Glossary

Child Asthma Medication Ratio (AMR-CH)—The ratio of a child's use of asthma controller medication to total medication (i.e. rescue inhalers and controller medications). This ratio approximates a child's level of control over their condition and by extension the quality of the asthma care they receive. A perfect ratio of one means that the child has control of their condition without the use of rescue medicine, indicating that they are not experiencing asthma attacks. An AMR below 0.5 indicates poor asthma control, and that the child may need more and/or better care.

Capitation—A method of payment in which an individual or institutional provider of health services is paid a fixed amount for each person they serve, regardless of the services and treatments provided. The capitation rate is often expressed in per-member per-month (PMPM) units, as in "the capitation rate in MCO X is $100 PMPM."

Disease Management—The process of identifying and targeting appropriate, efficient care to patient populations in order to help treat or prevent a disease. Asthma disease management may include care coordination, pharmaceutical management and patient education.

Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT)—A Medicaid benefit designed to provide comprehensive and preventive healthcare services. EPSDT requires states to assess the health needs of all children under age 21 enrolled in Medicaid through periodic screenings, to ensure that health problems are diagnosed and treated early. Asthma-related services that may be covered under EPSDT include physician visits, hospital services, medical care recognized under state law and provided by a practitioner acting within their scope of practice, home-based care and case management.

Federal Medical Assistance Percentage (FMAP)— The federal Medicaid matching rate, or percentage of Medicaid costs that the federal government contributes to each state. The Department of Health and Human Services calculates and publishes the rates each year, which can range from 50-83 percent for traditional Medicaid enrollees depending on the state's demographic and economic factors.

Health Homes—A model states may use to coordinate care for Medicaid beneficiaries with chronic conditions. Using a "whole person" approach, providers deliver comprehensive care management, care coordination, health promotion, transitional care and follow up, familial support and referrals to support services. States may choose to target health homes at certain populations, such as those with chronic diseases like asthma.

ICD-10—A set of codes providers use when billing Medicaid for services to indicate the diagnosis of the patient they are treating. The most recent update of these standardized codes made them more specific and able to capture data that could previously not be gleaned from claims data. For example, ICD-10 captures information about the

persistence of a child's asthma diagnosis and/or any cross-diagnoses with common comorbidities, such as chronic obstructive pulmonary disease (COPD).

Medicaid Delivery System Models—There are two main payment models for Medicaid. Most states employ a combination of the following two systems, although several still only maintain fee-for-service payment.

- *Fee For Service (FFS)*—In fee for service programs, Medicaid reimburses providers directly for the services provided.
- *Managed Care*—In managed care programs, the state contracts with private organizations (managed care organizations, or MCOs) to provide healthcare services for Medicaid enrollees. The state pays MCOs on a per patient per month basis according to their individual contracts.
- *Hybrid Models*—Most states with Medicaid managed care continue to operate FFS programs for certain enrollees or specific populations, often with high health care needs or in difficult to reach regions.

State Plan Amendment (SPA) — An agreement between a state and the federal government describing how that state administers its Medicaid program. States may use a SPA to implement coverage of a new treatment or service, such as home visits for asthma patients.

Medicaid Waivers—Tools under the Social Security Act allowing states certain flexibilities in how they operate their Medicaid/CHIP programs, within certain parameters. For example, states may use Section 1115 Research and Demonstration Project Waivers to waive certain provisions of Medicaid/CHIP in order to test policies that are "likely to assist in promoting the objectives of the program." These waivers must be opened to public comment and receive CMS approval. Some states have used 1115 waivers to establish their managed care programs.