Medicaid Glossary of Terms

Aged, Blind, and Disabled (ABD) – This Medicaid eligibility category includes adults ages 65 and older and those who are legally blind or who are classified as disabled by the Social Security Administration. Individuals must also meet income and asset requirements for eligibility.

Behavioral Health (BH) – A term that includes promotion of well-being by preventing or intervening in mental illness and substance abuse or other addictions.

- Severe and Persistent Mental Illness (SPMI)
- Substance Use Disorder (SUD)
- Serious Emotional Disturbance (SED)

Centers for Medicare and Medicaid Services (CMS) – CMS is the federal agency within the US Department of Health and Human Services that administers Medicare and works with states on their Medicaid program.

Children's Health Insurance Program (CHIP) – Enacted in 1997, CHIP is a federal-state program that provides health care coverage for uninsured low-income children who are not eligible for Medicaid. States have the option of administering CHIP through their Medicaid programs or through a separate program (or a combination of both). Ohio operates its CHIP program through its Medicaid program. The federal government matches state spending for CHIP but federal CHIP funds are capped.

Covered Families and Children (CFC) – This Medicaid eligibility category includes low income parents, children, and pregnant women.

Drug Rebate – Under a national agreement, in exchange for state Medicaid coverage of prescription drugs, manufacturers pay rebates on drugs dispensed to Medicaid recipients. These rebates are shared between the state and federal governments.

Dual Eligible – A dually eligible individual receives health coverage from both Medicaid and Medicare.

Federal Medical Assistance Percentage (FMAP) – FMAP refers to the percentage rate used to determine the matching rate for Medicaid and other social service programs. FMAP is computed annually from a formula that takes into account the three year average per capita income for each state relative to the national average. Most Medicaid services are matched at the FMAP rate (currently 63.32% for Ohio); however, federal match rates vary by population and service.

Federally Qualified Health Center (FQHC) – A federally-designated community-based organization that provides primary and preventive health care in a medically under-served area that provides care to all people regardless of ability to pay. In exchange for serving all people, FQHCs receive a federal cash grant, cost-based reimbursement for their Medicaid patients, and malpractice coverage under the Federal Tort Claims Act.

Federal Poverty Level (FPL) – Annually updated guidelines established by the US Department of Health and Human Services to determine eligibility for state and federal programs.

Fee for Service (FFS) – A health care delivery system where providers are paid for each service they provide.

Group VIII – Medicaid eligibility category that includes low income adults between the ages of 19 and 64 who have family income less than 138% of FPL and who are not eligible under other categories of Medicaid.

Home and Community-Based Services (HCBS) – Services provided in a home or community setting as an alternatives to institutional long-term care.

Hospital Care Assurance Program (HCAP) – Ohio's version of the federally required Disproportionate Share Hospital (DSH) program. This provides funding to hospitals that have a disproportionately high share of indigent patients (Medicaid consumers, those below poverty, and people without health insurance).

Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IDD) – Facility based care for individuals with developmental disabilities who meet income and level of care requirements. ICF's are licensed by DODD and must meet specific location. The Ohio Department of Health certifies the licensed facility as meeting the federal requirements for funding as an ICF/IID. The provider is responsible for all aspects of care the individual including financial matters, transportation, habilitation, and medical needs.

Level of Care (LOC) – Level of care criteria are based on an assessment of whether an individual needs assistance performing certain activities, requires supervision, requires administration of medication, or requires other skilled medical care. Level of care is used to determine eligibility for certain programs.

Long Term Care/Long Term Services and Supports (LTC/LTSS) – A set of health care, personal care, and social services provided to persons who have lost, or never acquired some degree of functional capacity (e.g., the chronically ill, aged, or disabled) in an institution or at home, on a long-term basis.

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

Medicaid Waiver – The Secretary of Health and Human Services may waive certain Medicaid requirements to allow a state to use federal Medicaid funds in ways that are not otherwise allowed under federal rules.

Medicare Premium Assistance Program (MPAP) – This limited benefit Medicaid program helps those who are eligible for Medicare and have limited income and assets by providing assistance for paying the cost of one or more of the following: Medicare premiums, Medicare deductibles, Medicare coinsurance.

Modified Adjusted Gross Income (MAGI) – MAGI is a consistent measure used to determine eligibility for Medicaid using a person's household size and income.

Ohio Department of Medicaid (ODM) – ODM acts as the single state agency charged with managing health care coverage for more than three million Ohio Medicaid recipients.

Pay for Performance (P4P) – Arrangements that provide financial incentives to carry out improvements and achieve better outcomes for patients.

Per Member Per Month (PMPM) – A measure of the average cost of care on a monthly basis for a population.

Preferred Drug List – A list of drugs that are covered by the Ohio Department of Medicaid without prior authorization.

Premium – An amount that is paid to a health plan for coverage. States have the option to charge a premium or enrollment fee to certain Medicaid populations.

Title XIX – Title XIX was enacted in 1965 as a result of the Social Security Act. This established the regulations for the Medicaid program, which provides funding for medical and health-related services for person with limited income.