

Medicaid Terms

There are numerous terms to learn when determining eligibility for an applicant for Medicaid. Some of the most common terms are listed below.

Adult Medicaid: Medicaid for individuals who are over age 65, blind, disabled or receiving Medicare. This is part of a comprehensive evaluation for NC Medicaid. Some programs offer full benefits or Minimum Essential Coverage (MEC), such as MAA, MAD, MAB. Others provide limited benefits or Non-Minimum Essential Coverage, like MQB.

Aid program/category: Classifications within Medicaid which may have different eligibility requirements, including income limits, and provide varying levels of medical coverage. Eligibility for specific Medicaid classifications is based on age, household situation, and income.

Alien: An individual who is not a U.S. citizen or national; they may or may not have a documented alien status. This term is also referred to as Immigrant or Immigration Status.

Applicant: A person who applies, either for themselves or for someone else for whom they can legally apply. Often you will see this referenced as a/b (applicant/beneficiary).

Authorized Representative (A/R): Any individual who is legally authorized or designated in writing by the applicant/beneficiary to act on their behalf.

Beneficiary: A person receiving Medicaid benefit, often referred to as a/b (applicant/beneficiary).

Caretaker Relative: The natural or adoptive parent, or a specified relative living with the child who is eligible for Medicaid, providing day-to-day care and supervision.

Categorically Needy: A Medicaid classification for non-SSI beneficiaries, including caretaker relatives and/or children under 21 who meet categorically needy income requirements. Classified as C or N. Individuals aged 19 and 20 who are not caretakers must be evaluated for MAF-N. Those eligible under a poverty coverage group are classified as N (either MIC or MPW). Caretaker relatives and children under 19 meeting categorically needy requirements are classified as C.

Medically Needy: A Medicaid classification for cases involving caretaker relatives, pregnant women, and/or children under 21 whose income exceeds categorically needy limits. These households must meet a deductible to qualify for Medicaid. Currently, the only Medically Needy program in F&C Medicaid is MAFM.

Certification Period (CP): The timeframe for which assistance is requested and during which all eligibility factors must be met.

- Certification periods are pre-set by the State and based on the application date.
- The applicant may have both a retroactive and/or an ongoing CP based on the same application.

Authorization Period: The timeframe during which all eligibility factors are met, and benefits are authorized or active.

- The Authorization Period start date marks when Medicaid begins to pay medical benefits for the individual.
- The Authorization Period start date, and the Certification Period start date may differ if all eligibility factors are not met by the first day of the CP.
- There will be no Authorization Period if the individual is not eligible for any part of the CP.

Change of Circumstances (COC): Any alteration in a beneficiary's situation, whether reported or discovered, could impact their eligibility for assistance. This is also known as a "Change in Circumstance."

Child: An individual under the age of 21. However, children under 19 have broader program eligibility and higher income limits.

Continuous Eligibility: Once a child under 19 qualifies for full Medicaid benefits, they are eligible for up to 12 months of coverage, regardless of changes in household composition or financial status.

Determination of Eligibility: The process of verifying eligibility factors for applicants or beneficiaries to decide on their eligibility for programs, based on the North Carolina Administrative Code, North Carolina General Statutes, and Federal Regulations. This is also referred to as "eligibility determination."

Division of Health Benefits (DHB): A division of the NC Department of Health and Human Services that administers the NC Medicaid program. Previously known as the Division of Medical Assistance (DMA), this term may still appear in older policies and forms.

Electronic Sources: Tools used by the agency to verify eligibility criteria for applicants/beneficiaries. Examples include the Online Verification System (OVS), The Work Number (TWN), and Systematic Alien Verification for Entitlements (SAVE). These are also known as "Electronic Verifications."

Emergency Services Medicaid: Non-qualified aliens are eligible for Medicaid only on the days when an emergency exists. An emergency is defined as labor and delivery or treatment following the sudden onset of a medical condition with acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to the patient's health, serious impairment of bodily functions, or serious dysfunction of any bodily organ or part.

Ex-parte: The process of determining Medicaid eligibility during a Change of Circumstances (COC) or Recertification using information available to the agency from electronic sources or agency records. The ex-parte process concludes when a worker must request information from the applicant/beneficiary.

Medical Assistance (MA): A program designed to help eligible aged, disabled, blind individuals, pregnant women, families, and/or children with the cost of medical care, commonly referred to as "Medicaid." Family & Children's Medicaid includes the following classifications:

- **MAF:** Medicaid to Families with Dependent Children, providing medical assistance to children and adults who meet eligibility requirements.
- **MIC:** Medicaid for Infants and Children, offering medical assistance to children under 19 whose countable income falls below a specified percentage of the federal poverty limit.
- **MPW:** Medicaid for Pregnant Women, providing medical assistance to pregnant women whose income falls below a specified percentage of the federal poverty limit.
- **MXP:** MAGI Adult Group Medicaid Expansion, offering medical assistance to adults aged 19-64 whose income falls below a specified percentage of the federal poverty limit.

Minimum Essential Coverage (MEC): Health coverage that meets the Affordable Care Act's requirement for having health insurance. Medicaid programs that provide full benefits, covering all medically necessary services, are considered MEC programs (e.g., MAFC/N, MICN/1, MPW, MXP).

Non-Minimum Essential Coverage (Non-MEC): Health coverage that does not meet the Affordable Care Act's requirement for having health insurance. Medicaid programs offering only limited benefits, such as the Family Planning Program (MAF/D) and MQB, are considered non-MEC programs.

Modified Adjusted Gross Income (MAGI): A methodology used to determine eligibility for medical assistance. This method uses tax filing status to determine household size and modified adjusted gross income to determine financial eligibility. Most Family & Children's Medicaid programs use MAGI methodology to determine eligibility.

Federally Facilitated Marketplace (FFM): The FFM uses MAGI budgeting. Both the Federal Marketplace and NC State Medicaid must use the same criteria to determine eligibility. Consequently, NC Family Medicaid adopted MAGI budgeting in 2013 with the implementation of the Affordable Care Act.

Family Medicaid Covered Groups:

- Infants and children under 19
- Pregnant women
- Individuals aged 19 & 20
- Parents/caretaker relatives
- Family Planning Program (no age restriction)
- Former Foster Care Children up to age 26 (MFC)
- HSF Foster Care
- Adults aged 19-64

Post-Eligibility: This is the period after Medicaid eligibility has been determined and benefits have been authorized. Some verifications are not required until this stage.

Potential Eligibility: This term refers to when an applicant or beneficiary (a/b) meets the criteria to be evaluated for a specific Medicaid program (e.g., MAFC, MICN, MPW) based on factors like age, caretaker status, and pregnancy status. It means they qualify to be assessed for coverage but have not yet been found eligible.

Recertification: A comprehensive review of all eligibility factors at the end of a beneficiary's Medicaid certification period. This process is also known as a "Review."

Re-evaluation: The process of determining future Medicaid eligibility for a beneficiary based on current household information. This is also referred to as "Redetermination" and can occur during Changes of Circumstances (COCs) or at Recertification.

Traditional: Refers to the method of determining Medicaid eligibility before the Affordable Care Act (ACA) was implemented. Traditional Medicaid has different rules for budgeting, household composition, and countable income and resources. Currently, there is only one Traditional program in Family & Children's Medicaid (MAFM).

Verification: The process of confirming information reported by the applicant or beneficiary (a/b) through electronic sources or documentation provided by the a/b or third parties (such as employers or medical providers).