



ALPHABET SOUP – A Glossary of Health Care Terms for Families of Children/Youth with Special Health Care Needs/Disabilities

The Affordable Care Act (ACA) is changing the way many families get and use health insurance to pay for needed services. This seems especially true for those families that have children with special health care needs. We must understand health insurance jargon in order to make good decisions for our children. If, unfortunately, decisions are made for us, it is even more important to know what they will mean for our child. Here's a beginning list of definitions. Please send us those we missed, and we'll update this list. Thanks!

Access - Ability to receive services from a health care system or provider.

Accountable Care Organization (ACO) - A group of health care providers who give coordinated care, chronic disease management, and thereby improve the quality of care patients get. The organization's payment is tied to achieving health care quality goals and outcomes that result in cost savings.

Accreditation - If a Marketplace health plan is approved, this is the "seal of approval" given to the plan by an independent organization to show that the plan meets national quality standards.

Acute Care - Medical services provided after an accident or for a disease, usually for a short time.

Advanced Premium Tax Credit - The ACA provides a new tax credit to help you afford health coverage purchased through the Marketplace. Advance payments of the tax credit can be used right away to lower your monthly premium costs. If you qualify, you may choose how much advance credit payments to apply to your premiums each month, up to a maximum amount. If the amount of advance credit payments you get for the year is less than the tax credit you're due, you'll get the difference as a refundable credit when you file your federal income tax return. If your advance payments for the year are more than the amount of your credit, you must repay the excess advance payments with your tax return. Also called premium tax credit.

Adverse Selection - Occurs when those joining a health plan have higher medical costs than the general population; if too many enrollees have higher than average medical costs, the health plan experiences adverse selection.

Affordable Care Act (ACA) - The comprehensive health care reform law enacted in March 2010. The law was enacted in two parts: The Patient Protection and ACA was signed into law on March 23, 2010 and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The

name "Affordable Care Act" is used to refer to the final, amended version of the law. Also referred to as ObamaCare.

Allowed Amount - Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your provider charges more than the allowed amount, you may have to pay the difference.

Ambulatory Care - Outpatient medical services (not provided in a hospital).

Annual Deductible Combined - Usually in Health Savings Account (HSA) eligible plans, the total amount that family members on a plan must pay out-of-pocket for health care or prescription drugs before the health plan begins to pay.

Annual Limit - A cap on the benefits your insurance company will pay in a year while you're enrolled in a particular health insurance plan. These caps are sometimes placed on particular services such as prescriptions or hospitalizations. Annual limits may be placed on the dollar amount of covered services or on the number of visits that will be covered for a particular service. After an annual limit is reached, you must pay all associated health care costs for the rest of the year.

Appeal - A request by you to have your health insurer or plan review a decision, such as their decision to not pay a claim or cancel your coverage. You have the right to appeal the decision and have it reviewed by a third party. You can ask that your insurance company reconsider its decision. Insurers have to tell you why they've denied your claim or ended your coverage. And they have to let you know how you can dispute their decisions.

There are two ways to appeal a health plan decision:

- **Internal appeal:** If your claim is denied or your health insurance coverage cancelled, you have the right to an internal appeal. You may ask your insurance company to conduct a full and fair review of its decision. If the case is urgent, your insurance company must speed up this process.
- **External review:** You have the right to take your appeal to an independent third party for review. This is called

external review. External review means that the insurance company no longer gets the final say over whether to pay a claim.

Attest/Attestation - When you apply for health coverage through the Marketplace, you're required to agree (or "attest") to the truth of the information provided by signing the application.

Authorized Representative- Someone who you choose to act on your behalf with the Marketplace, like a family member or other trusted person. Some authorized representatives may have legal authority to act on your behalf.

Benefits - Health and related services guaranteed to be provided in a health plan.

Brand Name (Drugs) - A drug sold by a drug company under a specific name or trademark and is protected by a patent. Brand name drugs may be available by prescription or over the counter.

Broker - An agent or broker is a person or business who can help you apply for help paying for coverage and enroll in a Qualified Health Plan (QHP) through the Marketplace. They can make specific recommendations about which plan you should enroll in. They're also licensed and regulated by states and typically get payments, or commissions, from health insurers for enrolling a consumer into an issuer's plans. Some brokers may only be able to sell plans from specific health insurers.

Bronze Health Plan – See Health Plan Category.

Capacity - Ability of a health organization to provide necessary health services.

Capitation - Way of pre-paying a health plan, provider, or hospital for health services based on a fixed monthly or yearly amount per person, no matter how few or many services a consumer uses.

Care Coordination - Care coordination is an approach to healthcare in which all of a patient's needs are coordinated with the assistance of a primary point of contact. The point of contact provides information to the patient and the patient's caregivers, and works with the patient to make sure that the patient gets the most appropriate treatment, while ensuring that health care is not accidentally duplicated.

The approach of care coordination is used for patients with special health care needs who require long term health care. Someone with the sniffles does not need care coordination; an older adult suffering from several chronic illnesses does, just as a child with developmental disabilities can benefit from care coordination. Care coordination can also be used to help people recover from serious accidents or strokes, to manage mental health conditions, and to assist patients with comorbidities.

The point person involved in the care coordination works with the patient and family on a regular basis. This person may accompany patients to appointments, or meet with care providers about the patient's care. The coordinator answers

questions from the patient and the family about health care options, choices which may present themselves during the health care process, and potential outcomes. One important role of the coordinator is to confirm that the patient is getting necessary care; if a patient needs physical therapy, for example, the coordinator makes sure that the patient has regular appointments with a physical therapist. Coordinators also confirm that health care providers have necessary information, such as a complete list of the patient's medications and a complete medical history for the patient.

Care Notebook - a tool that can help you organize important information about your child. You can bring the notebook to appointments and meetings, so you can easily share information with doctors, therapists, and school or child care staff. A Care Notebook can help you: 1) Keep track of your child's medicines or treatments; 2) Organize phone numbers for health care providers and community organization; 3) Prepare for appointments; 4) File information about your child's health history; 5) Share new information with your child's primary doctor, public health or school nurse, and others caring for your child. See <http://cshcn.org/planning-record-keeping/care-notebook>

Case Management – For some health plans and providers, Case Management is the same as Care Coordination. Other health plans and providers, however, may limit case management to the medical needs of the child and focus on managing services covered by the health plan.

Carve Out - In a carve-out or separate plan, mental health benefits may be provided on a fee-for-service basis or a Medicaid agency may contract separately with a managed care plan for mental health benefits.

Catastrophic Health Plan - Health plans that meet all of the requirements applicable to other Qualified Health Plans (QHPs) but that don't cover any benefits other than 3 primary care visits per year before the plan's deductible is met. The premium amount you pay each month for health care is generally lower than for other QHPs, but the out-of-pocket costs for deductibles, copayments, and coinsurance are generally higher. To qualify for a catastrophic plan, you must be under 30 years old OR get a "hardship exemption" because the Marketplace determined that you're unable to afford health coverage.

Centers for Medicare and Medicaid Services (CMS) - The federal agency that runs the Medicare, Medicaid, and Children's Health Insurance Programs (CHIP), and the federally facilitated Marketplace. For more information, visit cms.gov.

Certified Applicant Counselor - An individual (affiliated with a designated organization) who is trained and able to help consumers, small businesses, and their employees as they look for health coverage options through the Marketplace, including helping them complete eligibility and enrollment forms. Their services are free to consumers.

Children's Health Insurance Program (CHIP) - Insurance program jointly funded by state and federal government that provides health coverage to low-income children and, in

some states, pregnant women in families who earn too much income to qualify for Medicaid but can't afford to purchase private health insurance coverage.

Claim - A request for payment that you or your health care provider submits to your health insurer when you get items or services you think are covered.

Co-payment - What a consumer pays for each health visit or service received.

COBRA - A Federal law that may allow you to temporarily keep health coverage after your employment ends, you lose coverage as a dependent of the covered employee, or another qualifying event. If you elect COBRA coverage, you pay 100% of the premiums, including the share the employer used to pay, plus a small administrative fee.

Coinsurance - Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay coinsurance plus any deductibles you owe. For example, if the health insurance or plan's allowed amount for an office visit is \$100 and you've met your deductible, your coinsurance payment of 20% would be \$20. The health insurance or plan pays the rest of the allowed amount.

Community Health Centers – Local clinics that provide health care, mostly primary care, to those who are medically underserved (for example those who live in poor neighborhoods or rural areas). Some health centers work with specific populations – Migrant and Seasonal Farmworkers, Health Care for the Homeless, Public Housing, and Native Hawaiians.

Community Rating - A rule that prevents health insurers from varying premiums within a geographic area based on age, gender, health status or other factors.

Community Support Team (CST) - Also known as CSP (Community Support Program). A recovery and resiliency oriented intensive, community based rehabilitation and outreach service for adults and youth. It is team-based and consists of mental health rehabilitation interventions and supports necessary to assist the recipient in achieving and maintaining rehabilitative, resiliency and recovery goals. A Community Support Team is designed to meet the educational, vocational, residential, mental health, financial, social, and other treatment support needs of the recipient in addition to addressing their possible co-occurring disorders (mental health/substance use, mental health/developmental disability, mental health/chronic health condition). Interventions are provided primarily in natural settings, and are delivered face to face, by telephone, or by video conference with individual recipients and their family/significant others as appropriate, to the primary well-being and benefit of the recipient. A Community Support Team assists in the development of optimal developmentally appropriate community living skills, and in setting and attaining recipient (and family in the case of children) defined recovery/resiliency goals. It is available 24 hours per day, 7 days per week.

Conversion - The ability, in some states, to switch your job-based coverage to an individual policy when you lose eligibility for job-based coverage. Family members not covered under a job-based policy may also be able to convert to an individual policy if they lose dependent status (for example, after a divorce).

Coordination of Benefits - A way to figure out who pays first when 2 or more health insurance plans are responsible for paying the same medical claim.

Copayment - A fixed amount (for example, \$15) you pay for a covered health care service, usually when you get the service. The amount can vary by the type of covered health care service.

Cost Neutrality - Typically referred to in the context of Medicaid and applying for Medicaid waivers from CMS. For 1115 and 1915 waivers, the federal government requires that the state's proposed changes not result in additional costs to the federal government. Occasionally, states implement self-imposed state cost neutrality but this is not required by the federal statute. State plan amendment requests do not have the federal cost neutrality requirement.

Cost Sharing - The share of costs covered by your insurance that you pay out of your own pocket. This term generally includes deductibles, coinsurance, and copayments, or similar charges, but it doesn't include premiums, balance billing amounts for non-network providers, or the cost of non-covered services. Cost sharing in Medicaid and CHIP also includes premiums.

Cost Sharing Reduction - A discount that lowers the amount you have to pay out-of-pocket for deductibles, coinsurance, and copayments. You can get this reduction if you get health insurance through the Marketplace, your income is below a certain level, and you choose a health plan from the Silver plan category (See Health Plan Categories). If you're a member of a federally recognized tribe, you may qualify for additional cost-sharing benefits.

Coverage - Agreed upon set of health services that a plan will pay for and/or provide.

Creditable Coverage - Health insurance coverage under any of the following: a group health plan; individual health insurance; student health insurance; Medicare; Medicaid; CHAMPUS and TRICARE; the Federal Employees Health Benefits Program; Indian Health Service; the Peace Corps; Public Health Plan (any plan established or maintained by a State, the U.S. government, a foreign country); Children's Health Insurance Program (CHIP) or a state health insurance high risk pool. If you have prior creditable coverage, it will reduce the length of a pre-existing condition exclusion period under new job-based coverage.

CSHCN - Children with Special Health Care Needs. See Special Health Care Needs.

Cultural Competency - Cultural competency is one the main ingredients in closing the disparities gap in health care. It's the way patients and doctors can come together and talk

about health concerns without cultural differences hindering the conversation, but enhancing it. Health care services that are respectful of and responsive to the health beliefs, practices and cultural and linguistic needs of diverse patients can help bring about positive health outcomes.

CYSHCN – Children or Youth with Special Health Care Needs. See Special Health Care Needs.

Deductible - The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your deductible is \$1,000, your plan won't pay anything until you've met your \$1,000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.

Dependent - A child or other individual for whom a parent, relative, or other person may claim a personal exemption tax deduction. Under the ACA, individuals may be able to claim a premium tax credit to help cover the cost of coverage for themselves and their dependents.

Dual-Eligibles - People who are eligible for both Medicaid and Medicare.

DME - Durable Medical Equipment - Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

Early Intervention – Free services that are provided to young children who have or at risk for disabilities or special needs. Services for children age Birth to three (or "Zero to 3") are generally comprehensive and family-based, ranging from speech and occupational therapy to general intervention and instruction. At age three, there is a transition in services. From three to five, provision of Early Intervention is the responsibility of the state educational system and is determined based on whether the diagnosed disability will impact a child's ability to learn. When a child becomes kindergarten age-eligible, he no longer qualifies for Early Intervention and will, if appropriate, receive services via his school district's Special Education program. Early Intervention is authorized by Part C of the Individuals with Disabilities Education Act (IDEA) and is supported by state and federal funding.

Eligibility Assessment - In certain states, the Marketplace doesn't provide the final decision on Medicaid eligibility. Instead, the Marketplace conducts an assessment and passes the application to the State Medicaid agency to conduct a final eligibility determination.

Eligible Immigration Status - An immigration status that's considered eligible for getting health coverage through the Marketplace. The rules for eligible immigration status may be different in each insurance affordability program.

<https://www.healthcare.gov/immigration-status-and-the-marketplace/>

Employer Shared Responsibility Payment - The ACA requires certain employers with at least 50 full-time employees (or

equivalents) to offer health insurance coverage to its full-time employees (and their dependents) that meets certain minimum standards set by the ACA or to make a tax payment called the ESRP.

Enrollee - Person (consumer) who is covered under a health insurance plan, whether fee-for-service or managed care (see "Fee for Service" and "Managed Care").

EPSDT - Early and Periodic Screening, Diagnosis and Treatment Program, are mandatory Medicaid benefits and services for Medicaid-eligible children and adolescents under age 21; designed to ensure children's access to early and comprehensive preventive health care and treatment. State Medicaid programs must provide EPSDT benefits.

ERISA - Employee Retirement Insurance Security Act, a federal act that allows businesses to develop self-funded health insurance programs. Such programs can limit benefits packages because they are not under the jurisdiction of state insurance regulations.

Essential Health Benefits (EHB) - A set of health care service categories that must be covered by certain plans, starting in 2014. The ACA ensures health plans offered in the individual and small group markets, both inside and outside of the Health Insurance Marketplace, offer a comprehensive package of items and services, known as essential health benefits. Essential health benefits must include items and services within at least the following 10 categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Insurance policies must cover these benefits in order to be certified and offered in the Health Insurance Marketplace, and all Medicaid state plans must cover these services by 2014.

Exchange – Also known as the Health Insurance Market place. A resource where individuals, families, and small businesses can learn about their health coverage options; compare health insurance plans based on costs, benefits, and other important features; choose a plan; and enroll in coverage. The Marketplace also provides information on programs that help people with low to moderate income and resources pay for coverage. This includes ways to save on the monthly premiums and out-of-pocket costs of coverage available through the Marketplace, and information about other programs, including Medicaid and the Children's Health Insurance Program (CHIP). The Marketplace encourages competition among private health plans, and is accessible through websites, call centers, and in-person assistance. In some states, the Marketplace is run by the state. In others it is run by the federal government.

www.healthcare.gov

Excluded Service - Health care services that your health insurance or plan doesn't pay for or cover.

Exclusive Provider Organization (EPO) Plan - A managed care plan where services are covered only if you go to doctors, specialists, or hospitals in the plan's network (except in an emergency).

Explanation of Benefits (EOB) - A statement sent by the health plan to the patient explaining the payment of services that were covered on a health claim and what payment you may owe.

Explanation of Medicare Benefits (EOMB) - A statement from Medicare that explains what the provider billed Medicare, Medicare's approved amount, the amount Medicare paid, and what you have to pay.

External Review - A review of a plan's decision to deny coverage for or payment of a service by an independent third-party not related to the plan. If the plan denies an appeal, an external review can be requested. In urgent situations, an external review may be requested even if the internal appeals process isn't yet completed. External review is available when the plan denies treatment based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, when the plan determines that the care is experimental and/or investigational, or for rescissions of coverage. An external review either upholds the plan's decision or overturns all or some of the plan's decision. The plan must accept this decision.

F2F HIC - See Family-to-Family Health Information Centers

Family and Medical Leave Act (FMLA) - A Federal law that guarantees up to 12 weeks of job protected leave for certain employees when they need to take time off due to serious illness or disability, to have or adopt a child, or to care for another family member. When on leave under FMLA, you can continue coverage under your job-based plan.

Family Voices - A national organization that works to ensure that the needs of families of all children/youth with special health care needs/disabilities are voiced to policymakers to improve policies and programs. Chapters in every state (State Affiliate Organizations) provide free assistance and training to families to help them navigate systems, find health care financing, partner with providers and talk with other families for support. See www.familyvoices.org.

Family Voices State Affiliate Organizations (SAO) - See above.

Family-Centered Care - Family-Centered Care is a way that healthcare is provided. It honors the strengths, cultures, traditions and expertise that everyone brings to this relationship. Family-centered service recognizes that each family is unique; that the family is the constant in the child's life; and that they are the experts on the child's abilities and needs. The family works with service providers to make informed decisions about the services and supports the child

and family receive. In family-centered service, the strengths and needs of all family members are considered.

Family-to-Family Health Information Centers (F2F HICs) - Family-staffed organizations that assist families of children and youth with special health care needs (CYSHCN) and the professionals who serve them. F2F HICs provide free support, information, resources, and training around health issues. Find the F2F HIC in your state at <http://www.fv-ncfpp.org/f2fhic/find-a-f2f-hic/>.

Family/Professional Partnership - Effective partnerships between families and professionals are the foundation of family-centered care. Effective family professional partnerships mean that families and professionals work together in the best interest of the child and the family. As the child grows, s/he assumes a partnership role. Professionals and families respect the skills and expertise that they each bring to the relationship and build a trusting relationship. Communication and information is shared openly and objectively. Families and professionals make decisions together and negotiate effectively when needed. Studies show that when families and professionals make decisions together, health care improves. See www.fv-ncfpp.org.

Federal Poverty Level (FPL) - A measure of income level issued annually by the Department of Health and Human Services. Federal poverty levels are used to determine your eligibility for certain programs and benefits. (The amounts below are based on 2013 numbers and are likely to be slightly higher in 2014.)

- \$11,490 to \$45,960 for individuals
- \$15,510 to \$62,040 for a family of 2
- \$19,530 to \$78,120 for a family of 3
- \$23,550 to \$94,200 for a family of 4
- \$27,570 to \$110,280 for a family of 5
- \$31,590 to \$126,360 for a family of 6
- \$35,610 to \$142,440 for a family of 7
- \$39,630 to \$158,520 for a family of 8

Federally Qualified Health Center (FQHC) - Federally funded nonprofit health centers or clinics that serve medically underserved areas and populations. Federally qualified health centers provide primary care services regardless of your ability to pay. Services are provided on a sliding scale fee based on your ability to pay.

Federally Recognized Tribe - Any Indian or Alaska Native tribe, band, nation, pueblo, village or community that the Department of the Interior acknowledges to exist as an Indian tribe. <http://www.bia.gov/cs/groups/public/documents/text/idc-041248.pdf>

Fee - Starting January 1, 2014, if someone doesn't have a health plan that qualifies as minimum essential coverage, he or she may have to pay a fee that increases every year: from 1% of income (or \$95 per adult, whichever is higher) in 2014 to 2.5% of income (or \$695 per adult) in 2016. The fee for children is half the adult amount. The fee is paid on the 2014 federal income tax form, which is completed in 2015. People with very low incomes and others may be eligible for waivers.

See "What if someone doesn't have health coverage in insurance in 2014?" for more information.

Fee for Service - A method in which doctors and other health care providers are paid for each service performed. Examples of services include tests and office visits.

Flexible Benefits Plan - A benefit program that offers employees a choice between various benefits including cash, life insurance, health insurance, vacations, retirement plans, and child care. Although a common core of benefits may be required, you can choose how your remaining benefit dollars are to be allocated for each type of benefit from the total amount promised by the employer. Sometimes you can contribute more for additional coverage. Also known as a Cafeteria plan or IRS 125 Plan.

Flexible Spending Account (FSA) - An arrangement you set up through your employer to pay for many of your out-of-pocket medical expenses with tax-free dollars. These expenses include insurance copayments and deductibles, and qualified prescription drugs, insulin and medical devices. You decide how much of your pre-tax wages you want taken out of your paycheck and put into an FSA. You don't have to pay taxes on this money. Your employer's plan sets a limit on the amount you can put into an FSA each year.

There is no carry-over of FSA funds. This means that FSA funds you don't spend by the end of the plan year can't be used for expenses in the next year. An exception is if your employer's FSA plan permits you to use unused FSA funds for expenses incurred during a grace period of up to 2.5 months after the end of the FSA plan year.

(Note: Flexible Spending Accounts are sometimes called Flexible Spending Arrangements.)

Formulary - A list of prescription drugs covered by a prescription drug plan or another insurance plan offering prescription drug benefits. Also called a drug list.

Gatekeeper - Person, usually a primary care physician, designated by health plan to decide what services will be provided and paid for; approves all referrals, and sometimes coordinates care.

Generic Drugs - A prescription drug that has the same active-ingredient formula as a brand-name drug. Generic drugs usually cost less than brand-name drugs. The Food and Drug Administration (FDA) rates these drugs to be as safe and effective as brand-name drugs.

Gold Health Plan – See Health Plan Category.

Grandfathered - As used in connection with the ACA: Exempt from certain provisions of this law. Most health insurance plans that existed on March 23, 2010 are eligible for grandfathered status and therefore do not have to meet all the requirements of the health care law. But if an insurer or employer makes significant changes to a plan's benefits or how much members pay through premiums, copays or deductibles, then the plan loses that status.

The government's regulations spell out how much plans can change the amount paid by workers or employers before losing their status.

A grandfathered plan has to follow some of the same rules other plans do under the ACA. For example, the plans cannot impose lifetime limits on how much health care coverage people may receive, and they must offer dependent coverage for young adults until age 26 (although until 2014, a grandfathered group plan does not have to offer such coverage if a young adult is eligible for coverage elsewhere). They also cannot retroactively cancel your coverage because of a mistake you made when applying, a practice known as a rescission.

However, there are many rules grandfathered plans do not have to follow. For example, they are not required to provide preventive care without cost-sharing. In addition, they do not have to offer a package of "essential health benefits" that individual and small group plans must offer beginning in 2014. (Large employer plans are not required to offer the essential benefits package even if they are not grandfathered.)

Furthermore, grandfathered individual plans – the policies you purchase yourself, rather than through work – can still impose annual dollar limits, such as capping key benefits at \$750,000 in a given year. Grandfathered individual policies also can still lock out children under 19 if they have a pre-existing conditions.

Grievance Procedure - Defined process in a health plan for consumers or providers to use when there is disagreement about a plan's services, billings, or general procedures.

Guaranteed Issue - A requirement that health plans must permit you to enroll regardless of health status, age, gender, or other factors that might predict the use of health services. Except in some states, guaranteed issue doesn't limit how much you can be charged if you enroll.

Guaranteed Renewal - A requirement that your health insurance issuer must offer to renew your policy as long as you continue to pay premiums. Except in some states, guaranteed renewal doesn't limit how much you can be charged if you renew your coverage.

Habilitative/Habilitation Services - Health care services that help you keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Hardship Exemption - Under the ACA, most people must pay a fee if they don't have health coverage that qualifies as "minimum essential coverage." One exception is based on showing that a "hardship" prevented them from becoming insured. More information will be available later in 2013.

Health Care for the Homeless (HCH) Programs - Health Care for the Homeless Clinics are part of the Community Health

Center program and automatically receives 8.7% of the entire CHC budget. Sometimes they are stand-alone clinics but often they are part of a hospital or larger Community Health Center. These programs can also be overseen and operated by county health departments. The foundational funding is provided by HRSA, same as with Community Health Centers, but these clinics have additional requirements. The major differences between HCH and CHCs are that HCH programs must provide substance use treatment and must include people experiencing homelessness on their board of directors.

Health Home State Plan Option - The State Option to Provide Health Homes for Enrollees with Chronic Conditions, section 2703 of the ACA, will provide enhanced federal funding for states that are planning to expand or implement a health home initiative that will serve individuals with chronic conditions – provided certain criteria are met. This new Medicaid option was established as part of the ACA as a means of reducing costs and improving health outcomes for people who have chronic diseases by better integrating and coordinating primary, acute, behavioral health and long-term care services. States electing this option will receive an enhanced Medicaid federal reimbursement for 8 fiscal quarters for health home services to chronically ill populations. These services can be delivered by a designated provider, a team of health care professionals partnering with a designated provider or through a health team.

Health Insurance Marketplace – Also called an Exchange. A resource where individuals, families, and small businesses can learn about their health coverage options; compare health insurance plans based on costs, benefits, and other important features; choose a plan; and enroll in coverage. The Marketplace also provides information on programs that help people with low to moderate income and resources pay for coverage. This includes ways to save on the monthly premiums and out-of-pocket costs of coverage available through the Marketplace, and information about other programs, including Medicaid and the Children's Health Insurance Program (CHIP). The Marketplace encourages competition among private health plans, and is accessible through websites, call centers, and in-person assistance. In some states, the Marketplace is run by the state. In others it is run by the federal government.

www.healthcare.gov

Health Plan Category - Plans in the Marketplace are primarily separated into 4 health plan categories — Bronze, Silver, Gold, or Platinum — based on the percentage the plan pays of the average overall cost of providing essential health benefits to members. The plan category you choose affects the total amount you'll likely spend for essential health benefits during the year. The percentages the plans will spend, on average, are 60% (Bronze), 70% (Silver), 80% (Gold), and 90% (Platinum). This isn't the same as coinsurance, in which you pay a specific percentage of the cost of a specific service.

Health Reimbursement Account (HRA) - Health Reimbursement Accounts (HRAs) are employer-funded group health plans from which employees are reimbursed tax-free

for qualified medical expenses up to a fixed dollar amount per year. Unused amounts may be rolled over to be used in subsequent years. The employer funds and owns the account. Health Reimbursement Accounts are sometimes called Health Reimbursement Arrangements.

Health Savings Account (HSA) - A medical savings account available to taxpayers who are enrolled in a High Deductible Health Plan. The funds contributed to the account aren't subject to federal income tax at the time of deposit. Funds must be used to pay for qualified medical expenses. Unlike a Flexible Spending Account (FSA), funds roll over year to year if you don't spend them.

Health Resources and Services Administration (HRSA) - Part of the U.S. Department of Health and Human Services and their mission is to improve access to health care services for people who are uninsured, isolated, or medically vulnerable. Community health centers, including Health Care for the Homeless Clinics and other Federally Qualified Health Centers (FQHCs), are overseen by this agency.

Health Status - Refers to your medical conditions (both physical and mental health), claims experience, receipt of health care, medical history, genetic information, evidence of insurability, and disability.

HMO - Health Maintenance Organization, a type of health insurance plan that usually limits coverage to care from doctors who work for or contract with the HMO. It generally won't cover out-of-network care except in an emergency. An HMO may require you to live or work in its service area to be eligible for coverage. HMOs often provide integrated care and focus on prevention and wellness.

HEDIS - Healthcare Effectiveness Data and Information Set, a system for determining the quality of a health plan's services and outcomes, based on certain data. HEDIS data, information, and guidance about children are limited.

High-Cost Excise Tax - Under the ACA starting in 2018, a tax on insurance companies that provide high-cost plans. This tax encourages streamlining of health plans to make premiums more affordable.

High Deductible Health Plan (HDHP) - A plan that features higher deductibles than traditional insurance plans. High deductible health plans (HDHPs) can be combined with a health savings account or a health reimbursement arrangement to allow you to pay for qualified out-of-pocket medical expenses on a pre-tax basis.

High Risk Pool Plan (State)- Similar to the Pre-Existing Condition Insurance Plan under the ACA, for years many states have offered plans that provide coverage if you have been locked out of the individual insurance market because of a pre-existing condition. High-risk pool plans may also offer coverage if you're HIPAA eligible or meet other requirements. High-risk pool plans offer health insurance coverage that is subsidized by a state government. Typically, your premium is up to twice as much as you would pay for individual coverage if you were healthy.

HIPAA - Health Insurance Portability and Accountability Act, a US law designed to provide privacy standards to protect patients' medical records and other health information provided to health plans, doctors, hospitals and other health care providers.

HIPAA Eligible Individual - Your status once you have had 18 months of continuous creditable health coverage. To be HIPAA eligible, at least the last day of your creditable coverage must have been under a group health plan; you also must have used up any COBRA or state continuation coverage; you must not be eligible for Medicare or Medicaid; you must not have other health insurance; and you must apply for individual health insurance within 63 days of losing your prior creditable coverage. When you're buying individual health insurance, HIPAA eligibility gives you greater protections than you would otherwise have under state law.

Home and Community-Based Services (HCBS) - Services and support provided by most state Medicaid programs in your home or community that gives help with such daily tasks as bathing or dressing. This care is covered when provided by care workers or, if your state permits it, by your family.

Hospice Services - Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

In Person Assistance Personnel Program - Individual or organizations that are trained and able to provide help to consumers, small businesses, and their employees as they look for health coverage options through the Marketplace, including helping them complete eligibility and enrollment forms. These individuals and organizations are required to be unbiased. Their services are free to consumers.

In-network Coinsurance - The percent (for example, 20%) you pay of the allowed amount for covered health care services to providers who contract with your health insurance or plan. In-network coinsurance usually costs you less than out-of-network coinsurance.

In-network Copayment - A fixed amount (for example, \$15) you pay for covered health care services to providers who contract with your health insurance or plan. In-network copayments usually are less than out-of-network copayments.

Indemnity Health Insurance - Usually a fee-for-service health plan that reimburses physicians and other providers for health services furnished to plan enrollees.

Lifetime Limit - A cap on the total lifetime benefits you may get from your insurance company. An insurance company may impose a total lifetime dollar limit on benefits (like a \$1 million lifetime cap) or limits on specific benefits (like a \$200,000 lifetime cap on organ transplants or one gastric bypass per lifetime) or a combination of the two. After a lifetime limit is reached, the insurance plan will no longer pay for covered services.

Long-term Care (LTC) - Services that include medical and non-medical care provided to people who are unable to perform

basic activities of daily living such as dressing or bathing. Long-term supports and services can be provided at home, in the community, in assisted living or in nursing homes. Individuals may need long-term supports and services at any age. Medicare and most health insurance plans don't pay for long-term care services at any age.

Mandatory and Optional Medicaid Benefits - The federal legislation that created the Medicaid program detailed specific mandatory benefits that all Medicaid beneficiaries must receive. These benefits include: Inpatient hospital services, outpatient hospital services, family planning, FQHC services, midwife services, physician care, and Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services for children.

States also have the ability to provide optional benefits to all or specific Medicaid populations. These benefits include: prescribed drugs, rehabilitative, clinic services, dentistry, physical therapy, and primary care case management. In addition, services available through specific Medicaid waivers or state plan amendments are also considered optional services and the state can discontinue these additional benefits as they see fit.

Mandatory Enrollment - Requirement that certain groups of people must enroll in a program. Medicaid managed care is an example.

Managed Care - Way of financing and delivering health care for a set fee using a network of specific providers and services. The organizations that deliver managed care are known as **MCOs** (Managed Care Organizations), **HMOs** (Health Maintenance Organizations), and **PPOs** (Preferred Provider Organizations).

Marketplace – See Health Insurance Marketplace.

MCO/Managed Care Organization- Health organization, whether for-profit or non-profit, that finances and delivers health care using a specific provider network, services and products.

Medicaid (Title XIX of the Social Security Act) - A state-administered health insurance program for low-income families and children, pregnant women, the elderly, people with disabilities, and in some states, other adults. The Federal government provides a portion of the funding for Medicaid and sets guidelines for the program. States also have choices in how they design their program, so Medicaid varies state by state and may have a different name in your state. The ACA expands Medicaid eligibility to non-Medicare eligible individuals with incomes up to 133% of the FPL, establishing uniform eligibility for adults and children across all states by 2014.

Medical Home - A family-centered Medical Home is not a building, house, hospital, or home healthcare service, but rather an approach to providing comprehensive primary care. In a family-centered medical home the pediatric care team works in partnership with a child and a child's family to assure that all of the medical and non-medical needs of the patient are met. Through this partnership the pediatric care team can

help the family/patient access, coordinate, and understand specialty care, educational services, out-of-home care, family support, and other public and private community services that are important for the overall health of the child and family. See <http://www.medicalhomeinfo.org/>.

Medical Loss Ratio (MLR) - A basic financial measurement used in the ACA to encourage health plans to provide value to enrollees. If an insurer uses 80 cents out of every premium dollar to pay its customers' medical claims and activities that improve the quality of care, the company has a medical loss ratio of 80%. A medical loss ratio of 80% indicates that the insurer is using the remaining 20 cents of each premium dollar to pay overhead expenses, such as marketing, profits, salaries, administrative costs, and agent commissions. The ACA sets minimum medical loss ratios for different markets, as do some state laws.

Medically Necessary - Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

Medicare (Title XVIII of the Social Security Act) – A federal program that provides health care coverage to people age 65 and older, and to those who are under 65 and are permanently disabled or who have a congenital disability; or to those who meet other special criteria such as end-stage renal disease. Eligible individuals can receive coverage for hospital services (Medicare Part A), physician-based medical services (Medicare Part B), coverage through a private insurance plan (Medicare Part C – Medicare Advantage) and prescription drugs (Medicare Part D). Together, Medicare Part A and B are known as Original Medicare.

Medical Necessity - Legal term used to determine eligibility for health benefits and services. It describes services that are consistent with a diagnosis, meet standards of good medical practice, and are not primarily for convenience of the patient.

Minimum Essential Coverage - The type of coverage an individual needs to have to meet the individual responsibility requirement under the ACA. This includes individual market policies, job-based coverage, Medicare, Medicaid, CHIP, TRICARE and certain other coverage.

“Money Follows the Person” (MFP) - The Rebalancing Demonstration Program (MFP) helps States rebalance their long-term care systems to transition people with Medicaid from institutions to the community. Forty-three States and the District of Columbia have implemented MFP Programs. From spring 2008 through December 2010, nearly 12,000 people have transitioned back into the community through MFP Programs. The ACA of 2010 strengthens and expands the “Money Follows the Person” Program to more States. Goals of MFP are to: increase the use of home and community-based services (HCBS) and reduce the use of institutionally-based services; eliminate barriers in State law, State Medicaid plans, and State budgets that restrict the use of Medicaid funds to let people get long-term care in the settings of their choice; strengthen the ability of Medicaid programs to provide HCBS to people who choose to transition out of

institutions; and put procedures in place to provide quality assurance and improvement of HCBS.

Navigator - An individual or organization that's trained and able to help consumers, small businesses, and their employees as they look for health coverage options through the Marketplace, including completing eligibility and enrollment forms. These individuals and organizations are required to be unbiased. Their services are free to consumers.

Network - The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

Non-preferred provider - A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your health insurance or plan, or if your health insurance or plan has a “tiered” network and you must pay extra to see some providers.

Olmstead v. LC: On June 22, 1999, the United States Supreme Court issued its decision in *Olmstead v. L.C.* – a landmark disability rights case. The lawsuit, brought against the State of Georgia, questioned the state's continued institutionalization of two disabled individuals after physicians had determined that they were ready to return to the community. The Supreme Court described Georgia's action as “unjustified isolation,” and determined that the state had violated these individuals' rights under the Americans with Disabilities Act (ADA). The Court explained that unjustified isolation was a form of discrimination. It reflected two judgments:

- First, institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life ...
- Second, confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment.

The Supreme Court was careful to say that the responsibility of states to provide health care in the community was “not boundless.” States were not required to close institutions nor were they to use homeless shelters as community placements. The Department of Justice and others continue to bring lawsuits against states in order to ensure that people who can live in the community are allowed to live in the community. States are required to have *Olmstead* plans and work to move people, as appropriate, out of institutions and into housing of their choice.

Open Enrollment Period - The period of time during which individuals who are eligible to enroll in a Qualified Health Plan can enroll in a plan in the Marketplace. For 2014, the Open Enrollment Period is October 1, 2013–March 31, 2014. For 2015 and later years, the Open Enrollment Period is October 15 to December 7 of the previous year. Individuals may also qualify for Special Enrollment Periods outside of Open

Enrollment if they experience certain events. (See Special Enrollment Period and Qualifying Life Event)

You can submit an application for health coverage outside of the Marketplace, or apply for Medicaid or CHIP, at any time of the year.

Out-of-Network Coinsurance - The percentage (for example, 40%) you pay of the allowed amount for covered health care services to providers who don't contract with your health insurance or plan. Out-of-network coinsurance usually costs you more than in-network coinsurance.

Out-of-Network Copayment - A fixed amount (for example, \$30) you pay for covered health care services from providers who don't contract with your health insurance or plan. Out-of-network copayments usually are more than in-network copayments.

Out-of-Pocket Costs - Your expenses for medical care that aren't reimbursed by insurance. Out-of-pocket costs include deductibles, coinsurance, and copayments for covered services plus all costs for services that aren't covered.

Out-of-pocket maximum/limit - The most you pay during a policy period (usually a year) before your health insurance or plan begins to pay 100% of the allowed amount. This limit never includes your premium, balance-billed charges, or health care your health insurance or plan doesn't cover. Some health insurance or plans don't count your copayments, deductibles, coinsurance payments, out-of-network payments, or other expenses toward this limit. In Medicaid and CHIP, the limit includes premiums.

Patient Protection and Affordable Care Act – See Affordable Care Act

Patient-Centered Outcomes Research - Research that compares different medical treatments and interventions to provide evidence on which strategies are most effective in different populations and situations. The goal is to empower you and your doctor with additional information to make sound health care decisions.

Payment Bundling - A payment structure in which different health care providers who are treating you for the same or related conditions are paid an overall sum for taking care of your condition rather than being paid for each individual treatment, test, or procedure. In doing so, providers are rewarded for coordinating care, preventing complications and errors, and reducing unnecessary or duplicative tests and treatments.

PCCM - Primary Care Case Management, a system that pays primary care providers a monthly fee to coordinate medical services, especially as used by Medicaid.

PHP - Prepaid Health Plan, a health organization that receives prepaid capitation (see "Capitation") payments for select set of benefits; for example, physician services or lab tests.

Physician Hospital Organization (PHO) - A management service organization in which the partners are physicians and

hospitals. The PHO organization contracts for physician and hospital services

Plan Year - A 12-month period of benefits coverage under a group health plan. This 12-month period may not be the same as the calendar year. To find out when your plan year begins, you can check your plan documents or ask your employer. (Note: For individual health insurance policies this 12-month period is called a "policy year").

Platinum Health Plan – See Health Plan Category

Policy Year - A 12-month period of benefits coverage under an individual health insurance plan. This 12-month period may not be the same as the calendar year. To find out when your policy year begins, you can check your policy documents or contact your insurer. (Note: In group health plans, this 12-month period is called a "plan year").

POS - Point of Service Plan, a type of plan in which you pay less if you use doctors, hospitals, and other health care providers that belong to the plan's network. POS plans also require you to get a referral from your primary care doctor in order to see a specialist.

PPO - Preferred Provider Organization, managed care organization (MCO) that contracts with a network of providers who deliver services for set fees, usually at a discount to the MCO. PPOs usually sell to insurers and employers and do not assume insurance risk.

Pre-Existing Condition - A health problem you had before the date that new health coverage starts.

Pre-Existing Condition (Job-based Coverage) - Any condition (either physical or mental) including a disability for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period ending on your enrollment date in a health insurance plan. Genetic information, without a diagnosis of a disease or a condition, cannot be treated as a pre-existing condition. Pregnancy cannot be considered a pre-existing condition and newborns, newly adopted children and children placed for adoption who are enrolled within 30 days cannot be subject to pre-existing condition exclusions.

Pre-Existing Condition Exclusion Period (Individual Policy) - The time period during which an individual policy won't pay for care relating to a pre-existing condition. Under an individual policy, conditions may be excluded permanently (known as an "exclusionary rider"). Rules on pre-existing condition exclusion periods in individual policies vary widely by state.

Pre-Existing Condition Exclusion Period (Job-based Coverage) - The time period during which a health plan won't pay for care relating to a pre-existing condition. Under a job-based plan, this cannot exceed 12 months for a regular enrollee or 18 months for a late-enrollee.

Pre-existing Condition Insurance Plan (PCIP) - A program that will provide a health coverage option for you if you have been uninsured for at least six months, you have a pre-existing condition, and you have been denied coverage (or offered

insurance without coverage of the pre-existing condition) by a private insurance company. This program will provide coverage until 2014 when you will have access to affordable health insurance choices through the Health Insurance Marketplace, and you can no longer be discriminated against based on a pre-existing condition.

Preauthorization - A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost

Preferred Provider - A provider who has a contract with your health insurer or plan to provide services to you at a discount. Check your policy to see if you can see all preferred providers or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also "participating" providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.

Premium - The amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly or yearly.

Premium Subsidies - A fixed amount of money, or a designated percentage of the premium cost, that is provided to help people purchase health insurance. The ACA provides premium subsidies to individuals with incomes between 133% and 400% of the FPL level that purchase health plan through the Exchanges beginning in 2014. These are also known as premium tax credits under the ACA.

Premium Tax Credit - The ACA provides a new tax credit to help you afford health coverage purchased through the Marketplace. Advance payments of the tax credit can be used right away to lower your monthly premium costs. If you qualify, you may choose how much advance credit payments to apply to your premiums each month, up to a maximum amount. If the amount of advance credit payments you get for the year is less than the tax credit you're due, you'll get the difference as a refundable credit when you file your federal income tax return. If your advance payments for the year are more than the amount of your credit, you must repay the excess advance payments with your tax return.

Preventative Services - Routine health care that includes screenings, check-ups, and patient counseling to prevent illnesses, disease, or other health problems.

Primary Care - Health services that cover a range of prevention, wellness, and treatment for common illnesses. Primary care providers include doctors, nurses, nurse practitioners, and physician assistants. They often maintain long-term relationships with you and advise and treat you on a range of health related issues. They may also coordinate your care with specialists.

Primary Care Physician - A physician (M.D. - Medical Doctor or D.O. - Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.

Primary Care Provider - A physician (M.D. - Medical Doctor or D.O. - Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

Prior Authorization - Approval from a health plan that may be required before you get a service or fill a prescription in order for the service or prescription to be covered by your plan.

Public Health - A field that seeks to improve lives and the health of communities through the prevention and treatment of disease and the promotion of healthy behaviors such as healthy eating and exercise.

Qualified Health Plan - Under the ACA, starting in 2014, an insurance plan that is certified by the Health Insurance Marketplace, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements. A qualified health plan will have a certification by each Marketplace in which it is sold.

Qualifying Life Event - A change in your life that can make you eligible for a Special Enrollment Period to enroll in health coverage. Examples of qualifying life events are moving to a new state, certain changes in your income, and changes in your family size (for example, if you marry, divorce, or have a baby).

Quality Assurance - Monitoring and improving health care, either an individual plan or broad health systems review, in a consistent and organized way.

Referral - A written order from your primary care doctor for you to see a specialist or get certain medical services. In many Health Maintenance Organizations (HMOs), you need to get a referral before you can get medical care from anyone except your primary care doctor. If you don't get a referral first, the plan may not pay for the services.

Rehab Option - The Medicaid Rehabilitation State Plan Option (Rehab Option or MRO) is one of the categories of Medicaid services and covers rehabilitative, community-based services to persons with either a physical health need (such as recovering from a sports injury or car accident) or a mental health diagnosis. Increasingly states are using MRO for mental health services. MRO services can be delivered in the client's home as well as in a clinic or doctor's office. They focus specifically on assisting clients with gaining skills and resources that allow them to live and function as independently as possible.

Rehabilitative/Rehabilitation Services - Health care services that help you keep, get back, or improve skills and functioning for daily living that have been lost or impaired because you were sick, hurt, or disabled. These services may

include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Reinsurance - A reimbursement system that protects insurers from very high claims. It usually involves a third party paying part of an insurance company's claims once they pass a certain amount. Reinsurance is a way to stabilize an insurance market and make coverage more available and affordable.

Rescission - The retroactive cancellation of a health insurance policy. Insurance companies will sometimes retroactively cancel your entire policy if you made a mistake on your initial application when you buy an individual market insurance policy. Under the ACA, rescission is illegal except in cases of fraud or intentional misrepresentation of material fact as prohibited by the terms of the plan or coverage.

Rider (exclusionary rider) - A rider is an amendment to an insurance policy. Some riders will add coverage (for example, if you buy a maternity rider to add coverage for pregnancy to your policy.) In most states today, an exclusionary rider is an amendment, permitted in individual health insurance policies that permanently excludes coverage for a health condition, body part, or body system. Starting in September 2010, under the ACA, exclusionary riders cannot be applied to coverage for children. Starting in 2014, no exclusionary riders will be permitted in any health insurance.

Risk - Refers to the chance that a health plan or a provider takes when they agree to deliver health services to a group of people for a certain payment rate, even if costs for the services exceed the payments.

Risk Adjustment - The higher capitation (see "Capitation") rate paid to providers or health plans for services to a group of enrollees whose medical care is known to be more costly than average.

Risk-sharing - Occurs when two parties, usually Medicaid and an MCO, agree through a formula to share any losses that result when medical costs exceed payments.

Self-Insured Plan - Type of plan usually present in larger companies where the employer itself collects premiums from enrollees and takes on the responsibility of paying employees' and dependents' medical claims. These employers can contract for insurance services such as enrollment, claims processing, and provider networks with a third party administrator, or they can be self-administered.

Service Area - A geographic area where a health insurance plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine (non-emergency) services. The plan may disenroll you if you move out of the plan's service area.

Silver Health Plan - See Health Plan Category.

Skilled Nursing Care - Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

SNF - Skilled Nursing Facility, an institution providing skilled nursing and related services to residents; a nursing home.

Special Enrollment Period - A time outside of the open enrollment period during which you and your family have a right to sign up for job-based health coverage. Job-based plans must provide a special enrollment period of 30 days following certain life events that involve a change in family status (for example, marriage or birth of a child) or loss of other job-based health coverage.

Special Health Care Need - The health care and related needs of children who have chronic physical, developmental, behavioral or emotional conditions. Such needs are of a type or amount beyond that required by children generally. Information about children with special health care needs may be found at <http://www.childhealthdata.org>.

Specialist - A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of health care.

Spend-down - The process in which a consumer uses up all income and assets on medical care in order to qualify for Medicaid.

State Continuation Coverage - A state-based requirement similar to COBRA that applies to group health insurance policies of employers with fewer than 20 employees. In some states, state continuation coverage rules also apply to larger group insurance policies and add to COBRA protections. For example, in some states, if you're leaving a job-based plan, you must be allowed to continue your coverage until you reach the age of Medicare eligibility.

State Medical Assistance Office - A state agency in charge of the state's Medicaid program and can give information about programs in its state that help pay medical bills for people with limited income and resources.

Stop-loss - A form of health insurance that provides protection for medical expenses above a certain limit.

SSI/Supplemental Security Income - Monthly cash assistance for people, including children, who have low incomes, and who meet certain age or disability guidelines. In most states, SSI also includes access to Medicaid.

Subsidized Coverage - Health coverage that's obtained through financial assistance from programs to help people with low and middle incomes.

Summary of Benefits and Coverage (SBC) - An easy-to-read summary that lets you make apples-to-apples comparisons of costs and coverage between health plans. You can compare options based on price, benefits, and other features that may be important to you. You'll get the "Summary of Benefits and Coverage" (SBC) when you shop for coverage on your own or through your job, renew or change coverage, or request an SBC from the health insurance company.

Targeted Case Management - Refers to case management that is restricted to specific beneficiary groups. Targeted beneficiary groups can be defined by disease or medical condition, or by geographic regions, such as a county or a city within a state. Targeted, for example, may include individuals with HIV/AIDS, tuberculosis, chronic physical or mental illness, developmental disabilities, receiving foster care, or other groups identified by a state and approved by the Centers for Medicare and Medicaid (CMS). TCM and case management are optional services that states may elect to cover, but which must be approved by CMS through state plan amendment (SPAs).

TRICARE- A health care program for active-duty and retired uniformed services members and their families.

UCR - Usual, Customary, and Reasonable, the amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

Urgent Care - Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

Utilization Review - A series of processes to ensure that medically necessary acute inpatient and outpatient care has been provided in the most appropriate and cost-effective manner.

Value-Based Purchasing (VBP) - Linking provider payments to improved performance by health care providers. This form of payment holds health care providers accountable for both the cost and quality of care they provide. It attempts to reduce inappropriate care and to identify and reward the best-performing providers.

Waivers - The result of a process that allows state Medicaid agencies to apply for and receive permission from CMS to provide services not otherwise covered by Medicaid and/or to do so in ways not described by the Social Security Act. Most Medicaid managed care programs require waivers. The waivers, which can differ greatly, are known by their numbers (1115, 1119), as home-and community-based, or as Katie Beckett Waivers.

- **Section 1115 Medicaid Demonstration Waiver** - Section 1115 waivers provide states flexibility to test approaches in Medicaid that differ from federal program rules. While recent waivers and waiver proposals vary in their specifics, key themes are emerging, including using the waiver authority to get a jump start on the 2014 Medicaid expansion and to restructure delivery and payment systems, particularly for high-need individuals.
- **The 1915(c) waivers and 1915i State plan option** - These Medicaid authorities allow states to offer Home and Community Based Services (HCBS) benefits to various populations.
 - **1915c waivers** - These waivers are one of many options available to states to allow the provision of long term care services in home and community based settings under the Medicaid

Program. Beneficiaries must be meet the requirements for institutional care but have the ability to live in the community. States can offer a variety of services under an HCBS Waiver program. Programs can provide a combination of standard medical services and non-medical services. Standard services include but are not limited to: case management (i.e. supports and service coordination), homemaker, home health aide, personal care, adult day health services, habilitation (both day and residential), and respite care. States can also propose “other” types of services that may assist in diverting and/or transitioning individuals from institutional settings into their homes and community.

- **1915i State Plan Option** - States can also offer a variety of services under a State Plan Home and Community-Based Services (HCBS) benefit (1915i). This option was modified under the ACA to be a more flexible resource for states. Eligible persons must meet State-defined criteria based on need and typically get a combination of acute-care medical services (like dental services, skilled nursing services) and long-term services (like respite, case management, supported employment and environmental modifications).

Wraparound Services – Community-based services and supports for a child/adolescent with mental health need that focus on the strengths and needs of the child and family.

These often are¹:

- Are provided in the homes of families and in settings in the community rather than in an office setting;
- Are available when families need them, including after-school, in the evenings or on the weekends instead of only during office hours;
- Emphasize treatment through participation in purposeful activities, giving children the opportunity to practice life skills and make positive choices through involvement in community activities, instead of focusing on treatment through talking about problems; and
- Are built around engaging the child and family in activities that interest them and meet their goals instead of just around a goal of stopping negative behaviors.

1 Judge David L. Baselon Center for Mental Health Law, <http://www.baselon.org/Where-We-Stand/Success-for-All-Children/Mental-Health-Services-for-Children/Wraparound-Services-.aspx>

SOURCES:

Healthcare.gov Glossary, <https://www.healthcare.gov/glossary/>

Judge David L. Baselon Center for Mental Health Law, <http://www.baselon.org/Where-We-Stand/Success-for-All-Children/Mental-Health-Services-for-Children/Wraparound-Services-.aspx>

Health Terms and Practices Resource Glossary November 2012 http://www.csh.org/wp-content/uploads/2012/11/glossary_of_terms_final-Final-edits.pdf

Health Care Glossary For Affordable Care Act (Aca), <http://www.aldoi.gov/PDF/Consumers/HealthCareGlossary.pdf>



ABC's of Health Care – Acronyms for Families of Children/Youth with Special Health Care Needs/Disabilities

- | | |
|---|---|
| ACA: Affordable Care Act | HIPAA: Health Insurance Portability and Accountability Act |
| ACO: Accountable Care Organization | HMO: Health Maintenance Organization |
| CHIP: Children's Health Insurance Program | HRA: Health Reimbursement Account |
| CMS: Centers for Medicare and Medicaid Services | HRSA: Health Resources and Services Administration |
| CSHCN - Children with Special Health Care Needs | HSA: Health Savings Account |
| CSP: Community Support Program | IDEA: Individuals with Disabilities Education Act |
| CST: Community Support Team | LTC: Long-term Care |
| CYSHCN – Children and Youth with Special Health Care Needs | MCO: Managed Care Organization |
| DME: Durable Medical Equipment | MFP: “Money Follows the Person” |
| EHB: Essential Health Benefits | MLR: Medical Loss Ratio |
| EI: Early Intervention | MRO: Medicaid Rehabilitation Option |
| EOB: Explanation of Benefits | PCCM: Primary Care Case Management |
| EOMB: Explanation of Medicare Benefits | PCIP: Pre-existing Condition Insurance Plan |
| EPO: Exclusive Provider Organization | PCIP: Pre-existing Condition Insurance Plan |
| EPSDT: Early and Periodic Screening, Diagnosis and Treatment | PHO: Physician Hospital Organization |
| ERISA: Employee Retirement Insurance Security Act | PHP: Prepaid Health Plan. |
| ESRP: Employer Shared Responsibility Payment | POS: Point of Service |
| F2F HIC: Family-to-Family Health Information Center | PPO: Preferred Provider Organization |
| FMLA: Family and Medical Leave Act | QHP: Qualified Health Plan |
| FPL: Federal Poverty Level | SAO: Family Voices State Affiliate Organization |
| FQHC: Federally Qualified Health Center | SBC: Summary of Benefits and Coverage |
| FSA: Flexible Spending Account | SNF: Skilled Nursing |
| HCBS: Home and Community-Based Services | SSI: Supplemental Security Income |
| HCH: Health Care for the Homeless | TCM: Targeted Case Management |
| HDHP: High Deductible Health Plan | UCR: Usual, Customary, and Reasonable |
| HEDIS - Healthcare Effectiveness Data and Information Set | VBP: Value-Based Purchasing |