Health Words

2017

colorado health
INSTITUTE

What is an **Arveschoug-Bird**?
How do you **clawback**, exactly?
And remember when people were **uninsurable**? Working to compile this sixth edition of HealthWords, we were reminded how much and how fast the world of health and health policy changes.

Those words from the 2009 edition are not included in this 2017 edition. But health equity, for example, is now featured.

The Colorado Health Institute is proud to present HealthWords 2017. It is intended to help navigate the terms and, as is often the case, the acronyms that fill many conversations about health policy. We know that it's hard to keep up. And it is our hope that the words we use are never a barrier to entering the conversation for anyone who has good ideas about how to ensure that Coloradans are as healthy as possible.

Staff members compiled these definitions with an assist from the Henry J. Kaiser Family Foundation, the U.S. Department of Health and Human Services, local and national experts, and other sources. Our definitions are intended to be clear, but they are not a comprehensive source for a topic.

A list of **acronyms** is available at the end of this glossary.

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#

1332 Innovation Waiver: An option created by Section 1332 of the Affordable Care Act (ACA) that allows states to waive many of the law's key coverage provisions in favor of alternative programs. States will receive full ACA funding as long as they meet or exceed the law's requirements.

A

Access to Care. The ability to obtain needed health care. Factors affecting access to care include insurance, affordability, capacity of the health care workforce and provider location.

Accountable Care Collaborative (ACC). Colorado's signature effort to transform the delivery of primary health care to clients insured by Medicaid. Launched by the Colorado Department of Health Care Policy and Financing (HCPF) in mid-2012, it is separated into seven Regional Care Collaborative Organizations (RCCOs), which provide administrative support. Primary

Care Medical Providers (PCMPs) serve as patient medical homes and coordinate care, earning extra payments by meeting performance targets. The program is set to enter phase II in 2017.

Accountable Care Organization (ACO). A group of doctors, hospitals and other health care providers that join together to provide coordinated care with the goal of improving quality and lowering costs. Many ACOs are in the Medicare public insurance program, but some are in the private market. ACOs that improve quality and lower costs share a portion of the savings.

Activities of Daily Living (ADLs). Basic tasks performed in the course of everyday life, such as eating, bathing, dressing and using the bathroom.

Actuarial Value. The percentage of total average costs for benefits that a plan will cover. For example, if a plan has an actuarial value of 70 percent, an enrollee would be responsible for 30 percent of the costs of

covered benefits. However, an individual enrollee could be responsible for a higher or lower percentage of the total costs, depending on actual health care needs.

Acute Care. Medical care for an immediate illness or serious injury. Treatment is typically short-term and provided in an emergency department or hospital.

Adults Without Dependent Children (AwDC). Adults over the age of 18 who do not have children living with them or dependent on them. They are often referred to as "childless adults." Members of this group, despite low incomes, historically have not been eligible for the Medicaid public insurance program. Colorado expanded Medicaid eligibility to 10,000 of the lowest-income childless adults in 2012. More members of the group became eligible for Medicaid in 2014, when Colorado expanded eligibility under the Affordable Care Act to childless adults with incomes below 138 percent of the federal poverty level (FPL).

Adverse Childhood Experiences (ACEs): Potentially traumatic events, that occur between the ages of zero and 18, that can have lasting negative effects on health and well-being.

Adverse Selection. The tendency of people expecting high health care needs to seek health insurance at greater rates than healthier people. This can result in a health insurance risk pool filled disproportionately with less healthy and presumably more costly enrollees.

Affordable Care Act (ACA). Health reform act signed into law by President Barack Obama in March 2010 following a contentious national debate. Also known as the Patient Protection and Affordable Care Act (PPACA) and sometimes referred to as Obamacare. Components of the law include requiring most Americans to have health insurance or pay a penalty, requiring insurers to cover all applicants regardless of preexisting health conditions and mandating a minimum level of benefits. The ACA provides tax credits as well as lower

cost-sharing rates for some lower-income enrollees.

Agency for Healthcare Research and Quality (AHRQ). A U.S. Department of Health and Human Services agency that conducts and sponsors research on access to health care and health outcomes, as well as on the quality, safety and cost of care.

Aid in Dying: A process by which a terminally ill patient meeting certain conditions can request lethal medication to self-administer for purpose of hastening their own death. Alternative terms: Physician-assisted suicide and death with dignity.

All-Payer Claims Database (APCD). A secure database that includes insurance claims data from commercial health insurance plans, Medicare and Medicaid in Colorado. Designed to increase transparency, it was created by the state legislature and is managed by the Center for Improving Value in Health Care.

Ambulatory Care. Outpatient medical care. Patients are usually discharged on the same day they receive treatment, which is typically provided in doctors' offices, clinics or hospital emergency departments.

Amendment 35. A 2004 voter-approved amendment to the Colorado Constitution that increased the sales tax on tobacco products and earmarked the funds to expand access to health care and support tobacco education programs. If the Colorado General Assembly approves, tobacco tax money can be used for other health-related expenses in the state budget.

American Recovery and Reinvestment Act (ARRA). Federal legislation signed into law in February 2009 to stimulate the U.S. economy. In the health care sector, ARRA funds increased federal Medicaid money to states, provided COBRA health insurance premium subsidies for laid-off workers, promoted the use of health information technology and electronic medical records, expanded safety net clinic capacity and supported health professions

workforce initiatives, including student loan repayment programs.

Attribution. A process of assigning enrollees to primary care providers in a health program such as the Accountable Care Collaborative.

B

Basic Health Program (BHP). An optional coverage program under the Affordable Care Act that allows states to use federal dollars to subsidize coverage for residents with incomes greater than 133 percent but less than 200 percent of the federal poverty level (FPL). States can also offer the BHP to legal immigrants with incomes below 200 percent of the FPL who are not eligible for Medicaid. Colorado did not adopt this program in 2015.

Beacon. A federal program to demonstrate how health information technology and "meaningful use" of electronic health records advance patient-centered care and the Triple Aim of better health, better care

experience and lower cost. Four western Colorado organizations are among those receiving federal money for electronic health record and information exchange systems.

Behavioral Health. An umbrella term that includes mental health, substance use disorders and behaviors that contribute to chronic medical illnesses.

Behavioral Health Organization (BHO). An organization hired by the Colorado Medicaid program to manage mental health and substance use disorder services for all Medicaid enrollees living in a geographic region. Colorado is divided into five BHO regions.

Behavioral Health Providers. A variety of clinicians, including psychiatrists, psychologists, therapists and substance use counselors who provide behavioral health services such as individual or family counseling and support groups.

Behavioral Risk Factor Surveillance System (BRFSS). The largest survey in the world with more than 500,000 telephone interviews annually, the BRFSS – pronounced "bur-fus" – estimates the prevalence of health behaviors associated with premature illness or death among adults at national and state levels. Examples include smoking, binge drinking and obesity.

Benefit Package. Payment for medical and other services, such as hospitalizations, office visits and prescription drug coverage, included in an insurance plan.

Block Grant. A federal lump-sum payment with few strings attached that is awarded to a government, generally a state, to implement designated programs. For instance, block grants for Medicaid are often proposed as an alternative to the current financing model in which the federal government provides a match to states for each service provided to Medicaid enrollees.

Built Environment: The physical parts of where we live, such as roads, sidewalks, schools and parks. The safety and accessibility of these places influences levels of physical activity and can have a big impact on our health.

Bundled Payment. A single payment to a provider or group of providers for all services associated with a health condition, such as diabetes, or an event, such as a heart attack, or a medical procedure, such as hip replacement. Providers receive a share of any savings if the cost is lower than the payment, but lose money if the cost is higher than the payment. Most bundled care episodes have a reasonably well-defined beginning and end. For chronic conditions, a bundled payment covers all treatment over a certain period of time such as 12 months.

C

Capitation. A financial arrangement between a health insurer and a provider or group of providers in which providers agree

to offer a range of services to each covered enrollee in exchange for a fixed per member per month (PMPM) payment. The providers are at financial risk for care that exceeds the monthly payments, but keep the savings if the cost of care is below the monthly payments. Capitated payments are typically adjusted for the risk or severity of patients' conditions. They are often combined with quality metrics to prevent rationing of health care services.

Care Coordination. Efforts to better coordinate the care of patients, including facilitating communication between health care providers, assisting patients with creating self-directed care plans and providing education and self-care techniques.

Carve-Out. When an insurer contracts with a third party or vendor to manage specific benefits. One example could be behavioral health.

Case (Care) Management. A patient-centered process used by public and private health insurers and providers to manage the care of high-cost, high-need individuals.

Center for Medicare & Medicaid Innovation. Also known as the Innovation Center. Created by Congress to test new payment and service delivery models. The goal is to reduce costs for programs serving Medicaid, Medicare and Children's Health Insurance Program (CHIP) clients.

Centers for Medicare & Medicaid Services (CMS). The U.S. Department of Health and Human Services agency responsible for the federal administration of Medicaid, Medicare and the Children's Health Insurance Program. (Note: The Colorado Medical Society also uses CMS as its acronym.)

Certified Application Counselor. Providers of free education and outreach assistance to help individuals and small businesses understand and apply for health insurance through marketplaces established by the Affordable Care Act.

Certified Health Coverage Guides. Members of the Connect for Health Colorado Assistance Network who provide local and in-person education and help to individuals and small employers applying for health insurance. Their help is free to consumers. Coverage guides are funded through the health insurance marketplace.

Child Health Plan *Plus* (CHP+). The name of Colorado's Children's Health Insurance Program (CHIP). CHP+ provides coverage to children under 19 years old and pregnant women with a household income under 260 percent of the federal poverty level (FPL).

Children's Health Insurance Program (CHIP). A federal program earmarking money to help states insure low-income children whose family incomes are too high for Medicaid but not high enough to afford private insurance. The Affordable Care Act extended CHIP funding through 2015 and requires participating states to maintain current CHIP eligibility levels through 2019.

Chronic Care Management. The coordination of health care and support services to reduce costs and improve the health of patients with chronic conditions, such as diabetes and asthma. These initiatives focus on evidence-based interventions and education to improve patients' self-management skills.

Coinsurance. A method of cost-sharing in which an insured person pays a defined percentage of his or her medical costs after meeting the deductible.

Colocated Care. Health care delivered by different types of providers, such as physical health and behavioral health clinicians, who have offices in the same building.

Colorado Benefits Management System (CBMS). An integrated system for determining eligibility and calculating benefits for state-supervised assistance programs, such as Medicaid, SNAP (food stamps) and Temporary Assistance for Needy Families.

Colorado Commission on Affordable Health Care (CCAHC). Established by the state legislature in 2014 to study the drivers of health care costs and evidence-based strategies to contain them and make cost containment recommendations to the legislature and the governor. Twelve voting members represent health care providers, payers, employers, consumers and other interests. Five nonvoting members represent state agencies and not-for-profit organizations.

Colorado Department of Health Care Policy and Financing (HCPF). The state agency that administers Medicaid, CHP+ and other programs for low-income residents, seniors and people with disabilities.

Colorado Department of Human Services (CDHS). The state agency that administers social services, including behavioral health programs and services for adults, seniors and people with developmental disabilities, and coordinates early childhood programs.

Colorado Department of Public Health and Environment (CDPHE). The state agency responsible for administering public health functions, including air and water quality programs, hazardous waste management, childhood immunization and chronic disease management, among others. CDPHE also regulates health facilities.

Colorado Department of Regulatory Agencies (DORA). The state agency that oversees Colorado's businesses and provides consumer protection services. It houses the state's health professions licensing boards and the Division of Insurance, which regulates health, auto and property insurance companies statewide.

Colorado Health Access Survey (CHAS). The CHAS is a biennial random sample telephone survey of more than 10,000 households across the state. Respondents are asked about their health insurance coverage, access to health care, use of health care services and health status. The

Colorado Health Institute manages the administration and analysis of the CHAS, which is funded by The Colorado Trust. Data from the next CHAS will become available in summer 2017.

Colorado Health Care Affordability Act. A 2009 state law, HB 09-1293, assessing a fee on hospitals that generates matching federal funds. The money provides higher reimbursements to hospitals for Medicaid and Colorado Indigent Care Program (CICP) patients. It enabled expansion in 2010 of CHP+ coverage to children and pregnant women with incomes up to 250 percent of the federal poverty level (FPL) and parents with incomes up to 100 percent of the FPL. People with disabilities were able to "buy in" to Medicaid by paying a monthly premium based on income. The legislation extended eligibility to adults without dependent children with incomes below the federal poverty line, but enrollment was capped at 10,000.

Colorado Health Observation Regional Data Service (CHORDS): A seven-county network in metro Denver that uses electronic health record data to support public health evaluation and monitoring.

Colorado Indigent Care Program (CICP). A state-administered program that provides partial reimbursement to some health care providers who deliver a significant amount of care to uninsured people with incomes up to 250 percent of the federal poverty level. CICP benefits are not considered minimum essential health benefits under the Affordable Care Act.

Colorado Program Eligibility and Application Kit (PEAK). A website that allows Coloradans to determine their eligibility and apply for Medicaid, CHP+ and other health, nutrition and assistance programs.

Colorado Regional Health Information Organization (CORHIO). This nonprofit supports health information technology,

serving consumers, employers, doctors, hospitals, nursing homes, pharmacies, home health agencies, health plans and local health information exchanges. It also provides collaboration/convening services to communities and offers secure and confidential technical services.

Colorado State Innovation Model (SIM). A proposal for government funding to transform health care delivery in Colorado by providing access to integrated primary care and behavioral health services in coordinated community systems. It is designed to reach 80 percent of residents by 2019.

Colorado Telehealth Network (CTN). The state's federally designated provider of health care broadband infrastructure. The network provides federally subsidized Internet connections to more than 200 behavioral and physical health sites throughout the state.

Community-Centered Board (CCB). A private, nonprofit that is the single entry point into the long-term services and supports system for persons with developmental disabilities.

Community Safety Net Clinic (CSNC). Clinics that provide primary care and chronic care to uninsured, underinsured and low-income Coloradans. CSNCs include family medicine residency clinics, community clinics and free and charitable clinics. Unlike federally qualified health centers, CSNCs do not receive enhanced Medicaid or Medicare reimbursements or federal funding. These clinics rely primarily on grants, patient revenue and donations.

Community Health Assessment. A tool used to describe the health of a community by looking at who lives there, their health status, how the physical environment affects residents' health, what members of the community want and need and what resources are available.

Community Health Centers (CHCs). Federally designated and funded nonprofit health clinics that provide comprehensive primary care services regardless of patients' ability to pay. Also known as federally qualified health centers (FQHCs), these clinics receive cost-based reimbursement for Medicare and Medicaid patients and must use a sliding fee schedule. Colorado's 15 CHCs provide physical health care as well as some dental and mental health services.

Community Health Improvement Plan. A systematic effort to address health issues affecting a community. Colorado's state and local public health agencies work with community and regional partners to assess health data about the community and identify goals and strategies for improving health over five years.

Community Mental Health Centers (CMHCs). Federally certified centers that provide comprehensive mental health services, including outpatient services, 24-hour emergency care, rehabilitative

services and screening for admissions to state mental health facilities. Colorado has 17 CMHCs.

Comparative Effectiveness Research. A field of research that analyzes the impact of different options for treating a given condition in a particular group of patients. These analyses may focus only on the medical risks and benefits of each treatment or also consider the costs and benefits of treatment options.

Comprehensive Primary Care Initiative (CPCI). This initiative fosters collaboration between public and private health care payers to strengthen primary care. Medicare works with commercial and state health insurance plans and offers bonus payments to primary care doctors who better coordinate care for their patients. Colorado, one of seven states or regions nationally that is participating in CPCI, has 73 primary care practices, 335 providers, nine payers and about 41,000 Medicare beneficiaries involved in CPCI.

Connect for Health Colorado. The online marketplace that allows individuals and small businesses to comparison shop for health insurance plans that meet the requirements of the Affordable Care Act. Colorado is among a handful of states as well as the District of Columbia that elected to operate a state-based health insurance exchange instead of using the federal marketplace.

Consolidated Omnibus Budget Reconciliation Act (COBRA). Federal legislation that lets people maintain group health insurance coverage for 18 months after leaving a job. COBRA applies to firms with more than 20 employees. Those enrolling in the program, including laid-off workers, retirees, spouses, former spouses and dependent children, pay the full premium.

Consumer Assessment of Healthcare Providers and Systems (CAHPS). A survey developed by the Agency for Healthcare

Research and Quality that asks patients about their satisfaction with their health care. The Colorado Department of Health Care Policy and Financing currently administers the CAHPS every year to a portion of Medicaid and CHP+ enrollees.

Consumer-Directed Attendant Supportive Services (CDASS). A Medicaid optional benefit that allows long-term care consumers to hire and supervise personal care attendants who deliver a defined set of services. CDASS allows enrollees to directly purchase and manage the services they need.

Consumer-Driven Health Care. An insurance model that combines a high-deductible health insurance plan with a tax-preferred health savings account. An enrollee may use the account to pay for routine health care expenses up to a certain amount, usually around $2,000 per year. The model is based on the theory that individuals who are more directly responsible for the cost of routine health care will be more prudent purchasers and

consume only what they need to stay healthy.

Continuous Eligibility. This occurs when a person's eligibility for a particular program does not need to be redetermined for a specified period of time, such as a year rather than monthly. The Colorado Health Care Affordability Act included continuous eligibility for children in Medicaid and CHP+, guaranteeing 12-month enrollment for children under 19.

Copayment. (See cost sharing).

Cost Containment. A set of strategies to control the growth of health care costs. These measures focus on reducing overuse of services, addressing provider reimbursement issues, eliminating waste and increasing efficiency in the health care system.

Cost Sharing. The portion of health care expenses paid by an insured individual, usually a copayment (the amount charged for a service such as an office visit or a

prescription) and a deductible (the dollar amount that must be paid before insurance coverage begins).

Cost Sharing Reduction. Established by the Affordable Care Act, these reductions in out-of-pocket costs, including deductibles, copayments and coinsurance, are available for people with annual incomes below 250 percent of the federal poverty level (FPL) who purchase silver-level plans through health insurance marketplaces.

Countercyclical. A phenomenon in which a decline in the economy results in an increase in the demand for services. For example, more people apply for Medicaid when unemployment rises. As enrollment in Medicaid grows, program costs rise.

Crowd Out. This occurs when people drop their commercial health insurance to take advantage of a new or expanded public health insurance program designed to extend coverage to a previously uninsured population.

Current Population Survey (CPS). An annual survey of approximately 4,500 Colorado households conducted by the U.S. Census Bureau for the Bureau of Labor Statistics. Because the CPS is conducted in all 50 states, health insurance status as well as other indicators can be compared.

D

Deductible. A feature of insurance plans in which consumers are responsible for costs up to a specified dollar amount. When the deductible is reached, the insurer begins to pay for services. For example, many consumers have to pay the first $1,000 of their annual health costs before their insurance plan begins to pay benefits.

Defined Benefit. The most common model for employer-sponsored health insurance, in which the plan includes a certain set of benefits. The cost to the employer varies year to year depending on a number of factors, including use of medical services.

Defined Contribution. A health insurance purchaser, such as an employer, contributes a set amount toward the cost of coverage for each enrollee. The enrollee then uses that tax-free amount to purchase health insurance. This model is becoming more common as employers work to contain their health insurance costs.

Delivery System Reform Initiative (DSRIP). Initiatives that provide states with funding they can use to support hospitals and other providers working to improve how they provide care to Medicaid beneficiaries.

Department of Personnel and Administration. The agency overseeing Colorado's personnel system, including the state's employee group benefit plans, such as health, life and dental insurance, and short-term disability insurance.

Disease Management. Ongoing management of chronic disease through an integrative, patient-centered,

multidisciplinary approach. Disease management programs are designed to keep costs in check by engaging patients in managing their condition and by reducing the fragmentation of care that often happens when patients see multiple providers.

Disproportionate Share Hospital (DSH) Program. A federally funded program enacted in 1981 that provides enhanced Medicaid funding to hospitals that serve a significant number of low-income Medicaid and uninsured patients. In Colorado, the DSH program is a major source of funding for the Colorado Indigent Care Program. The Affordable Care Act calls for a reduction of these funds, based on the assumption of increased coverage and thus less unpaid hospital care.

Donut Hole. A coverage gap in Medicare prescription drug coverage (Part D). After the Medicare client and the drug plan spend a certain amount for prescription drugs – $2,960 in 2015 – the client pays all

costs up to a yearly limit, which is $4,700 in 2015. At that point, the gap ends and the client pays five percent of drug costs for the rest of the year. The Affordable Care Act includes provisions to phase out the donut hole by 2020, when Part D enrollees will pay 25 percent of the cost of their generic drugs until they reach the annual spending limit.

Dual Eligible. People who are eligible for both Medicaid and Medicare. Because they are eligible for Medicaid, they are generally low income. As Medicare clients, they are older than 65, blind or have disabilities. Colorado is participating in a Medicare Medicaid Eligible (MME) program to coordinate the care of this population.

Durable Medical Equipment (DME). Medical equipment provided to individuals with limitations due to physical or mental conditions or recovering after discharge from a hospital. Examples include modified shower equipment, walkers, wheelchairs and hospital beds.

E

Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT). A mandatory benefits package available to children, adolescents and pregnant women under 21 enrolled in Medicaid. The package is designed to ensure access to preventive health care and appropriate treatment. The state must provide these benefits under terms set by the federal Centers for Medicare & Medicaid Services.

Electronic Medical Record (EMR). An individual medical and treatment record that has been digitized and stored electronically by a provider. The records contain information about a patient's care and are shared by all providers involved in his or her treatment.

Eligible But Not Enrolled (EBNE). People who are eligible for public health insurance or discounted health insurance through the health insurance marketplace but nevertheless remain uninsured.

Emergency Medical Services (EMS). Services provided by first responders, such as ambulance crews, firefighters and police officers, in medical emergencies.

Emergency Medical Treatment and Active Labor Act (EMTALA). Federal legislation passed as part of the Omnibus Budget Reconciliation Act of 1986 that requires hospitals and ambulance services to stabilize or provide emergency treatment to everyone regardless of citizenship, legal status or the ability to pay.

Employer Health Care Tax Credit. An incentive created by the Affordable Care Act to encourage employers to offer health insurance to their employees. Federal tax credits are available for small employers and nonprofits to help cover the cost. To qualify, employers must purchase their policies on the small business health options (SHOP) insurance exchange.

Employer Mandate. A means of increasing health insurance coverage by requiring employers of 50 or more workers to provide

health insurance or pay a penalty. Penalties increase over time.

Employer-Sponsored Insurance (ESI). Health insurance coverage provided by an employer. ESI can be solely paid for by an employer or costs can be split between the employer and employee. Approximately 60 percent of insured Coloradans have employer-sponsored insurance.

Employment Retirement Income Security Act (ERISA). Federal legislation passed in 1974 that sets minimum standards for most voluntarily established pension and health plans in private industry. The law requires plans to provide participants with information on plan features and funding.

Entitlement Program. Federal programs, such as Medicare and Medicaid, providing benefits to people who meet eligibility criteria. The federal government must provide entitlement benefits, unlike discretionary programs. Enrollment in these programs cannot be capped, and neither

states nor the federal government may establish waiting lists.

Essential Community Providers (ECPs). Health care providers that serve patients who are high-risk, have special needs or live in underserved areas. An ECP waives charges or uses a sliding scale based on income to charge for services and does not restrict access to services based on financial status. In Colorado, HCPF designates ECPs.

Essential Health Benefits. A standard set of benefits provided by small group and individual insurance plans sold on and off of health insurance exchanges. These benefits are required by the Affordable Care Act.

Evidence-Based Medicine. The use of empirical, clinical evidence to inform treatment decisions in order to improve health outcomes.

Exclusive Provider Organization Plan (EPO). A managed care plan that covers the use of doctors, specialists and hospitals in its network, as well as out-of-network

provider services, with the exception of medical emergencies. EPOs are typically less expensive than other managed care plans. Unlike health maintenance organizations (HMOs), they do not usually require members to select a primary care physician or get referrals to see a specialist. EPOs balance these advantages with more restricted care networks.

F

Federal Medical Assistance Percentage (FMAP). The level of matching funds from the federal government to states for Medicaid and other programs. The FMAP varies by state. Colorado's fiscal year 2015 FMAP is 51.01, meaning the federal government contributes 51.01 percent and Colorado contributes 48.99 percent. An enhanced FMAP, called eFMAP, is used for the Children's Health Insurance Program. Colorado's 2015 eFMAP is 65.71.

Federal Poverty Level (FPL). Annually updated guidelines established by the U.S. Department of Health and Human Services

to determine eligibility for federal and state programs. The FPL for a family of four is $23,850 in 2014.

Federally Qualified Health Centers (FQHCs). (See Community Health Centers).

Fee-for-Service (FFS). A payment method in which an insurer reimburses a physician or hospital for each service provided according to a fee schedule.

Food Desert. A geographic area with limited or no access to fresh, healthy and affordable foods.

Food Swamp. A geographic area with abundant access to high-calorie foods, such as snack foods and fast foods. An area often is both a food desert and food swamp.

Formulary. A list of prescription drugs covered by a health insurance plan. It is also called a drug list.

Free-Standing Emergency Department (FSED). A facility that is structurally separate

from a hospital and provides a range of care, from routine to emergency. There are two types: A hospital outpatient department owned and operated by a medical center or hospital system or independent centers owned by individuals or groups. The independent centers do not accept public insurance such as Medicaid or Medicare.

G

Gain Sharing. Financial rewards to providers who reduce health care spending below the expected cost of treating a patient while maintaining quality. This is also called "shared savings."

Geographic Rating. Pure community rating is a method for calculating insurance premiums for people in a given community regardless of their health status, prior claims experience, age or gender. Adjustments can be made based on family size or plan design. Modified community rating, also known as adjusted community rating, permits insurers to consider certain

demographic factors in calculating rates, such as age, gender and geography, but not health status or claims history.

Global Payments. Global payments are the same thing as capitation. (Please see capitation.)

Grandfathered Plans. Health insurance plans that existed before March 23, 2010, when President Barack Obama signed the Affordable Care Act. They can meet the act's individual mandate requirement if they haven't substantially cut benefits or increased costs for consumers. These plans don't have to meet all the Affordable Care Act requirements of insurance, such as no-cost preventive services. Grandfathered plans can be job-based or individual.

Group Health Insurance. Health insurance that is offered to a group of people, such as employees of a company. The majority of Americans have group health insurance through their employer or their spouse's employer.

Guaranteed Issue. Health insurance coverage guaranteed for anyone regardless of health status, occupation, age or gender. The ACA includes guaranteed issue for everyone.

H

Habilitative Services. Medical services that help people gain new skills or functions. One example is speech therapy for a child who is not talking at the expected age. This is different from rehabilitative services, which focus on relearning existing skills or function — for example, relearning to speak after a stroke. Both rehabilitative and habilitative services are essential health benefits under the ACA.

Health Care Cooperative (CO-OP). A nonprofit health insurance organization governed by a board of directors elected by its members. Co-ops provide insurance coverage for individuals and small businesses and can operate at state, regional and national levels. The Colorado Health Insurance CO-OP, the first health care co-op

in the state, began providing coverage January 1, 2014. The Affordable Care Act provided grants to states to start co-ops.

Health Disparity. A difference in health status that is closely linked with factors such as race/ethnicity, religion, socioeconomic status, gender, mental health, sexual orientation, geographic location or disabilities. People negatively affected by health disparities may experience greater social and economic obstacles to health.

Health Equity: Attainment of the highest level of health for all people, regardless of their social, economic or demographic group.

Health in All Policies. A new approach to policymaking that systematically takes into account how decisions on a wide range of issues will impact a community's health. Health in All Policies seek to avoid harmful health impacts and improve population health and health equity.

Health Informatics. The interdisciplinary study of the design, development, adoption and application of IT-based innovations in health care services delivery, management and planning. It encompasses the resources, devices and methods required to improve the acquisition, storage, retrieval and use of information.

Health Information Technology (HIT). The automation of health information to promote the sharing of clinical information among providers and their patients, as well as demographic information among providers. The goal of HIT is to limit redundancies in testing and other diagnostic procedures and eliminate medical errors and the fragmentation of patient information.

Health Insurance Exchange. Also called Health Insurance Marketplace. An online marketplace created by the ACA that allows consumers to comparison shop for health insurance. The tax credits and cost-sharing support contained in the law are available

only when plans are purchased through the marketplace. Colorado is one of 16 states and the District of Columbia to create state-based marketplaces. There are 27 federally facilitated marketplaces and seven partnerships. Colorado's marketplace is called Connect for Health Colorado.

Health Insurance Portability and Accountability Act (HIPAA). Law passed by Congress in 1996 to provide health insurance coverage and patient privacy protections. The privacy rules require confidentiality of medical records and other health information provided to health plans, doctors and hospitals. HIPAA also protects health insurance coverage for workers and their families when they change or lose their jobs. (See Portability of Coverage)

Health Literacy. A person's capacity to obtain and understand basic health information, related to both health insurance and health care, in order to make appropriate decisions.

Health Maintenance Organization (HMO). A comprehensive health insurance plan that provides preventive and treatment services for a fixed per member per month (PMPM) payment. Health care providers can be employees of the HMO or provide care under contract. Enrollees receive services even when the cost exceeds the negotiated PMPM.

Health Reimbursement Account (HRA). A tax-exempt account that can be used to pay for current or future qualified health expenses. HRAs are funded solely by employers, with no limits on the contribution. HRAs often are paired with a high-deductible health plan, but that is not a requirement.

Health Savings Account (HSA). A tax-sheltered account funded by an employee and/or employer into which pre-tax dollars are deposited and used to pay for qualified medical expenses. Under current federal law, employees must be enrolled in a high-deductible health plan to establish an HSA.

Healthy Eating, Active Living (HEAL). A prevention-driven approach to health that supports policies and environmental changes that promote healthy eating and active living in neighborhoods, schools and workplaces.

Healthy Kids Colorado Survey. A statewide survey of the health and academic achievement of young Coloradans. It was launched in 2013 as an expanded version of the national Youth Risk Behavior Surveillance System (YRBSS). More than 220 schools and 40,000 youth participated in the inaugural survey overseen by the Department of Education, the Department of Human Services and the Department of Public Health and Environment.

Healthy Weight. Healthy weight is determined by a Body Mass Index (BMI) calculation that considers height and weight, age and sex. Generally, a BMI between 18.6 and 25 indicates a healthy weight.

High-Deductible Health Plan. A health insurance plan with lower premiums and

higher deductibles than more traditional plans.

Home and Community-Based Services (HCBS) Waiver. Under this waiver approved by the federal government, long-term services and supports can be provided in a home or community setting instead of an institutional setting. The goal of this waiver program is to meet the physical health, functional and behavioral health needs of low-income seniors and disabled individuals who otherwise would be eligible for placement in an institutional setting, such as a nursing home.

Hospital Provider Fee: A fee that hospitals pay to attract federal matching funds to increase Health First Colorado (Colorado's Medicaid Program) and Colorado Indigent Care Program (CICP) payments to hospitals, to fund hospital quality incentive payments, and to expand health care coverage in Health First Colorado and Child Health Plan Plus (CHP+) programs.

I

Independent Living Center or Center for Independent Living (ILC or CIL). A nonprofit agency that assists people with all types of disabilities. These agencies are consumer controlled, meaning clients make decisions regarding their own care, providers and living arrangements.

Individual Insurance Market. People who purchase health insurance on their own. Because they aren't receiving insurance through an employer, they must pay the entire cost of the premium. About eight percent of insured Coloradans are covered through individual insurance.

Individual Mandate. A provision of the Affordable Care Act that requires most people to purchase health insurance or pay a tax penalty. The penalty in 2015 is $325 per person or two percent of annual income, whichever is higher. In 2016, the penalty rose to $695 or 2.5 percent of annual income. It will be adjusted for inflation in subsequent years.

In-Home Support Services (IHSS). A service delivery option in the Home and Community-Based Services (HCBS) Medicaid waiver program. IHSS allows persons who require health care traditionally provided in a nursing home an opportunity to receive services at home, select their own personal attendants and direct their own care.

Insurance Broker. A person who assists individuals and businesses in purchasing health insurance. Brokers are licensed and regulated by the state and typically receive commissions for enrolling customers in an insurer's plan.

Integrated Care. A patient-centered approach to health care provided by a multidisciplinary team of clinicians. This care may address physical health, oral health, mental health, substance use disorders, health behaviors and more.

Interoperability. The ability of systems and organizations to work together. In health care, the capability of different

health information systems to securely communicate, exchange data and use shared information to ensure the delivery of services.

K

Key Performance Indicators (KPI). Measures used to monitor the impact of the Accountable Care Collaborative, Colorado's Medicaid primary care program, and the performance of care providers. The three indicators for fiscal year 2014-15 are reducing use of the emergency department, increasing postpartum visits and the percentage of children between 3 and 9 who receive at least one well-child checkup annually.

L

Lifetime Benefit Maximum. Before the Affordable Care Act, many insurers set limits on how much they would pay for covered benefits over the insured person's life. The health reform law prohibits insurers from imposing lifetime limits on essential health

benefits. Insurers may still place limits on nonessential benefits.

Long-Term Services and Supports (LTSS). Health care, personal assistance and other supportive services provided to people who are unable to care for themselves, often seniors or those with disabilities. LTSS may be provided in facilities, the home or community-based settings. Medicaid is the largest payer of LTSS, followed by Medicare.

M

Managed Care. A health delivery system that seeks to control access to and use of health care services to limit costs and improve the quality of care. Managed care arrangements typically rely on primary care physicians to act as gatekeepers and manage the care their patients receive.

Meaningful Use. Standards to ensure that electronic health records drive improvements in care. Through Medicaid and Medicare incentive programs, doctors and hospitals must achieve increasingly

complex meaningful use objectives to receive payment rewards and, in the case of the Medicare program, to avoid penalties.

Medicaid (Health First Colorado). The state-federal program created in 1965 to provide government health insurance to those with low incomes who fall within eligibility categories. States had the option to expand eligibility under the Affordable Care Act beginning in 2014. Colorado's legislature approved the expansion and more than 1 million Coloradans are now enrolled. The Colorado Department of Health Care Policy and Financing (HCPF) oversees the Medicaid program.

Medicaid Management Information System (MMIS). Medicaid providers use this computer system to submit claims for reimbursement of services.

Medicaid Waivers. Vehicles that states can use to test new ways to deliver and pay for health care services in the Medicaid program. Waiver requests must be

approved by the secretary of Health and Human Services. States can use waivers to implement home- and community-based services programs and managed care. Arkansas is using a waiver to provide premium assistance for Medicaid clients to buy private insurance on the state health insurance exchange.

Medical Home. An increasingly popular model of primary care that is team-based, often in the office of the primary care physician, and coordinated across the care system, including specialty care, hospitals, home health care and community supports. The team oversees all of a patient's health care needs, with a focus on preventive care. A 2007 Colorado law requires all children in Medicaid to have access to a medical home.

Medical Loss Ratio. The percentage of premium dollars an insurance company spends on medical care, as opposed to administrative costs or profits. Under the Affordable Care Act, health plans in the large group market that spend less than 85

percent of premiums on clinical services and plans in the individual and small group markets that spend less than 80 percent of premiums on clinical services are required to provide a rebate to enrollees.

Medically Needy. An optional eligibility category under Medicaid for people whose incomes are above the income threshold but who have extraordinary medical expenses. Colorado does not have this program.

Medicare. A national insurance program created in 1965 to provide health care coverage for people over 65, regardless of income. The program has expanded to cover younger people with permanent disabilities and those with end-stage renal disease. Colorado had about 785,400 enrollees in 2015. Part A covers hospital care and Part B covers medical care, generally outpatient. Part C, known as Medicare Advantage, is a plan offered through a private insurer that contracts with Medicare. Part D, the most recent addition, offers a subsidized prescription drug benefit.

Medicare Advantage. A health plan offered by a private company that contracts with Medicare to provide Part A and B benefits. Medicare Advantage Plans include health maintenance organizations, preferred provider organizations, private fee-for-service plans, special needs plans and Medicare medical savings account plans.

Medicare Supplemental Insurance (Medigap). Health insurance sold by private insurance companies to fill some of the payment and benefit gaps in Medicare coverage.

Metal Levels. Health insurance plans offered though state or federal marketplaces are arranged by four coverage levels, defined by the average share of total health spending on essential benefits, or the actuarial value: bronze, silver, gold and platinum. Bronze plans generally have the lowest premiums and pay 60 percent of covered expenses, silver plans pay 70 percent, gold plans pay 80 percent and platinum plans pay 90 percent.

Minimum Essential Coverage. The minimum level of benefits that must be included in a health insurance plan under the Affordable Care Act.

Modified Adjusted Gross Income (MAGI). A standard five percentage point deduction applied to an applicant's gross income to determine financial eligibility for Medicaid, CHP+ and tax credits offered through health insurance marketplaces. MAGI replaced different state rules addressing how much could be deducted to determine income eligibility for public insurance.

N

Narrow Network. When insurers limit the group of health care providers available to plan enrollees, generally in return for a discount on premiums.

Nongroup Market. Also known as the Individual Insurance Market.

No Wrong Door. A coordinated system that allows older adults and people with disabilities to apply for long-term services

and supports (LTSS) through different agencies and seamlessly routes them to the program that best meets their needs. Consumers are also able to apply for public health insurance programs through the no wrong door system.

O

Office of Behavioral Health. The state agency supporting and monitoring many mental health and substance use disorder treatment providers. It operates the Colorado Mental Health Institutes at Fort Logan and Pueblo.

Office of Personnel Management (OPM). In its health insurance role, OPM manages health benefits for federal employees and contracts with private insurers to offer multi-state insurance plan options under the Affordable Care Act.

Open Enrollment. The time when people can enroll in private health insurance plans inside or outside of the health insurance marketplace.

Out-of-Network Providers. Health care providers who are not employed by or under contract with a managed care plan or specified preferred provider organization (PPO) network. Health plan enrollees generally pay additional cost sharing for using out-of-network providers.

Out-of-Pocket Costs. Health care costs, such as deductibles, copayments and coinsurance that are not covered by an insurance policy. Out-of-pocket costs typically do not include premiums.

Out-of-Pocket Maximum. A yearly cap on the amount of money individuals are required to pay for health care costs, excluding the premium cost.

Outpatient Care. A patient who does not require an overnight stay. Also called ambulatory care.

P

Parity. Two medical conditions covered equally. The Mental Health Parity and Addiction Equity Act of 2008 requires care

for psychological conditions to be covered equivalently with care for physical illnesses.

Passive Enrollment. Under employer-sponsored insurance, rolling over benefits from the previous year rather than choosing a new plan. Under public insurance like Medicaid, the state or federal government notifies the client that he or she has been enrolled in a specific program.

Patient-Centered Medical Home (PCMH). A health care delivery model that emphasizes care coordination and communication to enhance a patient's care. Usually, a patient's primary care provider is considered the medical home and the provider coordinates care with other providers, including specialists. The aim is to provide better care, lower costs and improve the patient experience.

Patient Protection and Affordable Care Act (PPACA). The full title of the Affordable Care Act.

Per Member Per Month (PMPM). A fixed monthly payment based on each enrollee, regardless of the actual number or nature of services provided.

Pharmacy Benefit Managers (PBMs). Companies that manage the drug benefit coverage offered by employer-sponsored insurance.

Population Health. The health outcomes of a group of people, often a community, rather than one person. Population health considers the social, economic, personal and environmental factors that influence health.

Portability of Coverage. Under the Health Insurance Portability and Accountability Act, job changers are guaranteed coverage with their new employer without a waiting period.

Preferred Drug List (PDL). See Formulary.

Preferred Provider Organization (PPO). A defined benefit health insurance plan

in which health care providers agree to provide services to members at a negotiated price, usually a discounted fee.

Premium. Amount paid to an insurance company for providing health care coverage for benefits specified in a policy.

Premium Subsidy. Publicly financed assistance to help those with low incomes purchase insurance through a health insurance marketplace, a provision of the Affordable Care Act. The subsidy is calculated based on a sliding scale according to household income. Also known as an advanced premium tax credit.

Presumptive Eligibility. The ability to immediately enroll clients who are likely eligible for a program while awaiting an official determination. Previously, Colorado used presumptive eligibility in Medicaid only for pregnant women, children under 19 and women applying to the breast and cervical cancer program. The Affordable Care Act expands the ability of states to use

presumptive eligibility for Medicaid and Children's Health Insurance Program (CHIP).

Preventive Care. Health care that emphasizes the early detection and treatment of diseases. Prevention is intended to keep people healthier, reducing health care costs.

Primary Care. Medical care provided by physicians and other health professionals such as advanced practice nurses, physician assistants and certified nurse midwives. It is geared toward prevention, early intervention and continuous care for basic health care services. Primary care includes pediatrics, general, internal and family medicine and obstetrics and gynecology.

Primary Care Medical Provider (PCMP). The usual source of care for Medicaid clients enrolled in the Colorado Department of Health Care Policy and Financing's Accountable Care Collaborative. The PCMP coordinates specialist care for patients, is accountable to a regional care collaborative

and communicates with the statewide data and analytics organization.

Provider Payment Rates. The total payment a provider, hospital or community health center receives for medical services to a patient. Compensation rates are based on illness category and the type of service administered.

Public Health Agency. A governmental entity responsible for creating and maintaining conditions that keep people healthy. Duties include investigating health problems and threats, containing disease outbreaks and implementing health promotion programs.

Public Health Improvement Plan. A plan to improve the health of a community based on the findings of a community health assessment. Under Colorado's Public Health Act, local public health agencies conduct a community health assessment and create a public health improvement plan every five years. These local plans

inform a state public health improvement plan, which is also required every five years.

Purchasing Pool. Purchasers, such as small firms and individuals, who join together to leverage their bargaining power when purchasing health insurance. Purchasing pools have the advantage of spreading risk across a greater number of individuals.

Q

Qualified Health Plan. A health insurance plan that provides essential health benefits and meets other requirements of the Affordable Care Act.

Qualified Medicare Beneficiary (QMB). This Medicaid program helps Medicare beneficiaries below the federal poverty level to pay for all or some of Medicare's cost-sharing amounts. Medicaid pays the Medicare Part A monthly premiums (when applicable), Medicare Part B monthly premiums and the annual deductible and coinsurance amounts for services covered under both Parts A and B of Medicare.

Qualifying Life Event. A change in a person's life that makes him or her eligible to enroll in private health insurance outside of the open enrollment period. Examples include moving to another state, losing a job, getting married or divorced or having a baby.

R

Rate Review. A process that allows state insurance departments like the Division of Insurance (DOI) in Colorado to review rate changes before an insurance plan is authorized for the market. The DOI considers consumer comments as a part of the review process.

Regional Accountable Entity (RAE): Organization coordinating physical and behavioral health care for Medicaid members. It will be created in Phase II of the Medicaid Accountable Care Collaborative, scheduled for launch in 2018. Will be responsible for duties that have been performed by the Behavioral Health

Organizations (BHOs) and Regional Care Collaborative Organizations (RCCOs).

Regional Care Collaborative Organization (RCCO). Part of Colorado's Accountable Care Collaborative, RCCOs provide administrative coordination for the program. Seven RCCOs represent regions throughout Colorado.

Regional Health Connector: A new workforce dedicated to improving the coordination of local services to advance health and address the social determinants of health.

Rehabilitative Services. Services and equipment that help meet the needs of those with a disability, a chronic condition or an injury. This includes physical and occupation therapy, speech-language therapy and psychiatric rehabilitation.

Reinsurance. Insurance for insurance companies. A third-party insurer, sometimes the state, assumes responsibility for high-cost, low-frequency claims. This lowers the average risk and results in lower premiums for an insured group.

Retail Clinic. Health clinics usually located in a shopping mall or store that provide limited primary care on a fee-for-service basis. Services usually are provided by nurse practitioners or physician assistants.

Rural Health Clinic. A clinic certified by the Centers for Medicare & Medicaid Services to receive cost-based reimbursement for Medicare and Medicaid patients in order to improve access to primary care in underserved rural areas.

S

Safety Net. A largely nonprofit and public group of providers, including community clinics, school-based health centers, hospitals and others, that serve low-income, uninsured and underinsured Coloradans and those enrolled in publicly funded health care programs such as Medicaid and CHP+.

School-Based Health Centers (SBHCs). Health clinics that receive federal, state and local funds, patient revenue and in-kind contributions to provide primary health

care services in K-12 schools. Some SBHCs also provide dental, behavioral health and other services.

Section 125 Plan. Named after a section of the Internal Revenue Code, a Section 125 Plan allows employees to withhold a portion of their salary on a pre-tax basis to pay for insurance premiums and other medical expenses.

Self-Insured or Self-Funded Employers. An employer that assumes financial responsibility for the health care costs of its enrolled employees and their dependents based on factors such as salary history and employment duration. Unlike other health plans, it is regulated by the federal Employment Retirement Income Security Act rather than the state. A self-funded employer often uses a third-party administrator such as an insurance company to administer the plan.

Shared Savings. (See Gain Sharing).

Single Entry Point (SEP). A community agency that determines eligibility for Medicaid's community-based long-term services and supports (LTSS) programs based on the ability to perform such functions as self-care, learning, mobility, and independent living. SEP agencies provide care planning and case management for clients and make referrals to other resources.

Single-Payer System. The term used to describe a health insurance financing system in which one entity – either public, such as a state agency, or a private company – collects health insurance premiums and negotiates rates paid to providers for a defined benefit package available to all those who are covered.

Sliding Fee Schedule. Range of discounted prices charged for health care services provided to low-income uninsured patients, usually based on family size and household income.

Small Business Health Options Program (SHOP) Exchange. A section of the health insurance marketplace where employers can purchase employee health insurance. Open to employers with fewer than 50 full-time employees in 2015, it was expanded to employers with fewer than 100 full-time employees in 2016. Some small businesses qualify for a tax credit, but only on plans purchased through the SHOP.

Social Determinants of Health. Personal, social, economic, environmental and other circumstances that contribute to a person's health.

Social Security Disability Insurance (SSDI). Federal cash payments to people who have worked for a specified time and paid payroll taxes to the Social Security Trust Fund. These people have a disability severe enough to keep them from working in regular paying jobs for at least 12 consecutive months.

Specified Low-Income Medicare Beneficiary (SLMB). A Medicaid program

that helps low-income Medicare beneficiaries pay for cost-sharing amounts. Medicaid pays the Part B premium for those with monthly incomes between 100 percent and 120 percent of the federal poverty level (FPL).

State Innovation Model (SIM). Colorado's strategic blueprint to transform its health care system through the integration of primary care and behavioral health care. Colorado's SHIP was submitted to the Centers for Medicare & Medicaid Services in November 2013 as part of Colorado's State Innovation Model (SIM) initiative.

Statewide Data and Analytics Contractor (SDAC). One of three building blocks of Colorado's Accountable Care Collaborative, the SDAC collects and manages data. Its web portal provides data and analysis to better align provider payments with health outcomes and to identify interventions to improve the health of Medicaid clients. Treo Solutions is the SDAC contractor.

Stop-Loss Insurance. An insurance policy designed to protect self-insured employers from unpredictable or catastrophic losses. These policies cover claims after the employer has paid a predetermined amount in claims.

Store and Forward. The use of health technology to transmit medical information such as x-rays or EKGs between health care providers or between patients and their providers.

Substance Use Disorder. The use of one or more substances, such as alcohol and drugs, that results in clinically significant distress or impairment. Includes such diseases as alcoholism and drug addiction.

Supplemental Security Income (SSI). A federally funded cash assistance program to help low-income seniors and people who are blind or have other disabilities to meet their basic needs of food, clothing and shelter. People eligible for SSI are also eligible for Medicaid.

T

Tax Preference for Employer-Sponsored Insurance. This tax code provision allows employer contributions to health benefits to be excluded from most workers' taxable income. Contributions made by employees toward the premium cost for health insurance are also made on a tax-free basis.

Taxpayer's Bill of Rights (TABOR). State constitutional amendment passed in 1992 by Colorado voters to restrict how much governments at all levels can tax and spend. TABOR requires voter approval of any state or local tax increase and limits revenue growth to increases in population and inflation.

Telehealth: Harnessing information technology to remotely connect health care providers with patients for a wide array of health services.

Triple Aim. A widely used approach for improving the nation's health system that requires improving the patient's health care

experience, improving population health, and lowering per capita costs.

U

Uncompensated Care. Services provided by health care providers for which no payment is received from the patient or a third-party payer.

Underinsured. Public or private insurance that does not cover all necessary health care services, resulting in out-of-pocket expenses that may affect a person's ability to obtain health care.

Uninsured. People who lack public or private health insurance coverage.

U.S. Department of Health and Human Services (HHS). Manages programs that impact health, public health and human services. HHS oversees Medicare, Medicaid, the Children's Health Insurance Program and the health insurance marketplaces.

W

Welcome Mat Effect. An influx of applications to a new or expanded health program from people who had been eligible for coverage but had not previously enrolled. Public attention to a new program often results in this effect. A less preferred term is the "woodwork effect."

Wellness Benefits. Benefits covered by a health insurance plan that promote behaviors that improve health. For example, insurance plans may reward enrollees who exercise, quit smoking or lose weight with reduced copayments and deductibles.

Y

Young Adult Health Plan. These plans tend to offer lower premiums in exchange for high deductibles or limited benefit packages.

Young Invincibles. The term based on the perception that young adults, generally

between 18 and 34, decide not to obtain health insurance because they feel they don't need it. Recent studies suggest high costs may play a larger role in deterring young adults from obtaining coverage.

Youth Risk Behavior Surveillance System (YRBSS). A system of national, state, territorial, tribal and local school-based surveys monitoring six types of health risk behaviors, primarily among high school students. It is fielded every other year. Beginning in 2013, Colorado launched its own survey to measure youth health behaviors. (See Healthy Kids Colorado Survey.)

Acronyms

ACA. Affordable Care Act (short for the Patient Protection and Affordable Care Act)

ACC. Accountable Care Collaborative

ACO. Accountable Care Organization

ACS. American Community Survey

APCD. All-Payer Claims Database

APTC. Advanced Premium Tax Credit

ARRA. American Recovery and Reinvestment Act

AwDC. Adults Without Dependent Children

CAHPS. Consumer Assessment of Healthcare Providers and Systems

CBMS. Colorado Benefits Management System

CDASS. Consumer-Directed Attendant Supportive Services

CDPHE. Colorado Department of Public Health and Environment

CHAS. Colorado Health Access Survey

CHC. Community Health Center

CHIP. Children's Health Insurance Program

CHP+. Child Health Plan *Plus*

CICP. Colorado Indigent Care Program

CIVHC. Center for Improving Value in Health Care

CMS. Centers for Medicare & Medicaid Services OR Colorado Medical Society

COBRA. Consolidated Omnibus Budget Reconciliation Act

COHBE. Colorado Health Benefit Exchange

CORHIO. Colorado Regional Health Information Organization

CPCI. Comprehensive Primary Care Initiative

CPS. Current Population Survey

DHS. Colorado Department of Human Services

DME. Durable Medical Equipment

DOI. Division of Insurance

DORA. Colorado Department of Regulatory Agencies

DSH. Disproportionate Share Hospital Program

EHR. Electronic Health Record

EMR. Electronic Medical Record

EMTALA. Emergency Medical Treatment and Active Labor Act

EPSDT. Early and Periodic Screening, Diagnosis and Treatment Program

ERISA. Employment Retirement Income Security Act

ESI. Employer-Sponsored Insurance

FFS. Fee-for-Service

FMAP. Federal Medical Assistance Percentage

FQHC. Federally Qualified Health Center

FPL. Federal Poverty Level

HCBS. Home and Community-Based Services

HCPF. Colorado Department of Health Care Policy and Financing

HEAL. Healthy Eating, Active Living

HIPAA. Health Insurance Portability and Accountability Act

HIT. Health Information Technology

HMO. Health Maintenance Organization

HRA. Health Reimbursement Account

HSA. Health Savings Account

LTC. Long-Term Care

LTSS. Long-Term Services and Supports

MMIS. Medicaid Management Information System

PCMP. Primary Care Medical Provider

PEAK. Program Eligibility and Application Kit

PMPM. Per Member Per Month

PPO. Preferred Provider Organization

RCCO. Regional Care Collaborative Organization

SBHC. School-Based Health Center

SDAC. Statewide Data and Analytics Contractor

SEP. Single Entry Point

SHOP Exchange. Small Business Health Options Program

SIM Initiative. State Innovation Model Initiative

SSDI. Social Security Disability Insurance

SSI. Supplemental Security Income

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