Ohio Revised Code

Section 5162.01 Definitions.

Effective: October 3, 2023
Legislation: House Bill 33

(A) As used in the Revised Code:

(1) "Medicaid" and "medicaid program" mean the program of medical assistance established by Title XIX of the "Social Security Act," 42 U.S.C. 1396 et seq., including any medical assistance provided under the medicaid state plan or a federal medicaid waiver granted by the United States secretary of health and human services.

(2) "Medicare" and "medicare program" mean the federal health insurance program established by Title XVIII of the "Social Security Act," 42 U.S.C. 1395 et seq.

(B) As used in this chapter:

(1) "Exchange" has the same meaning as in 45 C.F.R. 155.20.

(2) "Expansion eligibility group" has the same meaning as in section 5163.01 of the Revised Code.

(3) "Federal financial participation" has the same meaning as in section 5160.01 of the Revised Code.

(4) "Federal poverty line" means the official poverty line defined by the United States office of management and budget based on the most recent data available from the United States bureau of the census and revised by the United States secretary of health and human services pursuant to the "Omnibus Budget Reconciliation Act of 1981," section 673(2), 42 U.S.C. 9902(2).

(5) "Healthcheck" has the same meaning as in section 5164.01 of the Revised Code.

(6) "Healthy start component" means the component of the medicaid program that covers pregnant women and children and is identified in rules adopted under section 5162.02 of the Revised Code as

the healthy start component.

(7) "Home and community-based services" means services provided under a home and community-based services medicaid waiver component.

(8) "Home and community-based services medicaid waiver component" has the same meaning as in section 5166.01 of the Revised Code.

(9) "ICF/IID" has the same meaning as in section 5124.01 of the Revised Code.

(10) "Individualized education program" has the same meaning as in section 3323.011 of the Revised Code.

(11) "Medicaid managed care organization" has the same meaning as in section 5167.01 of the Revised Code.

(12) "Medicaid MCO plan" has the same meaning as in section 5167.01 of the Revised Code.

(13) "Medicaid provider" has the same meaning as in section 5164.01 of the Revised Code.

(14) "Medicaid services" has the same meaning as in section 5164.01 of the Revised Code.

(15) "Medicaid waiver component" has the same meaning as in section 5166.01 of the Revised Code;

(16) "Nursing facility" and "nursing facility services" have the same meanings as in section 5165.01 of the Revised Code.

(17) "Ordering or referring only provider" means a medicaid provider who orders, prescribes, refers, or certifies a service or item reported on a claim for medicaid payment but does not bill for medicaid services.

(18) "Political subdivision" means a municipal corporation, township, county, school district, or

other body corporate and politic responsible for governmental activities only in a geographical area smaller than that of the state.

(19) "Prescribed drug" has the same meaning as in section 5164.01 of the Revised Code.

(20) "Provider agreement" has the same meaning as in section 5164.01 of the Revised Code.

(21) "Qualified medicaid school provider" means the board of education of a city, local, or exempted village school district, the governing board of an educational service center, the governing authority of a community school established under Chapter 3314. of the Revised Code, and Ohio deaf and blind education services to which both of the following apply:

(a) It holds a valid provider agreement.

(b) It meets all other conditions for participation in the medicaid school component of the medicaid program established in rules authorized by section 5162.364 of the Revised Code.

(22) "State agency" means every organized body, office, or agency, other than the department of medicaid, established by the laws of the state for the exercise of any function of state government.

(23) "Vendor offset" means a reduction of a medicaid payment to a medicaid provider to correct a previous, incorrect medicaid payment to that provider.