

# Little Blue Book

*A health glossary*

provided by the

Georgia Health Policy Center

June 2017



*Terms in italics are defined in this glossary*

**Accountable Care Organization (ACO)** – A group of health care providers who provide coordinated care and chronic disease management with the aim of improving 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.

**Actuarial Value (AV)** – Distinguishes health insurance plans by the average amount of medical costs a plan will pay. The higher the AV, the lower the *out-of-pocket* costs for plan members (and the higher the plan *premiums*). For example, an AV of 90% means the plan, on average, will cover 90% of an insured individual's medical expenses, and for most covered benefits the insured will be responsible for paying 10% of the costs.

**Advance Directive** – A legal document detailing individuals' health care wishes, including the person to whom they give the legal authority to act on their behalf and the treatment they do and do not want to receive, in the event they are unable to speak or communicate.

**Advance Premium Tax Credit (APTC)** – Subsidy available to individuals between 100% and 400% of the *federal poverty level* purchasing plans on the *Health Insurance Marketplace*. APTCs are paid out in advance to the health plans on behalf of the taxpayer to lower monthly *premiums*. APTC amounts are based on estimated annual income and family size.

**Adverse Selection** – The term, as used in health insurance, describes a situation where an individual's demand for insurance (the tendency to buy insurance, the quality of benefits purchased, or both) is positively related to the individual's risk of injury or illness (i.e., individuals with poorer health status buy better insurance), and the insurer is unable to allow for this relationship in the price of insurance.

**Affordable Care Act (ACA)** – The 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" or "ACA" is used to refer to the final, amended version of the law.

**Aged, Blind, Disabled (ABD)** – A *Medicaid* designation that provides benefits to poor Georgians who are aged 65 years or older, blind or disabled (disability as classified by the Social Security Administration for an adult or child).

**American Health Care Act (AHCA; H.R. 1628)** – U.S. House of Representatives' plan to repeal and replace the *Affordable Care Act*. As passed by the House on May 4, 2017, the AHCA includes the following key features: *Medicaid per capita caps* and *block grants* for states; ending the ACA's *Medicaid* expansion enhanced federal match; health insurance continuous coverage lapse penalty instead of an individual mandate and tax penalty; health care tax credits based on age instead of income and health insurance cost; increased amount that individual market insurance

*premiums* may vary by age; state option to waive *essential health benefits* and community rating (including preexisting conditions requirements); federal invisible high-risk pool and state funding for *high-risk pools* or other programs to help manage the expense of insuring individuals with costly, chronic conditions; repeal of most of the ACA's taxes; and enhanced *health savings accounts*.

**Block Grants** – A fixed amount of money allocated annually by the federal government to a state for a general purpose. In the field of health care, the term is usually used as an alternative way to finance state *Medicaid* programs. The federal share of a state's Medicaid spending would be a fixed amount per state per year. See also *per capita caps*.

**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 for the actual number or nature of services provided to each person in a set period of time.

**Care 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 develops and carries out a coordinated treatment plan.

**Care Management Organization (CMO)** – Georgia has four CMOs providing managed care services to *Medicaid* and PeachCare members statewide. The plans are Amerigroup Community Care, CareSource (as of July 1, 2017), Peach State Health Plan and WellCare. See also *Georgia Families*.

**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.

**Centers for Medicare and Medicaid Services (CMS)** – The federal agency within the U.S. Department of Health and Human Services that directs the *Medicare* and *Medicaid* programs (Titles XVIII and XIX of the Social Security Act). [www.cms.gov](http://www.cms.gov)

**Certificate of Need (CON)** – A certificate issued by a governmental body to an individual or organization proposing to construct or modify a health facility, acquire major new medical equipment or offer a new or different health service. CON is intended to control expansion of facilities, services and costs by preventing excessive or duplicative development of facilities and services.

**Children's Health Insurance Program (CHIP)** – A program enacted by Congress as part of the Balanced Budget Act of 1997 that provides federal matching funds for states to spend on health coverage for uninsured children. Georgia's CHIP program is *PeachCare for Kids*®.

**Children's Health Insurance Program Reauthorization Act (CHIPRA)** – Signed into law in February 2009, CHIPRA provided additional funding to renew *CHIP* and to help make *CHIP* and *Medicaid* coverage available to more eligible uninsured children as well as improve the quality of care received by enrollees. Georgia's *CHIP* program is

*PeachCare for Kids.*

**Co-insurance** – The percent of health care costs that an insured pays, after a *deductible* has been met, up to the *out-of-pocket* maximum.

**Community Care Services Program (CCSP)** – CCSP provides eligible *Medicaid* consumers with a range of community-based services that support the consumer's choice to remain at home or in the community. Consumers must meet the same medical, functional and financial criteria as for placement in a nursing facility under *Medicaid*.

**Community Health Center (CHC)** – An ambulatory health care program usually serving a catchment area that has scarce or nonexistent health services or a population with special needs.

**Community Health Worker (CHW)** – CHWs are lay members of communities who work either for pay or as volunteers in association with the local health care system in both urban and rural environments. They have been identified by many titles, such as community health advisers, lay health advocates, “promotores,” outreach educators, community health representatives, peer health promoters and peer health educators. CHWs may offer interpretation and translation services, provide culturally appropriate health education and information, assist people in receiving the care they need, give informal counseling and guidance on health behaviors, advocate for individual and community health needs and provide some direct services, such as first aid and blood pressure screening.

### **Consolidated Omnibus Budget Reconciliation Act**

**(COBRA)** – A 1986 act containing certain health benefit provisions that amend *Employee Retirement Income Security Act*, the IRS code and the Public Health Service Act to enable qualified individuals who lose their job to maintain the group coverage in which they were enrolled for an additional 18 months after leaving employment. Individuals are required to pay the standard *premium* of their previously provided plan. Applies to firms with more than 20 employees.

**Consumer-Driven Health Care** – This term applies to a broad range of health plan designs but is most commonly used to describe the combination of a high-deductible health insurance plan with a tax-preferred savings account used to pay for routine health care expenses.

**Copayments** – A fixed amount the insured pays for covered services, even after the *deductible* is met.

**Cost-Shifting** – Recouping the cost of providing uncompensated care by increasing revenues from some payers to offset losses and lower net payments from other payers. For example, hospitals may increase charges for private insurers to offset losses due to uncompensated or indigent care or lower payments (e.g., *Medicaid* or *Medicare*) from other payers.

**Cost-sharing reduction subsidies (CSRs)** – Subsidies to offset the cost of more generous coverage (plans with a higher *actuarial value*) in the *Health Insurance Marketplace* by lowering *out-of-pocket* costs. CSRs are available to certain individuals enrolled in the Health Insurance Marketplace with a family income between 100% and 250% of the *federal*



*poverty level who purchase a silver plan.*

**Creditable Coverage** – As referenced in the *Affordable Care Act*, creditable coverage is health insurance that must meet minimum standards to be creditable. The following plans meet the minimum standards: a group health plan, individual health insurance, student health insurance, *Medicare, Medicaid, CHAMPUS and TRICARE*, the Federal Employees Health Benefits Program, Indian Health Service, the Peace Corps, Public Health Plan (any plan established or maintained by a state, the U.S. government, a foreign country), *Children's Health Insurance Program* or a state health insurance *high-risk pool*.

**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 coverage.

**DATA-certified Physician (DATA)** – A physician certified to prescribe buprenorphine for treating opioid dependence outside of an opioid treatment program.

**Deductible** – A set amount of medical expenses a patient must pay before becoming eligible for benefits under an insurance program.

**Disease Management** – A process of identifying and delivering within selected patient populations (e.g., patients with asthma or diabetes) the most efficient, effective combination of resources, interventions or pharmaceuticals for the treatment or prevention of a disease.

**Disproportionate Share Hospital Program (DSH)** – A federal program that works to increase health care access for the poor. Hospitals that treat a “disproportionate” number of *Medicaid* and other indigent patients qualify for higher *Medicaid* payments based on the hospitals’ estimated uncompensated cost of services to the uninsured. See also *Indigent Care Trust Fund*.

**Dual Eligible** – A person who is eligible for both *Medicare* and *Medicaid*.

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

**Emergency Medical Services (EMS)** – Services utilized in responding to the perceived individual need for immediate treatment for medical or psychological illness or injury.

**Emergency Medical Treatment and Active Labor Act (EMTALA)** – An act Congress passed in 1986 as part of the *Consolidated Omnibus Budget Reconciliation Act* requiring hospitals and ambulance services to provide care to anyone needing emergency treatment regardless of citizenship, legal status or ability to pay.

**Employee Retirement Income Security Act (ERISA)** – A federal act passed in 1974 that established standards and reporting/disclosure requirements for employer-funded pension and health benefit programs. To date, self-funded health benefit plans operating under ERISA are exempt from state insurance laws.

**Essential Health Benefits** – As specified in the *Affordable Care Act*, plans in the *Health Insurance Marketplace*, as well as the individual and small-group market, are required to offer coverage for “essential health benefits” that must include ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services, chronic disease management and pediatric services (including pediatric oral and vision care).

**Federal Poverty Level (FPL)** – Annually updated guidelines established by the *U.S. Department of Health and Human Services* to determine eligibility for various federal and state programs (e.g., *Medicaid*). In 2017, the FPL for a family of four was \$28,290.

**Federally Qualified Health Center (FQHC)** – A health center in a medically underserved area or population that is eligible to receive cost-based *Medicare* and *Medicaid* reimbursement and annual grants. FQHCs provide direct reimbursement to nurse practitioners, physician assistants, and certified nurse midwives. They are sometimes referred to as *community health centers*.

**Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD)** – State agency that provides treatment and support services to people with behavioral health challenges and addictive diseases, and assists individuals who live with developmental disabilities. DBHDD serves people of all ages with the most severe and

likely to be long-term conditions.  
[www.dbhdd.georgia.gov](http://www.dbhdd.georgia.gov)

**Georgia Department of Community Health (DCH)** – State agency that provides health care benefits to more than 2 million citizens under the *Medicaid* and *PeachCare for Kids* programs and the State Health Benefit Plan.  
[www.dch.georgia.gov](http://www.dch.georgia.gov)

**Georgia Department of Human Services (DHS)** – State agency that provides services that promote child and adult protection, child welfare, stronger families and self-sufficiency. The department's three divisions are Aging Services, Child Support Services, and Family and Children Services. The department also includes the Office of Residential Child Care. [www.dhs.georgia.gov](http://www.dhs.georgia.gov)

**Georgia Department of Public Health (DPH)** – State agency responsible for disease control and prevention, the reduction of avoidable injury-related deaths and disabilities and the promotion of healthy lifestyles.  
[www.dph.georgia.gov](http://www.dph.georgia.gov)

**Georgia Families** – Georgia's managed care program for members in *Medicaid* and *PeachCare for Kids*. Medicaid and PeachCare for Kids members must enroll in *Georgia Families* to choose a health plan and to choose a *primary care provider* (PCP). If they do not enroll, a health plan and PCP are chosen for them. [www.georgia-families.com](http://www.georgia-families.com)

**Georgia Families 360°** – Georgia's managed care program for children in foster care, adoption assistance or juvenile justice. All services are covered by one *care management organization*, Amerigroup.

**Health Impact Assessment (HIA)** – A combination of procedures, methods and tools that systematically assesses the potential effects of a policy, program or project on the health of a population and the distribution of those effects within the population. HIA identifies appropriate actions to manage those effects.

**Health Information Exchange (HIE)** – The transmission of health care-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 Marketplace** – The *Marketplaces* must offer four levels of coverage (bronze, silver, gold, platinum plans) based on the plan's *actuarial value* (AV). Platinum plans have an AV of 90%, gold plans have an AV of 80%, *silver plans* have an AV of 70% and bronze plans have an AV of 60%.

**Health Insurance Marketplace Navigators** – *Marketplaces* are required to contract with professional associations and local organizations to provide *patient navigator* services. These services include providing education and information about qualified health plans that is culturally and linguistically appropriate; distributing fair and impartial information about enrollment; facilitating enrollment in health plans; and providing referrals for any enrollee with a grievance, complaint, or question regarding a health plan.

**Health Insurance Marketplace Plans** – The *Marketplaces* must offer four levels of coverage (bronze, silver, gold, platinum plans) based on the plan's actuarial value. The levels are defined based on their *actual value* (AV). Platinum plans have an AV of 90%, gold plans have an AV of 80%, *silver plans* have an AV of 70%, and bronze plans have an AV of 60%.

**Health Insurance Portability and Accountability Act (HIPAA)** – Passed by Congress in 1996, HIPAA includes various health insurance coverage and patient privacy protections. The 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)** – 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.

**Health Professional Shortage Area (HPSA)** – Areas may be designated by the Bureau of Primary Health Care in the *Health Resources and Services Administration* as having a shortage of primary medical care, dental or mental health providers. HPSAs may be urban or rural areas, population groups, or facilities.

**Health Resources and Services Administration (HRSA) –**

An agency of the *U.S. Department of Health and Human Services*, HRSA is the primary federal agency for improving access to health care services for people who are uninsured, isolated or medically vulnerable.

**Health Savings Account (HSA) –** An HSA is a tax-exempt savings account for medical expenses. Funds can be withdrawn from an HSA to meet the *deductible* of the *high-deductible health plan* and pay for other medical services and supplies. In order to qualify to open an HSA, in 2017, the HDHP minimum deductible must be at least \$1,300 (individual coverage) or \$2,600 (family coverage). The annual *out-of-pocket* limit (including deductibles and copays) cannot exceed \$6,550 (individual coverage) or \$13,100 (family coverage).

**High Deductible Health Plan (HDHP) –** An HDHP is an inexpensive health insurance plan that generally does not pay for the first several thousand dollars of health care expenses (i.e., the “*deductible*”) but will generally cover medical care after the deductible is met. HDHPs may have first-dollar coverage (no deductible) for preventive care and apply higher *out-of-pocket* limits (and copays and coinsurance) for non-network services.

**High-Risk Pool –** A high-risk pool groups health insurance consumers with greater risk (costly or chronic health conditions) into a separate insurance pool and then helps to subsidize insurance for these consumers. Removing individuals with greater risk from the original pool reduces that pool's risk, and in turn stabilizes *premiums* — reduces premium

increases for that group. High-risk pools can stabilize an insurance market and make coverage more available and affordable.

**Home- and Community-Based Services (HCBS)** – Any care or services provided in a patient’s place of residence or in a noninstitutional setting located in the community.

**Hospice** – A facility or program designed to provide palliative care for patients in the terminal phase of an illness.

**Indigent Care Trust Fund (ICTF)** – A program within Georgia’s *Department of Community Health (DCH)*, the ICTF supports hospitals that care for medically indigent Georgians. ICTF represents the largest component of *Disproportionate Share Hospital Program (DSH)* payments distributed through *Georgia Medicaid*. To participate in ICTF, a hospital must also be a DSH provider.

**Individual Mandate** – Under the *Affordable Care Act*, the individual mandate requires all individuals to obtain health care insurance or pay a penalty, although some exceptions do apply (financial hardship, religious reasons). The penalty, in the form of a tax, is \$325 or up to 2% taxable income in 2015 and \$695 or up to 3% taxable income in 2016.

**Invisible High-Risk Pool** – A hybrid high-risk pool/reinsurance program that targets a specific subset of health insurance consumers with greater risk (costly or chronic health conditions). However, instead of pulling these consumers out of the insurance pool and into their own pool, the program helps insurers to pay claims costs for these individuals.



**Insurance Subsidies** – A way to provide individuals and small employers with the resources necessary to make health insurance affordable.

**Katie Beckett Children** – Disabled children who qualify for home care coverage under a special provision of *Medicaid*, named after a girl who remained institutionalized solely to continue *Medicaid* coverage before the provision's enactment. Also known as a "Deeming Waiver."

**Long-Term Services and Supports (LTSS)** – A set of 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.

**Low-Income Medicaid** – *Medicaid* category for those with the lowest individual and family incomes. In 2017, qualified individuals must have an income of less than \$310 per month, and a family of four may qualify with an income of less than \$653 per month.

**Market Stabilization** – Measures taken by a state or federal government in an effort to stabilize the individual health insurance market. Possible measures include *high-risk pools*, *reinsurance* programs, and *premium* and *cost-sharing subsidies*.

**Medicaid** – A federally aided, state-administered and jointly funded health insurance program that provides medical benefits to qualified indigent or low-income persons in need of medical care. The program is subject to broad federal guidelines, and states determine the benefits covered and methods of administration. *The Department of*

Community Health administers Georgia's Medicaid program.

**Medication-Assisted Treatment (MAT)** – A method for treating opioid dependence with a combination of behavioral therapy and medication that limits cravings, such as methadone, buprenorphine, suboxone and naltrexone.

**Medical or Health 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 ensure that patients get the indicated care when and where they need it in a culturally and linguistically appropriate manner.

**Medical Loss Ratio** – Refers to the percentage of *premium* dollars that an insurance company spends on services and improving the quality of care versus how much is spent on administrative and overhead costs. The *Affordable Care Act* requires that 80% to 85% of the money collected by insurance companies be spent on health care services and health care quality improvement.

**Medical Nutritional Therapy** – Nutrition counseling provided by a registered dietitian.

**Medicare** – A federally funded health insurance plan that provides hospital, surgical and medical benefits to elderly persons over 65 and certain disabled persons. Medicare Part A provides basic hospital insurance, while Medicare Part B provides benefits for physicians' professional services. Medicare Part C (Medicare Advantage Plan) allows those

covered to combine their coverage under Parts A and B but is provided by private insurance companies. Medicare Part D helps pay for medications doctors prescribe for treatment.

**Naloxone** – A medication used to stop or reverse the effects of an opioid overdose that can be administered via injection or as a nasal spray.

**Out-of-Pocket** – The portion of health care costs paid by the person receiving care, including *co-insurance*, *copayments* and *deductibles*.

**Out-of-Pocket Maximum** – The maximum amount an insured must pay (*co-insurance*, *copayments* and *deductibles*) for covered services in a plan year.

**Patient Navigator** – A lay person who helps patients understand health care coverage, be aware of different types of health providers and services, apply for assistance and manage care received from multiple providers.

**Patient Protection and Affordable Care Act** – See *Affordable Care Act*.

**Patient Self-Determination Act (PSDA)** – A federal law passed by the U.S. Congress in 1990, which mandates that most hospitals provide patients with information on state laws regarding their right to refuse medical treatment and document their preferences through an advance directive.

**PeachCare for Kids®** – A comprehensive free or low-cost health care program for uninsured children living in Georgia. The health benefits include primary, preventive, specialist, dental and vision care. The program targets children in families with incomes up to 235% of the *federal*

poverty level. See also *Children's Health Insurance Program*.  
[www.peachcare.org](http://www.peachcare.org)

**Per Capita Caps** – A fixed amount of money per person allocated annually by the federal government to a state for a general purpose. In the field of health care, the term is usually used as an alternative way to finance state *Medicaid* programs. The federal share of a state's *Medicaid* spending would be a fixed amount per *Medicaid* enrollee per state per year. See also *block grants*.

**Pharmaceutical Assistance Program (PAP)** – A program that provides pharmaceutical coverage to those who cannot afford or have difficulty obtaining prescription drugs. Several states operate state-funded pharmaceutical assistance programs that primarily provide benefits to the low-income elderly or persons with disabilities who do not qualify for *Medicaid*.

**Pharmacy Benefit Manager (PBM)** – Companies that manage drug benefit coverage for employees and health plan members.

**Physician Order for Life-Sustaining Treatment (POLST)** – A medical order written by a physician that sets forth the patient's preferences for end-of-life care based on preferences verbalized to the physician or expressed in an *advance directive*.

**Preferred Drug List (PDL)** – A list of prescription drugs that are covered by a health plan or other payer (e.g., *Medicaid*).

**Preferred Provider Organization (PPO)** – A health insurance plan in which health care providers agree to provide services to members at a negotiated price. Covered individuals (members) receive all medically necessary services regardless of whether the cost of the services exceeds the *premium* paid, although members do have cost-sharing obligations.

**Premium** – Amount individuals pay for an insurance policy, usually expressed as a monthly or annual amount.

**Primary Care Provider (PCP)** – In insurance terms, a physician selected by or assigned to a patient who provides general care and supervises the patient's access to other medical services.

**Reinsurance** – A type of *high-risk pool* that protects insurers from very high claims costs. Instead of removing consumers with greater risk (costly or chronic health conditions), reinsurance programs “insure the insurers,” transferring funds to insurers to help pay a portion of claims associated with high-cost enrollees once the claim dollars have reached a certain amount. Reinsurance is a way to stabilize an insurance market and make coverage more available and affordable.

**Right from the Start Medicaid** – *Medicaid* category for pregnant women and children under age 1 whose family income is at or below 185% of the *federal poverty level*.

**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* and use physician assistants and/or nurse practitioners to deliver services.

**Rural Health Network** – Refers to any variety of organizational arrangements to link rural health care providers in a common purpose.

**Safety Net** – The safety net is made up of providers and institutions that provide low-cost or free medical care to medically needy, low-income or uninsured populations.

**Service Options Using Resources in a Community Environment (SOURCE)** – A state case-management program that serves frail, elderly and disabled *Medicaid Supplemental Security Income* beneficiaries to improve the health outcomes of persons with chronic health conditions by linking primary medical care with *home- and community-based services*.

**Silver Plan** – One of the four “metal” coverage levels for plans offered in the *Health Insurance Marketplace*. Silver plans have an *actuarial value* of 70%. Compared to the other levels (platinum, gold and bronze), silver plans fall somewhere in the middle, with moderate monthly *premiums* and *out-of-pocket* costs. *Cost-sharing reduction subsidies* only apply to silver plans.

**State Health Benefit Plan** – Provides health insurance coverage to state employees, school system employees, retirees and their covered dependents. The *Department of Community Health's* State Health Benefit Plan Division is responsible for day-to-day operations. The State Health Benefit Plan covered nearly 640,000 people as of June 2016.

**Supplemental Security Income (SSI)** – A federally funded cash assistance program designed to help low-income elderly, blind and disabled individuals who have little or no income with basic needs of food, clothing and shelter. Once eligible for SSI, these low-income individuals are also eligible for *Medicaid* coverage.

**Trauma System** – A trauma system is an organized, coordinated effort for a defined geographic area that delivers the full range of emergency care to all injured patients and is integrated with the local public health system.

**Uncompensated Care** – Service provided by physicians and hospitals for which no payment is received from the patient or from third-party payers.

**Underinsured** – People with public or private insurance policies that do not cover all necessary health care services, resulting in *out-of-pocket* expenses that exceed their ability to pay.

**Uninsurables** – High-risk persons who do not have health care coverage through private insurance and who fall outside the parameters of risks of standard health underwriting practices.

**Uninsured** – People who lack public or private health insurance.

**U.S. Department of Health and Human Services (HHS)** – HHS is the federal 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 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.

**Utilization** – Patterns or rates of use of a single service or type of service (e.g., hospital care, physician visits and prescription drugs). Use is also expressed in rate per unit of population at risk for a given period of time.



## Acronym Appendix

ABD:	Aged, Blind, Disabled
ACA:	Affordable Care Act
ACO:	Accountable Care Organization
AHCA:	American Health Care Act
APTC:	Advance Premium Tax Credit
AV:	Actuarial Value
CCSP:	Community Care Services Program
CHC:	Community Health Center
CHIP:	Children's Health Insurance Program
CHIPRA:	Children's Health Insurance Program Reauthorization Act
CHW:	Community Health Worker
CMO:	Care Management Organization
CMS:	Centers for Medicare and Medicaid Services
COBRA:	Consolidated Omnibus Budget Reconciliation Act
CON:	Certificate of Need
CSRs:	Cost-Sharing Reduction Subsidies
DATA:	Drug Addiction Treatment Act
DBHDD:	Department of Behavioral Health and Developmental Disabilities

DCH:	Department of Community Health
DHS:	Department of Human Services
DPH:	Department of Public Health
DSH:	Disproportionate Share Hospital
EMR:	Electronic Medical Record
EMS:	Emergency Medical Services
EMTALA:	Emergency Medical Treatment and Active Labor Act
ERISA:	Employee Retirement Income Security Act
FPL:	Federal Poverty Level
FQHC:	Federally Qualified Health Center
HCBS:	Home and Community-Based Services
HDHP:	High Deductible Health Plan
HHS:	Health and Human Services
HIA:	Health Impact Assessment
HIE:	Health Information Exchange
HIPAA:	Health Insurance Portability and Accountability Act
HIT:	Health Information Technology
HMO:	Health Maintenance Organization
HPSA:	Health Professional Shortage Area
HRSA:	Health Resources and Services Administration
HSA:	Health Savings Account

ICTF:	Indigent Care Trust Fund
LTSS:	Long-Term Services and Supports
MAT:	Medication-Assisted Treatment
PAP:	Pharmaceutical Assistance Program
PBM:	Pharmacy Benefit Manager
PCP:	Primary Care Provider
PDL:	Preferred Drug List
POLST:	Physician Order for Life-Sustaining Treatment
PPO:	Preferred Provider Organization
PSDA:	Patient Self-Determination Act
SOURCE:	Service Options Using Resources in a Community Environment
SSI:	Supplemental Security Income

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The Georgia Health Policy Center, established in 1995, provides evidence-based research, program development and policy guidance at the local, state and national levels to improve health status at the community level.

Located within Georgia State University's Andrew Young School of Policy Studies, the center distills qualitative and quantitative research findings to connect decision-makers with the evidence-based research and guidance needed to make informed decisions about health policy and programming.

Today, the center is at work nationwide focusing on some of the most complex policy issues facing health care today, including behavioral health, child health and well-being, community health systems development, health and health care financing, health in all policies, health system transformation, long-term services and supports, population health and rural health.





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