

GLOSSARY

A

Accountable Care Organization/Global Payments (ACO) – A group of health care providers who provide coordinated care, chronic disease management, and thereby improve the quality of care patients receive. The organization’s payment is tied to achieving health care quality goals and outcomes that result in cost savings. ACOs seek to provide financial incentives for cost containment and quality improvement across multiple sites of patient care under a global or capitated payment for all health care provided to each patient over a fixed period of time. ACOs are entities or virtual entities that share responsibility for treating a group of patients.

Acuity Factor – Measurement of an individual’s relative health care needs based on the CDPS model and the individual’s demographic and diagnostic information. (Also referred to as a case score.)

Adverse Selection – People with a higher-than-average risk of needing health care are more likely than healthier people to seek health insurance. Health coverage providers strive to maintain risk pools of people whose health, on average, is the same as that of the general population. Adverse selection results when the less healthy people disproportionately enroll in a risk pool.

Adult Expansion- Beginning January 1, 2014, a new group of Ohioans were eligible for Medicaid coverage in Ohio. This group includes adult non-parents (childless adults) between the ages of 19 to 64, who are between 0 – 138%* of the Federal Poverty Level (FPL) and are not eligible under another category of Medicaid and adult parents who are between 91-138% of the Federal Poverty Level.

Affordable Care Act (ACA) – The federal health care reform law enacted in March 2010. The law was enacted in two parts: the Patient Protection and Affordable Care Act was signed into law on March 23, 2010 and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name “Affordable Care Act” is used to refer to the final, amended version of the law.

Aged, Blind, Disabled (ABD) Children– These are Children with Special Health Care Needs who have transitioned to Medicaid Managed Care as of July 2013. A Medicaid designation that assists with medical expenses for poor individuals who are blind or disabled (disability as classified by the Social Security Administration for a child).

Aged Blind and Disabled (ABD) Adults - A Medicaid designation that assists with medical expenses for poor individuals who are, blind or disabled (disability as classified

by the Social Security Administration for an adult). Ohioans age 65 and older, with a major disabling condition who qualify for Medicaid coverage if they meet certain financial requirements. Enrollment in Ohio's Medicaid managed care program is currently mandatory for the ABD population except for Institutionalized individuals, individuals eligible for Medicaid by spending down their income or resources to a level meeting the Medicaid program's financial eligibility requirements; or Individuals receiving Medicaid services through a Medicaid Waiver component. ABD adults that are non-dually eligible for Medicare, non-institutional, and non-waiver; some people in this category are residents of nursing facilities or receive community-based long-term care services (e.g., home care). People in this category must have income and resources that are within Medicaid limitations.

Application Period – The time period during which the case mixes will be used to adjust the capitation rates.

Average Selection – Indicates that an MCP has enrolled average recipients. This condition can be identified when budget neutral case mixes are equal to 1.0000.

B

Base Data Period – Represents the 12-month time period during which data were collected for risk assessment. (Also referred to as a Study Period.)

Base Rates – Pre-determined payments to MCPs for each member they enroll. The per-member-per-month dollar amount is based on the regional status of the member. (Also referred to as the Capitation Rates.)

Baseline Factor – A component within the CDPS model that is intended to explain the health risk of individuals that cannot be attributed to a specific disease condition or certain age/gender characteristics.

Budget Neutrality Adjustment – The final step in the risk-adjustment process, where the MCP case mixes are adjusted to ensure that no unintended reductions or overages in total capitation payments will occur. The final result is referred to as the budget neutral or final case mix.

Bundled Payments – Bundled payments include all services associated with an episode of care such as an inpatient stay plus care required for a limited period of time post-discharge (e.g., 15 to 60 days). The payments to hospitals and physicians are combined into one patient severity adjusted amount that is shared among the providers. The idea is to create incentives for provider communication and coordination regarding the processes of care and their associated financial consequences. The challenge here is to

define the services to be bundled, risk adjust the payment to reflect patient health status, and determine the recipient of the payment.

C

Capitation – A method of payment for health services in which an individual or institutional provider is paid a fixed amount for each person served without regard to the actual number or nature of services provided to each person in a set period of time.

Capitation Rates – See Base Rates.

Case Management – A process where a health plan identifies covered individuals with specific health care needs (usually for individuals who need high-cost or extensive services or who have a specific diagnosis) and devises and carries out a coordinated treatment plan. Activities performed on behalf of consumers to coordinate services among health care providers. MCPs must provide case or care management (CM) services to coordinate and monitor treatment rendered to members with specific diagnoses or who require high-cost or extensive services.

Case-Mix Unadjusted – Estimated MCP health risk as measured prior to budget neutrality. This is calculated by averaging the acuity factors of those members assigned to the MCP. Recipients are assigned to an MCP based on their enrollment using a specific point in time. (Also referred to as a composite case mix.)

Categorically Needy – Medicaid’s eligibility pathway for individuals who can be covered. There are more than 25 eligibility categories organized into five broad groups: children, pregnant women, adults with dependent children, individuals with disabilities and the elderly. Persons not falling into one of these groups (notably childless adults) cannot qualify for Medicaid no matter how low their income. The ACA simplifies Medicaid eligibility, expanding coverage to all adults up to 138% of FPL (133% + 5% income disregard). This will extend eligibility to an estimated 560,000 Ohioans.

Centers for Medicare and Medicaid Services (CMS) – The federal agency within the Department of Health and Human Services that directs the Medicare and Medicaid programs (Titles XVIII and XIX of the Social Security Act). Formerly the Health Care Financing Administration (HCFA). www.cms.gov

CDPS – Chronic Illness and Disability Payment System (CDPS) is a diagnostic classification system that estimates health risk using demographic and diagnostic characteristics. The design and values associated with this model were developed specifically for TANF and Disabled Medicaid beneficiaries. The CDPS model was designed by the UCSD.

CFR – Code of Federal Regulations.

Consumer – A person who has been determined to be eligible for Ohio Medicaid.

Coordination of Benefits – A procedure establishing the order in which health care entities pay their claims.

Cost Weight – A cost weight is derived from comparing the relative cost associated with each CDPS category to the average cost of the population. The term Standard Cost Weights is used to describe the relative cost associated with the CDPS categories, as published within the Improving Health-Based Payment for Medicaid Beneficiaries paper. The term Modified Cost Weights is used to reference the set of factors that have been modified to reflect the population and benefits that will be covered in Ohio's ABD managed care program.

Covered Families and Children (CFC) – One of two general categories of Medicaid consumers (the other is Aged, Blind or Disabled). CFC is comprised of Healthy Families and Healthy Start consumers. CFC provides medical assistance to families, children to age 21, and pregnant women.

Covered Services – Those medical services set forth in rule 5101:3-26-03 of the Administrative Code or a subset of those medical services.

Creditable Coverage – Health insurance that must meet minimum standards.

Crowd-Out – A phenomenon whereby new public programs or expansions of existing public programs designed to extend coverage to the uninsured prompt some privately insured persons to drop their private coverage and take advantage of the expanded public subsidy.

D

Data books – Documents summarizing by county and/or region Medicaid eligibility demographics, FFS/managed care Medicaid cost, and FFS/managed care Medicaid rates of utilization by category of service.

Demographic Factors – Factors incorporated into the CDPS model to estimate the medical resources not contained within the diagnostic categories.

Department of Health and Human Services (HHS) – HHS is the U.S. government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves. Many HHS-

funded services, including Medicare, are provided at the local level by state or county agencies or through private sector grantees. The department's programs are administered by 11 operating divisions, including eight agencies in the U.S. Public Health Service and three human services agencies.

Diagnostic Data – Data that contains a recipient's diagnosis. This is used to classify recipients into specific disease conditions, which then renders classification into CDPS categories. This data will initially be FFS claims, but will ultimately include both FFS and MCP submitted encounters (FFS and encounter). To avoid the potential for false positive disease identification, laboratory/ radiology services and durable medical equipment services occurring in a non-inpatient setting will be removed from the diagnostic data used to measure individual and MCP risk.

Diagnostic Impact Rank – Measurement of the impact that a particular diagnostic category may have on the development of the case mixes. This measurement takes into account the magnitude of the CDPS category weight in conjunction with the portion of the population presenting with the chronic condition. The lower the diagnostic impact rank, the greater the category's impact on the case mix (one equals the greatest impact). Conversely, the higher the diagnostic impact rank, the less impact on the case mix (55 equals the least impact). The Diagnostic Impact Rank is a quick resource for determining the diagnostic categories that result in risk variation among MCPs.

Diagnostic Related Group (DRG) – A system used to classify patients (especially Medicare beneficiaries) for the purpose of reimbursing hospitals. Under the system, hospitals are paid a fixed fee for each case in a given category, regardless of the actual costs.

Dual Eligible – A person who is eligible for two health insurance plans, often referring to a Medicare beneficiary who also qualifies for Medicaid benefits. The following describes the various categories of individuals who, collectively, are known as dual eligibles. Medicare has two basic coverage's: Part A, which pays for hospitalization costs; and Part B, which pays for physician services, lab and x-ray services, durable medical equipment, and outpatient and other services. Dual eligibles are individuals who are entitled to Medicare Part A and or Part B and are eligible for some form of Medicaid benefit.

E

Electronic Medical Record (EMR) – An individual medical record that has been digitized and stored electronically.

Eligibility File – Data that contains demographic information used to identify the target ABD population for managed care enrollment. This information is also used to classify

each recipient into a region and a CDPS demographic category. The eligibility data contains Medicaid eligibility segments used to determine whether the individual has sufficient experience (six months or more during study period) to receive a CDPS acuity factor.

EQRO – External Quality Review Organization

F

Federal Medical Assistance Percentage (FMAP) – The statutory term for the federal Medicaid matching rate—i.e., the share of the costs of Medicaid services or administration that the federal government bears. In general, the FMAP for each state and U.S. territory is based on the state’s per capita income, with a minimum matching percentage of 50% and a maximum matching percentage of 83%. Ohio’s FMAP for SFY 14 is 63.02% in FFY14 and 62.64% in FFY15.

Federally-Qualified Health Center (FQHC) – A health center in a medically under-served area or population that is eligible to receive cost-based Medicare and Medicaid reimbursement and provides direct reimbursement to nurse practitioners, physician assistants and certified nurse midwives. FQHCs are sometimes referred to as CHCs (Community Health Centers). A CHC is an ambulatory health care program usually serving a catchment area that has scarce or non-existent health services or a population with special needs.

Fee-for-Service – A traditional method of paying for medical services under which doctors and hospitals are paid for each service they provide. Bills are either paid by the patient, who then submits them to the insurance company, or are submitted by the provider to the patient’s insurance carrier for reimbursement.

H

Health Information Exchange (HIE) – Health Information Exchange is the transmission of healthcare-related data among facilities, health information organizations and government agencies according to national standards.

Health Information Technology (HIT) – The secure sharing of medical information to assist health care providers in managing patient care. HIT includes the use of electronic medical records (EMRs) instead of paper medical records to maintain people’s health information.

Health Insurance Exchange – A way to pool risk, the Health Insurance Exchange is a competitive insurance marketplace where individuals and small businesses can buy affordable and qualified health benefit plans. Exchanges offer a choice of health plans that meet certain benefits and cost standards. The Exchange can set standards beyond those required by the federal government, accept bids, and negotiate contracts with insurers. An example of this arrangement is the Commonwealth Connector, created in Massachusetts in 2006. Under the ACA, states will have the option to either establish their own exchanges or participate in a national exchange starting in 2014.

Health Insurance Portability & Accountability Act (HIPAA) – Passed by Congress in 1996, HIPAA includes various health insurance coverage and patient privacy protections. The privacy rules were established to protect patients' privacy through the strict enforcement of confidentiality of medical records and other health information provided to health plans, doctors, hospitals and other health care providers.

Health Maintenance Organization (HMO) or Managed Care Plan (MCP) – A health insurance plan that provides a coordinated array of preventive and treatment services for a fixed payment per month. HMOs provide services through a panel of health care providers. Enrollees receive medically necessary services regardless of whether the cost of those services exceeds the premium paid on the enrollees' behalf. "MCP", also referred to as plan, means a Health Insuring Corporation (HIC) licensed in the state of Ohio that enters into a provider agreement with ODM in the managed health care program pursuant to rule of the Administrative Code. For the purpose of this chapter, MCP does not include entities approved to operate as a PACE site.

Healthy Families – Low Income Families (LIF) refers to the collective group of families receiving Medicaid in connection with OWF cash assistance, as well as to the new federally mandated covered group of families who do not receive OWF cash but who would have qualified under ADC regulations in effect as of July 1996. Beginning in July 2000, Ohio began using the term "Healthy Families" to refer to the group of families who do not receive OWF cash assistance.

Healthy Start (HST) – Ohio's name for the special Medicaid eligibility expansion program which provides Medicaid services for pregnant women, infants and children up to specified age and income limits.

Healthcare Effectiveness Data and Information Set (HEDIS) – is a widely used set of performance measures in the managed care industry, developed and maintained by the National Committee for Quality Assurance (NCQA). HEDIS was designed to allow consumers to compare health plan performance to other plans and to national or regional benchmarks. Although not originally intended for trending, HEDIS results are increasingly used to track year-to-year performance.

Hospital – An institution located at a single site which is engaged primarily in providing to inpatients, diagnostic services and therapeutic services for medical diagnosis and treatment or rehabilitation of injured, disabled, or sick persons. "Hospital" does not mean an institution which is operated by the United States government or the Ohio department of mental health

Hospital Services – Those inpatient and outpatient services that are generally and customarily provided by hospitals.

HIC – “Health Insuring Corporation” as defined in section 1751.01 of the Revised Code. Health insuring corporation" means a corporation, as defined in division (H) of this section, that, pursuant to a policy, contract, certificate, or agreement, pays for, reimburses, or provides, delivers, arranges for, or otherwise makes available, basic health care services, supplemental health care services, or specialty health care services, or a combination of basic health care services and either supplemental health care services or specialty health care services, through either an open panel plan or a closed panel plan.

I

ICD-9 Codes – International Classification of Diseases, 9th Revision (ICD-9) is the input used in the CDPS model used to assess a member’s health risk based on their historical chronic conditions. These chronic conditions will be identified using the provider-submitted ICD-9 codes. ICD-10 Codes are planned to be used in the future.

ICF-MR – Intermediate care facility for the mentally retarded (ICF-MR)" means a long-term care facility, or part of a facility, for the mentally retarded/developmentally disabled, currently certified by the Ohio department of health as being in compliance with the ICF-MR standards and Medicaid conditions of participation.

Inpatient Facility – An acute or general hospital, rehabilitation facility, or nursing or ICF-MR facility.

L

Low Acuity Non-Emergency (LANE) – An efficiency adjustment added to the Managed Care rate-development process consistent with ODM’s goal for value-based purchasing. LANE identifies instances when Medicaid enrollees would not have needed to make a

trip to the emergency room if they had received effective outreach, care coordination and access to preventive care.

Long-Term Care (LTC) – 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, disabled, or retarded) in an institution or at home, on a long-term basis.

M

MAGI: Modified Adjusted Gross Income:

MAGI Groups: Deemed newborns (Medicaid and CHIP), Infants and Children Under Age 19 (Medicaid and CHIP), Pregnant women, Parents & Caretakers, MAGI Adult Extension (Group VIII), Former Foster Children (ages 18-26, no budget), Transitional (TMA) & Extended Medical Assistance (EMA), “Rib kids” age 19 or 20 with income below cash assistance levels, Individuals receiving Adoption or Foster Care Assistance, and Family Planning Services (FPS).

Non-MAGI Groups: Aged, Blind, and Disabled Individuals (ABD), Individuals determined by the Social Security Administration to be eligible under SSA 1619 (a or b), Individuals receiving institutional Long-Term Care (NF, Hospital-30 days or more, ICF-IID), Individuals receiving Home and Community-Based Services (HCBS waiver), Medicare Premium Assistance (MPAP), Individuals eligible for the Breast and Cervical Cancer Project (BCCP), and Medicaid Buy-In for Workers with Disabilities (MBIWD).

Managed Care – health care systems that integrate the financing and delivery of appropriate health care services to covered individuals. Managed care systems arrange with selected providers to furnish a comprehensive set of health care services.

-A delivery system in which the overall care of a patient is overseen by a single provider or organization, such as a MCP. Many state Medicaid programs include managed care components as a method of ensuring quality and access in a cost efficient manner.

-A health care purchasing arrangement that aims to maximize outcomes reduce unnecessary care and control costs by use of some organized means of identifying, directing and coordinating the health care that a consumer needs.

Managed Care Plan (MCP) A managed care plan that is a Health Insuring Corporation licensed by the Ohio Department of Insurance and that has entered into a provider agreement with - ODM.

Major Categories – The CDPS model classifies diagnoses into major categories. These categories are representative of body systems (e.g., cardiovascular or pulmonary) or

illnesses that affect multiple systems (e.g., infectious disease or diabetes). Nineteen major categories exist.

Medical Home – An approach to providing comprehensive primary care that facilitates partnerships between individual patients, and their personal providers, and when appropriate, the patient’s family. Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need it in a culturally and linguistically appropriate manner.

Medical Intensity Subcategories – The CDPS model further classifies the conditions within the major category into medical intensity subcategories based on their perceived medical intensity.

Medical Loss Ratio (MLR) – The percentage of premium dollars an insurance company spends on medical care, as opposed to administrative costs or profits. The health reform law requires insurers in the large group market to have an MLR of 85% and insurers in the small group and individual markets to have an MLR of 80%.

Member Enrollment Mixed Adjustment (MEMA)— Member Enrollment Mix Adjustment (MEMA). To address the potential variations in risk among the participating MyCare Ohio ICDS Plans, the State will be using a MEMA for the Medicaid portion of the capitation. A MEMA will enable the State to better match payment to risk by recognizing the relative risk/cost differences of major and objectively identifiable population groups included in each NFLOC rate cell.

Member – A Medicaid consumer who is enrolled in an MCP.

MyCare Ohio- Ohio’s fully integrated care delivery system that comprehensively manages the full continuum of Medicare and Medicaid benefits for Medicare-Medicaid enrollees, including LTSS under a capitated managed care model.

N

Nursing facility (NF) – means any long-term care facility (excluding intermediate care facilities for the mentally retarded/developmentally disabled), or part of a facility, currently certified by the Ohio department of health as being in compliance with the nursing facility standards and Medicaid conditions of participation.

P

PACE – The program of all inclusive care for the elderly. The PACE program integrates the provision of acute and long-term care across settings for frail older adults who have been determined to require at least an intermediate level of care as defined in rule of the Administrative Code.

Pay-for-Performance (P4P) – A health care payment system in which providers receive incentives for meeting or exceeding quality and cost benchmarks. Some systems also penalize providers who do not meet established benchmarks. The goal of pay for performance programs is to improve the quality of care over time.

Potentially Preventable Admissions (PPA) – An efficiency adjustment added to the Managed Care rate-development process consistent with ODM’s goal for value-based purchasing. Identifies inpatient admissions that could have been avoided through high-quality outpatient care and/or reflects conditions that could be less severe and not warrant an inpatient level of care if treated early and appropriately.

Positive Selection – Indicates that an MCP has enrolled healthier-than-average recipients. This condition can be identified when budget neutral case mixes are less than 1.0000.

Prevalence Reports – This report allows each MCP to compare their population’s characteristics (as measured by CDPS) to the characteristics of the entire population enrolled in managed care in that region. The prevalence reports also provide the interim steps used to develop the final case mixes.

Prospective Model – This model measures existing conditions and their ability to predict future health care costs.

Prior Authorization – Under a system of utilization review, a requirement imposed by a health plan or third party administrator that a provider justify the need for delivering a particular service in order to receive reimbursement. Prior authorization may apply to all services or only to those that are potentially expensive and/or overused.

R

Request for Proposals (RFP) – A document distributed by a government agency to obtain bids from persons and/or organizations to carry out a particular project for the agency.

Risk – Risk or "underwriting risk" means the possibility that an MCP may incur a loss because the cost of providing services may exceed the payments made by ODM to the contractor for services covered under the provider agreement.

Risk Adjustment – Adjustment of MCP capitation revenue based on health risk associated with their members, as measured based on demographic characteristics and their historical chronic disease conditions. The intent of this approach is to provide higher reimbursement to those MCPs experiencing adverse selection and lower reimbursement to those MCPs experiencing positive selection. This process is an improvement over the traditional reimbursement based solely on age and sex characteristics.

RUGs III – Resource Utilization Groups Version III.

RUGs IV – Resource Utilization Groups Version IV – used by Medicare since October 2010.

Both of these are means to classify nursing home residents based on amount of staff time needed to care for the residents. RUGs III was first used in 1992 with time studies done in 1995 and 1997 to update the time values. RUGs IV updates RUGs III with a time study completed in 2007 to better capture how care is delivered to the high acuity residents. Approximately 28 state Medicaid programs use either RUGs III or RUGs IV to determine nursing home payments.

Rural Health Clinic – A public or private hospital, clinic, or physician practice designated by the federal government as in compliance with the Rural Health Clinics Act (Public Law 95-210). The practice must be located in a medically underserved area or a Health Professional Shortage Area (HPSA) and use physician assistants and/or nurse practitioners to deliver services.

S

SFY (State Fiscal Year) – means the period July first through June thirtieth, corresponding to the state of Ohio's fiscal year.

Scored Recipients – Recipients with six or more months of Medicaid eligibility during the study period.

Special Needs Plan (SNP) – A special needs plan (SNP) is a special type of Medicare advantage plan that provides more concentrated health care for specific groups of people. It is designed to attract and enroll Medicare beneficiaries who are identified as special needs individuals on examination. There are two types of SNPs: exclusive SNP

and disproportionate share SNP. According to Medicare Prescription Drug, Improvement, and Modernization Act of 2003, special needs individuals are classified into three : (1) institutionalized beneficiaries (2) dually eligible beneficiaries and (3) beneficiaries with chronic conditions. SNP is often pronounced as 'snip'.

Study Period – See Base Data Period.

U

UCSD – University of California San Diego (UCSD) staff developed the CDPS model. Their web site can be found at the following address:

<http://www.medicine.ucsd.edu/fpm/cdps/>. To access the CDPS software, a license agreement must be completed.

Unscored Recipients – Recipients that do not receive an acuity factor because they did not have six months of eligibility within the study period. It is expected that unscored members will be attracted to MCPs in the same relationships as the scored members. Therefore, the unscored recipients will be assigned the average risk of the scored members assigned to their MCP.

Source: Adapted from Health Policy Institute of Ohio, Glossary of Health Policy Terms; Ohio Managed Care Rules Definitions, and Ohio Medicaid Report, April 2001. SNP definition: <http://definitions.uslegal.com/s/special-needs-plan-snp/>

ACRONYM APPENDIX

ABD: Aged, Blind & Disabled for Children and Adults

ACA: Affordable Care Act

ACO: Accountable Care Organization

ASA: Associate of the Society of Actuaries

BBA: Balanced Budget Act

BIAR: Business Intelligence Archive Resource

BHSR: Bureau of Health Services Research

BCMh: Bureau of Children with Medical Handicaps

CDJFS: County Department of Job and Family Services

CDPS: Chronic Illness & Disability Payment System

CFC: Covered Families and Children

CFR: Code of Federal Regulations

CM: Care Management

CMMI: Centers for Medicare and Medicaid Innovation

CMS: Centers for Medicare and Medicaid Services

CY: Calendar Year

DRG: Diagnostic Related Group

EDGE: Encouraging Diversity, Growth, and Equity

EMR: Electronic Medical Records

EPSDT: Early and Periodic Screening Diagnosis and Treatment

FSA: Fellow of the Society of Actuaries

FFP: Federal Financial Participation

FMAP: Federal Medical Assistance Percentage

FPMRS: Financial Planning, Management, and Rate Setting Section

FQHC: Federally Qualified Health Center

FTP: File Transfer Protocol

HEDIS: Healthcare Effectiveness Data and Information Set

HHS: Department of Health and Human Services

HIC: Health Insuring Corporation

HIE: Health Information Exchange

HIT: Health Information Technology

HIPAA: Health Insurance Portability & Accountability Act

HMO: Health Maintenance Organization

HST: Healthy Start

ICD-9: International Classification of Diseases, 9th Revision

ICD-10: International Classification of Diseases, 10th Revision

ICF-IID: Intermediate Care Facility for Individuals with Intellectual Disabilities

ICF-MR: Intermediate Care Facility for the Mentally Retarded

LANE: Low Acuity Non-Emergent diagnosis and procedure codes

LTC: Long Term Care

MAGI: Modified Adjusted Gross Income

MBE: Minority Business Enterprise

MCCA: Managed Care Contract Administration

MCP: Managed Care Plan

MEMA: Member Enrollment Mixed Adjustment

MIT: Medicaid Information Technology System

MLR: Medical Loss Ratio

NF: Nursing Facility

OAC: Ohio Administrative Code

OBM: Office of Budget and Management

ODA: Ohio Department of Aging

ODH: Ohio Department of Health

ODDD: Ohio Department of Developmental Disabilities

ODM: Ohio Department of Medicaid

ODMHAS: Ohio Department of Mental Health and Addiction Services

OHT: Office of Health Transformation

ORC: Ohio Revised Code

OWF: Ohio Works First

PACE: Program of All inclusive Care for the Elderly

PCP: Primary Care Physician

PCMH: Patient Centered Medical Home

P4P: Pay-for-Performance

PPA: Potentially Preventable Admissions

QDSS: Quality Decision Support System

RUGS: Resource Utilization Groups (Versions III and IV)

RFP: Request for Proposals

SCHIP: State Children's Health Insurance Program

SFY: State Fiscal Year

SNP: Special Needs Plan

TANF: Temporary Assistance for Needy Families

UCSD: University of California San Diego