

# Appendix 10: Glossary

## Glossary

- **Actuarial report** - As used in the toolkit, Medicaid managed care organizations must submit actuarial reports to the state Medicaid agency to demonstrate their financial solvency or soundness.
- **Authority** - It is important that the source of requirements (authority) for Medicaid (or other programs) eligibility, programs and services are identified and understood. Authority can be provided through federal or state laws or regulations. Some requirements cannot be changed, unless federal law is changed, while other requirements can be changed through state-level actions. Requirements that are at the state's discretion can usually be changed by amending state laws, regulations or rules, and may require CMS approval. Other requirements can be changed by the state requesting a waiver of program requirements from CMS (See Home and Community-Based Services Waiver and Medicaid Waiver below).
- **Centers for Medicare and Medicaid Services (CMS)** - The federal agency responsible for administering the Medicare and Medicaid programs and well as other health and human services-related programs and services. CMS was formerly known as the Health Care Financing Administration or HCFA. For the CMS home page, visit <http://www.cms.gov>.
- **Dual Eligibility** - This term is used to describe individuals who are eligible for both federal Medicare and their state's Medicaid program benefits and services. CMS has provided an overview that describes individuals who are considered to be "dual eligible" at <https://www.cms.gov/DualEligible>.
- **Home and Community-Based Services (HCBS) Waiver** - States may seek to try different approaches for providing programs and services, through the Medicaid program, that help individuals remain in their homes or in the community, rather than receiving care in an institutional setting. These non-institutional settings are known as "home and community-based services" or HCBS. In order for states to be able to provide HCBS, they may need to seek permission from CMS to "waive" Medicaid requirements. The Social Security Act [Section 1915(c)] authorizes multiple waiver and demonstration authorities to allow states flexibility in operating Medicaid programs. Each authority has a distinct purpose, and

distinct requirements. An overview of Medicaid waivers and a listing of current waivers granted to states can be found at [http://www.cms.gov/MedicaidStWaivProgDemoPGI/01\\_Overview.asp](http://www.cms.gov/MedicaidStWaivProgDemoPGI/01_Overview.asp).

- **Federal Medical Assistance Percentage (FMAP)** - The FMAP is the share of state Medicaid benefit costs paid for by the federal government. It is calculated based on a three-year average of state per capita personal income compared to the national average. Each state has its own FMAP. CMS publishes state FMAP each year. It is important to know your state's FMAP in order to estimate the state cost of any proposed change to Medicaid programs or services.
- **Federal Poverty Level (FPL)** - Federal Poverty Level Guidelines are established by the federal Health and Human Services Agency and are used for administrative purposes to determine eligibility for certain federally-funded programs. To find the federal poverty guidelines for each year, visit <http://aspe.hhs.gov/poverty/index.shtml>.
- **Katie Beckett Waiver** - The Katie Beckett provision is a statute—the Tax Equity and Fiscal Responsibility Act (TEFRA) 134—added to Medicaid in 1982. Katie Beckett is the name of the child whose parents petitioned the Federal government for her to receive Medicaid services at home instead of in a hospital, and whose plight led the Reagan Administration to urge Congress to enact the provision. TEFRA 134 gives states the option to cover non-institutionalized children with disabilities. Prior to enactment of this provision, if a child with disabilities lived at home, the parents' income and resources were automatically counted (deemed) as available for medical expenses. However, if the same child was institutionalized for 30 days or more, only the child's own income and resources were counted in the deeming calculation—substantially increasing the likelihood that a child could qualify for Medicaid. This sharp divergence in methods of counting income often forced families to institutionalize their children simply to get them medical care.

TEFRA 134 amended the Medicaid law to give states the option to waive the deeming of parental income and resources for children under 18 years old who were living at home but would otherwise be eligible for Medicaid-funded institutional care. Not counting parental income enables these children to receive Medicaid services at home or in other community settings. Many states use this option, which requires states to determine that (1) the child requires the level of care provided in an institution; (2) it is appropriate to provide care

outside the facility; and (3) the cost of care at home is no more than the cost of institutional care. In states that use this option, parents may choose either institutional or community care for their Medicaid eligible children. (Source: <http://www.hcbs.org/files/54/2668/primer.pdf>)

- **Life-limiting** - No realistic hope of cure; life-limiting conditions are those that are not curable and will end in premature death.
- **Life-threatening** - Cure may be possible; life-threatening conditions are those that carry a substantial potential of death in childhood, although treatment may succeed in curing the condition or substantially prolonging life.
- **Medicaid Hospice Benefit/Services** - A package of services provided for patients with a prognosis of 6 months or less (as certified by two physicians) should the disease follow its normal course) who agree to forgo curative treatment. Modeled on the Medicare benefit, services are paid on a per-diem basis and involve 4 levels of care: routine home care; continuous home care; general inpatient care (symptom management); and inpatient respite care. The benefit covers services provided by an interdisciplinary team (physician, nurse, nursing assistant/home health aide, spiritual counselor, bereavement coordinator, volunteers) as well as durable medical equipment, medications, and supplies related to the terminal diagnosis. While hospice is an optional benefit for adults under federal Medicaid requirements, the 1989 EPSDT amendments stipulate that children must have coverage for hospice services.
- **Medicaid Waiver** - In addition to the Home and Community-Based waivers previously described, state may seek other types of flexibility in how they administer their state Medicaid program. A description of the different types of Medicaid waivers are found in Appendix 4 of this Toolkit. A copy of the most recent state waivers approved by CMS can be found at [http://www.cms.gov/MedicaidStWaivProgDemoPGI/01\\_Overview.asp](http://www.cms.gov/MedicaidStWaivProgDemoPGI/01_Overview.asp).
- **Palliative Care Services** - Services designed to prevent, relieve, reduce, or soothe the suffering produced by serious medical conditions or their treatment, provided by an interdisciplinary team of specialists trained to address physical, emotional, spiritual and practical needs of patients and their families. Interdisciplinary teams may be made up of specialists in medicine, nursing, social work, grief and bereavement, spiritual care, expressive therapy, rehabilitation, child life, nutrition, mental health, case management and/or care coordination, body work, education, ethics and research.

- **Pediatric palliative care (PPC)** - An organized system of holistic care that improves the quality of life of children facing life-threatening conditions and their families, through the prevention and relief of suffering produced by a complex, chronic and/or life-threatening medical condition or its treatment. In addition to aggressive symptom control, PPC helps patients with such conditions and their families live as normally as possible by addressing physical/medical, emotional/psychological, social, practical, spiritual, cognitive/developmental, and educational/vocational domains of suffering while providing them with timely and accurate information and support in decision making. PPC is best provided concurrently with curative or life-prolonging care from time of diagnosis.
- **Supplemental Security Income (SSI)** - The Supplemental Security Income is an income supplement program funded by general tax revenues (not Social Security taxes). It is designed for persons who are aged, blind or have disabilities and who have little or no income with cash payments to help meet basic needs. For more information on eligibility for this program, visit <http://www.ssa.gov/ssi>.
- **State Medicaid Agency (Director)** - Each state must have an agency or department that is responsible for the administration of the state Medicaid program, in accordance with federal and state laws. This designated agency is called the “State Medicaid Agency” and the head of that agency is known as the “State Medicaid Agency Director.”
- **State Medicaid Director Letter** - CMS communicates changes, updates, guidance and clarifications in federal requirements for states to administer the state Medicaid program through several mechanisms. One of the more common methods is through the issuance of State Medicaid Director Letters or SMDLs. The link to SMDLs issued by CMS is <http://www.cms.gov/smdl>.
- **State Medicaid Plan** - Each state must have a State Plan that describes the eligibility criteria, and scope of benefits and services for the state’s Medicaid program. This State Plan must be approved by CMS. Most states post a copy of their State Plan on their state Medicaid agency’s website.
- **State Plan Amendment (SPA)** - Any time a state Medicaid agency wants to change the scope of services or benefits, or eligibility criteria for the state Medicaid program it must amend the state plan to reflect those changes. The state Medicaid program must submit proposed SPAs to CMS for approval. A listing of more recent SPAs approved can be found at <http://www.cms.gov/MedicaidGenInfo/StatePlan/list.asp>. Each state’s Medicaid agency may also post SPAs on their website.

- **Terminally Ill** - Terminal illness is defined in federal Medicare hospice regulations as, "Terminally ill means that the individual has a medical prognosis that his or her life expectancy is 6 months or less if the illness runs its normal course." (42 CFR 418.3) This definition is also used by state Medicaid programs. This definition is used to determine if an individual patient is eligible for hospice benefits and services. Some states may have a more flexible definition of terminal illness, if changed by their state plan amendment, waiver and/or state law. The text of this definition and the federal Medicare hospice conditions of participation are found at <http://ecfr.gpoaccess.gov/cgi/t/text/textidx?c=ecfr&sid=f9e5f47021625232afa96271958fb413&rqn=div8&view=text&node=42:3.0.1.1.5.1.3.3&idno=42>.