



ACS' Medicaid Glossary

Medicaid is a jointly funded, federal-state health insurance program for people with low-income. Each state's Medicaid programs covers certain populations (the elderly, people with disabilities, the blind, children, and pregnant women), but financial eligibility levels for these populations differs from state-to-state. The healthcare and health insurance field is filled with industry jargon that can be confusing to even those who have worked in this area for a long time. Advocacy & Communication Solutions' Medicaid Glossary helps anyone understand the basic industry terms or help event the experts de-jargon their language to make their communication as effective as possible with industry and non-industry audiences. Use our Medicaid Glossary to improve your communication and advocacy! If you have a question about a term that is not included, please [contact us](#)! Check out ACS' other glossaries on [Health and Human Services](#), [Workforce Development](#), and [K-12 Education](#).

1. Affordable Care Act (ACA)

The comprehensive health care reform law enacted in March 2010, also sometimes referred to as "Obamacare." The law is intended to make affordable health insurance available to more people and to address potential barriers such as pre-existing conditions. The law provides consumers with subsidies that lower costs for households with incomes between 100 and 400 percent of the federal poverty level and expands the Medicaid program, for participating states, to cover all adults with income below 138 percent of the federal poverty level. Many attempts have been made by Congress and the administration to repeal or weaken the law with the most successful effort being the recent repeal of the individual mandate.

2. Adult Care Facility (ACF)

Adult Care Facilities (ACF), also known as residential facilities, are publicly or privately operated programs that provide individuals with mental illness with housing accommodations, supervision, personal care services, and access to health and social work professionals. Adult Care Facilities are typically licensed with rules and regulations differing from state to state.

3. Centers for Medicare and Medicaid Services (CMS)

Housed within the United States Department of Health and Human Services, CMS is the federal agency responsible for administering Medicare and working with states to administer the Medicaid and Children's Healthcare Insurance programs. CMS is also responsible for administering standards for the Health Insurance Portability and Accountability Act (HIPPA), nursing home facilities, and clinical laboratory quality standards.

4. Children's Healthcare Insurance Program (CHIP)

Administered by CMS in partnership with states, CHIP is a program that provides matching funds to states to provide health insurance for uninsured children whose parents' income are modest but do not qualify for Medicaid. States have the authority to design their own eligibility requirements, including the ability to seek waivers to utilize CHIP funds to provide services to parents of children on CHIP, pregnant women, and other adults.

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5. Community Health Centers

Community-based health care organizations that provide comprehensive, high-quality primary health care services to vulnerable populations such as families in poverty, people experiencing homelessness, residents of public housing, and veterans. In areas where access to affordable health care services are limited, community-based health centers often provide access to additional resources such as treatment for oral health, substance abuse, and mental health. Such organizations are patient-directed and operate under the direction of governing boards made up of local community-based organizations.

6. Coordinated Care

Refers to the deliberate and coordinated organization of patient care activities between multiple participants, including the patient, to provide the delivery of appropriate health care services. Coordinated care is particularly critical for patients with complex health needs whose care often relies on multiple individuals with specialized knowledge and skills that may need to share information to ensure that the appropriate health care services are provided at the right time in the right setting.

7. Delivery System Reform and Incentive Payment (DSRIP)

DSRIP programs are part of Medicaid that operates as a pay-for-performance model utilizing a rewards-based payment structure. DSRIP has been implemented in six states to fund projects intended to increase the quality and efficiency of care while better managing programmatic costs. DSRIP has been criticized due to many states utilizing the funds to preserve payments to safety-net hospitals to make up for lack of funding. While the implementation of DSRIP suggests that it will not be an ongoing, sustainable source of funding its implementation does signal an increased effort to connect performance to payment.

8. Dual Eligibility

Dual eligibility refers to individuals who qualify for benefits under both Medicare and Medicaid. Dual eligibility may cover nursing home services, prescription drugs, and payments for Medicare premiums, deductibles, and co-insurance.

9. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)

EPSDT is the program within Medicaid that provides health care for children. Under federal law, states must provide a range of preventive and treatment services for children under the age of 21 who participate in their state's Medicaid program. States are required to create wellness visit schedules, known as periodicity schedules, for periodic screening for impairments with development, vision, dental and hearing. Recent studies have shown that a majority of children eligible for EPSDT services do not fully utilize the program and policy advocates have worked to produce recommendations to remove many of the barriers between families and access to EPSDT services.

10. Eligibility

Though Medicaid is a joint federal and state program, states have wide latitude to determine criteria for eligibility to participate in their state's Medicaid program. Under federal law, states are required to provide coverage to certain groups of individuals such as low income families, qualified pregnant women and children, and individuals receiving Supplemental Security Income (SSI). Under the ACA, eligibility was expanded to at least 133 percent of the federal poverty level (FPL) in every state and states were given the option to expand eligibility to adults with income at or below 133 percent of the FPL. States also have the ability to create a "medically needy program" for individuals with significant health issues who income is too high to financially qualify for Medicaid.

11. Federal Medical Assistance Percentage (FMAP)

FMAP refers to the percentage rates used by the federal government to determine the amount of matching funds allocated each year for medical and social service programs at the state and local level.

12. Federally-Qualified Health Centers (FQHC)

FQHCs are community-based health care providers that receive federal funding from the Health Resources & Services Administration to provide primary care in underserved areas. FQHCs are operated by governing boards made up of local community-based organizations and must include patient as part of its membership. FQHCs must also provide services regardless of patients' ability to pay utilizing a sliding fee scale.

13. Fee-for-service (FFS)

FFS is a health care payment model wherein health care providers' services are unbundled and each service paid for separately. The goal behind FFS is to incentivize health care providers to provide all of the appropriate care because payment is dependent on the quantity of care, rather than the quality of care.

14. Individual Mandate

In many cases, the individual mandate is considered a significant lynchpin of the Affordable Care Act (ACA). An individual mandate was enacted in the ACA to prevent a market collapse due to the increase of insurance rates caused by healthier individuals opting out of the insurance system. The individual mandate has also been a major focus of the law's critics and was challenged in court several times before ultimately being upheld by the U.S. Supreme Court. President Donald Trump recently signed legislation repealing the individual mandate in 2019 as part of the Tax Cuts and Jobs Act.

15. Managed Care

Managed care is a system of delivering health care to patients wherein they agree to only visit certain doctors and hospitals, and in which the cost of treatment is monitored by a managing company to ensure efficiency and realize program cost-savings.

16. Managed Care Organizations (MCO)

Organizations contracted by government or private entities to provide managed care in an effort to reduce the cost of providing health care while improving the quality of that care. Many states contract with MCOs and pay a monthly capitated rate per member to the MCOs to provide comprehensive care and accept the risk of managing the total cost of providing health care services. Though 90 percent of insured Americans are now in enrolled in plans with some form of managed care critics argue that the managed care model has not delivered on its promise of reducing costs or improving the quality of health care.

17. Medicaid

Medicaid is a joint state and federal program that provides assistance to 74 million low-income individuals and families who cannot afford health insurance. The program is jointly funded but managed by state governments with each state having the authority to determine eligibility for the program. Medicaid is also utilized to provide financial support for people with disabilities and elderly individuals in need of nursing home care. Medicaid also provides dental coverage for children enrolled in the program though research shows this service is underutilized by its participants due to a lack of dental providers who accept Medicaid.

18. Medicaid expansion

One of the goals of the Affordable Care Act was to significantly expand eligibility and federal funding for Medicaid. The law originally required states that participated in the Medicaid program to grant benefits to individuals and families with income up to 133 percent of the federal poverty level. However, the U.S. Supreme Court ruled that states do not have to agree to the expansion to receive previously established levels of Medicaid funding. Medicaid expansion has been a topic of political debate due to the overall partisan debate surrounding the creation and implementation of the ACA with many states deciding not to opt-into the expansion program after the U.S. Supreme Court's ruling. Currently 33 states (and the District of Columbia) have elected to expand Medicaid within their state as part of the ACA while 18 states have not chosen to participate in Medicaid expansion.

19. Medicare

Medicare is a federal program that provides health coverage for individuals who are age 65 and older or those who have a severe disability, no matter their income. Medicare Part A insures for hospital care, Part B covers certain doctors' services, outpatient care, medical supplies and preventive services. Medicare Part C is the Medicare Advantage Plan that is offered by a private company (such as a Health Maintenance Organization (HMO), Preferred Provider Organizations (PPO), Fee-for-Service Plans, Special Needs Plans or Medicare Medical Savings Account Plans. Medicare Part D provides prescription drug coverage.

20. Performance-based care

Performance-based care is a system of health care delivery and payment that rewards health care providers for meeting benchmarks regarding the quality and efficiency of care. This model is often utilized to drive cost-savings while also increasing the quality of care in state Medicaid programs by encouraging providers to follow guidelines and meet treatment goals for typically high-cost conditions. Performance awards may take vary depending on state implementation but examples include bonuses, enhanced fee schedules and an increase in Medicaid patients.

21. Rural Health Clinic (RHC)

The RHC program works to increase access and overcome barriers to primary care services for Medicaid and Medicare patients in rural communities. Such programs must be located in rural, underserved areas but may be public, nonprofit, or for-profit in nature. RHCs are required to utilize a team of physicians and non-physician practitioners and provide outpatient primary care and basic laboratory services. RHCs receive enhanced reimbursement rates for providing services to Medicaid and Medicare patients

22. State Medicaid Plan

While Medicaid is a joint federal and state program, federal law requires states to submit documentation detailing how they plan to administer their state's Medicaid and CHIP programs. Such plans are intended to ensure that states receiving Medicaid funding follow federal rules and regulations for the program. The plans must include information on who will be eligible, the services provided, and the method of reimbursement to health care providers.

23. Temporary Assistance for Needy Families (TANF)

TANF is a federal program administered by the U.S. Department of Health & Human Services that provides time-limited, financial assistance for families with children. Funding is provided to states, territories, and tribes to provide assistance to families, promoting job preparation, work, and marriage. States, territories, and tribes may exercise flexibility in the administration of TANF programs, such as determining eligibility, the type and amount of payments available, and the type of services provided.