed dollar amount paid by a Medicaid beneficiary at the time of receiving a covered service from a participating provider. Copayments may be imposed by state Medicaid programs only upon certain groups of beneficiaries, only with respect to certain services, and only in nominal amounts as specified in federal regulation.

Comprehensive outpatient rehabilitation facility (CORF) – A CORF is a nonresidential rehabilitation facility certified under Medicare Part A. Its purpose is to provide (under the supervision of an MD) diagnostic, therapeutic, and restorative services to outpatients for the rehabilitation of the injured, disabled, or sick.

Cost-sharing – Medicaid programs may impose cost-sharing on recipients for certain types of services. This cost-sharing could be through premiums, enrollment fees, or co-payments, thereby requiring the Medicaid recipient to share in the cost of their care. Cost-sharing can also be referred to as out-of-pocket costs. Cost-sharing may vary based on income levels. However, there are limits as to how much a state may require a Medicaid recipient to pay and the maximums are reviewed quarterly. Furthermore, some Medicaid recipients are exempt from any cost-sharing.

Covered service – Mandatory medical services required by CMS and optional medical services approved by the State that are paid for by Medicaid. Examples of covered services are prescription drug coverage and physician office visits.

D

Disease Management – A process of identifying and delivering within selected patient populations (e.g., patients with asthma or diabetes) the most efficient, effective combination of resources, interventions or pharmaceuticals for the treatment or prevention of a disease

Disenrollment – The process for which a Medicaid recipient may change their MCO.

Disenrollment with cause – Beyond the 90 day period that a recipient may disenroll from their MCO without cause, the recipient may disenroll anytime with cause. The following are some of the reasons for a disenrollment with cause:

- The recipient moves out of the MCOs service area.
- The plan, does not, because of moral or religious objections, cover the service the recipient seeks.
- The recipient needs services not available in the MCO network.

Disenrollment without cause – A recipient may disenroll without cause during the 90 days following the date of the recipient's initial enrollment with an MCO or at the annual open enrollment period.

Drug formulary – List of drugs covered by Medicaid, which includes the drug code, description, strength, and manufacturer.

Dual eligible – A person enrolled in Medicare and Medicaid at the same time, whether due to age or disability.

Durable Medical Equipment (DME) – Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

E

Earned Income – Earned income may include wages, tips, salaries, or net earnings from self-employment. It may also include other compensation received from performing work activity. Earned Income is often used in determining a person's eligibility for Medicaid and other social services available through the State.

Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT) - A comprehensive and preventive child health program for some Medicaid- or CHIP-enrolled individuals under the age of 21. EPSDT includes periodic screening, vision, dental and hearing services.

Eligible member – Person certified by the State as eligible for medical assistance.

Eligible providers – Person, organization, or institution approved by the State as eligible for participation in Medicaid.

Emergency Medical Condition – A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that one could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or death.

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

Excluded Services – Health care services that your Medicaid will not cover.

F

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

Family Planning Service – Any medically approved diagnosis, treatment, counseling, drugs, supplies, or devices prescribed or furnished by a physician to individuals of child-bearing age for purposes of enabling such individuals to determine the number and spacing of their children.

Federal Poverty Level (FPL) – Annually updated guidelines established by the U.S. Department of Health and Human Services to determine eligibility for various federal and state programs.

Federally-Qualified Health Center (FQHC) – A health center in a medically under-served area or population that is eligible to receive cost-based Medicare and Medicaid reimbursement and provides direct reimbursement to nurse practitioners, physician assistants and certified nurse midwives. FQHCs are sometimes referred to as CHCs (Community Health Centers).

Fee-for-Service – A traditional method of paying for medical services under which doctors and hospitals are paid for each service they provide. Bills are submitted by the provider to Medicaid for reimbursement. A

Kentucky Medicaid recipient that is not enrolled in a managed care organization would be a Fee-for-Service Medicaid recipient.

First Steps – Provides early intervention for families who have infants and toddlers (birth to age three) with developmental delays or who show signs of being at risk to have certain delays in the future. This program is administered by the Kentucky Department for Public Health.

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

Freedom of choice – A state must ensure that Medicaid beneficiaries are free to obtain services from any qualified provider. Exceptions are possible through waivers of Medicaid and special contract options. However, the provider must participate with Medicaid and/or the recipient’s managed care organization.

G

Generic drug – A chemically equivalent copy designed from a brand name whose patent has expired and is typically less expensive.

H

Habilitation Services – Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn’t walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance Portability & Accountability Act (HIPAA) – Passed by Congress in 1996, HIPAA includes various health insurance coverage and patient privacy protections. The privacy rules were established to protect patient’s privacy through the strict enforcement of confidentiality of medical records and other health information provided to health plans, doctors, hospitals and other health care providers.

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, home-delivered meals, transportation services, respite care, housekeeping, companion services, etc. These services are primarily designed to help older people and people with disabilities remain in their homes for as long as possible.

Hospice – A facility or program designed to care for patients in the terminal phase of an illness.

I

Income – In terms of eligibility, money that you earn through a job, self-employment (earned income), or money that is paid to you directly, such as SSI or SSDI (unearned income).

Intermediate care facility for individuals with intellectual disabilities (ICF/IID) – An ICF/IID provides residential care treatment for Medicaid-eligible individuals with intellectual disabilities.

J

K

Kentucky Children’s Health Insurance Program (KCHIP) – KCHIP is a health care program for children younger than 19 that do not have health insurance. Children in families with incomes less than 213% of the federal poverty level are eligible. For more information on KCHIP, please visit www.kidshealth.ky.gov.

L

Level-of-care (LOC) – Determinations that are rendered by OMPP staff for purposes of determining nursing home or institutional placement of an individual.

Lock-In Program – The Lock-In Program is designed to ensure appropriate use of prescription drugs, emergency room usage and physicians. States review claims data for inappropriate or excessive use of plan benefits, such as excessive emergency room usage, or utilizing multiple hospital emergency room, multiple prescriptions from different doctors, etc.

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.

Long-Term Care Facility (LTCF) – 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. Long-term care facilities include nursing homes, rehabilitation facilities, inpatient behavioral health facilities and long-term chronic care hospitals.

M

Managed care – System where the overall care of a patient is overseen by a single provider or organization. Many state Medicaid programs include managed care components as a method of ensuring quality health care to its members in a cost-efficient manner.

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

Mandated or required services – Services a state is required to offer to categorically needy clients under a state Medicaid plan. (Medically needy clients may be offered a more restrictive service package.) Mandated services include the following: hospital, nursing facility care (21 and over), home health care, family planning, physician, nurse midwives, dental (medical/surgical), rural health clinics, certain nurse practitioners, federally qualified health centers, renal dialysis services, and medical transportation.

Medicaid – A federally-aided, state-administered and jointly-funded health insurance program that provides medical benefits to qualified indigent or low-income persons in need of health and medical care. The program is subject to broad federal guidelines and states determine the benefits covered and methods of administration.

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

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

Medically needy – Individuals whose income and resources equal or exceed the levels for assistance established under a state or federal plan but are insufficient to meet their costs of health and medical services.

Medicare – A federally funded health insurance plan that provides hospital, surgical and medical benefits to elderly persons over 65 and certain disabled persons. Medicare Part A provides basic hospital insurance, and Medicare Part B provides benefits for physician’s professional services. Medicare Part C (Medicare Advantage Plan) allows those covered to combine their coverage under Parts A and B but is provided by private insurance companies. Medicare Part D helps pay for medications doctors prescribe for treatment.

Mental illness – A single severe mental disorder, or a combination of severe mental disorders, as defined in the most current edition of the American Psychiatric Association's DSM.

N

Network – The facilities, providers and suppliers your managed care organization has contracted with to provide health care services.

Nursing facility (NF) – Facility licensed by and approved by the State in which eligible individuals receive nursing care and appropriate rehabilitative and restorative services under the Title XIX (Medicaid) Long Term Care Program.

O

Optional services or benefits – More than 30 different services that a state can elect to cover under a state Medicaid plan. Examples include personal care, rehabilitative services, prescribed drugs, therapies, diagnostic services, ICF-IID, targeted case managed, and so forth.

Other insurance – Any health insurance benefit(s) that a patient might possess in addition to Medicaid or Medicare.

Outpatient services – Hospital services and supplies furnished in the hospital outpatient department or emergency room and billed by a hospital in connection with the care of a patient who is not a registered bed patient.

P

Participating Provider – means a doctor, hospital, lab, or any other medical provider that has signed a contract to accept Medicaid reimbursement on behalf of the Medicaid recipient. You must use a participating provider for your services or you will be responsible for the cost of care you receive. Also, if a doctor prescribes a medication for you, or orders any services, he/she must participate in Medicaid in order for the prescription drug to be covered. If you are a Medicaid recipient that has an MCO, your providers must participate with your MCO.

Per diem – Daily rate charged by institutional providers (i.e., hospitals).

Plan of care (POC) – A formal plan developed to address the specific needs of an individual. It links clients with needed services.

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 are contracted with each of our MCOs as well as for our Fee-for-Service recipients. The PBM handles the drug benefit for Medicaid.

Preauthorization – A decision by Medicaid or your MCO that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification. Medicaid may require preauthorization for certain services before you receive them, except in an emergency.

Preferred Drug List (PDL) – A list of prescription drugs which are covered by Medicaid - also known as a formulary.

Preferred Provider – A provider who has a contract with your MCO and/or Medicaid to provide services to you. See also Participating Provider.

Prescription medication – Drug approved by the FDA that can, under federal or state law, be dispensed only pursuant to a prescription order from a duly licensed physician.

Presumptive eligibility – Medicaid Presumptive Eligibility (MPE) is for pregnant women. Under MPE, pregnant women can get immediate outpatient services for a limited time. Eligibility is based on a medically verified pregnancy and the pregnant woman's statement of her family's gross monthly income. Only qualified providers can determine eligibility for the MPE program.

In accordance with federal requirements, only organizations that receive funding under one of the following programs can be a MPE provider.

- Federal community or migrant health programs (Section 329, 330 or 340 of the Public Health Service Act)
- Title V Maternal and Child Health Block Grant
- Title V of the Indian Health Improvement Act

- Title XIX (Medicaid) or Title XXI (SCHIP) for prenatal services
- The Indian Health Service or a health program

Preventive care – Comprehensive care emphasizing priorities for prevention, early detection and early treatment of conditions, generally including routine physical examination, immunization, and well person care.

Primary Care Provider (PCP) – A physician selected by or assigned to a patient who provides general care and supervises the patient’s access to other medical services.

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

Provider – A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), health care professional or health care facility licensed, certified or accredited as required by state law.

Q

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

R

Recipient identification number or member identification number (RID) – The unique number assigned to a member who is eligible for Medicaid services. This number can be found on the front of your Medicaid ID card.

Referring provider – Provider who refers a member to another provider for treatment service. The referring provider must be a Medicaid participating provider.

Resources – Relating to Medicaid eligibility, these are goods or items that have a monetary value. Resources can include a checking or savings account, cash on hand, and certain items that you own such as a vehicle or property.

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. 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.

S

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

“medically 173 needy”—individuals may qualify for Medicaid coverage even though their countable incomes are higher than the specified income standard by “spending down.” Under this process, the medical expenses that an individual incurs during a specified period are deducted from the individual’s income during that period. Once the individual’s income has been reduced to a state-specified level by subtracting incurred medical expenses, the individual qualifies for Medicaid benefits for the remainder of the period.

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

Supplementary Security Income (SSI) – A federal supplemental security program providing cash assistance to low-income aged, blind, and disabled persons.

T

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

Traditional Medicaid – In the beginning, Medicaid was a Fee-for-Service (FFS) program. This meant that the government paid providers, like doctors, clinics and hospitals, for each of the services they provided with Medicaid. In most states, Medicaid has been shifting to a managed-care system. In a managed-care Medicaid plan, the government pays a health plan a certain dollar amount for each Medicaid beneficiary enrolled, and in return, the plan managed the health care of the beneficiaries.

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

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

U

Unearned Income – Disability payments or other funds that an individual receives without any physical or mental work performed. Examples of unearned income may be Social Security Disability Insurance Benefits, income from a trust, investments, support payments, or funds received from any other source other than work.

V

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

W

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

Women, Infants, and Children Program (WIC) – A federal program administered by the Kentucky Department of Public Health that provides nutritional supplements to low-income pregnant or breast-feeding women and to infants and children younger than five years old.

X

Y

Z