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90-day Clock	The informal term for the ninety-day calendar period within which CMS must approve or disapprove a state's request to amend its State plan, initiate a new waiver, renew a waiver, or amend a waiver. The 90-day clock begins on the date that CMS receives the request from a state, either electronically or by other delivery method.
§209(b) State	A state that applies at least one eligibility criterion for purposes of determining Medicaid eligibility for aged or disabled Supplemental Security Income (SSI) beneficiaries that is more restrictive than SSI criteria. States electing this option may not use more restrictive standards than were in effect on January 1, 1972, and must permit individuals to deduct incurred medical expenses from income through Medicaid spenddown so that they may qualify for Medicaid.
300% of SSI Rule	See Special Income Rule.
§435.217 Group	See Special Home and Community-Based Waiver Group
§1115 Research and Demonstration Waiver	Research and demonstration programs that operate under waivers that are granted under the provisions of §1115 of the Social Security Act to authorize experimental, pilot, or demonstration project(s) that, in the judgment of the Secretary of Health and Human Services are likely to assist in promoting the objectives of the Act, including but not limited to Title XIX (the Medicaid statute) of the Act. The §1115 research and demonstration authority has been employed to implement alternative approaches to the delivery of Medicaid services.
§1634 State	A state that has entered into a contract with the Social Security Administration (SSA) under the provisions of §1634(a) of the Act for SSA to determine Medicaid eligibility at the same time that eligibility for SSI benefits and/or federally administered state supplementary payments is determined. In §1634 states, SSI beneficiaries do not make a separate application for Medicaid.

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§1915(b)

A provision of the Social Security Act that authorizes the Secretary of HHS to grant certain waivers of Medicaid statutory requirements. The §1915(b) authority may be used to:

(a) mandate the enrollment of Medicaid beneficiaries into managed care plans (§1915(b)(1));

(b) employ a central enrollment broker (§1915(b)(2));

(c) use cost savings to provide additional services to enrollees (§1915(b)(3); and/or limit the number of providers through selective contracting (§1915(b)(4)).

Waivers granted under the provisions of §1915(b) may be effective for a period of two years and may be renewed for subsequent two year periods.

§1915(b)/§1915(c) Concurrent Waivers

The simultaneous use of the §1915(b) and §1915(c) waiver authorities to permit the integration of the delivery of home and community-based services with State plan services in order provide a coordinated array of services to beneficiaries.

States also use the §1915(b) authority to limit free of choice of provider while using use the §1915(c) authority to provide the home and community-based services and expand Medicaid eligibility to the special home and community-based waiver group under 42 CFR §435.217. There is no authority under §1915(b) to cover individuals in the 42 CFR §435.217 group who are Medicaid eligible. A state can implement §1915(b)/§1915(c) concurrent waivers as long as all federal requirements for both waiver programs are met. Therefore, when submitting applications for concurrent §1915(b)/(c) programs, a state must submit a separate application for each waiver type and satisfy all of the applicable requirements under each authority.

§1915(c)

The provision of the Social Security Act that authorizes the Secretary of HHS to grant waivers of certain Medicaid statutory requirements so that a state may furnish home and community services to Medicaid beneficiaries who need a level of institutional care that is provided in a hospital, nursing facility or Intermediate Care Facility for the Mentally Retarded (ICF/MR).

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§1915(g)(1)	A provision of the Social Security Act that permits a state to furnish “targeted case management services” under the State plan to groups of Medicaid beneficiaries specified by the state on a statewide or less than statewide basis. See also “targeted case management.”
AAA	See Area Agency on Aging
Abuse	The infliction of injury, unreasonable confinement, intimidation, punishment, mental anguish, sexual abuse or exploitation on an individual. Types of abuse include: (a) physical abuse (a physical act by an individual that may cause physical injury to another individual); (b) psychological abuse (an act, other than verbal, that may inflict emotional harm, invoke fear and/or humiliate, intimidate, degrade or demean an individual); (c) sexual abuse (an act or attempted act such as rape, incest, sexual molestation, sexual exploitation or sexual harassment and/or inappropriate or unwanted touching of an individual by another); and, (d) verbal abuse (using words to threaten, coerce, intimidate, degrade, demean, harass or humiliate an individual).
Abuse Registry	An official, state-maintained listing of individuals who have been convicted of abuse or found through a civil/administrative procedure to have committed abuse against a person.
Accreditation	An evaluative process through which a provider organization undergoes an examination of its policies, procedures and performance by a nationally-recognized external organization (''accrediting body'') to determine that the provider meets predetermined criteria.
Act	The federal Social Security Act (42 U.S.C. §1396 *et seq*.)

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Activities of Daily Living (ADL)	Basic personal everyday activities that include bathing, dressing, transferring (e.g., from bed to chair), toileting, mobility and eating. The extent to which a person requires assistance to perform one or more ADLs often is a level of care criterion.
ADL	See Activities of Daily Living
Administration	Necessary activities that are undertaken by a state to implement and operate its Medicaid program, including complying with federal administrative requirements. Administrative activities include but are not limited to the payment of provider billings, utilization management, and the operation of an MMIS.
Administrative FFP	The federal share of the expenses for performing activities that are necessary for the proper and efficient administration of the State plan. FFP rates vary by function, not by state. The general FFP administrative rate is 50%. Some administrative functions qualify for enhanced FFP administrative rates of 75 percent or more as specified in 42 CFR §433.15. (e.g., survey and certification, fraud control units).
Aged	As provided in §1905(a)(iii) of the Act, persons age 65 and older.
Agency Provider	A public or private organization/entity that holds a Medicaid provider agreement and furnishes services to waiver participants using its own employees or subcontractors.

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Agency with Choice (Model)	One of the two Employer Authority options that may be made available to waiver participants who direct some or all of their services. Also known as the "coemployment option," an arrangement wherein an organization (a co-employment agency) assumes responsibility for: (a) employing and paying workers who have been selected by waiver participants to provide services to them; (b) reimbursing allowable services; (c) withholding, filing and paying federal, state and local income and employment taxes; and, (d) sometimes providing other supports to the participant. Under this model, the participant acts as the "Managing Employer" and is responsible for hiring, managing, and possibly dismissing the worker. The Agency with Choice model can enable participants to exercise choice and control over services while relieving them of the burden of carrying out financial matters and other legal responsibilities associated with the employment of workers. Under this model, the co-employment agency is considered the common law employer of workers who are selected/hired by the waiver participant.
ALOS	See Average Length of Stay
Amendment	A formal request submitted by a state to modify an approved waiver.
Amount (of services)	A term that refers to the total volume of services (measured in units or dollars) that are furnished to an individual.
Annual Waiver Report	See CMS-372(S)
Approved Waiver	A waiver that has been approved by CMS and is in effect.
Area Agency on Aging (AAA)	Agencies established in each state under the provisions of the federal Older Americans Act to meet the needs of persons age 60 and over in local communities.

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Assessment	One or more processes that are used to obtain information about an individual, including his/her condition, personal goals and preferences, functional limitations, health status and other factors that are relevant to the authorization and provision of services. Assessment information supports the determination that an individual requires waiver services as well as the development of the service plan.
Assisted Living	An assisted living facility provides residents personal care and other assistance as needed with ADLs and IADLs but does not provide round-the-clock skilled nursing services. Assisted living facilities generally provide less intensive care than nursing facilities and emphasize resident privacy and choice.
Assurance	The commitment by a state to operate a HCBS waiver program to meet statutory requirements. Approval of a new waiver is contingent on CMS determining that the program's design will result in meeting the assurances contained in 42 CFR §441.302. Renewal of a waiver is contingent on CMS finding that a waiver has been operated in accordance with the assurances and other federal requirements.
Average Length of Stay (ALOS)	The average number of days during a waiver year that a waiver participant is served on a waiver.
Backup	Provision for alternative arrangements for the delivery of services that are critical to participant well being in the event that the provider responsible for furnishing the services fails to or is unable to deliver them.
BBA-97	Balanced Budget Act of 1997 (P.L. 105-33)
Beneficiary	An individual who is eligible for and enrolled in the Medicaid program.
Billing	The request for payment by a provider from the state for services rendered to a Medicaid beneficiary.

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Budget Authority	The participant direction opportunity by which a waiver participant exercises choice and control over a specified amount of waiver funds (participant-directed budget). Under the budget authority, the participant has decision-making authority regarding who will provide a service, when the service will be provided, and how the service will be provided consistent with the waiver's service specifications and other requirements. The participant has the authority to make changes in the distribution of funds among the waiver services included in the participant directed budget. Budget changes and the service plan must be synchronized.
Bundled Service	A waiver service that encompasses two or more discrete services that are not closely related. When a state proposes to cover a bundled service, it must demonstrate that bundling will result in more efficient and economical delivery of services and ensure that waiver participants enjoy free choice of provider.
Capitation Payment	A method of payment for an array of services wherein a single fixed payment is made periodically (usually monthly) to a provider (e.g., a managed care entity) on behalf of each beneficiary who is enrolled with the provider and for whom the provider is obligated to furnish the services included in the array. The state makes the payment regardless of the actual number or nature of the services provided. Capitation payment methods are commonly employed in managed care arrangements.
Caregiver	A person who helps care for someone who is ill, has a disability, and/or has functional limitations and requires assistance. Informal caregivers are relatives, friends or others who volunteer their help. Paid caregivers provide services in exchange for payment for the services rendered.

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Case Management	A set of activities that are undertaken to ensure that the waiver participant receives appropriate and necessary services. Under a HCBS waiver, these activities may include (but are not necessarily limited to) assessment, service plan development, service plan implementation and service monitoring as well as assistance in accessing waiver, State plan, and other non-Medicaid services and resources. Case management sometimes is referred to as "care management," "service coordination," or "support coordination."
Categorical Eligibility	A phrase that describes Medicaid's policy of restricting eligibility to individuals in certain specified groups or categories, such as children, older persons (the aged), or individuals with disabilities (the disabled). In order to be determined eligible for Medicaid, individuals who fall into approved, statutorily recognized categories must also satisfy financial eligibility requirements, including income and, in most cases, resource tests imposed by the state in which they reside.
Categorically Needy	A phrase that describes certain groups of Medicaid beneficiaries who qualify for the basic mandatory package of Medicaid benefits. There are mandatory categorically needy groups that states must cover, such as pregnant women and infants with incomes at or below 133 percent of the Federal Poverty Level (FPL). There are also optional categorically needy groups that states may elect to cover at their option, such as pregnant women and infants with incomes above 133 percent and up to 185 percent of the FPL. Unlike the medically needy, categorically needy individuals do not spenddown to qualify for Medicaid.
Center for Medicaid and State Operations (CMSO)	The component within CMS that is responsible for federal administration of the Medicaid and the State Children's Health Insurance Program (SCHIP) programs.

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Centers for Medicare & Medicaid Services (CMS)	The agency in the Department of Health and Human Services that is responsible for federal administration of the Medicaid, Medicare, and State Children's Health Insurance Program (SCHIP) programs. CMS was formerly known as the Health Care Financing Administration (HCFA).
Certification	The result of formal processes that are undertaken by a state to verify that a provider meets regulatory standards for the delivery of a service.
Certified Public Expenditure (CPE)	The expenditure by a state or local public agency to provide or purchase services that qualify for Medicaid federal financial participation. The public agency certifies these expenditures to the Medicaid agency which (a) includes them in its claim for FFP and (b) pays the certifying public agency the federal share of allowable expenditures.
CFR	Code of Federal Regulations. The CFR contains the regulations that have been officially adopted by federal agencies. Federal regulations that govern the Medicaid program are contained in 42 CFR §430 *et seq*.
Chore Services	Assistance with household tasks such as home repairs, yard work, and heavy housecleaning.
Chronic Illness	A long-term or permanent illness (e.g., diabetes, arthritis) that may result in some type of disability for which assistance may be required on a continuing basis.
Chronic Mental Illness	See Serious Mental Illness
Claim	The formal request by the state for federal financial participation in the costs of services furnished to beneficiaries and expenses for the administrative activities that the state has incurred to operate its Medicaid program.
CMS	See Centers for Medicare & Medicaid Services

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CMS Waiver Number	The unique numeric identifier assigned by CMS to each HCBS waiver program.
CMS-372(S)	The annual report that a state must submit to CMS following the completion of each waiver year that details: (a) the number of unduplicated individuals who participated in a waiver during the waiver year; (b) the unduplicated number of persons who utilized each waiver service and the amount of funds expended for each service; (c) expenditures for Medicaid State plan services on behalf of waiver participants; and, (d) information concerning assuring the health and welfare of waiver participants. The information submitted via the CMS-372(S) provides evidence of the waiver's cost-neutrality on an ongoing basis. The CMS-372(S) was formerly known as Form HCFA 372. The CMS-372(S) simplified the information that states previously reported on Form HCFA 372.
CMS-373Q	The report that will replace the health and welfare part of the CMS-372(S) in 2006. The CMS-373Q will provide for the reporting of state performance in meeting the waiver assurances and for updates to the waiver Quality Management Strategy.
CMS-373S	The report that will replace the financial and statistical portion of the CMS-372(S) in 2006.
CMSO	See Center for Medicaid and State Operations
Co-Employer	See Agency with Choice model
Co-Employment Agency	See Agency with Choice model.

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Co-Insurance	A fixed percentage of the cost of a specific service that must be paid by the beneficiary. Under Medicaid, co-insurance amounts must be nominal and may not exceed 5% of the cost of the service. Co-insurance is distinguished from copayment where a fixed dollar amount is charged to a beneficiary for a service.
Common Law Employer	A common law employer-employee relationship generally exists when the person for whom services are performed has the right to control and direct the individual who performs the services, not only as to the result to be accomplished but also as to the detail and means by which that result is accomplished.
Common Law Employer (Option)	One of the two Employer Authority options that may be made available to waiver participants who direct some or all of their services. Under this option, the waiver participant is the common law employer of workers who furnish services and supports and assumes all responsibilities associated with being the employer of such workers. When this option is selected, a Fiscal/Employer Agent performs employer-related tasks on behalf of the participant but does not serve as the common law employer of participant-hired workers.
Community Transition	Activities that are undertaken to assist an institutionalized person to return to the community or facilitate a person served in a congregate living arrangement in the community to their own private residence.
Comparability	The requirement contained in §1902(a)(10)(B) of the Act that a state must offer services in the same amount, duration, and scope to individuals within categorically or medically needy groups covered under its State plan and that services available to any categorically needy recipient cannot be less than those available to a medically need recipient. This is one of the provisions of the Act for which a state must request a waiver in order to provide home and community-based services to a specified target group of Medicaid beneficiaries.

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Complaint	The formal expression of dissatisfaction by a participant with the provision of a waiver service or the performance of an entity in conducting other activities associated with the operation of a waiver.
Computable Waiver Costs	The amount expended by the state for waiver services net of adjustments for offsets such as participant post-eligibility treatment of income financial liability and cost-sharing. Only computable waiver costs are eligible for federal financial participation.
Continuous Improvement	The utilization of systematically-complied data and quality information derived from discovery activities in order to engage in actions to secure better performance in the operation of a waiver.
Co-Payment	A fixed dollar amount that a Medicaid beneficiary is expected to pay at the time of receiving a specified covered service from a provider. Co-payments, like other forms of Medicaid beneficiary cost-sharing (e.g., deductibles, coinsurance), may only be imposed by a state upon certain groups of beneficiaries, only with respect to certain services, and only in nominal amounts as specified in federal regulation.
Cost Neutrality	The requirement that an HCBS waiver must be designed and operated so that the average cost per unduplicated participant of furnishing waiver services and other Medicaid benefits is no greater than the average cost per unduplicated individual of furnishing institutional services and other Medicaid benefits to institutionalized persons at the same level of care. Cost neutrality must be demonstrated prospectively in order for a new waiver or a waiver renewal to be approved. It also must be verified each year that the waiver is in effect (by the submission of the annual CMS 372(S) report).
Cost-Sharing	The required out-of-pocket payment that an individual must pay for a covered service. Cost sharing generally takes one of three forms: co-insurance, copayments or deductibles.

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Countable Income or Resources	The amount of income or resources that is left after the application of all financial eligibility methodologies and that is compared to the applicable income or resource standard for the purpose of determining Medicaid eligibility.
CPE	See Certified Public Expenditures
Criminal History/ Background Investigation	A process that is undertaken to determine whether a person has been convicted of a crime. Requirements for conducting criminal history/background investigations are typically established through state law/regulations. Under such requirements, a human services agency or health care provider must conduct an investigation prior to hiring a person or permitting an employee to furnish services directly to individuals and, in some cases, may prohibit the employment of individuals who have been convicted of specified crimes.
Critical Incident (Event)	An alleged, suspected, or actual occurrence of: (a) abuse (including physical, sexual, verbal and psychological abuse); (b) mistreatment or neglect; (c) exploitation; (d) serious injury; (e) death other than by natural causes; (f) other events that cause harm to an individual; and, (g) events that serve as indicators of risk to participant health and welfare such as hospitalizations, medication errors, use of restraints or behavioral interventions.
DAC	See Disabled Adult Child
Deductible	A specified dollar amount that the beneficiary must incur before Medicaid will pay for services. Under Medicaid law, the amount of the deductible must be nominal (e.g., $2 per family or individual per month).

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Deemed Status	The use of the findings of a private accreditation organization, in whole or in part, to supplement or substitute for state verification of provider quality standards.
DEHPG	See Disabled and Elderly Health Programs Group
Design	The process of structuring an HCBS waiver (including its benefits and operational processes) in order to achieve its intended purpose(s).

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Developmental Disability

As provided in The Developmental Disabilities Assistance and Bill of Rights Act of 2000 (P.L. 106-402 – 42 USC §15002(8)(A)&(B)), the "term 'developmental disability' means a severe, chronic disability of an individual that - (i) is attributable to a mental or physical impairment or combination of mental and physical impairments; (ii) is manifested before the individual attains age 22; (iii) is likely to continue indefinitely; (iv) results in substantial functional limitations in 3 or more of the following areas of major life activity:

(I) Self-care.
(II) Receptive and expressive language.
(III) Learning.
(IV) Mobility.
(V) Self-direction.
(VI) Capacity for independent living.
(VII) Economic self-sufficiency; and (v) reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated.

"An individual from birth to age 9, inclusive, who has a substantial developmental delay or specific congenital or acquired condition, may be considered to have a developmental disability without meeting 3 or more of the criteria … if the individual, without services and supports, has a high probability of meeting those criteria later in life." [N.B., The foregoing definition is not the same as the Medicaid specification of individuals who may receive ICF/MR services. ICF/MR services are furnished to persons with mental retardation and other related conditions (see below). When a waiver targets individuals with developmental disabilities, a state should define its use of the term "developmental disability."]

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Disability	For Social Security purposes and as provided in §1614(a)(3) of the Act, disability means the inability of a person age 18 or older to engage in substantial gainful activity (work) by reason of any medically determinable physical or mental condition that can be expected to result in death or to last for a continuous period of not less than 12 months. In the case of children (persons age 17 and younger), the child must have a physical or mental condition that results in marked and severe functional limitations. The condition also must be expected to result in death or to last for a continuous period of not less than 12 months.
Disabled	As provided in §1905(a)(vii) of the Act, for Medicaid purposes the term "disabled" means persons under the age of 65 who have been determined to have a disability for Social Security purposes (as provided in §1614(a)(3) of the Act).
Disabled Adult Child (DAC)	A SSDI beneficiary whose disability began before age 22. For an adult with disabilities to become eligible for this benefit, one of his or her parents must: (a) be receiving Social Security retirement or disability benefits or (b) must have died and have worked long enough under Social Security. These benefits are also payable to an adult who received dependents benefits on a parent's Social Security earnings record prior to age 18, if he or she is disabled at age 18.
Disabled and Elderly Health Programs Group (DEHPG)	The organization within CMSO that, among its other duties, is responsible for federal administration of the HCBS waiver program.

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Discovery	Engaging in activities to collect data about the conduct of processes, the delivery of services, and direct participant experiences in order to assess the ongoing implementation of a waiver, identifying both concerns as well as other opportunities for improvement. Examples of discovery activities include, but are not limited to, monitoring, complaint systems, incident management systems, and regular systematic reviews of critical processes such as participant-centered planning and level of care determinations. Discovery activities are usually designed to identify problems that require remediation and sometimes lead to systemic changes/improvements.
Disregard	An informal term for the state's methodology for counting or excluding income and resources in determining Medicaid eligibility. For certain eligibility categories, such as poverty-related children or working disabled adults, states may disregard – that is, not count – certain income or resources in determining whether the individual meets its Medicaid income or resource standards. The effect of an income or resource disregard is to enable an individual to qualify for Medicaid even if his or her gross income or resources exceed the state eligibility standard.
Donation	The transfer of funds from a provider or provider organization to the state to provide the non-federal share of Medicaid expenditures. Allowable donations are termed "bona fide donations," as defined in 42 CFR §433.54. Other donations are generally not allowable.
Drug Used as Restraint	Any drug that: (1) is administered to manage an individual's behavior in a way that reduces the safety risk to the individual or others; (2) has the temporary effect of restricting the individual's freedom of movement; and (3) is not a standard treatment for the individual's medical or psychiatric condition.

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Dual Eligible (Full Benefit)	An individual who is eligible for both Medicare and for full Medicaid coverage, including the payment of the person's Medicare premium, deductibles, and coinsurance.
Duration (of services)	The length of time that a service will be provided. A limit on the duration of services means that the service will no longer be provided after a specified period of time or, after a specified period of time, the necessity for the service is subject to review and reauthorization.
Early and Periodic Screening, Diagnosis and Treatment (EPSDT)	Medicaid's comprehensive child health program for individuals under the age of 21. EPSDT is authorized under §1905(r) of the Act and includes the performance of periodic screening of children, including vision, dental, and hearing services. §1905(r)(5) of the Act requires that any medically necessary health care service that is listed in §1905(a) of the Act be provided to an EPSDT beneficiary even if the service has not been specifically included in State plan. Federal EPSDT regulations are located in 42 CFR §441.50 *et seq*.
Eligibility Determination	Refers to the processes that are employed to ascertain whether an individual meets the requirements specified in the State plan to receive Medicaid benefits. Such requirements include the determination of whether a person is a member of an eligibility group specified in the State plan and meets applicable income and resource standards. Eligibility determination must be performed by the Medicaid agency or another agency specified in 42 CFR §431.10(c) with which the Medicaid agency has an agreement as provided in 42 CFR §431.10(d).
Eligibility Group	Any one of the distinct groups of individuals identified in §1905(a) of the Act or elsewhere in the Act to which a state must or may furnish Medicaid benefits.
Emergency Backup	See Backup.

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Employer Authority

The participant direction opportunity by which the participant exercises choice and control over individuals who furnish waiver services authorized in the service plan. Under the employer authority, the participant may function as the coemployer (managing employer) or the common law employer of workers who furnish direct services and supports to the participant.

Enhanced Payment

See Supplemental Payment

Enrollment

An informal term used to describe the entry of an individual into a HCBS waiver.

Synonymous with the term Entrance.

Entrance

The result of the completion of all processes that must be completed in order for an individual to begin to receive waiver services. A person may start to receive waiver services when:

(a) the person has been determined to meet applicable Medicaid eligibility criteria;

(b) there has been a determination that the person is member of a target group that is included in the waiver;

(c) there has been a determination that the person requires a level of care specified for the waiver;

(d) the person has exercised freedom of choice and has elected to receive waiver instead of institutional services; and,

(e) a service plan has been developed that includes one or more waiver services.

FFP is not available for the costs of services furnished to an individual until all of these steps have been completed. Entrance may be expedited by the preparation of an interim service plan.

EPSDT

See Early and Periodic Screening, Diagnosis and Treatment

Evaluation

The processes that are undertaken to determine whether an individual requires the level of care specified for the waiver.

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Evidence	Data or facts that support determining whether something is true or not true.
Evidence-Based	A broad term that is used to describe methods or practices that have been demonstrated (through formal research and systematic analysis of data) to secure specified outcomes efficiently and efficaciously.
Exploitation	An act of depriving, defrauding or otherwise obtaining the personal property of an individual by taking advantage of a person's disability or impairment.
Extended State Plan Service	The coverage in a waiver of a State plan service for the purpose of furnishing the State plan service in an amount, frequency or duration that is greater than allowed under the State plan.
Extension	The approved continued operation of an HCBS waiver beyond its expiration date until a determination is made by CMS whether to renew the waiver. An extension must be requested by the state and approved by CMS and is limited a 90-day period.
Fair Hearing	The administrative procedure established in §1902(a)(3) of the Act and further specified in 42 CFR Subpart E (42 CFR §431.200 through §431.246) that affords individuals the statutory right and opportunity to appeal adverse decisions regarding Medicaid eligibility or benefits to an independent arbiter. An individual has the opportunity to request a Fair Hearing when denied eligibility, when eligibility is terminated, or when denied a covered benefit or service.
FBR	See Federal Benefit Rate
Feasible Alternatives	The types of waiver services that may be available to an individual who is a candidate for entrance to the waiver (e.g., meets requirements for entrance such as the need for a level of care specified in the waiver). During the waiver entrance process, a person must be informed of the feasible alternatives under the waiver so that the person may exercise freedom of choice between waiver and institutional services.

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Federal Benefit Rate (FBR)	The maximum federal monthly payment that is paid to an SSI recipient or a couple who has no other countable income. The amount of the FBR is updated annually to take into account inflation by applying a Cost of Living Adjustment (COLA). The new COLA-adjusted FBR takes effect on January 1 of each calendar year.
Federal Financial Participation (FFP)	The technical term for federal Medicaid matching funds paid to states for allowable expenditures for Medicaid services or administrative costs. Except in certain circumstances, states receive FFP for service expenditures at different rates (FMAPs), depending on each state's per capita incomes. FFP for Medicaid administrative expenditures (see Administrative FFP) also varies in its rate, depending upon the type of administrative function as provided in §1903(a)(2) of the Act.
Federal Insurance Contributions Act (FICA)	The federal law that authorizes taxes on the wages of employed persons to provide for contributions to the federal Old Age, Survivors and Disability Insurance (OASDI – Social Security) and Medicare Health Insurance (Part A) programs. Covered workers and their employers pay FICA taxes in equal amounts.
Federal Medical Assistance Percentage (FMAP)	The statutory term for the federal Medicaid matching rate for medical assistance furnished under the State plan – i.e., the share of the costs of Medicaid *services* that the federal government bears. In most cases, FMAP varies from 50 to 83 percent, depending upon a state's per capita income. FMAP rates are re-calculated annually under the formula set forth in §1903(b) of the Act.
Federal Poverty Level (FPL)	The federal government's working definition of poverty that is used as the reference point for the income standard for Medicaid eligibility for certain groups of beneficiaries. The FPL is adjusted annually for inflation and is published by the Department of Health and Human Services in the form of Poverty Level Guidelines by household size.

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Federal Register (FR)	The official federal daily publication that contains proposed rules, final regulations and notices of federal agencies and organizations as well as Executive Orders and other Presidential documents. The Federal Register is cited by volume number and page number(s).
Federal Unemployment Tax Act (FUTA)	The Federal Employment Tax Act authorizes the Internal Revenue Service to collect a federal employer tax used to fund state workforce agencies. Employers pay this tax annually by filing IRS Form 940. FUTA covers the costs of administering the UI and Job Service programs in all states. In addition, FUTA pays one-half of the cost of extended unemployment benefits (during periods of high unemployment) and provides for a fund from which states may borrow, if necessary, to pay benefits.
Fee for Service	A method of paying providers for services rendered to individuals. Under a fee-for- service system, the provider is paid for each discrete service rendered to an individual.
FFP	See Federal Financial Participation
FICA	See Federal Insurance Contribution Act.
Financial Accountability	The assurance by a state that claims for federal financial participation in the costs of waiver services are based on state payments for waiver services that have been rendered to waiver participants, authorized in the service plan, and properly billed by qualified waiver providers in accordance with the approved waiver.
Financial Eligibility	In order to qualify for Medicaid, an individual must meet both categorical (e.g., have a disability) and financial eligibility requirements. Financial eligibility requirements vary state-to-state and by eligibility category. These requirements generally include limits on the amount of countable income (income standard) and the amount of countable resources (resource standard) an individual is allowed to have in order to qualify for coverage.

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Financial Management Services	A support that is provided to waiver participants who direct some or all of their waiver services. This support may be furnished as a waiver service or conducted as an administrative activity. When used in conjunction with the Employer Authority, this support includes (but is not necessarily limited to) operating a payroll service for participant employed workers and making required payroll withholdings. When used in conjunction with the Budget Authority, this support includes (but is not necessarily limited to) paying invoices for waiver goods and services and tracking expenditures against the participant-directed budget.
Fiscal Agent	The entity that processes or pays Medicaid vendor billings under contract with the Medicaid agency and that meets the requirements contained in 42 CFR §434.10. Sometimes referred to as a “financial intermediary.”
Fiscal/Employer Agent	A term used by the IRS for entities that perform tax withholding for employers.
FMAP	See Federal Medical Assistance Percentage
FPL	See Federal Poverty Level
FR	See Federal Register
Fraud and Abuse	In the context of provider billings for Medicaid services, *fraud* means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law. *Abuse* means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary costs to the Medicaid program. State plan requirements concerning fraud detection and investigation are located in 42 CFR §455.12 *et seq*.

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Free Choice of Provider	As specified in §1902(a)(23) of the Act and 42 CFR §431.51, the right of a Medicaid beneficiary to obtain Medicaid services from any institution, agency, pharmacy, person, or organization that is (a) qualified to furnish the services; and (b) willing to furnish them to the beneficiary. Free choice of provider may be limited under a waiver granted under §1915(b) of the Act. §1915(c) of the Act (the statute authorizing the HCBS waiver program) does not grant the Secretary the authority to waive §1902(a)(23) of the Act.
Freedom of Choice	The right afforded an individual who is determined to be likely to require a level of care specified in a waiver to choose either institutional or home and community-based services, as provided in §1915(c)(2)(C) of the Act and in 42 CFR §441.302(d).
Frequency (of services)	How often a service will be furnished to a beneficiary.
FUTA	See Federal Unemployment Tax Act
GAGAS	See Generally Accepted Government Auditing Standards
Generally Accepted Government Auditing Standards (GAGAS)	Standards for financial audits issued by the Comptroller General of the United States through the U.S. General Accounting Office. The standards and guidance apply to audits and attestation engagements of government entities, programs, activities, and functions, and of government assistance administered by contractors, nonprofit entities, and other nongovernmental entities. A number of statutes and other mandates require that auditors follow GAGAS. The Single Audit Act Amendments of 1996 (Public Law 104-156) require that GAGAS be followed in audits of state and local governments and nonprofit entities that receive federal awards. The Office of Management and Budget (OMB) Circular A-133, *Audits of States, Local Governments, and Non-Profit Organizations*, which provides the government-wide guidelines and policies on performing audits to comply with the Single Audit Act, also requires the use of GAGAS.

Glossary of Terms and Abbreviations

Grievance	A formal, beneficiary complaint about the way that a service provider is furnishing a Medicaid service or about the conduct of a waiver administrative process.
Habilitation	Services that are provided in order to assist an individual to acquire a variety of skills, including self-help, socialization and adaptive skills. Habilitation is aimed at raising the level of physical, mental, and social functioning of an individual. Habilitation is contrasted to rehabilitation which involves the restoration of function that a person has lost.
HCBS	Home and Community-Based Services
HCBS Quality Framework	The HCBS Quality Framework identifies seven focus areas concerning the operation of HCBS waiver programs and emphasizes the application of ongoing quality management activities (i.e., discovery, remediation, and improvement) to secure specified desired outcomes. The seven focus areas are participant access, participant-centered planning and service delivery, provider capacity and capabilities, participant safeguards, participant rights and responsibilities, participant outcomes and satisfaction, and system performance. The HCBS Quality Framework is located in Attachment A of the Instructions.
Health Insurance Portability and Accountability Act of 1996 (HIPAA)	The federal law (P.L. 104-191) that requires (among its other provisions) that each state's Medicaid management information system (MMIS) have the capacity to exchange data with the Medicare program and which contains "Administrative Simplification" provisions that require state Medicaid programs to use standard, national codes for electronic transactions related to the processing of health claims. HIPAA also mandates certain standards and practices with regard to the privacy of consumer health information.
HHS	U.S. Department of Health and Human Services
HIPAA	See Health Insurance Portability and Accountability Act of 1996

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Home Health Aide	A person who, under the supervision of a home health, assists elderly, ill or a person with a disability with household chores, bathing, personal care, and other daily living needs.
Home Health Services	As specified in 42 CFR §440.70, the provision of part-time or intermittent nursing care and home health aide services and, at a state's option, physical therapy, occupational therapy, speech pathology and audiology services, medical equipment, medical supplies, and appliances that are provided to Medicaid beneficiaries in their place of residence. Home health services are a mandatory Medicaid benefit. Home health services must be ordered by a physician as part of a plan of care that the physician reviews at least every sixty days.
Homemaker Services	The performance of general household tasks (e.g., meal preparation and routine household care) provided by a qualified homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home.
IADL	See Instrumental Activities of Daily Living
IBA	See Individual Budget Amount
ICF/MR	See Intermediate Care Facility for the Mentally Retarded
IDEA	See Individuals with Disabilities Education Improvement Act of 2004
IGT	See Intergovernmental Transfer
IMD	See Institutions for Mental Disease
Income Standard	The maximum amount of countable income that a person can have and still be financially eligible for Medicaid.
Indicator	A key quality characteristic that is measured, over time, in order to assess the performance, processes, and outcomes of service delivery components.

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Individual Budget Amount (IBA)	As used in the waiver application, the term "individual budget amount" means a prospectively-determined amount of funds that the state makes available for the provision of waiver services to a participant. The IBA may encompass all waiver services or a subset of waiver services. An IBA may serve as the basis for but is not necessarily synonymous with the term "participant-directed budget" when a waiver provides for the Budget Authority participant direction opportunity.
Individual Cost Limit	A limitation on the entrance of individuals to a waiver that is based on the comparison of the expected costs of HCBS waiver and State plan services to the expected costs of institutional and State plan services that the person would receive in lieu of participation in the waiver. When a state adopts an individual cost limit, the state denies entrance to the waiver when the expected cost of HCBS waiver and State plan services required by an individual exceeds the limit established by the state.
Individual Risk Agreement (Contract)	An agreement that outlines the risks and benefits to the participant of a particular course of action that might involve risk to the participant, the conditions under which the participant assumes responsibility for the agreed upon course of action, and the accountability trail for the decisions that are made. A risk agreement permits individuals to assume responsibility for their choices personally, through surrogate decision makers, or through planning team consensus.
Individuals with Disabilities Education Improvement Act of 2004 (IDEA)	The federal law (P.L. 108-446; 20 USC §1400 *et seq*.) that ensures "that all children with disabilities have available to them a free appropriate public education that emphasizes special education and related services designed to meet their unique needs and prepare them for further education, employment, and independent living."

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Information and Assistance in Support of Participant Direction	Activities that are undertaken to assist a waiver participant to direct and manage his/her waiver services. Such activities might include assisting a participant in carrying out employer responsibilities under the Employer Authority or locating sources of waiver goods and services and managing the participant-directed budget. This support is furnished by individuals or entities that work on behalf of and under the direction of the person. These activities may be provided as a distinct waiver service, in conjunction with the provision of case management, as an administrative activity or using a combination of service delivery methods. Also known as “supports brokerage” or “personal agent.”
Institution	In the context of the waiver application, a hospital, nursing facility or ICF/MR for which the state makes Medicaid payment under the State plan.
Institutions for Mental Disease (IMD)	As defined in 42 CFR §435.1009, an IMD is a public or private facility that has more than 16 beds and is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases (disorders). This includes not just public or private hospitals for individuals with mental illness but also nursing homes or other long-term care facilities that primarily serve such individuals. As provided in 42 CFR §435.1008, federal Medicaid matching funds are not allowable for the costs of any Medicaid services furnished to individuals under 65 years of age who reside in an IMD except that, per 42 CFR §440.160, a state may provide optional inpatient coverage for individuals under age 21 in accredited psychiatric facilities. Per 42 CFR §440.140, a state may provide optional coverage for individuals age 65 and older in hospitals or nursing facilities that are IMDs. A facility that serves fewer than 17 individuals with mental disorders is not considered an IMD.

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Instrumental Activities of Daily Living (IADL)	Activities related to independent living, including preparing meals, managing money, shopping for groceries or personal items, performing light or heavy housework, and communication. The extent to which a person requires assistance in performing IADLs is often assessed in conjunction with the evaluation of level of care.
Interagency Agreement	A formal document that sets forth the responsibilities that are assumed by two or more governmental agencies in their pursuit of common goals and objectives. In the context of the HCBS waiver, the Medicaid agency may enter into an interagency agreement (or, alternatively, a Memorandum of Understanding or MOU) with another state agency to operate a waiver, provided that the Medicaid agency retains ultimate authority over the administration of the waiver.
Intergovernmental Transfer (IGT)	The transfer of non-Federal public funds from a local government or another state agency to the Medicaid agency for the purpose of providing the non-federal share of a Medicaid expenditure in order to draw down federal Medicaid matching funds.
Intermediate Care Facility for the Mentally Retarded (ICF/MR)	A public or private facility that provides health and habilitation services to individuals with mental retardation or related conditions (e.g., cerebral palsy). The ICF/MR benefit is an optional Medicaid service that is authorized in §1905(d) of the Act. Ices/MR facilities have four or more beds and must provide active treatment to their residents.
IRS	Internal Revenue Service

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Katie Beckett Option	The popular name for the Medicaid eligibility option available to states under §1902(e)(3) of the Act to extend Medicaid eligibility to children with disabilities or chronic conditions under the age of 19 who require the level of care provided in a hospital, nursing facility, or ICF/MR but who can be cared for at home and would not otherwise qualify for Medicaid unless institutionalized. This option is sometimes called the TEFRA 134 option. Federal regulations concerning this eligibility option are located in 42 CFR §435.225.
Keys Amendment	The popular name for the requirement contained in §1616(e) of the Act which requires that each state establish, maintain, and insure the enforcement of standards for any category of institutions, foster homes, or group living arrangements in which a significant number of SSI recipients resides or is likely to reside. The standards must be: (a) appropriate to the needs of residents and the character of the facilities involved and (b) govern such matters as admission policies, safety, sanitation, and protection of civil rights.
Legal Representative	A person who has legal standing to make decisions on behalf of another person (e.g., a guardian who has been appointed by the court or an individual who has power of attorney granted by the person).
Legally Responsible Individual	A person who has a legal obligation under the provisions of state law to care for another person. Legally responsible individuals include the parents (natural or adoptive) of minor children, legally-assigned caretaker relatives of minor children, and spouses.
LEP	See Limited English Proficient Persons
Level of Care	The specification of the minimum amount of assistance that an individual must require in order to receive services in an institutional setting under the State plan.

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License	Proof of official or legal permission issued by the government for an entity or individual to perform an activity or service. In the absence of a license, the entity or individual is debarred from performing the activity or service.
Limited English Proficient (LEP) Persons	Individuals who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English may be limited English proficient (LEP) and eligible to receive language assistance in conjunction with a particular type of service, benefit, or encounter. Recipients of federal assistance from HHS (including Medicaid) are required to provide language assistance to LEP persons under the HHS Office of Civil Rights guidelines that are included in Attachment D to these instructions.
Line of Authority	In the context of the waiver application, the specification of whether a waiver is operated by the Medicaid agency or by another state agency under the supervision of the Medicaid agency.
Live-In Caregiver	An unrelated personal caregiver who resides in the same household as the waiver participant. For purposes of the waiver, a live-in caregiver does not include staff or personnel who reside with a participant or participants in a residence that is owned or leased by a provider of Medicaid services.
Local/Regional Non- State Entity	A local or regional public agency or a non-governmental organization that performs waiver operational and administrative functions on behalf of the state. Such entities do not include the local or regional offices of state agencies.
Long-Term Care	A variety of services that help people with health or personal needs and activities of daily living over a period of time. Long-term care can be provided at home, in the community, or in various types of facilities, including nursing homes and assisted living facilities.

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Maintenance Allowance	A term that is sometimes used for the amount of income that a waiver participant in the §435.217 group is permitted to retain in order to meet shelter, food and other living expenses of the waiver participant (and his/her spouse and family, if applicable) in the community
Managed care	A method of organizing and financing the delivery of health care and other services that emphasizes cost-effectiveness and coordination of care. Managed care organizations receive a fixed amount of money per member per month (called a capitation), no matter how much care a member needs during that month. Managed care integrates the financing and delivery of appropriate services to covered individuals by means of: arrangements with selected providers to furnish an array of services to members, explicit criteria for the selection of health care providers, and financial incentives for members to use providers and procedures associated with the plan. Federal Medicaid managed care regulations are located in 42 CFR §438.
Managed Care Organization (MCO)	As defined in 42 CFR §438.2, an entity that has a comprehensive risk contract with the Medicaid agency and is (1) A federally qualified Health Maintenance Organization (HMO) or (2) makes the services it provides to its Medicaid enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid recipients within the area served by the entity.
Managing Employer	See Agency with Choice Model.
Mandatory	The term used to describe the eligibility groups and services that a state which participates in the Medicaid program must include in its program.
MCO	See Managed Care Organization

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Measure	A numeric value associated with an indicator. In the quality management context, a quality indicator describes the attributes of care or services related to quality. A measure is a way of quantifying attributes. For example, a quality indicator might be expressed as "eligibility is determined promptly." A measure associated with this indicator could be "the average number of days to complete eligibility determination."
Mechanical Restraint	Any device attached or adjacent to an individual's body that he or she cannot easily remove that restricts freedom of movement or normal access to his or her body.
Medicaid	The joint federal and state program to assist states in furnishing medical assistance to eligible needy persons. Federal law concerning the Medicaid program is located in Title XIX of the Act. Within broad national guidelines established by federal statutes, regulations, and policies, each state (1) establishes its own eligibility standards; (2) determines the type, amount, duration, and scope of services; (3) sets the rate of payment for services; and (4) administers its own program.
Medicaid agency	See Single State Agency

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Medicaid Buy-In	Refers to the Medicaid eligibility options that were created in BBA-97 and the Ticket to Work and Work Incentives Improvement Act of 1999 that permit states to provide Medicaid to working people with disabilities whose earnings are otherwise too high for them to qualify for Medicaid. In particular, states may elect to cover: • Working individuals with disabilities with incomes up to 250% of poverty (BBA-97; §§1902(a)(10)(A)(ii)(XIII)) of the Act • Working individuals with disabilities who are at least age 16, but less than 65 years of age using income and resource limits set by the State (TWWIIA; §1902(a)(10)(A)(ii)(XV) of the Act, and • Employed individuals covered under the group described above who lose that coverage due to medical improvement, but who still have a medically determinable severe impairment. (TWWIIA §1902(a)(10)(A)(ii)(XVI) of the Act).
Medicaid Management Information System (MMIS)	A CMS-approved information system that supports the operation of the Medicaid program. The MMIS includes the following types of sub-systems or files: recipient eligibility, Medicaid provider, claims processing, pricing, SURS, MARS, and potentially encounter processing.
Medical Assistance	The term used in Title XIX of the Act to refer to the payment for items and services covered under a state's Medicaid program on behalf of Medicaid beneficiaries.
Medical Assistance Unit	The state government entity established in accordance with 42 CFR §431.11(b). The Medical Assistance Unit may be the same as the Medicaid agency or a division/unit within the Medicaid agency.
Medically Necessary	Services or supplies that are proper and needed for the diagnosis or treatment of a medical condition, are provided for the diagnosis, direct care, and treatment of the condition, and meet the standards of good medical practice.

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Medically Needy	A term used to describe an optional Medicaid eligibility group made up of individuals who qualify for coverage because of high medical expenses, commonly hospital or nursing home care. These individuals meet Medicaid categorical requirements (i.e., they are children or parents or aged or individuals with disabilities) but their income is too high to permit them to qualify for categorically needy coverage. Instead, they qualify for coverage by spending down (i.e., reducing their income by incurring medical expenses). States that elect to cover the medically needy do not have to offer the same benefit package to them as they offer to the categorically needy.
Medically Needy Income Level (MNIL)	The maximum amount of income remaining after spenddown that permits an individual to qualify for the medically-needy eligibility group. The MNIL varies by state.
Medicare	The federally-administered health insurance program established in Title XVIII of the Act for persons age 65 and older and certain persons with disabilities under age 65. Medicare eligibility is determined by the Social Security Administration. Medicare has three parts: Part A (hospital insurance); Part B (optional medical insurance which covers physicians' services and outpatient care in part and which requires the payment of a monthly premium); and, Part D (prescription drugs).
Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA)	The federal legislation (P.L. 108-173) that, among its other provisions, created the Part D Prescription Drug Benefit for Medicare beneficiaries.
Medication Administration	The provision of a medication by a service provider to an individual who is not able to self-administer his/her own medications.

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Medication Error	A mistake in medication administration that includes but is not necessarily limited to the following: (a) wrong medication (an individual receives and takes medication which is intended for another person, discontinued, or inappropriately labeled; (b) wrong dose (an individual receives the incorrect amount of medication); (c) wrong time (an individual receives medication dose at an incorrect time interval); and, (d) omission (missed dose) is when an individual does not receive a prescribed dose of medication, not including when an individual refuses to take medication.
Medication Management	Processes and activities that are undertaken in order to ensure that the full range of medications that a person receives is appropriate. Medication management may include periodic review of medications to determine their necessity, to identify possible over medication, and to identify contraindicated medications.
Memorandum of Understanding (MOU)	See Interagency Agreement.
Mental Retardation	A condition/disability that is manifested by (1) significant sub-average intellectual functioning as measured on a standardized intelligence test; (2) significant deficits in adaptive behavior/functioning (e.g., daily living, communication and social skills); and, (3) on-set during the developmental period of life (prior to age 18).
Methodology (Eligibility)	The rules that a state uses in counting an individual's income or resources in determining whether he or she meets its Medicaid eligibility standards. For some eligibility categories, states have the flexibility to disregard certain income and resources in determining whether the individual qualifies for Medicaid.
MMA	See Medicare Prescription Drug, Improvement, and Modernization Act of 2003
MNIL	See Medically Needy Income Level

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Model Waiver	A HCBS waiver that is designed to serve no more than 200 individuals at any point in time. It is a state option to designate a waiver as a model waiver.
Monitoring	The ongoing oversight of the provision of waiver and other services to determine that they are furnished according to the participant's service plan and effectively meet his/her needs, including assuring health and welfare. Monitoring activities may include (but are not limited to) telephone contact, observation, interviewing the participant and/or the participant's family (as appropriate) (in person or by phone), and/or interviewing service providers.
MOU	Memorandum of Understanding; see also Interagency Agreement
Neglect	The failure to provide an individual the reasonable care that s/he requires, including but not limited to food, clothing, shelter, medical care, personal hygiene, and protection from harm.
Non-Federal Share	The amount of funds that a state must provide from its own funds or other permissible funding sources (e.g., local tax revenues) toward the cost of Medicaid services or administrative activities.
Non-Risk Contract	A type of Medicaid contract under which a provider furnishes an array of Medicaid services but is not at financial risk for changes in utilization or for costs incurred under the contract, subject to the upper payment limits specified in 42 CFR §447.362. The provider may be reimbursed by the state at the end of the contract period on the basis of the incurred costs, subject to the specified limits.

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Nursing Facility (NF)	Sometimes referred to as nursing homes. Nursing facility services for individuals age 21 and older are a mandatory Medicaid benefit. A state may provide nursing facility services to individuals under age 21 on an optional basis. Nursing facilities are institutions that primarily provide: • Skilled nursing care and related services for residents who require medical or nursing care; • Rehabilitation services for the rehabilitation of injured, disabled or sick persons; and/or • Health-related care and services, on a regular basis, to individuals who because of their mental or physical condition require care and services, above the level of room and board, which can be made available to them only through institutional facilities.
OASDI	See Old-Age, Survivors, and Disability Insurance
Office of Inspector General (OIG)	The agency within HHS charged with the responsibility to protect the integrity of HHS programs, as well as the health and welfare of the beneficiaries of those programs. The OIG has a responsibility to report both to the Secretary and to the Congress program and management problems and recommendations to correct them. OIG duties are carried out through a nationwide network of audits, investigations, inspections and other mission-related functions performed by OIG components.
OHCDS	See Organized Health Care Delivery System
Old-Age, Survivors, and Disability Insurance (OASDI)	The Social Security programs that pay monthly cash benefits to (1) retired-worker (old-age) beneficiaries, their spouses and children, and survivors of deceased insured workers (OASI); and (2) disabled-worker beneficiaries and their spouses and children, and for providing rehabilitation services to the disabled (SSDI). These programs are established in Title II of the Social Security Act.

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Ombudsman	A representative of a public agency or a private nonprofit organization who is empowered under state law to investigate and resolve complaints made by or on behalf of individuals who receive services. Under the provisions of the Older Americans Act, each state has established a Long-Term Care Ombudsman Office to investigate and resolve complaints about services in nursing and certain other long-term care facilities. Some states have established similar programs for individuals with disabilities.
Operating Agency	A state agency other than the Medicaid agency that is responsible for the day-today operation and administration of a waiver. An operating agency conducts waiver operation and administration functions under an interagency agreement or memorandum of understanding with the Medicaid agency.
Operation (Waiver)	The constellation of administrative activities and processes that are necessary so that individuals may receive services through the waiver. Such activities may include functions such as payment rate determination, training and technical assistance, utilization management, and prior authorization.
Optional	The term used to describe Medicaid eligibility groups or service categories that states may cover if they choose and for which they may receive FFP.

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Organized Health Care Delivery System (OHCDS)	As defined in 42 CFR §447.10, an OHCDS is an organization that provides at least one Medicaid service directly (utilizing its own employees) and contracts with other qualified providers to furnish other services. When there is an OHCDS, the required Medicaid provider agreement is executed between the state and the OHCDS. Since the OHCDS acts as the Medicaid provider, it is not necessary for each subcontractor of an OHCDS to sign a provider agreement with the Medicaid agency. (However, subcontractors must meet the standards under the waiver to provide waiver services for the OHCDS.) When OHCDS provides waiver services, payment is made directly to the OHCDS and the OHCDS reimburses the subcontractors. Waiver providers may not be restricted to participating only through an OHCDS. Such an arrangement must be voluntary. In addition, participants may not be required to secure services exclusively through an OHCDS.
Outcome	The result of the performance (or nonperformance) of a function or process, including the provision of services.
Outcome Indicator	A key quality characteristic that is measured, over time, in order to assess whether the provision of services or the performance of activities resulted in a desired result.
PACC	See Program for All-Inclusive Care for Children
Part D	The Medicare Prescription Drug Benefit that was established by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) to take effect on January 1, 2006.
Participant	An individual who has met waiver entrance requirements, chooses to receive waiver services, enters the waiver and subsequently receives waiver services authorized in a service plan.
Participant Cap	A term used to describe the maximum number of individuals who may participate in a waiver during the year.

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Participant Direction	Provision of the opportunity for a waiver participant to exercise choice and control in identifying, accessing, and managing waiver services and other supports in accordance with their needs and personal preferences.
Participant-Centered	A general term used to describe waiver processes and activities that are designed to address each participant's unique goals, preferences and needs.
Participant-Directed Budget	An amount of waiver funds that is under the control and direction of the waiver participant when a waiver makes available the Budget Authority participant direction opportunity. Sometimes called the "individual budget."
Participant-Directed Service	A waiver service that the state specifies may be directed by the participant using the Employer Authority, the Budget Authority or both.
Performance Measure	A gauge used to assess the performance of a process or function of any organization. Quantitative or qualitative measures of the services that are delivered to individuals (process) or the end result of services (outcomes). Performance measures also can be used to assess other aspects of an individual or organization's performance such as access and availability of care, utilization of care, health plan stability, beneficiary characteristics, and other structural and operational aspect of health care services.
Personal Agent	See Information and Assistance in Support of Participant Direction

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Personal Care Services	A range of human assistance provided to persons with disabilities and chronic conditions of all ages to enable them to accomplish tasks that they would normally do for themselves if they did not have a disability. Assistance may take the form of hands-on assistance or as cueing so that the person performs the task by him/herself. Such assistance most often relates to performance of activities of daily living (ADLs) and instrumental activities of daily living (IADLs), which includes assistance with daily activities such as eating, bathing, dressing, toileting, transferring, personal hygiene, light housework, medication management, etc. Personal care may be furnished in the home or outside the home. Also known as “personal assistance” or “attendant care.” Personal care is an optional State plan benefit (42 CFR §440.167) and is a waiver service recognized in §1915(c) of the Act.
Personal Needs Allowance	In the case of a Medicaid beneficiary who is a resident of a nursing facility or ICF/MR, the amount of monthly income that he or she is allowed to keep for personal expenses like haircuts and laundry. The remainder of the beneficiary’s monthly income is applied to the costs of care at the facility. The minimum PNA that a state must allow an institutionalized beneficiary is $30 per month. In the context of the waiver application, the PNA is the amount of income that a waiver participant is allowed to keep to meet living expenses when a state that uses spousal impoverishment eligibility rules also elects to apply spousal posteligibility rules to individuals in the §435.217 group who have a community spouse. The PNA amount specified by the state must be sufficient to meet the persons food, shelter and other living expenses in the community.
Personal Restraint	Personal restraint means the application of physical force without the use of any device, for the purposes of restraining the free movement of an individual's body.

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Person-Centered Planning	An assessment and service planning process is directed and led by the individual, with assistance as needed or desired from a representative or other persons of the individual's choosing. The process is designed to identify the strengths, capacities, preferences, needs, and desired outcomes of the individual. The process may include other persons, freely chosen by the individual, who are able to serve as important contributors to the process. The PCP process enables and assists the individual to identify and access a personalized mix of paid and non-paid services and supports that assist him/her to achieve personally defined outcomes in the community.
Persons Living With AIDS (PLWAs)	Individuals who have Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) Infection
PETI	See Post Eligibility Treatment of Income
Phase-In	The planned implementation or expansion of an HCBS waiver program over a specified period of time by increasing the waiver participant cap in staged increments across one or more waiver years.
Phase-Out	The planned contraction of an HCBS waiver program over a specified period of time by decreasing the participant cap in specified decrements across one or more waiver years.
Plan of Care	See Service Plan
Post Eligibility Treatment of Income (PETI)	The determination of the financial liability (if any) of waiver participants who are in the §435.217 group for their share of the costs of waiver services. PETI calculations are only made for members of the §435.217 group. A state must provide for an allowance for the needs of the waiver participant to meet shelter, food and other living expenses in the community, an allowance for the needs of a spouse and the participant's family (if applicable), and medical and remedial care expenses for services not covered under the State plan.

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Poverty-Level Groups	A popular term for eligibility groups, both mandatory and optional, for whom Medicaid income eligibility is determined against an income standard that is based on a percentage of the federal poverty level (FPL) (e.g., pregnant women and infants with family incomes at or below 133 percent of the FPL).
Premium	A regularly-paid specified dollar amount that a Medicaid beneficiary must pay by virtue of enrollment in the Medicaid program.
Prepaid Ambulatory Health Plan (PAHP)	As defined in 42 CFR §438.2, an entity that: (1) provides medical services to Medicaid enrollees under contract with the Medicaid agency on the basis of prepaid capitation payments, or other payment arrangements that do not use State plan payment rates; (2) does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees; and (3) does not have a comprehensive risk contract.
Prepaid Health Plan	A prepaid managed care entity that provides less than comprehensive services on an at-risk basis or one that provides any benefit package on a non-risk basis. BBA-97 defines two types of prepaid health plans: prepaid ambulatory plans and prepaid inpatient plans.
Prepaid Inpatient Health Plan (PIHP)	As defined in 42 CFR §438.2, an entity that: (1) provides medical services to enrollees under contract with the Medicaid and on the basis of prepaid capitation payments, or other payment arrangements that do not use State plan payment rates; (2) provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and, (3) does not have a comprehensive risk contract.

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Prior Authorization	A mechanism that is employed to control the 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, payment is not made unless approval for the item or service is obtained in advance either from state agency personnel or from a state fiscal agent or other contractor.
Private Residence	As used in the waiver application: (1) The home that a waiver participant owns or rents in his or her own right or the home where a waiver participant resides with other family members or friends. A private residence is not a living arrangement that is owned or leased by a service provider; or, (2) The home of a caregiver who furnishes foster or respite care to a waiver participant
Process	A goal-directed, interrelated series of actions, events, mechanisms, or steps.
Process Improvement	A methodology utilized to make improvements to a process through the use of continuous quality improvement methods.
Process Indicator	A gauge that measures a goal-directed interrelated series of actions, events, mechanisms, or steps.
Program for All-Inclusive Care for Children (PACC)	A program offering a blended package of curative and palliative care services designed to provide support for children with life-threatening conditions and their families.
Provider	A qualified individual or entity that undertakes to render Medicaid services to beneficiaries and has an agreement with the Medicaid agency.
Provider Agreement	The contract between the Medicaid agency and a service provider under which the provider or organization agrees to furnish services to Medicaid beneficiaries in compliance with state and federal requirements. Federal regulations concerning provider agreements are located at 42 CFR §431.107.

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Provider Qualification	Standards established by the state that specify the education, training, skills, competencies and attributes that an individual or provider agency must possess in order to furnish services to waiver participants.
Provider Tax	A tax, fee, assessment, or other mandatory payment that health care providers are required to make to the state. In limited circumstances, a state may use revenues derived from provider taxes to meet the non-federal share of Medicaid expenditures. These circumstances are specified in federal Medicaid law and regulations (see 42 CFR §433.55 – 433.74).
Provider-Managed Service	A waiver service for which a provider is responsible for directing and managing in accordance with the service plan. In the waiver application, a state may designate a service as provider managed, participant-directed or both.
Pubic Input	As used in the waiver application, processes that are undertaken in order to obtain the comments, suggestions and recommendations of parties affected by a waiver concerning its design and operation.
QMS	See Quality Management Strategy
Quality Assurance	The process of looking at how well a service is provided. The process may include formally reviewing the services furnished to a person or group of persons, identifying and correcting problems, and then checking to see if the problem was corrected.
Quality Management	The performance of discovery, remediation and quality improvement activities in order to ascertain whether the waiver meets the assurances, correct shortcomings, and pursue opportunities for improvement. Quality management also is employed to address other areas of waiver performance.

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Quality Management Strategy (QMS)	The document that is submitted with the waiver application that describes how the state will continually assess whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and how it identifies opportunities for improvement. A QMS describes the processes of discovery, remediation and quality improvement activities; the frequency of those processes; the source and types of information gathered, analyzed, and utilized to measure performance; and key roles and responsibilities for managing quality. The QMS may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will go beyond regulatory requirements. Information about performance and updates to the QMS will be submitted using the CMS-373Q when it takes effect.
RAI	See Request for Additional Information
Reassignment (of Payment)	The voluntary assignment of the payment for services by the provider to a governmental entity.
Reevaluation	The periodic but at least annual review of an individual's condition and service needs to determine whether the person continues to need a level of care specified in the waiver.
Regular Waiver	A waiver program that is not a model waiver. A regular waiver may serve any number of participants.

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Rehabilitation

Services that have the purpose of improving/restoring a person's physical or mental functioning. Such services may include therapeutic services such as occupational and physical therapy services, as well as mental health services such as individual and group psychological therapies, psychosocial services, and addiction treatment services. Rehabilitative services may be provided at home, in the community or in long-term care facilities. Medicaid rehabilitation services, defined at 42 CFR §440.130(d), may be covered as an optional State plan benefit or as waiver services.

Related Condition

For the purpose of ICF/MR services and as provided in 42 CFR §435.1009, a person with related conditions is an individual who has a severe, chronic disability that meets all of the following conditions:

(a) It is attributable to-- (1) Cerebral palsy or epilepsy; or (2) Any other condition, other than mental illness, found to be closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, and requires treatment or services similar to those required for these persons.

(b) It is manifested before the person reaches age 22.

(c) It is likely to continue indefinitely.

(d) It results in substantial functional limitations in three or more of the following areas of major life activity:

- (1) self-care;
- (2) understanding and use of language;
- (3) learning;
- (4) mobility;
- (5) self-direction;
- (6) capacity for independent living.

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Remediation	Activities designed to correct identified problems at the individual, provider or system level. Examples of individual level remediation include providing additional needed services when discovery activities indicate that an individual/participant has not received the necessary services. Provider level remediation includes sanctioning a provider for failure to re-evaluate participants in accordance with state policy. System-level remediation activities may include the correction of underlying waiver design problems.
Representative	A person who may act on behalf of another. A representative may be: (a) a legal representative (a court-appointed guardian, a parent of a minor child, or a spouse) or (b) an individual (family member or friend) selected by an adult to speak for and act on his/her behalf.
Request for Additional Information (RAI)	A formal, written document issued by CMS that identifies serious problems with a waiver request that potentially could cause CMS to disapprove the request. An RAI stops the 90-day clock. Once a state responds to the RAI, a new 90-day clock is started.
Resource Standard	The maximum amount of countable resources a person can have and still be eligible for Medicaid.
Resources	Sometimes referred to as assets, resources are items of economic value that are not income. Resources include financial instruments such as savings accounts and certificates of deposit, personal property such as an automobile (above a specified value), and real estate (other than an individual's home). Some Medicaid eligibility groups must meet a resource test; others (at state option) are not subject to a resource test. In establishing a resource test, a state must specify both the resource standard (e.g., the amount of countable resources an individual may retain and still be eligible for Medicaid) and the resource methodology (e.g., the resources that are counted and how are they valued).
Restraint	Any physical, chemical or mechanical intervention that is used to control acute, episodic behavior that restricts the movement or function of the individual or a portion of the individual's body.

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Restrictive Intervention	An action or procedure that limits an individual's movement, a person's access to other individuals, locations or activities, or restricts participant rights. Restraints or seclusion are a subset of restrictive interventions.
Risk	Factors that, if unaddressed, might pose a high threat to an individual's health and welfare. These include: (a) health risk (medical conditions that require continuing care and treatment); (b) behavioral risk (behaviors or conditions that might cause harm to the person or others); and, (c) personal safety risk (e.g., safe evacuation).
Risk Management Agreement	See Individual Risk Agreement
RO	CMS Regional Office
Room and Board	The term "room" means shelter type expenses, including all property-related costs such as rental or purchase of real estate and furnishings, maintenance, utilities, and related administrative services. The term "board" means three meals a day or any other full nutritional regimen. Board does not include the provision of a meal at an adult day health or similar facility outside the participant's home. Board also does not include the delivery of a single meal to a participant at his/her own home through a meals-on-wheels service.
Safeguard	Policies or procedures that are designed to prevent harm to an individual or to ensure that the application of a policy takes into account potentially adverse effects on a person.
Seclusion	Seclusion means the involuntary confinement of an individual alone in a room or an area from which the individual is physically prevented from having contact with others or leaving.
Secretary	Secretary of the U.S. Department of Health and Human Services
Self-Administration	The administration of medications or other procedures by a person without assistance.

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Self-Direction	See Participant Direction
Serious Emotional Disturbance	The range of diagnosable emotional, behavioral, and mental disorders that are of sufficient duration so as to result in functional impairment that substantially interferes with or limits one or more major life activities of children and adolescents up to age 18 in the home, school, or community. Such disorders include externalizing behavior disorders (e.g., attention deficit hyperactivity disorder and conduct disorder), internalizing emotional disorders (e.g., anxiety and depression) and other disorders of lesser frequency but often great severity, such as bipolar disorder, pervasive developmental disorder, and psycho-physiological disorder.
Serious Injury	An injury that requires the provision of medical treatment beyond what is commonly considered first aid.
Serious Mental Illness	Pursuant to §1912(c) of the Public Health Service Act, adults with serious mental illnesses are persons: (1) age 18 and over and (2) who currently have, or at any time during the past year have had a diagnosable mental, behavioral or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-IV or their ICD-9-CM equivalent (and subsequent revisions) with the exception of DSM-IV "V" codes, substance use disorders, and developmental disorders, which are excluded, unless they co-occur with another diagnosable serious mental illness and (3) the disorder has resulted in functional impairment, which substantially interferes with or limits one or more major life activities.

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Service Plan	As used in the waiver application, the written document that specifies the waiver and other services (regardless of funding source) along with any informal supports that are furnished to meet the needs of and to assist a waiver participant to remain in the community. The service plan must contain, at a minimum, the types of services to be furnished, the amount, the frequency and duration of each service, and the type of provider to furnish each service. FFP may only be claimed for the waiver services that are furnished to a waiver participant when they have been authorized in the service plan. In the application, "service plan" is synonymous with the statutory term "plan of care."
Single Audit Act Amendments of 1996	The federal law (P.L. 104-156, U.S.C. Title 31, Chapter 75) that establishes standards for the performance of audits of entities that receive federal funds, including Medicaid.
Single State Agency	The agency within state government that has been designated pursuant to §1902(a)(5) of the Act as responsible for administration of the State plan. The single state agency is not required to directly administer the entire Medicaid program; it may provide that administrative functions are conducted by other state (or local) agencies or private contractors (or both) so long as the Single State Agency maintains ultimate authority and responsibility for the administration of the State plan. In the waiver application, the Single State Agency is referred to as the Medicaid agency.
Social Security Act	Public Law 74-271, enacted on August 14, 1935, and its subsequent amendments. The Medicaid program is authorized in Title XIX of the Act; the Medicare program is authorized in Title XVIII of the Act; and, Title XXI of the Act establishes the State Children's Health Insurance Program.
Social Security Administration (SSA)	The federal agency that, among its other duties, administers the Old Age, Survivors, and Disability Insurance (OASDI) and Supplemental Security Income (SSI) programs and determines the initial entitlement to and eligibility for Medicare benefits.

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Social Security Disability Insurance (SSDI)	The system of federally provided payments to eligible workers (and, in some cases, their families) when they are unable to continue working because of a disability. Benefits begin with the sixth full month of disability and continue until the individual is capable of substantial gainful activity.
SPA	See State Plan Amendment
Special Home and Community-Based Waiver Group	The eligibility group defined in 42 CFR §435.217 that is composed of individuals in the community who would be eligible for Medicaid if institutionalized to whom the state elects to provide waiver services. Also referred to as the §435.217 group.
Special Income Group	The eligibility group defined in 42 CFR §435.236 that is composed of individuals in institutions who have too much income to qualify for SSI benefits but not enough income to cover their expensive long-term care. This group also is referred to as individuals who qualify for Medicaid under the 300% of SSI rule. A state may provide that persons with incomes up to 300% (or a lower percentage specified by the state) of the SSI FBR may qualify for Medicaid when institutionalized.
Spenddown	For most Medicaid eligibility categories, having countable income above a specified amount disqualifies an individual from Medicaid. However, in some eligibility categories—most notably the “medically needy”—individuals may qualify for Medicaid coverage even though their countable incomes are higher than the specified income standard by “spending down” to the Medically Needy Income Level. Under this process, the medical expenses that an individual incurs during a specified period are deducted from the individual’s income during that period. Once the individual’s income has been reduced to a state-specified level by subtracting incurred medical expenses, the individual qualifies for Medicaid benefits for the remainder of the period.

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Spousal Impoverishment Protections	The term used to describe the set of eligibility rules that states are required to apply under the provisions of §1924 of the Act in the case when a Medicaid beneficiary resides in a nursing facility and his or her spouse remains in the community. The rules, which specify minimum amounts of income and resources each spouse is allowed to retain without jeopardizing the institutionalized spouse's eligibility for Medicaid benefits, are designed to prevent the impoverishment of the community spouse. A state may elect to use these rules in determining eligibility for a waiver.
SSA	See Social Security Administration
SSDI	See Social Security Disability Insurance
SSI	See Supplemental Security Income
SSI Criteria State	A state that uses the SSI income and resource criteria to determine eligibility for Medicaid for aged, blind and disabled individuals but requires that such individuals apply separately to the state for Medicaid.
State Medicaid Director (SMD) Letter	A formal letter issued by the Director of the Center for Medicaid and State Operations (CMSO) to state Medicaid directors for the purpose of providing technical guidance or updated information regarding the operation of the Medicaid program.
State Medicaid Plan (State Plan)	The document that specifies the eligibility groups that a state will serve through its Medicaid program, the benefits that state covers, and how the state addresses additional federal Medicaid statutory requirements concerning the operation of its Medicaid program. The State plan must be submitted to and approved by CMS, acting on behalf of the Secretary of HHS. Proposed changes to the State plan take the form of State plan amendments (SPAs) that are submitted to, reviewed and approved by CMS.
State Plan	See State Medicaid Plan

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State Plan Amendment (SPA)	In order to change its Medicaid eligibility criteria or its covered benefits or its provider reimbursement methodology, a state must amend its state Medicaid plan to reflect the proposed change. Similarly, states must conform their state plans to changes in federal Medicaid law. In either case, the state must submit a state plan amendment (SPA) to CMS for approval.
State Supplementary Payment (SSP)	The amount (if any) by which a state elects to supplement the basic SSI cash assistance payment to individuals and couples.
State Unemployment Tax (SUTA)	The tax paid to a state workforce agency that is used solely for the payment of benefits to eligible unemployed workers.
Statewideness	The requirement in §1902(a)(1) of the Act that a state must operate its Medicaid programs throughout the state and may not exclude individuals residing in, or providers operating in, particular counties or municipalities. This requirement may be waived under §1115, §1915(b), and §1915(c) waivers.
Supplemental (or Enhanced) Payment	Any payment to a Medicaid provider that is in addition to the state's standard direct payment for services rendered to a Medicaid beneficiary and billed by a provider.
Supplemental Security Income (SSI)	The federal entitlement program established under Title XVI of the Act to provide cash assistance to certain persons who are aged, blind, or disabled and whose income and resources fall below the SSI income and resource standards that are set by the federal government.
Supports Broker (Brokerage)	See Information and Assistance in Support of Participant Direction
SUTA	See State Unemployment Tax

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Target Group	A group of Medicaid beneficiaries who have similar needs, conditions or characteristics to whom a state elects to furnish waiver services. Common HCBS waiver target groups include older persons, individuals with physical disabilities, persons who have experienced a brain injury, and persons with developmental disabilities. A state must specify the target group(s) that it serves in the waiver.
Targeted Case Management	As provided in §1915(g) of the Act, optional State plan services that are furnished to assist Medicaid beneficiaries to gain access to needed medical, social, educational, and other services. TCM services may be furnished to target groups specified by the state on a statewide or less than statewide basis.
TCM	See Targeted Case Management
Technology Dependent	A person who needs both a medical device to compensate for the loss of a vital body function and substantial and ongoing nursing care to avert death or further disability.
TEFRA 134	See Katie Beckett Option
Telemedicine	The use of communication equipment to link health care practitioners and patients in different locations. This technology is used by health care providers for many reasons, including increased cost efficiency, reduced transportation expenses, improved patient access to specialists and mental health providers, improved quality of care, and better communication among providers.
Temporary Assistance for Needy Families (TANF)	A block grant program that makes federal matching funds available to states for cash and other assistance to low income families with children. TANF replaced the Aid to Families with Dependent Children (AFDC) program. States may but are not required to extend Medicaid coverage to all families who receive TANF benefits; however, as provided in §1931 of the Act, a state must extend Medicaid to families with children who meet the eligibility criteria that were in effect under its AFDC programs as of July 16, 1996.

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Third Party Liability (TPL)	The Medicaid term used to refer to another source of payment for Medicaid covered services provided to a beneficiary. For example, if a Medicaid beneficiary is also eligible for Medicare, the Medicare program is liable for the costs of that beneficiary's hospital and physician services, up to the limit of Medicare's coverage. From the Medicaid program's standpoint, Medicare is a liable third party. Other examples include private health insurance coverage, automobile and other liability insurance, and medical child support.
Timeout	Time out means the restriction of an individual for a period of time to a designated area from which the person is not physically prevented from leaving for the purpose of providing the person an opportunity to regain self-control.
Title XIX	Refers to Title XIX of the Social Security Act (42 U.S.C. 1396 *et seq*.), the federal statute that authorizes the Medicaid program.
TPL	See Third-Party Liability
Tribal Government	The government of an ''Indian tribe,'' including an Indian or Alaska Native tribe, band, nation, pueblo, village, or community that the Secretary of the Interior acknowledges to exist as an Indian tribe pursuant to the Federally Recognized Indian Tribe List Act of 1994, 25 U.S.C. 479a.
TWWIIA	Ticket to Work & Work Incentives Improvement Act of 1999 (P.L. 106-170). See also Medicaid Buy-In.
Unduplicated Participant	A unique individual who receives waiver services at any point during a waiver year, regardless of the length of time that the person is enrolled in the waiver or the amount of waiver services that the person receives. A person who enters, exits and then reenters the waiver is considered to be one unduplicated participant.
Waiver Capacity	A term used to describe the maximum unduplicated number of individuals who may participate in a waiver during a year.

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Waiver Period	The period of time that a waiver is in effect. In the case of a new waiver, the waiver period is three years. In the case of a renewal, the waiver period is five years.
Waiver Year	The 12-month period that begins on the date the waiver takes effect and the 12- month period following each subsequent anniversary date of the waiver.
Workers' Compensation	State-mandated system under which employers assume the cost of medical treatment and wage losses for employees who suffer job-related illnesses or injuries, regardless of who is at fault.