Beneficiary Advisory Council (BAC) and Medical Services Fund Advisory Council (MSFAC) Glossary

Acronyms

An acronym is typically used as a short version of a word, phrase, or name. We will try to avoid using and/or define acronyms during meetings, but if we end up using one, feel free to ask what it means. We have also developed this quick reference in case you hear or come across common acronyms.

Acronym	Meaning
ABD	Aged, Blind, and Disabled
ACA	Patient Protection and Affordable Care Act
ADLs	Activities of Daily Living
ADW	Aged and Disabled Waiver
BBH	West Virginia Bureau for Behavioral Health
BMS	West Virginia Bureau for Medical Services
BSS	West Virginia Bureau for Social Services
CCBHC	Certified Community Behavioral Health Clinic
CHIP	The Children's Health Insurance Program
CMS	The Centers for Medicare and Medicaid Services
CSEDW	Children with Serious Emotional Disorders Waiver
IDDW	Intellectual and Developmental Disabilities Waiver
DME	Durable Medical Equipment
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
FFS	Fee for Service
FQHC	Federally Qualified Health Center
HCBS	Home and Community Based Services
HIM	Health Insurance Marketplace
HHR	Health and Human Resources
LTC	Long-term Care
LTSS	Long-term Supports and Services
MAC	Medicaid Advisory Committee (Federal term for MSFAC)
MAGI	Modified Adjusted Gross Income
MCO	Managed Care Organization
MMIS	Medicaid Management Information System
NF	Nursing Facility
PCP	Primary Care Provider
PHE	Public Health Emergency
SNF	Skilled Nursing Facility
SPA	State Plan Amendment
SSA	Social Security Administration
SSI	Supplemental Security Income
TANF	Temporary Assistance for Needy Families
TPL	Third-Party Liability

Some Key Terms and Definitions

Activities of Daily Living (ADL): Personal care tasks (e.g., bathing, dressing, toileting, transferring, and eating/feeding). An individual's degree of dependence in performing these activities is part of determining the appropriate level of care and service needs.

Authorized Representative: Person who is authorized in writing to conduct the personal or financial affairs for an individual.

Benefit: Medicaid benefits are all services and supports provided to an individual through the program, including primary care, prescriptions, and emergency services. Medicaid benefits typically offer full coverage of a person's medical needs. While Medicaid benefits are often seen as exclusive to health care, the program also provides a variety of Home and Community-Based Services (HCBS) through waivers, such as personal care, transportation, and homemaking services.

Coinsurance: The portion of Medicare, Medicaid, or other insurance-allowed charges for which the patient is responsible.

Co-Payment: The portion of Medicaid-allowed charges which a member is required to pay directly to the provider for certain services or procedures rendered.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT): A program of preventive health care and well child examinations with tests and immunizations for children and teens from birth up to age 21. Medically necessary services needed to correct or improve defects and physical or mental illnesses (discovered during a screening examination) may be covered as a part of the EPSDT program even if they are not covered under the State's Medicaid benefit plan.

Freedom of Choice: Refers to both the right of providers to choose whether to participate in the Medicaid program and the right of Medicaid beneficiaries to choose providers among those participating.

Health Insurance Portability and Accountability Act of 1996 (HIPAA): Requires each state's Medicaid management information system (MMIS) to have capacity to exchange data with the Medicare program and contains "Administrative Simplification" provisions that require state Medicaid programs to use standard, national codes for electronic transactions to the processing of health claims.

Managed Care Organization (MCO): A managed care organization (MCO), also known as a managed care entity (MCE), delivers health care benefits in an efficient, streamlined manner that emphasizes improving cost, utilization, and quality of care. Within Medicaid, MCOs establish contractual arrangements with state agencies to deliver health benefits and related services. These are based on an established rate of payment for those services and a set number of members receiving care within a month.

Medically Necessary: Reasonable and necessary services for the diagnosis or treatment of an illness or injury or to improve physical functioning.

Medically Needy: Individuals who meet Medicaid covered group requirements but have excess income. A medically needy determination requires a resource test and includes pregnant women, children under the age of 18, foster care and adoption assistance, and those in ICF/IIDs up to age 21, ABD up to age 21. Parents and caretaker relatives do not qualify under medically needy. Medically needy individuals are excluded from managed care enrollment.

Premium: The monthly amount paid for a health insurance policy.

Primary Care Provider (PCP): The doctor or clinic that provides most personal health care needs, gives referrals to other health care providers when needed, and monitors Medicaid member health. May be an internist, a pediatrician (children's doctor), OB/GYN (women's doctor), or certain clinics and health departments.

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

Social Security Administration (SSA): The federal agency that administers the Social Security program, a social insurance program consisting of retirement, disability, and survivors' benefits.

Supplemental Security Income (SSI): A federal program administered by the Social Security Administration that pays monthly benefits to individuals who are disabled, blind, or age 65 or older with limited income and resources. Children and adults who are blind or disabled can receive SSI benefits.

Third-Party Liability (TPL): The legal obligation of third parties, i.e., certain individuals, entities, or programs, to pay all or part of the expenditures for medical assistance furnished under the State Plan.

Waiver: A Medicaid waiver does as its name implies: waives a Medicaid rule or law to deliver a certain benefit or expansion of coverage that isn't normally covered within a state's Medicaid plan. Waivers are commonly used to deliver Home and Community-Based Services (HCBS), such as at-home caretaking, transportation or providing medical equipment. Common waivers are: 1115, 1915(b), 1915(c), 1915(i), and 1915 (k).