GLOSSARY

Adjusted Average Per Capita Cost (AAPCC)—Prior to the establishment of the M+C program beginning 1998, the basis of payment for Medicare-risk HMOs was the AAPCC, a yearly projection of program expenditures in FFS Medicare (i.e., beneficiaries not enrolled in HMOs). Medicare paid risk HMOs 95 percent of the AAPCC for each enrolled Medicare beneficiary, based on the beneficiary's county of residence, age, sex, Medicaid status, institutional status, and supplemental insurance status (refer to M+C).

Administration Costs—The costs incurred for marketing, enrollment, customer services, overhead, claims processing, and profits of for-profit entities.

Adults—Under Medicaid, parents or caretaker relatives of dependent children are eligible as adults based on one of several criteria: (1) they qualify as parents or caretaker relatives under section 1931 provisions, which relate to prior AFDC cash assistance standards (including unemployed parents), (2) they are medically needy, (3) they qualify under poverty-related eligibility criteria (including pregnant women), (4) they are eligible under a section 1115 demonstration, or (5) they qualify under other adult eligibility provisions. Adults who have been granted Medicaid eligibility under disability provisions are usually identified as disabled beneficiaries. Some persons under age 21, who are parents, or caretaker relatives of dependent children or who are pregnant, may be identified as adults. In some States, childless adults (non-disabled adults who are not parents or caretaker relatives of dependent children or pregnant women) may qualify for Medicaid as adults under section 1115 rules. By Federal law, all States have to extend Medicaid to pregnant women with income less than 133 percent of the FPL.

Aged—One of the categories used for classifying Medicare enrollees and Medicaid eligibles. Under Medicare, persons age 65 or over are included in this category if they are: entitled to monthly SSA benefits or payments from the RRB, uninsured for SSA or RRB benefits, but transitionally insured for Medicare, or not included in the previously mentioned groups, but based on meeting certain criteria, elect to purchase HI and/or SMI coverage by paying the appropriate monthly premium. Persons age 65 or over identified as having ESRD are included. Under Medicaid, persons age 65 or over are included if, in addition to initially being age 65 or over met certain means (income and resources) criteria or incur medical expenses for health care that when deducted from income qualifies the individual for Medicaid. Not all persons age 65 or over are included in this group. For example, persons initially enrolled and classified as disabled may remain so classified even when they reach age 65.

Aid to Families with Dependent Children (AFDC)—Cash assistance program which covered single-parent and two-parent families with an unemployed principal earner. All recipients of AFDC received Medicaid automatically. Each State set its own income limits for AFDC. The Personal Responsibility and Work Opportunities Reconciliation Act of 1996 (PRWORA) ended Federal entitlement for cash welfare benefits under AFDC. Thus, PRWORA severed the link between cash welfare benefits under AFDC and eligibility for Medicaid. Subject to specific

limitations, States must continue to offer Medicaid eligibility to former AFDC cash recipients under provisions outlined in section 1931. PRWORA established a new block grant program to States, called TANF. Under TANF, States may impose time limits on the receipt of welfare benefits and work requirements. There is no direct link between eligibility for TANF benefits and Medicaid (refer to PRWORA and TANF).

Allowed Charge—An individual charge determination (approved amount) made by a carrier on a covered Part B medical service or supply.

Ambulatory Surgical Center (ASC)—A facility that provides surgical services that do not require a hospital stay. Medicare pays an institutional fee for use of an ASC for certain approved surgical procedures. Medicare will also pay for physician and anesthesia services that are provided for these procedures.

Amount, Duration, and Scope—Criteria used to determine the Medicaid benefits and limitations in a State's Medicaid plan. Each State defines these parameters; therefore, State Medicaid plans vary in what is actually covered.

*Amount***—**The number of visits, prescriptions, treatments, etc. allowed for Medicaid reimbursement.

*Duration***—**The number of days in a hospital, nursing facility, or ICF covered for reimbursement.

*Scope***—**The package of mandatory and optional health care services covered by Medicaid for specific subgroups of Medicaid beneficiaries.

Assigned Claim—A claim for which the physician or supplier agrees to accept the amount approved by Medicare as the total payment. Medicare pays the physician or supplier 80 percent of the Medicare approved fee schedule (less any unmet deductible). The doctor or supplier can charge the beneficiary only for the coinsurance, which is the remaining 20 percent of the approved amount. A participating physician or supplier agrees to accept assignment on all claims.

Average Annual Rate of Change (AARC)—The constant annual percent of change which, when compounded over a period of years, gives the same result as a given set of annual percent changes over the same period. Also referred to as average annual rate of growth.

Balance Billing—A type of cost sharing under Medicare in which a beneficiary is responsible for the difference between the physician's submitted charge and the Medicare allowed charge on unassigned claims. Currently, a non-participating physician cannot charge a Medicare beneficiary more than 115 percent of the amount listed in the Medicare fee schedule for unassigned physician claims.

Basis of Eligibility—The programmatic authority under which a person receives Medicaid eligibility (e.g., adults, aged, blind, children, disabled, etc.).

Beneficiary—As used in this Supplement, a Medicare beneficiary is an enrollee who used a covered medical service during a specified period of time (e.g., CY), whether or not the service was reimbursable. The term is often used generically, however, to refer to a person who is enrolled in one or both parts of the Medicare program, whether actual services are used or not. Under Medicaid, a beneficiary is an enrollee who receives a Medicaid-covered service or (beginning 1998) has a managed care or private health insurance premium paid on his/her behalf (an alternate reference to recipient).

Beneficiary Identification Code (BIC)—The code that identifies the relationship between an individual and a primary Social Security or RRB beneficiary.

Benefit Package—Services an insurer, government agency, or health plan offers to a group or individuals, subject to premiums, cost sharing, and other requirements or limitations.

Benefit Payments—Benefit payments under Medicare comprise all withdrawals from the HI and SMI trust funds to directly pay providers for services rendered for covered services to Medicare enrollees under the FFS payment system and monthly premiums to managed care and other M+C organizations under capitated payment systems. Under FFS, payments recorded on bills (referred to as program payments) and payments made independently of the billing system (e.g., lump-sum adjustments to interim rates and end-of-year adjustments from cost settlements) are included. Estimates of benefit payments by Federal FY or CY are prepared by the CMS' Office of the Actuary both on a paid and on an incurred basis.

Benefit Period—The unit of time for measuring the use of Part A benefits (spell of illness). A benefit period begins the first day an enrollee is furnished inpatient hospital or extended care services by a qualified provider, and it ends when the enrollee has not been an inpatient of a hospital or other facility primarily providing skilled nursing or rehabilitation services for 60 consecutive days. There is no limit to the number of benefit periods an enrollee can have. The enrollee must pay the hospital insurance deductible for each new benefit period.

Buy-In—A Medicare beneficiary who is also eligible for Medicaid, and for whom Medicare Part B premiums and/or Part A premiums are paid by a State Medicaid program (refer to dual eligible, dual entitlement, MN, QMB, QDWI, and SLMB).

Calendar Year (CY)—The 12-month period running from January 1-December 31 that is used for establishing the payment of the voluntary Part A and the Part B premiums, deductibles, and coinsurance requirements. It is used as the basis for tabulating the Medicare program utilization and cost sharing, program payments, and PHCE.

Capitation—A prospective payment method that pays the provider of service a uniform amount for each person served, usually on a monthly basis; rather than on a per service basis. Capitation is used in managed care alternatives such as comprehensive plans (e.g., HMOs) or partial plans (e.g., PHPs).

Carrier—An organization that has contracted with DHHS to process and pay approved physician and supplier claims, and perform other services under Medicare Part B (SMI) program.

Case Management—A process whereby covered persons with specific health care needs are identified and a plan that efficiently utilizes health care resources is formulated and implemented to achieve the optimum outcome in the most cost-effective manner (refer to PCCM).

Center for Beneficiary Choices (CBC)—This CMS component serves as the focal point for all Agency interactions with beneficiaries, their families, caregivers, health care providers, and others operating on their behalf concerning improving beneficiary ability to make informed decisions about their health and program benefits. These activities include strategic and implementation planning, execution, assessment, and communications. CBC is also responsible for Medicare contractor management, including leading the development of a long-term contractor strategy to ensure that future Medicare program contracts align with the mission and needs of the agency.

Centers for Medicare & Medicaid Services (CMS)—The Federal Agency within DHHS that runs Medicare. In addition, CMS works with the States to run the Medicaid and SCHIP programs. CMS works to make sure that the beneficiaries in these programs are able to get high-quality health care.

Center for Medicaid and State Operations (CMSO)—This CMS component focuses on programs administered by States. This includes Medicaid and SCHIP, insurance regulation functions, survey and certification, and the Clinical Laboratory Improvements Act (CLIA) program.

Center for Medicare Management (CMM)—This CMS component is responsible for management of the traditional Medicare FFS program. This includes development of payment policy and management of the Medicare FFS contractors.

Children—Under Medicaid, children are eligible based on one of several criteria: (1) they are dependent children who qualify under section 1931 provisions, which relate to prior AFDC cash assistance standards (including children of unemployed parents), (2) they are medically needy, (3) they qualify under poverty-related eligibility criteria, (4) they are foster care or adoptive children, (5) they are eligible under a section 1115 demonstration, or (6) they qualify under other child eligibility provisions. States may elect to define the age cutoff for children at 19, 20, or 21 years. Children who have been granted Medicaid eligibility under disability provisions are usually identified as disabled beneficiaries. Some persons under age 21, who are pregnant, or who are parents or caretaker relatives of dependent children, may be identified as adults. By Federal law, all States have to extend Medicaid to children under age 6 with family income less than 133 percent of the FPL and to children under age 19 with family income less than 100 percent of the FPL.

Claim—A request to a carrier, intermediary, a State by a beneficiary, or by a provider acting on behalf of a beneficiary for payment of benefits under Medicare or Medicaid.

CMS-64 (Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program; formerly the HCFA-64)—A quarterly report of each state's Medicaid expenditures for which states are entitled to Federal matching payments. It includes categories of expenditures not reported in the Medicaid Statistical Information System (the source of person-level eligibility and utilization information), such as disproportionate share hospital payments, drug rebates, and (prior to 1998) managed care and certain other premiums.

Coinsurance—The portion of reimbursable hospital and medical expenses, after subtraction of any deductible, that Medicare does not cover and for which the beneficiary is responsible; or, for which Medicaid may pay in the case of certain dually entitled beneficiaries. Under Part A HI, there is no coinsurance for the first 60 days of inpatient hospital care; from the 61st-90th day of inpatient care, the daily coinsurance amount is equal to one-fourth of the inpatient hospital deductible. For each of the 60 lifetime reserve days used, the daily coinsurance amount is equal to one-half of the inpatient hospital deductible. There is no coinsurance for the first 20 days of SNF care; from the 21st-100th day of SNF care, the daily coinsurance amount is equal to one-eighth of the inpatient hospital deductible. Under Part B SMI, after the annual deductible has been met, Medicare pays 80 percent of reasonable charges for covered services and supplies; the remaining 20 percent of reasonable charges are the coinsurance payable by the enrollee. However, there is no coinsurance for home health services or for clinical laboratory services under SMI.

Comparability—Under the Medicaid program, the State must ensure that the same Medicaid benefits are available to all people who are eligible. Exceptions include benefits approved under Medicaid waiver or demonstration programs for special subpopulations of Medicaid eligibles.

Competitive Medical Plan (CMP)—Legislation in the 1982 TEFRA created this type of MCO to facilitate the enrollment of Medicare beneficiaries into MCPs. CMPs are organized and financed similar to HMOs. The difference is that CMPs are not tied by all the regulatory requirements of HMOs.

Coordinated Care Plan (CCP)—A plan that includes a CMS-approved network of providers that are under contract or arrangement with the M+C organization to deliver the benefit package approved by CMS. CCPs include plans offered by HMOs, PSOs, PPOs, as well as other types of network plans (except network MSA plans).

Cost-Based HMO—A MCO paid by Medicare for the actual cost of providing care to Medicare enrollees. The term includes cost HMOs, cost CMPs, and HCPPs.

Cost Sharing—The generic term that includes copayments, coinsurance, deductibles, and out-of-pocket payments for balanced billing on unassigned claims. Excludes monthly premiums for SMI coverage, voluntary HI coverage, and supplemental insurance.

Copayments—A specified dollar amount, typically modest, that insured persons must pay for a particular unit of service, such as an office visit, emergency room visit, or the filling of a prescription.

Coinsurance—A percentage share of medical bills which a beneficiary must pay.

Deductibles—Specified amounts of spending which an individual or a family must incur before insurance begins to make payments.

Covered Charges—Services or benefits for which a health plan makes either partial or full payment (refer to total charges).

Covered Day of Care—A day of care which was covered in full or in part by HI Medicare benefits. This excludes days of care prior to the start of the program on July 1, 1966, days of care prior to the person's entitlement to HI benefits, and days of care after exhaustion of benefits (refer to total days of care).

Covered Services—Services and supplies for which Medicare, Medicaid, or SCHIP will reimburse. (Examples of covered services are given in this glossary under specific headings, such as SNF.)

Current Procedural Terminology (CPT) Codes—A medical code set used for reporting medical services and procedures performed by physicians or other qualified providers. CPT codes, descriptions, and other data only are copyright 2001 American Medical Association. All Rights Reserved (or such other date of publication of CPT). CPT is a trademark of the American Medical Association (AMA).

Deductible—The amounts paid by enrollees or by a third party for covered services before Medicare or Medicaid makes reimbursements. The Medicare HI deductible applies to each new benefit period, is determined each year by a formula specified by law, and approximates the current cost of a 1-day inpatient hospital stay. The Medicare SMI deductible is, by law, the first $100 of covered charges per CY, effective January 1, 1991.

Deficit Reduction Act of 1984 (DEFRA)—Required States to provide Medicaid coverage to the following groups meeting AFDC income and resources requirements: (1) first-time pregnant women who would be eligible for AFDC if the child were born; (2) pregnant women in two-parent families with an unemployed principal breadwinner; and (3) children born after September 30, 1983, up to age 5, in two-parent families. Extends one year of automatic Medicaid eligibility (e.g., without separate application) to infants born to women who were eligible for and receiving Medicaid at the time of the child's birth. Child remains eligible so long as the mother remains eligible.

Department of Health and Human Services (DHHS)—Administers many of the social programs of the Federal Government dealing with the health and welfare of the citizens of the U.S.

Diagnosis Related Groups (DRGs)—A patient classification system that categorizes patients into groups that are clinically coherent and homogeneous with respect to inpatient SSH resource

use. The Medicare PPS uses approximately 500 DRGs as the basis for paying participating SSHs under Medicare.

Disabled—One of the categories used for classifying Medicare enrollees and Medicaid eligibles. Under Medicare, disabled under age 65 receiving Social Security or RRB disability insurance benefits for 24 months are eligible for coverage. Individuals under age 65 who are diagnosed with ESRD are also eligible to receive Medicare benefits and are included with the disabled unless otherwise noted. Under Medicaid, refers to low-income individuals of any age who are eligible as persons meeting SSA's programmatic definition of disability. This includes individuals receiving SSI as well as those whose incomes are too high for SSI, but qualify under separate Medicaid income standards.

Discharge—A formal release from a hospital (under Medicare or Medicaid), a SNF (under Medicare), or a NF (under Medicaid). Discharges include persons who died during their stay or were transferred to another facility.

Disproportionate Share Hospitals (DSHs)—Hospitals that serve a disproportionately large volume of low-income persons. Hospitals that meet DSH criteria may receive supplemental payments from Medicare and Medicaid.

Dual Eligible—A person having entitlement to more than one program or plan. The term is sometimes limited to an individual who is eligible both for Medicare and Medicaid coverage, depending on the services and limitations placed by the State, as well as payment of Medicare monthly premium, deductibles, and coinsurance. More broadly used to include Medicare beneficiaries eligible for some or all of the Medicare cost sharing, but not full Medicaid benefits (refer to buy-in, dual entitlement, MN, QMB, QDWI, and SLMB).

Dual Entitlement—Indicates that an individual is entitled to both Medicare and some or all Medicaid coverage (refer to buy-in, dual eligible, MN, QMB, QDWI, and SLMB).

Durable Medical Equipment (DME)—Under Medicare, Medicaid, and SCHIP DME includes certain medical supplies and such items as hospital beds, wheelchairs, assistive devices, and oxygen, etc., used in a patient's home.

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)—A screening and diagnostic and treatment program under Medicaid with the specific focus toward recipients under age 21, which reviews any physical or mental problems and the associated medical requirements to address these problems.

Eligibility—Meeting the requirements for coverage under Medicare, Medicaid, or SCHIP. In Medicaid data, the term eligible is often used to refer to individuals who qualify and have actually enrolled in the program.

End Stage Renal Disease (ESRD)—Irreversible kidney failure. To survive, the patient must either receive a kidney transplant or periodic kidney dialysis. Individuals with ESRD are eligible for Medicare benefits under a special entitlement.

Enrollee—A person who is eligible for coverage and is enrolled in the Medicare, Medicaid, or SCHIP programs.

ESRD Enrollees—Individuals who have chronic kidney disease requiring renal dialysis or a kidney transplant are considered to have ESRD. To qualify for Medicare coverage, such individuals must be fully or currently insured under Social Security or the Railroad Retirement System or be the dependent of an insured person. Eligibility for Medicare coverage begins the third month after the month in which a course of renal dialysis begins; coverage may begin sooner if the patient participates in a self-care dialysis training program provided by an approved facility. Also, coverage may begin on admittance to a hospital to receive a kidney transplant or to receive dialysis before the transplant.

Federal HI Trust Fund—A trust fund of the U.S. Treasury in which monies collected from taxes on annual earnings of employees, employers, and self-employed persons covered by Social Security are deposited. Disbursements from the fund are made to help pay for benefit payments and administrative expenses incurred by the HI program.

Federal Medical Assistance Percentage (FMAP)—The percentage of Medicaid benefit payments reimbursed by the Federal Government. FMAP is calculated annually based on a formula designed to provide a higher Federal matching rate to States with lower per capita income and by law may range from a minimum of 50 percent and to a maximum of 83 percent.

Federal SMI Trust Fund—A trust fund of the Treasury of the United States consisting of amounts deposited in or appropriated to the fund as provided by Title XVIII of the Social Security Act, including premiums paid by enrollees under SMI and contributions by the Federal Government from general revenues. Disbursements from the fund are made for benefit payments and administrative expenses incurred by the SMI program.

Federally Qualified Health Center (FQHC)—Health centers that have been approved by the Federal Government for a program to give low cost health care. Medicare pays for some health services in FQHCs that are not usually covered, like preventive care. FQHCs include community health centers, tribal health clinics, migrant health services, and health centers for the homeless. Typically, Medicaid provides higher payment rates for outpatient facilities designated as FQHCs compared to facilities not so designated.

Federally-Qualified HMO—An HMO which meets Federal requirements for certification as a prepaid health plan that is able to offer a comprehensive range of services through a specified network of providers.

Federal Poverty Level (FPL)—Low-income guidelines established annually by the Federal Government. Public assistance programs, including Medicaid and SCHIP, often define income limits in relation to FPL.

Fee-for-Service (FFS) Reimbursement—The traditional health care payment system, under which physicians and other providers receive a payment for each unit of service they provide.

Fiscal Year (FY)—The 12-month period under which the Federal Government operates. Until 1976, the FY extended from July 1 of each year-June 30 of the following year. Beginning in 1976, the FY was changed to October 1-September 30. (The 3-month period July-September 1976—the so-called transition quarter—does not belong to any FY.) FY's are labeled by the year in which they end, e.g., October 1, 2000-September 30, 2001 is called FY 2001.

Freedom of Choice—Under Medicaid, the principle that 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.

General Hospital—A hospital maintained primarily for short-term inpatient care of acute illness or injury and for obstetrics.

Geographic Classifications:
*All Areas—*The United States, Guam, Puerto Rico, Virgin Islands, other outlying areas, and foreign countries are included.

*All Other Areas—*American Samoa, Canton Island, Caroline Islands, Guam, Puerto Rico, Mariana Islands, Marshall Islands, Midway Islands, Virgin Islands, and Wake Islands comprise this category.

*Place of Residence—*The beneficiary's place of residence classification is a mailing address, not necessarily an actual place of residence. Some beneficiaries have their checks mailed to a post office or to a representative payee in a State or county that may differ from their own residence.

*Metropolitan Areas (MAs)—*The general concept of a MA is one of a core area containing a large population nucleus, together with adjacent communities that have a high degree of social and economic integration with that core. Metropolitan Statistical Areas (MSAs), Consolidated Metropolitan Statistical Areas (CMSAs), and Primary Metropolitan Statistical Areas (PMSAs) are defined by the Office of Management and Budget (OMB) as a standard for Federal agencies in the preparation and publication of statistics relating to metropolitan areas. The entire territory of the United States is classified as metropolitan (inside MSAs or CMSAs) (PMSAs are components of CMSAs) or non-metropolitan (outside MSAs or CMSAs). MSAs, CMSAs, and PMSAs are defined in terms of entire counties except in New England, where the definitions are in terms of cities and towns. OMB also defines New England County Metropolitan Areas (NECMAs) which are county-based alternatives to the MSAs and CMSAs in the six New England States. Over time, new MAs are created and the boundaries of others change. The analysis of historical trends, therefore, must be made cautiously (refer to urban and rural).

*Urban and Rural—*The urban population comprises all persons living in (a) places of 2,500 or more inhabitants incorporated as cities, villages, boroughs (except in Alaska and New York), and towns (except in the New England States, New York, and Wisconsin), but excluding those

persons living in the rural portions of extended cities (places with low population density in one or more large parts of their area); (b) census designated places (previously termed unincorporated) of 2,500 or more inhabitants; and (c) other territory, incorporated or unincorporated, included in urbanized areas. An urbanized area comprises one or more places and the adjacent densely settled surrounding territory that together have a minimum population of 50,000 persons. In all definitions, the population not classified as urban constitutes the rural population.

HCFA-2082 (Statistical Report on Medical Care: Eligibles, Recipients, Payments, and Services)—An annual statistical report designed to collect State-reported data on Medicaid eligibles, beneficiaries, and expenditures by basis of eligibility, maintenance assistance status, type of service and characteristics of the beneficiary. The reporting system continued through FY 1998 and was replaced in 1999 by tables produced from the Medicaid Statistical Information System (MSIS). The HCFA-2082 differed from the HCFA-64 (now the CMS-64) in that not all actual expenditures are reported, the biggest differences being the absence of disproportionate share hospital payments, drug rebates, and prior to 1998 managed care and certain other premiums. Internal to the report itself, certain lump-sum, aggregate payments could not be associated with individual Medicaid beneficiaries, and their characteristics, which is the basis of reporting in the HCFA-2082 and from MSIS.

Healthcare Common Procedure Coding System (HCPCS)—A Medicare coding system for all services performed by a physician or supplier. It is based on the American Medical Association physicians' CPT codes and is augmented with codes for physician and non-physician services and supplies (such as ambulance and DME) which are not included in CPTs. State Medicaid agencies, with local modifications, use this system as a basis for reimbursement for ambulatory services.

Health Care Financing Review (HCFR)—The *Health Care Financing Review* is published quarterly by CMS' Office of Research, Development, and Information. The *Review* seeks to contribute to an improved understanding of the Medicare and Medicaid Programs and the U.S. health care system by presenting information and analyses on a broad range of health care financing and delivery issues. The *Review* highlights the results of policy-relevant research and provides a forum for a broad range of diverse viewpoints to stimulate discussions among a diverse audience that includes policymakers, planners, administrators, insurers, researchers, and health care providers.

Health Care Prepayment Plan (HCPP)—A MCO that contracts with CMS to enroll Medicare beneficiaries for coverage of some or all Medicare-covered physician and supplier services (Part B). HCPPs are paid on a reasonable-cost basis.

Health Insurance Claim Number (HICN)—A unique identifier of each Medicare beneficiary. It consists of a Social Security or RRB account number plus a BIC.

Health Insurance Flexibility and Accountability (HIFA)—Demonstration initiative which encourages new comprehensive State approaches that will increase the number of individuals with health insurance coverage within current-level Medicaid and SCHIP resources. Emphasis is

on broad statewide approaches that maximize private health insurance coverage options and target Medicaid and SCHIP resources to populations with income below 200 percent of the FPL.

Health Maintenance Organization (HMO)—An organization that manages and delivers a comprehensive package of health services under a risk-based arrangement. The HMO usually receives a monthly premium or capitation payment for each enrollee. The dollar amount is based on a projection of what the typical patient will cost. If enrollees cost more, the HMO may suffer loses. If the enrollees cost less, the HMO profits, thus providing incentive for cost control (refer to managed care).

Home and Community-Based Services (HCBS) Waiver—An enabling Section, 1915(c), in the Social Security Act that authorizes the Secretary of HHS to alter a State Medicaid program. This waiver offers special services to beneficiaries who are at risk of being placed in a nursing facility or facility for the mentally retarded. HCBS include case management, homemaker/home health aide services, personal case services, adult day health services, rehabilitation services, and respite care.

Home and Community Care for the Functionally Disabled Elderly—An optional Medicaid State plan benefit which allows States to provide home and community-based services to functionally disabled elderly individuals.

Home Health Agency (HHA)—A public or private organization that provides skilled nursing services and other therapeutic services in the patient's home and that meets certain conditions to ensure the health and safety of the individual.

Home Health Services—Services furnished in a patient's home under the care of physicians. These services are furnished under an established plan and periodically reviewed by a physician. They include part-time or intermittent skilled nursing care; physical, occupational, or speech therapy; medical social services; medical supplies and appliances (other than drugs and biological); home health aide services; and services of interns and residents.

Hospice—A public agency or private organization that is primarily engaged in providing pain relief, symptom management, and supportive services to patients that are certified to be terminally ill. Medicare beneficiaries may elect to receive hospice care instead of standard Medicare benefits for terminal illnesses. Under Medicaid, beneficiaries electing hospice no longer receive Medicaid covered therapeutic services.

Hospital Insurance (HI)—Medicare HI (also known as Medicare Part A) is an insurance program providing basic protection against the costs of hospital and related post-hospital services for individuals who are age 65 or over and are eligible for retirement benefits under the Social Security or the RRB system, for individuals under age 65 who have been entitled for at least 24 months to disability benefits under the Social Security or RRB system, and for certain other individuals who are medically determined to have ESRD and are covered by the Social Security or RRB system.

Hospital Insurance (Part A)—The part of Medicare that pays for inpatient hospital stays, care in a SNF, hospice care, and some home health care.

Independence Plus—An initiative which expedites the ability of States to offer many Medicaid program participants greater opportunities to take charge of their own health and direct their own services through a self-directed option. Families and individuals exercise greater choice, control, and responsibility for their services within cost neutral standards. Statutory authority for this initiative is found at §1115 and §1915(c) of the Social Security Act. Independence Plus allows eligible families and individuals to use a cash allowance or individual budget to obtain personal assistant services and related supports. In the 1115 demonstration, the participant may or may not manage the cash directly. In the 1915(c) waiver, the participant uses fiscal/employer agent and does not manage cash directly.

Inpatient Hospital Services—Items and services furnished to an inpatient of a hospital by the hospital, including room and board, nursing and related services, diagnostic and therapeutic services, and medical or surgical services.

Institutional Services—For Medicare, includes those services provided by hospitals (outpatient and inpatient), HHAs, hospices, comprehensive outpatient rehabilitation facilities, ESRD facilities, local health clinics, and SNFs. For Medicaid, also includes NFs and ICFs/MR.

Intermediary—An organization selected by providers of health care that has an agreement with DHHS to process and pay institutional claims and perform other functions under Medicare's health insurance program.

Intermediate Care Facilities for the Mentally Retarded (ICF/MR)—Optional Medicaid service that provides residential care and services for individuals with mental retardation.

***International Classification of Diseases - 9th Revision, Clinical Modification* (ICD-9-CM)—**A diagnosis and procedure classification system. ICD-9-CM codes are the basis for grouping patients into DRGs.

Laboratory and Radiological Services—Professional and technical laboratory and radiological services which may be ordered and provided by or under the direction of a physician or other licensed practitioner, or ordered by a physician and provided by a referral laboratory. These services must meet requirements of the Clinical Laboratory Improvement Amendment of 1988.

Lifetime Reserve—A Medicare HI enrollee has a non-renewable lifetime reserve of 60 days of inpatient hospital care to draw on if the 90 covered days per benefit period are exhausted. Patients are required to pay a daily coinsurance amount equal to one-half of the inpatient hospital deductible for each lifetime reserve day.

Managed Care—A system in which 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 in a cost-efficient manner.

Managed Care Organization (MCO)—Entities that serve Medicare or Medicaid beneficiaries on a risk basis through a network of employed or affiliated providers. These include entities such as HMOs, PPOs, and point of service plans. In the Medicaid world, other organizations may set up programs to provide Medicaid managed care. These organizations include FQHCs, integrated delivery systems, and public health clinics.

Managed Care Plan (MCP)—A general term applied to a wide range of insurance plans, including HMOs, where choice of providers is limited and administrative measures control utilization of services. The types of Medicare and Medicaid MCPs include HMOs, CMPs, and HCPPs.

Mandatory versus Optional Services—Mandatory services are a specific set of services that must be covered by any State participating in the Medicaid Program (unless waived under section 1115 of the Social Security Act) as opposed to those which a State may elect to include under its Medicaid plan or waivers.

Medicaid—The joint Federal/State entitlement program, enacted in 1965 as Title XIX of the Social Security Act, that pays for medical care on behalf of certain groups of low-income persons.

Medicaid Drug Rebate Program—Created by the Omnibus Budget Reconciliation Act of 1990 (OBRA1990), the Medicaid Drug Rebate Program requires a drug manufacturer to enter into and have in effect a national rebate agreement with the Secretary of the Department of Health and Human Services for States to receive Federal funding for outpatient drugs dispensed to Medicaid patients. The drug rebate program is administered by the CMS' CMSO.

Medicaid Statistical Information System (MSIS)—As a result of legislation enacted from the Balanced Budget Act of 1997, States are required to submit all their eligibility and claims data on a quarterly basis, beginning in FY 1999, through the MSIS. MSIS is the basic source of State-reported eligibility and claims data on the Medicaid population, their characteristics, utilization, and payments. This system replaced the HCFA-2082.

Medical Savings Account (MSA)—A plan for the purpose of paying the qualified expenses of the account holder from a custodial account or trust.

Medically Needy (MN) Eligibles—An optional Medicaid eligibility group consisting of individuals who qualify under an income standard—the MN income level—that is separate from the standards used for categorically needy coverage. MN enrollees must meet Medicaid's categorical requirements (aged, disabled, adults with children, children) and may meet the MN income level by incurring high medical expenses—usually from hospital or nursing home care—which are deducted from their incomes in the process known as "spend-down".

Medicare Advantage (MA)—The Medicare health plan program established by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), which replaced the Medicare+Choice program (refer to M+C). MA options for beneficiaries can include CCPs (local HMOs, PPO plans, private FFS plans, and MSA plans, as well as regional PPO plans). In

addition to introducing the regional PPO option, the MMA also introduced special needs plans (SNPs). While other MA plans are required to permit enrollment by any eligible beneficiary residing in the plan's service area, SNPs may limit their enrollment to certain categories of individuals, such as dual-eligible beneficiaries (those eligible for Medicare and Medicaid) or people with special health care needs (such as those with chronic illnesses, or those with ESRD). The MMA continued the M+C requirement that in order to enroll, a beneficiary must be entitled to Part A and enrolled in Part B. The prohibition on enrollment for beneficiaries with ESRD continues in MA except in the case of ESRD special needs plans. The MMA also made changes to the payment rules for plans by introducing a bidding system and a requirement that plans return to the government 25 percent of the savings that they can achieve in providing Medicare A and B services (in relation to a benchmark payment level).

Medicare Catastrophic Coverage Act (MCCA)—An amendment to Title XVIII of the Social Security Act designed to provide protection against catastrophic medical expenses and for other purposes. Many of its provisions were rescinded after being in effect for only CY 1989.

Medicare Current Beneficiary Survey (MCBS)—Survey in which a sample of Medicare beneficiaries is interviewed to collect information on demographic characteristics, health status and functioning, insurance coverage, financial resources, and family supports. The beneficiaries are interviewed again periodically to form a continuous profile of their health care experience.

Medicare+Choice (M+C)—A Medicare Program established by the Balanced Budget Act of 1997 that is designed to provide Medicare enrollees more choices among health plans. Beneficiaries entitled to Part A and enrolled in Part B are eligible to enroll in an M+C plan (except those beneficiaries who already have ESRD). M+C also modified the methodology used to determine capitation payments to covered plans (refer to AAPCC).

Medicare Supplemental Insurance (MSI) or Medigap—Private insurance which supplements Medicare by paying Medicare deductibles and coinsurance. There are 10 nationally standardized policies. Some policies offer coverage not provided by Medicare, such as coverage for outpatient prescription drugs and care outside the U.S.

Midpoint Enrollment—Enrollment as of July 1 has been chosen as the denominator for Medicare utilization rates. The choice was based on the similarity of the July 1 enrollment to a 12-month average enrollment.

National Center for Health Statistics (NCHS)—The component of the U.S. Public Health Service which collects and maintains national and subpopulation statistics on various aspects of public health.

Non-Institutionalized—Individuals not living in facilities such as nursing homes.

Nursing Facility (NF)—A facility licensed by the State and certified by Federal statute and regulations that a NF meets applicable requirements, services are provided to beneficiaries age 21 or over.

Office of Clinical Standards and Quality (OCSQ)—This CMS component serves as the focal point for all quality, clinical, and medical science issues and policies for the Agency's programs. OCSQ has overall responsibility for the End Stage Renal Disease (ESRD) Network, and for the quality improvement organizations, formerly the peer review organization program.

Office of Financial Management (OFM)—This CMS component has overall responsibility for the fiscal integrity of CMS' programs.

Office of Information Services (OIS)—This CMS component is the organizational home to the CMS Chief Information Officer and the maintainer of the CMS data infrastructure. OIS provides connectivity, data maintenance, data dissemination, and technical assistance to the internal and external CMS.

Office of Research, Development, and Information (ORDI)—This CMS component provides the Agency with analytic support and information. ORDI is responsible for environmental scanning activities, designing and conducting research and evaluations of health care programs, designing and assessing potential improvements, and developing new measurement tools. ORDI coordinates all Agency demonstration activities, and develops research, demonstration, and other publications and papers related to health care issues.

Office of the Actuary (OACT)—This CMS component provides actuarial, economic and statistical services to various CMS components, other Federal agencies, the Medicare Board of Trustees, Congress, national advisory commissions, health research groups, and outside organizations.

Omnibus Budget Reconciliation Act (OBRA)—Federal law of a given year which directs how Federal monies are to be expended. Amendments to Medicaid eligibility and benefit rules are frequently made in such acts. Legislative changes may also be enacted directly (refer to TEFRA, DEFRA, MCCA).

Optional versus Mandatory Services—Optional services are those services which a State elects to include under its plan or managed care waivers as opposed to those which are required.

Outpatient Hospital Services—Services furnished to outpatients by a participating hospital for diagnosis or treatment of an illness or injury.

Outpatient Services—Medical and other services provided by a hospital or other qualified facility or supplier, such as mental health clinic, rural health clinic, X-ray mobile unit, or freestanding dialysis unit. Such services include: outpatient physical therapy, diagnostic X-ray and laboratory tests, and X-ray and other radiation therapy.

Participating Physician or Supplier—A physician/supplier that agrees to accept assignment on all Medicare claims under the Medicare SMI program. In Medicaid, participating providers agree to accept Medicaid reimbursement as payment in full.

Personal Health Care Expenditures (PHCE)—Health care goods and services purchased directly by or for individuals. They exclude: public program administration costs, the net cost of private health insurance, research by non-profit groups and government entities, and the value of new construction put in place for hospitals and nursing homes.

Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996— Created the TANF program to replace the earlier AFDC program (refer to AFDC and TANF).

Persons Served—A concept used for measuring utilization of covered services and program payments for these services. In general, under Medicare, a person served is considered to be a Medicare enrollee who used a covered health care or medical service under fee-for-service and incurred expenses greater than the deductible amount, resulting in the program making a payment on the enrollee's behalf. (When the term person served is used to describe a person who used a covered service regardless of having met the deductible, it will be indicated by the footnotes.)

Under Medicaid, a person served is considered to be a person for whom some sort of payment has been made for selected categories of service or coverage within the categories reported in the applicable Medicaid statistical reporting systems. Under the HCFA-2082 reporting system, person served generally referred to persons for whom Medicaid made a payment to a provider under fee-for-service. The concept was expanded in the Medicaid Statistical Information System to include persons for whom managed care capitated premiums and certain private health insurance premiums were made. Under Medicaid a person served is variously referred to as a Medicaid recipient or beneficiary. (Note: For utilization reporting, the payment of the Medicare Part B premium alone for a Medicare/Medicaid dual eligible beneficiary has never been construed as qualifying the person to be considered a person served.)

For both programs, persons are counted once for each type of covered service used, regardless of the number of services used. That is, a person receiving the same service two or more times in a year is counted as one person served. For example, persons having two or more hospitalizations during a year are counted as one person served for inpatient hospital services. In addition persons are counted once in aggregate or overall categories, regardless of the different categories of services used. Thus a person who receives inpatient hospital services and nursing home care (skilled nursing facility under Medicare, nursing facility under Medicaid) services in a year is counted separately as receiving each of these services, but is counted only once in calculating all persons served.

Physician Payment Reform (PPR)—Was implemented by OBRA 1989. Under OBRA 1989, a Medicare fee schedule payment system for physician services replaced the previous reasonable charge payment system.

Physician Services—Under Medicare, physicians' services are services provided by an individual licensed under State law to practice medicine or osteopathy. Services covered by hospital bills are not included.

Poverty-Related Eligibles—These individuals are eligible for Medicaid without regard to cash assistance or MN standards. They are eligible for Medicaid based on income below a stated percentage of the FPL. They include pregnant women, newborns up to age 1, children up to age 18, aged, blind, and disabled individuals. At State option, certain aged, blind, and disabled poverty-related eligibles may receive the full scope of Medicaid benefits.

Preferred Provider Organization (PPO)—An arrangement between a provider network and a health insurance or a self-insured employer. Providers generally accept payments less than traditional FFS payments in return for a potentially greater share of the patient market. PPO enrollees are not required to use the preferred providers, but are given financial incentives to do so, such as reduced coinsurance and deductibles. Providers do not accept financial risk for the management of care.

Premium—A monthly fee that may be paid by Medicare, Medicaid, and SCHIP enrollees. Medicare HI enrollees who are Social Security or RRB beneficiaries and who qualify for coverage through age or disability are not required to pay premiums. Aged persons who are not eligible for automatic HI enrollment may pay a monthly premium to obtain HI coverage. SMI enrollees pay a monthly premium that is updated annually to reflect changes in program costs.

Prepaid Health Plan (PHP)—A partially capitated managed care arrangement in which a managed care company is at risk for certain outpatient services.

Primary Care—Basic or general health care, traditionally provided by family practice, pediatrics, and internal medicine.

Primary Care Case Management (PCCM)—Managed care option allowed under Section 1915(b) of the Social Security Act in which each participant is assigned to a single primary care provider who must authorize most other services, such as care by specialty physicians, before the other providers can be reimbursed by Medicaid. Usually, services for care other than the case management fee are reimbursed on a FFS basis.

Principal Diagnosis—Under Medicare, the medical condition that is chiefly responsible for the admission of a patient to a hospital or for services provided by a physician or other provider. Under Medicaid, the diagnosis reported as the principal diagnosis on the last dated claim for a hospital stay.

Program Payments—The Medicare program payment amount includes only the amount shown in bills received and processed (as of a specific cutoff date) by the Medicare program in the CMS central office files. Not included in program payments are interim payments to institutional providers, payments to institutional providers resulting from adjustments to the end of FY cost reports, capitation payments for prepaid group health plans, beneficiary cost-sharing amounts, and administrative costs.

Programs of All-inclusive Care for the Elderly (PACE)—An optional Medicaid benefit that combines medical, social, and long-term care services for frail people. To be eligible, a person must:

- Be age 55 or over.
- Live in the service area of the PACE program.
- Be certified as eligible for nursing home care by the appropriate State agency.
- Be able to live safely in the community.

The goal of PACE is to help people stay independent and live in their community as long as possible, while getting high quality care they need.

Prospective Payment System (PPS)—A method of reimbursement in which Medicare payment is made based on a predetermined, fixed amount. The payment amount for a particular service is derived based on the classification system of that service (for example, DRGs for inpatient hospital services).

Provider—A Medicare provider is a facility, supplier, physician, or other individual or organization that furnishes health care services. Under Medicaid, a provider is an individual, group, or agency that provides a covered Medicaid service to a Medicaid enrollee.

Provider-Sponsored Organization (PSO)—Public or private entities established by or organized by health care providers or a group of affiliated providers that provide a substantial proportion of health care items and services directly through providers or affiliated groups of providers and share substantial financial risk.

Qualified Disabled and Working Individuals (QDWI)—Medicaid is required to pay Medicare Part A premiums for certain disabled individuals who lose Medicare coverage because of work. These are individuals whose income is below 200 percent of the FPL and whose resources are not more than twice the value allowed under SSI (refer to buy-in, dual eligible, dual entitlement, MN, QMB, and SLMB).

Qualified Medicare Beneficiary (QMB)—A low-income Medicare beneficiary who qualifies for certain assistance under Medicaid. The beneficiary must have Medicare Part A and income less than or equal to 100 percent of the FPL and resources below twice the value allowed under SSI. For those who qualify, the Medicaid program must pay Medicare Part A premiums (if applicable), Part B premiums, and Medicare deductibles and coinsurance amounts for Medicare covered services depending on the State's fee schedule. Some of these individuals may qualify for full Medicaid benefits and are sometimes referred to as "QMB pluses" (refer to buy-in, dual eligible, dual entitlement, MN, QDWI, and SLMB).

Qualifying Individual (QI)—A low-income Medicare beneficiary for whom Medicaid pays all or part of the Medicare Part B premium, depending on beneficiary income and resources. States receive 100 percent matching from the Federal Government for this program. Congress provided funding for the QI program through FY 2002.

Railroad Retirement Board (RRB)—Independent agency of the Federal Government charged with administering the retirement-survivor and unemployment-sickness benefit program for railroad workers and their families.

Railroad Retirement System—Was legislated by the Railroad Retirement and Railroad Unemployment Insurance Acts as a comprehensive retirement-survivors and unemployment-sickness benefits programs for railroad workers and their families.

Reasonable Cost—In processing claims for HI benefits, intermediaries use CMS guidelines to determine the reasonable cost incurred by individual providers in furnishing covered services to enrollees. The reasonable cost is based on the actual cost of providing such services, including direct and indirect costs of providers and excluding any costs that are unnecessary in the efficient delivery of services covered by the HI program.

Recipient—A Medicaid enrollee who receives a Medicaid-covered service (an alternate reference to beneficiary).

Reduction Amount—The difference between the physician's submitted charge and the Medicare allowed charge.

Revenue Center—A facility cost center for which a separate charge is billed on an institutional claim.

Risk Contract—An agreement with an MCO to furnish services for enrollees for a determined, fixed payment. The MCO is then liable for services regardless of their extent, expense, or degree.

Risk HMO—An organization that is paid a predetermined per-member payment by Medicare or Medicaid to provide all necessary covered services to its enrollees.

Resource Utilization Group Version III (RUG-III)—A patient classification system used to classify nursing home residents into homogeneous patient groups according to common health characteristics and the amount and type of resources they use.

Secondary Diagnosis—A medical condition other than the principal diagnosis that affected the treatment received, or length of stay in a hospital, or services rendered by a physician or other provider.

Short-Stay Hospital (SSH)—A hospital in which the average length of a stay is less than 30 days. General and special hospitals are included in this category.

Single State Agency—The Social Security Act requires that the State designate a single agency to administer or supervise administration of the State's Medicaid plan.

Skilled Nursing Facility (SNF)—In Medicare, an institution that has a transfer agreement with one or more participating hospitals, is primarily engaged in providing skilled nursing care and rehabilitative services to inpatients, and meets specific regulatory certification requirements.

SNF Services—In Medicare, services furnished to inpatients of a certified SNF that meets standards required by the Secretary of the DHHS and billed by the facility.

Social Security Act—The Titles of the 1965 Social Security Act include: Title II—Old Age, Survivors, and Disability Insurance Benefits (OASDI); also, Social Security; Title IV-A AFDC; Title IV-B—Child Welfare; Title IV-D—Child Support; Title IV-E—Foster Care and Adoption; Title IV-F—Job Opportunities and Basic Skills Training; Title V—Maternal and Child Health Services; Title XVI—SSI; Title XVIII—Medicare; Title XIX—Medicaid; Title XX—Social Services; and Title XXI—SCHIP.

Social Security Administration (SSA)—The Federal agency responsible for administering the Old Age, Survivors, and Disability Insurance (OASDI) program as well as the Supplemental Security Income (SSI) program of the Social Security Act.

Specified Low Income Medicare Beneficiary (SLMB)—A low-income Medicare beneficiary who qualifies for certain assistance under Medicaid. The beneficiary must have income above 100 percent, but not in excess of 120 percent of the FPL and limited resources. For those who qualify, the Medicaid program pays the Medicare Part B premium. Some of these individuals may qualify for full Medicaid benefits and are sometimes referred to as "SLMB pluses" (refer to buy-in, dual eligible, dual entitlement, MN, QMB, and QDWI).

State Children's Health Insurance Program (SCHIP)—A program designed to provide health coverage to uninsured children with incomes too high to qualify for Medicaid, but too low to afford private health insurance. SCHIP is funded through a Federal/State partnership and was enacted as part of the Balanced Budget Act of 1997.

Statewideness—A State Medicaid program must offer the same benefits to everyone throughout the State, exceptions being possible through Medicaid waivers and special contracting options (refer to waivers).

Supplemental Security Income (SSI)—A program of income support for low-income, aged, blind, and disabled persons established in Title XVI of the Social Security Act.

Supplementary Medical Insurance (SMI)—Also known as Medicare Part B, this is a voluntary insurance program that provides insurance benefits for physicians, outpatient hospital services, ambulatory services, and other medical supplies and services to aged and disabled individuals who elect to enroll under the program in accordance with the provisions of Title XVIII of the Social Security Act. The SMI program is financed by enrollee premium payments and contributions from funds appropriated by the Federal Government.

Supplier—An organization that has been issued a Medicare supplier number, and which provides DME (such as wheelchair, walker, and oxygen equipment), medical devices (such as artificial limbs and braces), or medical supplies (such as surgical dressings).

Supplier Services—The SMI program pays for covered supplier services. As defined in the CMS Part B Medicare annual data users' manual, these services include those provided by

medical supply companies (for example, supplies and DME), ambulance suppliers, independent laboratories (billing independently), pharmacies, portable X-ray suppliers (billing independently), and voluntary health or charitable agencies.

Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA)—Permits States to cover under Medicaid disabled children under age 19 who live at home who would have been eligible if in an institution. States must determine that institutional care would have been required, that home care is appropriate, and that the estimated cost of home care is no more than institutional care.

Temporary Assistance for Needy Families (TANF)—Created by the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996, TANF provides assistance and work opportunities to needy families. This program replaced the earlier AFDC program (refer to AFDC and PRWORA).

Total Charges—The hospital's charges for room, board, and ancillary services as recorded on the billing form (refer to covered charges).

Total Days of Care—Any day during which inpatient hospital services were furnished to a person eligible for HI benefits under Medicare including covered and non-covered days of care.

Total Personal Health Care Expenditures (PHCE)—The sum of all expenditures for health care by Medicare, Medicaid, private insurance, out-of-pocket, and all other public and private sources.

Uniform Bill 82 (UB82)—A Medicare claim form used by institutional providers from 1984 to 1993. In October 1993, the UB82 was replaced by the UB92.

Unique Physician Identification Number (UPIN)—A number which uniquely identifies an individual physician.

Utilization—A measure of the extent to which the members of a covered group use a program or obtain a particular service, or category of procedures, over a given period of time. Usually expressed as the number of services used per year or per number of persons eligible for the services.

Waiver—An exception to the usual requirements of Medicare or the usual requirements of Medicaid granted to a State by CMS, authorized through the following sections of the Social Security Act or Social Security Amendments:

*402 of the Social Security Amendments of 1967***—**Provides Medicare demonstration authority to test alternative methods of Medicare payment and changes to the Medicare benefit package.

*1115 of the Social Security Act***—**Allows States to waive provisions of Medicaid law to test new concepts which are congruent with the goals of the Medicaid Program. Radical, systemwide changes are possible under this provision.

1915(b) of the Social Security Act—Allows States to waive freedom of choice. States may require that beneficiaries enroll in HMOs or other managed care programs, or select a physician to serve as their primary care case manager.

1915(c) of the Social Security Act—Allows States to waive various Medicaid requirements to establish alternative, community-based services for individuals who qualify for services in an ICF/MR, nursing facility, institution for mental disease, or inpatient hospital.

1929 of the Social Security Act—Allows States to provide a broad range of home and community-based services to functionally disabled individuals as an optional State plan benefit. In all States except Texas, the option can serve only people age 65 or over.