Medicaid/CHIP State Operations

T-MSIS Data Guide

Glossary of Terms

Numbers

1915 waivers (e.g. 1915(a), 1915(b))

1915 waivers are Managed Care Authorities offered by Medicaid, which allow States to implement a managed care delivery system using a basic type of federal authorities known as Waiver authority [Section 1915 (a) and (b)].

1932(a) State Plan Basics

1932(a) are Managed Care Authorities offered by Medicaid, which allow States to implement a managed care delivery system using the Medicaid State Plan.

A

Accreditation

An evaluative process in which a healthcare organization undergoes an examination of its policies, procedures and performance by an external organization ("accrediting body") to ensure that it is meeting predetermined criteria.

Adjustment

A term used to refer to a change made to a previously processed claim.

After-the-fact Collections

A collection process to obtain the full or partial Medicaid-Paid-Amount from a Third Party, which was paid by the State Medicaid/CHIP Agency on behalf of a beneficiary, when the financial responsibility itself belongs to a Third Party.

Application date

The month, day and year an individual submitted an application for insurance affordability programs.

Application Method

The method by which a person applies for the Medicaid/CHIP programs. Typical methods include telephone, mail, in person, electronic. In some cases, it may be an automatic or presumptive entitlement based on various conditions.

Authorized Medicaid/CHIP Eligibility Group

In context of Medicaid/CHIP Managed Care, authorized eligibility groups (types of eligibility groups reportable in T-MSIS) come from the scope of services available to the subset of eligibility groups [authorized] set forth in contracts between the Managed Care Organization and State Medicaid/CHIP Agencies.

B

Beneficiary

A term used to refer to a person who has health care insurance through the Medicaid program.

Benefit

The money or services provided by an insurance policy. In a health plan, benefits are the health care you get.

Benefit category

Benefit categories are classifications of benefits for Medicaid and CHIP programs. Medicaid benefit categories are mandatory and optional. Mandatory benefits include services including inpatient and outpatient hospital services, physician services, laboratory and x-ray services, and home health services, among others. Optional benefits include services including prescription drugs, case management, physical therapy, and occupational therapy.

C

Capitation payment

A specified amount of money paid to a health plan or doctor. This is used to cover the cost of a health plan member's health care services for a certain length of time.

Children’s Health Insurance Program (CHIP)

The Children’s Health Insurance Program (CHIP) provides health coverage to eligible children, through both Medicaid and separate CHIP programs. CHIP is administered by states, according to federal requirements. States and the federal government fund the program jointly.

CHIP State plan

The State plan is a comprehensive written statement that describes the purpose, nature, and scope of the State's CHIP and gives an assurance that the program is administered in conformity with the specific requirements of title XXI, title XIX (as appropriate), and the regulations in this chapter. The State plan contains all information necessary for CMS to determine whether the plan can be approved to serve as a basis for Federal financial participation (FFP) in the State program.

Claim

A request for payment submitted to Medicare, Medicaid or other healthcare provider for items and services covered.

CMMI Innovation Models

CMMI Innovation Models are payment and service delivery research and demonstration projects provided in accordance with the requirements of section 1115A of the Social Security Act.

Combination Program

A term used to refer to a program under which a State implements both a Medicaid expansion program and a separate child health program.

Contract

A legal agreement between two parties such as;

A. State Medicaid/CHIP Agency and Managed Care Organization(MCO)
B. State Medicaid/CHIP Agency and a Provider, Physician, Group, and/or other health care provider
C. A MCO and a Provider, Physician, Group, and/or other health care provider.

Coordination of Benefits

Process for determining the respective responsibilities of two or more health plans that have some financial responsibility for a medical claim.

Coverage

The range of particular healthcare goods and services available under titles XIX and XXI of the Act. Coverage includes a determination of what code, if any, is assigned to a service or determination with respect to the amount of payment to be made for the service under the coverage.

D

Demographics

Characteristics such as race, age, location or income) used to identify and describe Medicaid/CHIP beneficiaries

Disenrollment

The act of removing an eligible individual from an insurance plan such as Medicaid, Medicaid expansion CHIP, Separate CHIP.

E

Effective date

The first day of coverage under the current period of eligibility for an eligible individual under a State Medicaid or CHIP program.

Effective time span

The specific span of time between the start date and the end date.

Eligible

An individual determined by a state to be eligible for an insurance affordability plan administered by the state, e.g. state Medicaid plan.

Eligibility criteria

Conditions, which are tested to determine the ability for individuals to qualify federal healthcare, program coverage such as Medicaid and CHIP.

Eligibility assessment

An eligibility assessment is a process which applies federal healthcare program eligibility criteria to a person's personal, income and demographics to provide an 'approval' or 'denial' for federal healthcare program coverage that may pay for healthcare goods and services received by a person (eligible, enrollee).

Eligibility determination

A process, which applies federal healthcare program eligibility criteria to a person's demographics to approve or deny federal healthcare program coverage that, may pay for healthcare goods and services received by a person (eligible, enrollee).

Eligibility period

A period/range of time upon which a Medicaid/CHIP beneficiary is eligible for coverage.

Encounter

A visit that may be conducted by a provider and/or a practitioner who delivers medical item(s) or service(s) e.g. Office visits (such as physician visits): and other outpatient items and services (such as outpatient surgery, facility charges for day treatment centers, laboratory charges, or other medical items).

End date

The last day of coverage under the current period of eligibility/enrollment for an eligible individual under a State Medicaid or CHIP program.

Enrollee

An eligible individual that is, or becomes, officially enrolled in an insurance affordability plan administered by the state, e.g. state Medicaid plan

*Enrollee means a Medicaid beneficiary who is currently enrolled in an MCO, PIHP, PAHP, PCCM, or PCCM entity in a given managed care program.

Enrollment

The act of placement of an eligible individual into a federal healthcare program (Medicaid, Medicaid expansion CHIP, Separate CHIP) that is, or becomes, officially qualified as eligible for inclusion into such program, administered by the state.

F

Facility

A place where patients receive care such as an inpatient hospital, skilled nursing facility, or an intermediate care facility.

Federal healthcare program

Any healthcare program provided by the Federal government.

Federal Tax ID

A number used to identify a business also known as an Employer Identification Number (EIN).. It is a unique nine-digit number assigned by the Internal Revenue Service (IRS) to business entities operating in the United States for the purposes of reporting taxes.

Fee-for-service (FFS) claim

A system of health insurance payment in which a doctor or other health care provider is paid a fee for each particular service rendered, essentially

rewarding medical providers for volume and quantity of services provided, regardless of the outcome.

G

Group practice

The association of physicians and other health professionals who work together.

H

Healthcare goods and services

Refers to the furnishing of medicine, medical or treatment.

Health maintenance organization (HMO)

A type of health insurance plan that usually limits coverage to care from doctors who work for or contract with the HMO. It generally won't cover out-of-network care except in an emergency. An HMO may require you to live or work in its service area to be eligible for coverage. HMOs often provide integrated care and focus on prevention and wellness.

Health Reimbursement Accounts or Health Reimbursement Arrangements (HRAs)

Health Reimbursement Accounts or Health Reimbursement Arrangements (HRAs) are US Internal Revenue Service (IRS)-sanctioned employer-funded, tax-advantaged employer health benefit plans that reimburse employees for out-of-pocket medical expenses and individual health insurance premiums. Using a Health Reimbursement Account yields 'tax advantages to offset health care costs' for both employees as well as employers.

I

Identifier

A sequence of letters and/or numbers (usually unique) used to identify or refer to a person, organization, provider, or program.

Insurance affordability program

Insurance affordability program means a program that is one of the following:

A. A State Medicaid program under title XIX of the Act.

B. A State children's health insurance program (CHIP) under title XXI of the Act.

C. A State basic health program established under section 1331 of the Affordable Care Act.

D. A program that makes coverage in a qualified health plan through the Exchange with advance payments of the premium tax credit established under section 36B of the Internal Revenue Code available to qualified individuals.

E. A program that makes available coverage in a qualified health plan through the Exchange with cost-sharing reductions established under section 1402 of the Affordable Care Act.

Inter record relationship

The relationship between multiple records in medical claim records file. For example, these are the typical inter record relationships: adjustments, voids, replacement claim records, marginal increase, and marginal decrease.

M

Managed care organization

Managed Care Organizations are entities that serve Medicare or Medicaid beneficiaries on a risk basis through a network of employed or affiliated providers.

Managed care

A health care delivery system organized to manage cost, utilization, and quality. Medicaid managed care provides for the delivery of Medicaid health benefits and additional services through contracted arrangements between state Medicaid agencies and managed care organizations (MCOs) that accept a set per member per month (capitation) payment for these services.

Mandated obligation

A binding agreement committing to the provision of an item.
E.g. The binding agreement that the Federal Health Programs must provide health insurance coverage.

Mandatory Medicaid Benefits

Benefits which states are required to provide under federal law.

Medicare Beneficiary Identifier (MBI)

An identification number assigned to individuals who have coverage under the Medicare program.

Medical record number

A unique identifier, assigned by a healthcare provider to associate a patient with the record associated with their visit.

Medicaid

A joint federal and state program that helps with medical costs for some people with limited income and resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Medicaid expansion program

A program under which a State receives Federal funding to expand Medicaid eligibility to optional targeted low-income children.

Medicaid State Plan (MSP)

A comprehensive written statement submitted by the agency describing the nature and scope of its Medicaid program and giving assurance that it will be administered in conformity with the specific requirements of title XIX, the regulations in this Chapter IV, and other applicable official issuances of the Department. The State plan contains all information necessary for CMS

to determine whether the plan can be approved to serve as a basis for Federal financial participation (FFP) in the State program.

Medically needy

Individuals with significant health needs whose income is too high to otherwise qualify for Medicaid under other eligibility groups.

Medicare Savings Program (MSP)

A Medicaid program where a state help people with limited income and resources pay for some or all of their Medicare premiums, deductibles, and coinsurance.

Modified adjusted gross income (MAGI)

The figure used to determine eligibility for premium tax credits and other savings for Medicaid and the Children's Health Insurance Program (CHIP). MAGI is adjusted gross income (AGI) plus these, if any: untaxed foreign income, non-taxable Social Security benefits, and tax-exempt interest.

Monthly Capitation

A set payment amount made on a monthly basis by the State under a contract and based on the agreed upon rate for the provision of services under the State plan.

MSIS Identification Number

A state-assigned unique identification number used to identify a Medicaid/CHIP enrolled individual and any claims submitted to the system.

N

National Association of Insurance Commissioners ID

A number assigned to identify each individual insurance carrier.

NPI

A unique 10-digit identification number used to identify health care personnel (e.g., physicians and other clinicians) and facilities (e.g., hospitals and laboratories).

Network association

In terms of the delivery of medical care and services to Medicaid and CHIP beneficiaries, the service provided may or may not be part of the network associated/contracted to deliver services.

Non-MAGI

Non-MAGI Medicaid offers comprehensive health insurance for low-income State residents. Most people who qualify for non-MAGI Medicaid are individuals who are over 65, disabled, or blind.

Non-MAGI Groups

Eligibility groups which can be assigned to applicants who are found to be not eligible in a Mandatory MAGI Group**.** These applicants are assigned to a non-MAGI optional eligibility group.

O

Optional MAGI Groups

Eligibility groups which may be assigned to applicants who are found not to meet mandatory MAGI eligibility requirements. These applicants may be assigned to a MAGI eligibility group in Medicaid or CHIP, which is called Optional.

P

Programs of All-Inclusive Care for the Elderly (PACE)

A special type of health plan that provides all the care and services covered by Medicare and Medicaid as well as additional medically necessary care and

services based on your needs as determined by an interdisciplinary team. PACE serves frail older adults who need nursing home services but are capable of living in the community. PACE combines medical, social, and long-term care services and prescription drug coverage.

Participation period

In terms of an enrollee's participation, the participation period is defined by a specific start date of enrollment and specific end date of enrollment.

Payment

The amount of money paid by Medicaid/CHIP or the managed care plan on behalf of a beneficiary's claim**.**

Payment method

In terms of Medicaid and CHIP, the payment method usually refers to the method by which States pay for the delivery of care – for example whether Fee-For-Service or capitation.

Payment record

Information about the beneficiary, service, payment date, payment amount, payee and payment method.

Point of service healthcare plan

A healthcare plan, which is a blend of HMO and PPO healthcare plans. A person with POS must select a primary care physician and need referrals. The cost coverage is the same as a PPO plan: more coverage for preferred providers and less for out-of-network ones.

Preferred provider organization (PPO)

A managed care in which you use doctors, hospitals, and providers that belong to the network. You can use doctors, hospitals, and providers outside of the network for an additional cost.

Presumptive eligibility

A Medicaid policy option that permits states to authorize specific types of "qualified entities," such as federally qualified health centers, hospitals, and schools, to screen eligibility based on gross income and temporarily enroll eligible children, pregnant women, or both in Medicaid or the Children's Health Insurance Program (CHIP).

Program Demonstrations (Section 1115)

A term used to refer to an approved experimental, pilot, or demonstration projects likely to assist in promoting the objectives of the Medicaid program.

Program Waivers

A type of authorization that give states the flexibility to not comply with requirements of Medicaid and CHIP Program.

Provider

A term that refers to any organization, institution, or individual that provides health care services to Medicaid and CHIP beneficiaries.

Primary Care Case Management (PCCM) PROVIDER

A PCCM provider is a provider (usually a physician, physician group practice, or an entity employing or having other arrangements with such physicians, but sometimes also including nurse practitioners, nurse midwives, or physician assistants) who contracts to locate, coordinate, and monitor covered primary care (and sometimes additional services). This category includes any PCCMs and those PHPs, which act as PCCMs.

R

Regulatory authority

An autonomous authority or agency established by a federal, state or provincial government. Certain regulatory authorities may be established with the power to enforce regulations regarding the Medicaid and CHIP Programs.

Replacement Claim

A replacement of a prior claim involves submitting the entire claim as a replacement claim if there were charges omitted or there is changed claim information (i.e., diagnosis codes, dates of service, member information, etc.)

Risk-Based Health Maintenance Organization/Competitive Medical Plan

A type of managed care organization. After any applicable deductible or copayment, all of an enrollee/member's medical care costs are paid for in return for a monthly premium. However, due to the "lock-in" provision, all of the enrollee/member's services (except for out-of-area emergency services) must be arranged for by the risk-HMO. Should the Medicare enrollee/member choose to obtain service not arranged for by the plan, he/she will be liable for the costs. Neither the HMO nor the Medicare program will pay for services from providers that are not part of the HMO's health care system/network.

Rule Based Measure

Traditionally, a rule is used to test data requirements and count errors. Some rules are now used to measure how many errors occur (numerator) over how many total records (denominator). This type of rule is referred to as a rule based measure.

S

Service(s) plural

Medical care and items such as medical diagnosis and treatment, drugs and biologicals, supplies, appliances, and equipment, medical social services, and use of hospital RPCH or SNF facilities.

Service area

A term used to describe the size of a geographic space upon which healthcare providers delivers care.

Service authorization

A confirmation from the Medicaid or CHIP agency for the delivery of a service based on provider requests, beneficiary requests made by their providers or the beneficiary’s authorized representative.

Service delivery network

Provider and facilities based network of service delivery options and locations available to Medicaid and CHIP beneficiaries where beneficiaries may visit to receive Medicaid and CHIP services allowed within the respective State Plans.

Service rationale

The reason or purpose that the Medicaid or CHIP beneficiary receives a medical or other service.

Service rendering location

A place where a beneficiary received healthcare services. Often the physical street address where the Medicaid/CHIP beneficiary receives benefits and medical care.

Social Security Disability Insurance (SSDI)

The SSDI is a disability benefit program of the Social Security Administration.

Start date

A date used to identify the beginning of a time period/span.

State Health Insurance Assistance Program (SHIP)

A state program that gets money from the federal government to give free local health insurance counseling to people with Medicare.

State Medicaid Plan

A document that describes a state's unique implementation of the federal Medicaid program.

State plan options

State Plan Options are programs, benefits, and coverage of some populations, which are optional decisions that can be made by State Medicaid Agencies.

Supplemental Security Income (SSI)

A benefit paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 or older. SSI benefits aren't the same as Social Security retirement or disability benefits.

T

Taxonomy

A system of classification.In Medicaid and CHIP, taxonomy is used for purposes of discussing and defining health care service provider type, classification, and area of specialization.

Terms and conditions

A set of rules and statements that are used by Medicaid/CHIP to permit States, MCOs and other entities to do business with Federal and State stakeholder. Entities have to follow and agree to Terms and conditions if they wish to perform service delivery, enact reimbursement arrangements, bill for services, use services, etc.

Third Party Liability (TPL)

Third Party Liability (TPL) refers to the legal obligation of third parties (for example, certain individuals, entities, insurers, or programs) to pay part or all of the expenditures for medical assistance furnished under a Medicaid state plan.

Tort settlement

A monetary based outcome made as a decision/result of a lawsuit.

Transaction ID

A transaction ID is a record key used to index records in files such that inter-record and inter-file relationships can be known.

U

Utilization record

An accounting or report of services and procedures received by beneficiaries in Medicaid and CHIP programs. Typically, information on facilities and providers are reported on utilization records.

V

Void

A cancellation of a prior claim.