

# Health Words

2019





**We know it's hard to keep up** with the ever-changing vocabulary of health policy. We hope that the words we use are never a barrier to entering the conversation for anyone who has good ideas about how to improve health for Coloradans.

With that in mind, the Colorado Health Institute is proud to present the 2019 edition of Health Words. It is intended to help navigate the terms and, as is often the case, the acronyms that fill many conversations about health policy.

CHI 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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**1115 Demonstration Waiver.** A vehicle used by states, with federal approval, to test new ways to deliver and pay for health care services in Medicaid and the Children's Health Insurance Program (CHIP). Colorado has one 1115 waiver, focused on expanded prenatal care for low-income pregnant women.

**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 receive full ACA funding as long as they meet or exceed the law's requirements and do not increase federal spending.

A

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

## **Accountable Care Collaborative (ACC).**

Colorado's signature effort to transform the delivery of primary health care to clients insured by Medicaid. When launched by the Colorado Department of Health Care Policy and Financing (HCPF) in mid-2012, it was managed by seven Regional Care Collaborative Organizations (RCCOs), which provided administrative support. Primary Care Medical Providers (PCMPs) serve as patient medical homes and coordinate care, earning extra payments by meeting performance targets. The structure was changed in ACC Phase Two.

**ACC Phase Two.** The second iteration of the ACC, which began in 2018. Phase Two involves several policy and payment changes, including increasing integration of physical and behavioral health care, replacing RCCOs and Behavioral Health Organizations (BHOs) with Regional Accountable Entities (RAEs) and encouraging greater quality and efficiency through approaches that reward better performance.

### **Accountable Care Organization (ACO).**

A group of doctors, hospitals and other health care providers that join 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.

### **Accountable Health Communities Model (AHCM).**

A federally-funded program to address the health-related social needs of Medicare and Medicaid members. Colorado has received two awards to implement this model with participating providers, one in metro Denver and one on the Western Slope.

**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.**

Adults over the age of 18 who do not have children living with them or children who are dependent upon them. Members of this group, despite having low incomes, historically have not been eligible for Medicaid. Colorado expanded Medicaid eligibility to a limited number in 2012. When Colorado opted to expand Medicaid under the Affordable Care Act in 2014, all members of this group with incomes below 138 percent of the federal poverty level (FPL) became eligible.



**Adverse Childhood Experiences (ACEs).**

Potentially traumatic events experienced by children and youth before age 18 that can have lasting negative effects on health and well-being.

**Adverse Selection.** The tendency of people who expect to have 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 Obamacare. The law requires most Americans to have health insurance or pay a penalty, requires insurers to cover all applicants regardless of preexisting health conditions and mandates a minimum level of benefits, among other changes. It also provides tax credits as well

as lower cost-sharing rates for some lower-income enrollees. Congress eliminated the penalty for not being insured as of 2019.

**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.

**Age-Rating Ratio.** The practice of varying health insurance premiums based on age. Under the Affordable Care Act, insurance carriers are limited to a 3:1 ratio, meaning that an older person can be charged no more than three times as much as a younger person for the same coverage. Also referred to as age band rating.

**Aid in Dying.** A process by which a terminally ill person meeting certain conditions can request lethal medication to voluntarily end his or her life. Colorado voters in 2016 approved Proposition 106, “Access to Medical Aid in Dying,” allowing this practice.

**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 (CIVHC).

**Alternative Payment Model (APM).** A form of payment reform that incorporates quality and total cost of care into reimbursement models in contrast to traditional fee-for-service structures.

**Ambulatory Care.** Outpatient medical care. Patients are usually discharged on the same day they receive treatment, which is typically provided in a doctor's office, clinic or hospital emergency department.

**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.

**Association Health Plans (AHP).** AHPs are group plans that employer groups and associations offer to provide health coverage for employees based on common geography or industry.

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

## B

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

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

**Behavioral Risk Factor Surveillance System (BRFSS).** The largest continuously conducted health survey in the world with more than 400,000 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.

**Business Intelligence and Data Management System (BIDM).** A system used to improve an enterprise’s decision making by combining tools for gathering, storing, accessing, and analyzing business data. Truven Health Analytics was provided a five-year contract by the Colorado Department of Health Care Policy and Financing to build a first-of-its-kind, state data warehouse that will collect, consolidate

and organize data from multiple sources, and fully integrate Medicaid eligibility and claims data, for reporting and business process analysis.

**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 aspects 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 impact 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.



**Capitation.** A financial arrangement between a health insurer and 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 they 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 people with high health needs.

### **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 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. Congress has authorized CHIP to continue through 2027.

**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, Supplemental Nutrition Assistance Program (SNAP) and Temporary Assistance for Needy Families (TANF).

**Colorado Commission on Affordable Health Care.** Established by the state legislature in 2014 to study the drivers of health care costs and evidence-based strategies to contain them. It made final recommendations to the legislature and governor in 2017.

**Colorado Department of Health Care Policy and Financing (HCPF).** The state agency that administers Medicaid, CHP+ and other programs for low-income residents, older adults 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, older adults and people with developmental disabilities, and coordinates early childhood programs.

**Colorado 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.

**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 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. Data from the latest CHAS was released in September 2017.

### **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 Healthcare Affordability and Sustainability Enterprise (CHASE).**

The organization that operates Healthcare Affordability and Sustainability Fee. The CHASE Board makes recommendations to the Medical Services Board about the amount and allocations of the fee. The legislature created CHASE in 2017 to replace the Hospital Provider Fee.

### **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 interChange.** The Medicaid Management Information System (MMIS) launched March 1, 2017, by the Colorado Department of Health Care Policy and Financing. The platform processes claims from providers and performs many other functions for the state Medicaid program. Colorado was the 15th state to implement the platform.

**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).** A nonprofit supporting 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 federally funded program that transforms health care delivery in Colorado by providing access to integrated primary care and behavioral health services in coordinated community systems. It aims 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 their 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.

**Community Rating.** A system for pricing health insurance — also known as geographic rating — that requires all people covered by an insurer in the same geographic area to pay the same premiums, regardless of their health status. Pure community rating means that gender and age are not considered in determining premiums. The ACA established adjusted community rating in the individual market, meaning that insurers are allowed some ability to vary premiums by age and tobacco use.

**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 may consider the costs and benefits of treatment options.

### **Comprehensive Primary Care Plus (CPC+).**

A five-year advanced primary care medical home model launched by the Centers for Medicare & Medicaid Services in January 2017 in 14 regions, including Colorado. It builds on the Comprehensive Primary Care (CPC) initiative that was active from 2012 through 2016. The goal is to foster 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.

**Connect for Health Colorado.** The health insurance marketplace created by Colorado's legislature in 2011. Qualifying customers may receive tax credits to purchase coverage under provisions of the Affordable Care Act. Colorado is one of 11 states plus the District of Columbia to create a state-based marketplace instead of using the federal marketplace.

**Continuum of Care.** A comprehensive

approach to treating behavioral health care as a chronic disease. The Continuum of Care model has four parts: promotion, prevention, treatment and recovery.

### **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 people 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 eligibility for a particular program moves from a month-by-month determination to a longer period, generally annually. The

Colorado Health Care Affordability Act included continuous eligibility for children in Medicaid, 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 insuree, usually a copayment (the amount a patient pays for a service such as an office visit or a prescription) and a deductible (the dollar amount that must be paid by a patient before insurance coverage begins).

**Cost Sharing Reduction (CSR).** 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 health 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).** A 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, annual estimates of health insurance status as well as other indicators can be compared across states.

## 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, a consumer might 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 enrollees.

**Disease Management.** Ongoing management of chronic disease through an integrated, patient-centered, multidisciplinary approach. 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 less unpaid care.

**Direct Primary Care.** A payment and care model in which health care providers do not take insurance to deliver care. Instead, their patients pay a flat fee – usually less than \$100 per month – for a range of primary care services.

**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 – \$3,700 in 2017 – the client pays all costs up to a yearly limit, which is \$4,950 in 2017. 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.

### **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.



### **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.** An Affordable Care Act requirement for employers of 50 or more workers to provide health insurance for their employees or pay a penalty. Penalties increase over time.

**Employer-Sponsored Insurance (ESI).**

Health insurance coverage provided by an employer. ESI can be paid for by an employer or costs can be split between the employer and employee. Nearly 50 percent of Coloradans had employer-sponsored insurance in 2017.

**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.** Public programs such as Medicare and Medicaid that provide benefits to people who meet eligibility criteria. Federal and state governments are required to provide the benefits; they are not discretionary. Enrollment 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 required by the Affordable Care Act to be included in small group and individual health insurance plans. The benefits are

required of plans sold both on the insurance marketplaces created under the Affordable Care Act as well as off those sold off of the marketplaces.

**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 joint programs. FMAP varies by state. Colorado's fiscal year 2019 FMAP for the Medicaid program is 50.00, meaning the federal government contributes 50 percent and Colorado contributes 50 percent to fund the program.

**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. In 2018, the FPL for individuals is \$12,140, and for a family of four it is \$25,100.

**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 known as a drug list.

**Free-Standing Emergency Department.**

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.



**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.”

**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’s requirements for insurance plans, 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. About half of

Americans have group health insurance through their employer or a family member's employer.

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



**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 functions — for example, relearning to speak after a stroke. Both rehabilitative and habilitative services are essential health benefits under the Affordable Care Act.

**Health Care Sharing Ministries (HCSM).** Organizations that facilitate the sharing of health care costs among individual members

who share religious beliefs. HCSMs are not a form of health insurance.

**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 First Colorado.** The name of Colorado's Medicaid program as of June 27, 2016 (see Medicaid).

**Health in All Policies.** An approach to policymaking that takes into account how decisions on a wide range of issues will affect 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 Exchange (HIE).**

The electronic mobilization of health care information across organizations within a region, community, or hospital system.

**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 a health insurance marketplace. (See Connect for Health Colorado.)

**Health Insurance Portability and Accountability Act (HIPAA).** Law passed by Congress in 1996 to provide 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 ability 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.

### **Healthcare Affordability and**

**Sustainability Fee.** A fee levied on hospitals to draw federal matching funds in Medicaid to pay for expanded Medicaid eligibility and higher reimbursement rates to hospitals. Colloquially known as the Hospital Provider Fee. The fee is administered by the Colorado

Healthcare Affordability and Sustainability Enterprise Board.

**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).

**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 Medicaid 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 older adults 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 payments to hospitals, to fund hospital quality incentive payments, and to expand health care coverage in Medicaid and Child Health Plan *Plus* (CHP+). The fee was established through the Colorado Health Care Affordability Act of 2009 (HB09-1293), and it was updated in 2017 through the Colorado Healthcare Affordability and Sustainability Enterprise Act (SB17-267). See Healthcare Affordability and Sustainability Fee.

## 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. (Some consumers receive subsidies through the Affordable Care Act.) 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 was 2.5 percent of total household income for tax year 2017, or \$695 per adult. The mandate will no longer

be enforced starting January 1, 2019, due to the Tax Cuts and Jobs Act of 2017.

**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 individual customers 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 in Colorado's Medicaid program. The seven indicators for fiscal year 2018-19 are behavioral health engagement, dental visits, well visits, prenatal engagement, emergency department visits, potentially avoidable costs, and health neighborhoods.

## 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.

**Local Public Health Agency.** Under Colorado's decentralized public health system, each of the state's 64 counties must operate a local public health agency or participate in a district public health agency. Colorado has 53 local public health agencies working on the front lines of public and environmental health. The overarching goal is to keep Coloradans healthy. Duties include investigating health problems and threats, containing disease outbreaks and implementing health promotion programs.

**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 older adults 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

### **Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).**

A law passed by Congress in 2015 that established new ways of paying physicians caring for Medicare patients. It repealed the old method for determining reimbursement rates for physicians and replaces it with a method that incentivizes quality and efficiency over volume.

**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 joint federal-state program created in 1965 to cover the health care costs of people with low incomes who fall within eligibility categories. Colorado in 2014 chose to expand eligibility, an option under the Affordable Care Act, to more adults and to former foster kids up to age 26. More than 1.3 million Coloradans are now enrolled. The Colorado Department of Health Care Policy and Financing (HCPF) oversees the Medicaid program.

**Medicaid Managed Care.** A system of delivering care in which the state Medicaid agency contracts with a managed care organization, which is responsible for providing care at an agreed-upon cost and quality level. This usually involves paying a capitated (per-person) rate to the managed care organization as an incentive to control costs.

**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.

**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 843,000 enrollees in 2017. 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.

**Medication-Assisted Treatment.** An evidence-based approach to treating opioid addiction with a combination of medication and psychosocial support services.

**Metal Levels.** Health insurance plans offered through 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.



**Narrow Network.** 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.



**Office of Behavioral Health (OBH).** The state agency supporting and monitoring many behavioral 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

multistate insurance plan options under the Affordable Care Act.

**Open Enrollment.** The limited time when people may enroll in private health insurance plans inside or outside of the health insurance marketplace. People who are eligible for Medicaid may enroll at any time.

**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 Capita Cap.** A funding model under which federal spending on state partnership programs such as Medicaid would rise at a specified rate, regardless of the actual increase in state spending. The specified growth rate would be applied to every enrollee in a given program.

**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 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. Colorado provides presumptive eligibility in the Medicaid and CHP+ programs for children under 19, pregnant women, and women applying for the breast and cervical cancer program.

**Prevention and Public Health Fund (PPHF).** Created under the Affordable Care Act, the fund invests in activities to improve health outcomes such as disease surveillance, immunizations, public health workforce training, tobacco use prevention and other evidence-based initiatives.

**Preventive Care.** Health care that emphasizes the early detection and treatment of diseases. Prevention is intended to keep people healthier and reduce 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 accountable entity, 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 Charge.** A provision of federal law that is used to prohibit entry into the U.S. by immigrants who cannot financially support themselves without becoming a “public charge” and relying on government benefits. The term first appeared in the Immigration Act of 1882, and the interpretation of who is a public charge has varied over the years.

**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.



**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. RAEs were created in Phase Two of the Medicaid Accountable Care Collaborative in July 2018. Seven RAEs 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 group of providers, including community clinics, school-based health centers, hospitals and others, that serves 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 (ERISA) 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.

**Short-term Insurance Plan.** Provides temporary health care insurance during unexpected coverage gaps. There is no enrollment period, and it can be purchased at any time.

**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 National Health Insurance.**

Also known as “Medicare for all,” a system in which a single public or quasi-public agency organizes health care financing while the delivery of care remains largely in private hands. Under a single-payer system, each resident of the United States would be covered for all medically necessary services.

**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.

**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 clients 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).

**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 Abuse and Mental Health Services Administration (SAMHSA).** A

branch of the U.S. Department of Health and Human Services charged with improving the quality and availability of treatment and rehabilitative services for substance abuse and mental illnesses.

**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 older adults 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.

**Surprise Billing.** Occurs when a patient receives higher than expected bills from a provider, often the result of receiving care out-of-network.

## T

**Tax Preference for Employer-Sponsored Insurance.** Employer contributions to health benefits can be excluded from most workers' taxable income. Contributions made by employees toward health insurance premiums 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.

**Universal Coverage.** A health care system that provides health insurance to all residents.

**Upstream.** Upstream is a movement that seeks to reframe public discourse to address the social determinants of health in an effort to improve health and reduce disparities.

**US 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.



**Virtual Dental Home (VDH).** A community-based oral health delivery system in which people receive preventative and simple therapeutic services in a community setting, such as schools, or receive educational, social or general health services.



**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.



**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.** State Innovation Model

**SSDI.** Social Security Disability Insurance

**SSI.** Supplemental Security Income





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