2013 Health Glossary of Terms

Access: An individual's ability to obtain appropriate health care services. Barriers to access can be financial (insufficient monetary resources), geographic (distance to providers), organizational (lack of available providers) and sociological (e.g. discrimination, language barriers). Efforts to improve access often focus on providing/improving health coverage.

Access for Infants and Mothers Program (AIM): California's low-cost health coverage for pregnant women. AIM is for middle-income families who don't have health insurance and whose income is too high for no-cost Medi-Cal. AIM is also available to women who have private health insurance plans with a maternity-only deductible or copayment greater than $500.

Accountable Care Organization (ACO): A provider-led organization whose mission is to manage the full continuum of care and be accountable for the overall costs and quality of care for a defined population.

Acute Care: Medical services provided to treat an illness or injury, usually for a short time. Contrast with Chronic Care.

Administrative Procedures Act (APA): Enacted June 11, 1946, APA is the federal law that governs the way in which administrative agencies may propose and establish regulations.

Adult Day Health Care (ADHC): Adult Day Health Care is a non-residential program and can often be an alternative to nursing home care for people who do not need care 24 hours, seven days a week.

Adverse selection: A tendency for utilization of health services in a population group to be higher than average. From an insurance perspective, adverse selection occurs when persons with poorer-than-average health status apply for, or continue, insurance coverage to a greater extent than do persons with average or better health expectations.

AIDS Drug Assistance Program (ADAP): Under CDPH's Office of AIDS, ADAP helps ensure that people living with HIV and AIDS who are uninsured and under-insured have access to medication.

Affordable Care Act (ACA): A shortening of Patient Protection and Affordable Care Act of 2010, a federal law enacted in March 2010, phasing in major expansions in insurance coverage and changes in insurance rules and delivery systems over several years.

Ambulatory Surgical Center (ASC): Medical facilities that specialize in elective same-day or outpatient surgical procedures. They do not offer emergency care. Ambulatory surgical centers are also known as surgicenters.

Americans with Disabilities Act (ADA): A wide-ranging civil rights law that prohibits, under certain circumstances, discrimination based on disability.

Amyotrophic Lateral Sclerosis (ALS): ALS is a progressive and fatal neurodegenerative disease that affects motor neurons in the brain and the spinal cord.

Autism Spectrum Disorders (ASD): The developmental disorders known as ASDs include autism, Asperger's syndrome, Rett's syndrome, childhood disintegrative disorder, and pervasive developmental disorder not otherwise specified. ASDs are characterized by three distinctive types of behavior, which can range from mild to disabling. The main features of ASDs are impaired social interaction and communication, an inability to empathize, and failure to understand social cues. Other characteristics include repetitive behaviors, such as rocking, twirling, and head banging; and narrow, obsessive interests. Persons with ASDs also often have numerous co-occurring conditions, including behavioral disorders and particular health problems, such as sleep disorders, gastrointestinal problems, and immune system deficiencies.

Balance Billing: (1) Physician charges in excess of Medicare-allowed amounts, for which Medicare patients are responsible, subject to a limit. (ProPAC). (2) In Medicare and private fee-for-service health insurance, the practice of billing patients in excess of the amount approved by the health plan. In Medicare, a balance bill cannot exceed 15 percent of the allowed charge for nonparticipating physicians.

Behavioral Health Services: Medical services encompassing mental health care and substance abuse treatment.

Benchmark: A goal to be attained. These goals are chosen by comparisons with other providers, by consulting statistical reports available, or are drawn from the best practices within the organization or industry. Benchmarks are used in quality improvement programs to encourage improvement of care, efficiencies or services. Benchmarks are also used for length of stay comparisons, costs, utilization review, risk management and financial analysis. The benchmarking process identifies the best performance in the industry (health care or non-health care) for a particular process or outcome, determines how that performance is achieved, and applies the lessons learned to improve performance.

Bundled Payments: The use of a single comprehensive charge or payment for a group of related health services.

California Cancer Registry (CCR): California's statewide population-based cancer surveillance system.

California Children's Services Program (CCS): A state program for children with certain diseases or health problems. Through this program, children up to 21 years old can get the health care and services they need.

California Health Benefits Review Program (CHBRP). CHBRP responds to requests from the California Legislature to provide independent analysis of the medical, financial, and public health impacts of proposed health insurance benefit mandates and repeals.

California Health Facilities Financing Authority (CHFFA): The State's entity, administered through the State Treasurer's Office, for providing financial assistance, such as loans, grants and tax-exempt bonds, to public and non-profit health care providers, including small and rural health facilities.

California Healthcare Eligibility, Enrollment and Retention System (CalHEERS): An information technology (IT) system intended to serve as a consumer-friendly web-based portal and the consolidated IT support for eligibility, enrollment, and retention for the California Health Benefit Exchange, Medi-Cal and Healthy Families.

California Health Information Survey (CHIS): CHIS is conducted by the UCLA Center for Health Policy Research in collaboration with the California Department of Public Health and the Department of Health Care Services. It is a random-dial telephone survey conducted on a continuous basis on a wide range of health topics and it is the nation's largest state health survey. CHIS provides a detailed picture of the health and health care needs of California's large and diverse population. A full data cycle takes two years to complete and surveys over 50,000 Californians.

California Institute for Regenerative Medicine (CIRM). CIRM is a state agency that was established through the passage of Proposition 71, the California Stem Cell Research and Cures Initiative, approved by California voters on November 2, 2004, to make grants and provide loans for stem cell research, research facilities and other research opportunities.

California Retail Food Code (CRFC): Established to govern all aspects of retail food safety and sanitation in California and makes local environmental health departments primarily responsible for enforcing the CRFC through local food safety inspection programs.

California Work Opportunity and Responsibility to Kids Program (CalWORKs): A welfare program that gives cash aid and services to eligible needy California families. The program serves all 58 counties and is operated by county welfare departments. If a family has little or no cash and needs housing, food, utilities, clothing or medical care, they may be eligible to receive immediate short-term help. Families that apply and qualify for ongoing assistance receive money each month to help pay for housing, food and other necessary expenses.

Capitation: A method of payment for health services in which an individual or institutional provider is paid a fixed amount for each person served, without regard to the actual number or nature of services provided to each person in a set period of time. Capitation is the characteristic payment method in certain health maintenance organizations. It also refers to a method of federal support of health professional schools.

Under these authorizations, each eligible school receives a fixed payment, called a "capitation grant" from the federal government for each student enrolled.

Carrier: An insurer; an underwriter of risk that finances health care. Also refers to any organization, which underwrites or administers life, health or other insurance programs. When an employer has a "self-insured" plan, the carrier (such as Aetna or Blue Cross) may not serve as carrier in this case, but may serve only as "third party administrator".

Carve out: Regarding health insurance, an arrangement whereby an employer eliminates coverage for a specific category of services (e.g., vision care, mental health/psychological services and prescription drugs) and contracts with a separate set of providers for those services according to a predetermined fee schedule or capitation arrangement. Carve out may also refer to a method of coordinating dual coverage for an individual.

Case Management: A process where a health plan identifies covered persons with specific health care needs, then devises and carries out for them a plan to achieve the best patient outcome in the most cost-effective manner.

Centers for Medicare and Medicaid Services (CMS): A branch of the U.S. Department of Health and Human Services, CMS is the federal agency which administers Medicare, Medicaid, and the Children's Health Insurance Program.

Centers for Disease Control and Prevention (CDC): The federal agency under the Department of Health and Human Services that works in partnership with state health departments and other organizations to protect public health and safety through health promotion, prevention of disease, injury and disability, and preparedness for new health threats.

Certified Nurse Midwife (CNM): Provide health care involving emotional and physical support to women before, during, and after childbirth. They are registered nurses with specialized training in assisting pregnant women and their newborn babies.

Charity Care: Care rendered by hospitals or other providers without the expectation of payment from the patient or a government-sponsored or private insurance program.

Child Health and Disability Prevention Program (CHDP): A preventive program that delivers periodic health assessments and services to low income children and youth in California.

Chronic Disease: A condition that is not expected to improve, that lasts a year or longer or recurs, and may result in long-term care needs. Chronic illnesses include Alzheimer's disease, arthritis, diabetes, epilepsy and some mental illnesses.

Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). A federally funded health program that provides beneficiaries with medical care, supplemental to that available in federal military facilities.

Coinsurance: A cost-sharing requirement under a health insurance policy. It provides that the insured party will assume a portion of the costs of covered services. The health insurance policy provides that the insurer will reimburse a specified percentage of all, or certain specified, covered medical expenses in excess of any deductible amounts payable by the insured. The insured is then liable for the remainder of the costs until their maximum liability is reached.

Community-Based Adult Services (CBAS): A program created as a settlement to a lawsuit challenging the elimination of the Adult Day Health Center (ADHC) which had been an option benefit under Medi-Cal. CBAS provides necessary medical and social services to older adults with multiple chronic conditions. Eligibility to participate in CBAS is determined by state medical professionals on the basis of medical need, and the benefits provided are coordinated with managed care plans.

Community-Based Healthcare Worker (CHW): CHWs are members of a community who are chosen by community members or organizations to provide basic health and medical care to their community. Other names for this type of health care provider include village health worker, community health aide, community health promoter, promotores and lay health advisor.

Community Health Center: Organization providing comprehensive primary care to medically underserved populations, regardless of their ability to pay. These public and non-profit entities receive federal funding under Section 330 of the Public Health Service Act.

Community rating: A method of calculating health plan premiums using the average cost of actual or anticipated health services for all subscribers within a specific geographic area. The premium does not vary for different groups or subgroups of subscribers on the basis of their specific claims experience.

Comprehensive Perinatal Services Program (CPSP): Provides a wide range of culturally competent services to Medi-Cal pregnant women, from conception through 60 days postpartum. In addition to standard obstetric services, women receive enhanced services in the areas of nutrition, psychosocial and health education.

Computed Tomography X-Ray (CT): CT imaging is a diagnostic procedure that uses special X-ray equipment to obtain cross-sectional pictures of the body that provides detailed images of organs, bones, and other tissues.

Confidentiality of Medical Information Act (CMIA): Covers disclosure of medical information by health care providers, Knox-Keene regulated health plans (e.g. HMOs), health care clearinghouses, and employers. CMIA is primarily aimed at protecting an individual's health information from unauthorized disclosures to third parties.

Consolidated Omnibus Budget Reconciliation Act (COBRA): COBRA is a law passed by the U.S. Congress on a reconciliation basis that, among other things, mandates

an insurance program giving some employees the ability to continue health insurance coverage after leaving employment.

Consumer Assessment of Healthcare Providers and Systems (CAHPS): The CAHPS program produces free, nonproprietary survey instruments designed to support standardized measurement of the experiences of patients and health plan enrollees with care in a variety of settings. They have been developed by prominent research organizations under the auspices of the U.S. Agency for Healthcare Research and Quality.

Consumer Directed Health Plan (CDHP): Includes plans that are coupled with health spending accounts into which employers or individuals contribute pre-tax dollars to be used for health care purchases. These mechanisms aim to change employees from receivers of health care into purchasers by having them participate more fully in health care and cost decisions.

Consumer Operated and Oriented Plans (CO-OP): The ACA calls for the establishment of the federal CO-OP Program, which will foster the creation of qualified nonprofit health insurance issuers through a loan program to finance the creation of CO-OPs. CO-OPs are to be nonprofit, member-governed plans that will create innovative care delivery and payment models to compete in states' individual and small group health insurance markets.

Coordinated Care Initiative (CCI): A state initiative intended to better integrate delivery of medical, behavioral, and long-term care services and to integrate Medicare and Medi-Cal for people in both programs, called "dual eligible" beneficiaries. The two components of the CCI are:

1) Duals Demonstration: A voluntary three-year demonstration program for Medicare and Medi-Cal dual eligible beneficiaries will coordinate medical, behavioral health, long-term institutional, and home-and community-based services through a single health plan. The CCI provides state authority for the demonstration, which is pending federal approval.

2) Medi-Cal Long-Term Supports and Services (LTSS) linked to managed care: All Medi-Cal beneficiaries, including dual eligible beneficiaries, will be required to join a Medi-Cal managed care health plan to receive their Medi-Cal benefits, including LTSS and Medicare wrap-around benefits.

Co-Payment, Copayment, Copay: A cost-sharing arrangement in which the health plan enrollee pays a specified flat amount for a specific service (such as $10 for an office visit or $5 for each prescription drug). When first implemented, it was thought that the amount paid must be nominal to avoid becoming a barrier to care. However, the amounts of copays can vary widely from plan to plan, and, many now can be viewed as barriers to care. Copay normally does not vary with the cost of the service, unlike co-insurance that is based on a percentage of the cost.

Corporate Practice of Medicine (CPM): California has one of the strictest laws against CPM. Hospitals are generally barred from hiring physicians as employees. The CPM Act (or doctrine) prohibits corporations and other artificial legal entities from having professional rights, privileges, or powers in relation to the practice of medicine. Further, under the CPM doctrine, the state prohibits hospitals and other entities from employing physicians to provide professional services. This law was created to prevent corporations and other entities or non-professionals, from unduly influencing the professional judgment and practice of medicine by licensed physicians.

Cost sharing: Payment method where a person is required to pay some health costs in order to receive medical care. The general set of financing arrangements whereby the consumer must pay out-of-pocket to receive care, either at the time of initiating care, or during the provision of health care services, or both. This includes deductibles, coinsurance and copayments, but not the share of the premium paid by the person enrolled.

Cost Shifting: The practice by which a seller of a health service, such as a hospital, increases charges for some payers to offset losses due to uncompensated or indigent care or lower payments from other payers.

Coverage: The guarantee against specific losses provided under the terms of an insurance policy. Coverage is sometimes interchangeable with benefits or protection, and is also used to mean insurance or insurance contract.

County Health Initiative Matching Fund (CHIM) Program: The Program provides health coverage for eligible children up to age 19 in families with incomes between 250 and 400% of the federal poverty level that are not eligible for Medi-Cal or the Healthy Families Program. Coverage is provided through county-sponsored insurance programs, which provide comprehensive benefits similar to the Healthy Families Program. Program costs are funded by matching county expenditures with federal funds in participating counties that have been approved by the federal government. The Managed Risk Medical Insurance Board manages the intergovernmental transfer of federal funds, and the counties administer the program.

County Organized Health System (COHS): A local agency created by a county board of supervisors to contract with the Medi-Cal program.

Covered California: California's state-based Health Benefit Exchange, established pursuant to the ACA. Covered California is creating a new insurance marketplace in which individuals and small businesses will be able to purchase competitively priced health plans using federal tax subsidies and credits in October 2013, with coverage starting in 2014. Covered California is overseen by a five-member board appointed by the Governor and Legislature; the California Health and Human Services Secretary serves as an ex officio voting member and is its current Chair.

Crowd-out: A phenomenon whereby new public programs or expansions of existing public programs designed to extend coverage to the uninsured prompts some privately insured persons to drop their private coverage and take advantage of the expanded public subsidy.

Deductible: The amount of loss or expense that must be incurred by an insured or otherwise covered individual before an insurer will assume any liability for all or part of the remaining cost of covered services. Deductibles may be either fixed-dollar amounts or the value of specified services (such as two days of hospital care or one physician visit). Deductibles are usually tied to some reference period over which they must be incurred, e.g, $100 per calendar year, benefit period, or length of illness.

Defined Contribution: A health benefit model used by employers or government programs where health services covered may fluctuate based on choice of plan, but the employer or government contributes a set amount (percentage or dollar amount) towards the purchase of the selected health plan. A defined contribution plan limits the financial liability of employers or the government, because the contribution is defined, or fixed.

Deoxyribonucleic Acid (DNA): An informational molecule encoding the genetic instructions used in the development and functioning of all known living organisms and many viruses.

Disproportionate Share Hospital (DSH): A hospital that receives increased payment under Medicare's prospective payment system or under Medicaid to serve a relatively large number of low-income uninsured patients.

Dual Eligible: An individual who is eligible for health care through both the Medicare and Medi-Cal programs.

Elder Death Review Team (EDRT): Examine deaths associated with suspected elder abuse and/or neglect; identify, and work towards the implementation of prevention strategies to protect the state's elder population.

Electronic Health Record (EHR)/Electronic Medical Record (EMR): Computerized records of a patient's health information including medical, demographic, and administrative data. This record can be created and stored within one health care organization or it can be shared across health care organizations and delivery sites.

Employer-sponsored Insurance: A voluntary system in which employers choose to provide health insurance for employees.

Enrollee (also called a member or subscriber): A person enrolled in an HMO.

Entitlement Programs: Federal programs, such as Medicare and Medicaid, for which people who meet eligibility criteria have a federal right to benefits. Changes to eligibility criteria and benefits require legislation. The federal government is required to spend the

funds necessary to provide benefits for individuals in these programs, unlike discretionary programs for which spending is set by Congress through the appropriations process. Enrollment in these programs cannot be capped and neither states nor the federal government may establish waiting lists.

Essential Health Benefits (EHBs): Under the ACA, individual and small employer policies (unless grandfathered) must cover a minimum set of benefits, considered Essential Health Benefits, in 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. EHBs were defined in California law through the selection of the Kaiser Small Group HMO plan as the benchmark health plan.

Federal Medical Assistance Percentage (FMAP): Percentage used to determine the amount of federal matching funds for state Medicaid expenditures. Before the recession of 2008 – 2009, the FMAP was not less than 50 percent or more than 80 percent. Congress increased the federal match in the American Recovery and Reinvestment Act of 2009 to help states during the recession, and later extended increased FMAP payments through June 2011.

Federal poverty level (FPL): The amount of income determined by the federal Department of Health and Human Services to provide a bare minimum for food, clothing, transportation, shelter, and other necessities. FPL is reported annually and varies according to family size (e.g. for a family of 3 in 2006 the FPL was $16,600 or $1,383 per month). Public assistance programs usually define income limits in relation to FPL.

Federally Qualified Health Center (FQHC): Facilities that have been approved by the government for a program to provide low cost health care. They include community health centers, tribal health clinics, migrant health centers, rural health centers and health centers for the homeless.

Fee-for-service (FFS): Method of billing for health services under which a physician or other practitioner charges separately for each patient encounter or service rendered; it is the method of billing used by the majority of US physicians. Under a fee-for-service payment system, expenditures increase if the fees themselves increase, if more units of service are provided, or if more expensive services are substituted for less expensive ones. This system contrasts with salary, per capita, or other prepayment systems, where the payment to the physician is not changed with the number of services actually used.

Formulary: A list of selected pharmaceuticals and their appropriate dosages created by health insurance plans and state Medicaid programs, which are usually intended to include a broad array of prescription drugs that are also cost-effective for patient care. Physicians are often required or urged to prescribe from the formulary developed by the insurance plans, pharmacy benefit managers or HMOs with which they are affiliated.

Group Insurance: Health insurance offered through business, union trusts or other groups and associations. The policy holder is generally the employer or other entity. This system of health insurance is the most common in the US.

Guaranteed issue: Requirements that insurance carriers offer coverage to groups and/or individuals during some period each year. HIPAA requires that insurance carriers guarantee issue of all products to small groups (2-50). Some state laws exceed HIPAA's minimum standards and require carriers to guarantee issue to additional groups and individuals.

Guarantee renewal: Requirements that insurance carriers renew existing coverage to groups and/or individuals. HIPAA requires that insurance issuers guarantee renewal of all products to all groups and individuals.

Health Impact Assessment Program (HIAP): a combination of procedures, methods and tools that systematically judges the potential, and sometimes unintended, effects of a policy, plan, program or project on the health of a population and the distribution of those effects within the population. HIAP identifies appropriate actions to manage those effects.

Health in All Policies (HiAP): A collaborative approach to policymaking that recognizes that health and prevention are impacted by policies that are managed by non-health government and non-government entities, and that many strategies that improve health will also help to meet the policy objectives of other agencies.

Health Care Service Plan (HCSP): The statutory term for HMOs and other managed care health plans in California. The Department of Managed Health Care regulates health care service plans. Approximately 17 million Californians are enrolled in HMOs and other health plans.

Health insurance: Financial protection against the medical care costs arising from disease or accidental bodily injury. Such insurance usually covers all or part of the medical costs of treating the disease or injury. Insurance may be obtained on either an individual or group basis. Although the term is often used by policymakers to refer to comprehensive coverage, insurers and regulators use it also to refer to other forms of coverage such as long term care insurance, supplemental insurance, specified disease policies, and accidental death and dismemberment insurance.

Health Insurance Exchange: A mechanism that creates a single marketplace facilitating the buying and selling of private health insurance. Similar to a stock exchange or a farmers market where buyers and sellers are brought together, the system is intended for individuals, small businesses, and their employ-ees, while maintaining existing employer-based access to health insurance. The ACA calls for the creation of exchanges through which individuals who are U.S. citizens and legal immigrants, and businesses can buy coverage in every state.

Health Insurance Portability and Accountability Act (HIPAA): A 1996 federal law that provides some protection for employed persons and their families against discrimination in health coverage based on past or present health. Generally, the law guarantees the right to renew health coverage, but does not restrict the premiums that insurers may charge. HIPAA does not replace the states' role as primary regulators of insurance. HIPAA also requires the collection of certain health care information by providers and sets rules designed to protect the privacy of that information.

Health Insurer: The statutory term for traditional (indemnity) health insurance companies. This accounts for approximately 15 percent of the health insurance market in California today. The Department of Insurance (DOI) regulates health insurers, including many Preferred Provider Organizations.

Health maintenance organization (HMO): An organized system providing health care in a geographic area, which accepts the responsibility to provide or otherwise assure the delivery of an agreed-upon set of basic and supplemental health maintenance and treatment services to a voluntarily enrolled group of persons; and for which services the entity is reimbursed through a predetermined fixed, periodic prepayment made by, or on behalf of, each person or family unit enrolled. The payment is fixed without regard to the amounts of actual services provided to an individual enrollee. Individual practice associations involving groups or independent physicians can be included under the definition.

Health Plan: An entity that assumes the risk of paying for medical treatments, i.e. uninsured patient, self-insured employer, payer, or HMO.

Healthy Families Program (HFP): The Healthy Families program is California's version of the federal State Children's Health Insurance Program (S-CHIP). Healthy Families provides low-cost health insurance to children of families whose incomes are too high to qualify for Medi-Cal, but are below 250 percent of the FPL. Beginning in 2013, children in the HFP will be transitioned to Medi-Cal.

High risk pool: Subsidized health insurance pools that are organized by some states. High risk pools offer health insurance to individuals who have been denied health insurance because of a medical condition or to individuals whose premiums are rated significantly higher than average due to health status or claims experience. High risk pools can be a form of qualified health coverage for the Health Coverage Tax Credit if they are deemed state-qualified. To be considered qualified, the high risk pool must provide coverage to all individuals guaranteed coverage through HIPAA, not impose any preexisting condition exclusions, meet certain requirements for premium rates and covered benefits, and be officially qualified by the state.

Independent Practice Association (IPA): A physician organization which typically contracts with a HMO to provide services to the HMO's enrollees. The HMO usually makes capitated payments to the IPA, but the IPA may choose to reimburse its physicians

on a fee-for-service basis. Physicians can contract with other HMOs and see other fee-for-service patients.

Indigent care: Health services provided to the poor or those unable to pay. Since many indigent patients are not eligible for federal or state programs, the costs which are covered by Medicaid are generally recorded separately from indigent care costs.

Individual Mandate: A law requiring individuals to obtain health care coverage, and in some cases, forcing individuals to pay a penalty if they choose not to participate. The individual mandate of the ACA goes into effect Jan. 1, 2014. Exemptions will be granted for certain people, including American Indians, those with religious objections and those facing financial hardships.

Individual Market: The market where individuals who do not have public or group (usually employer-based) coverage purchase private health insurance. This market is also referred to as the non-group market.

Intergovernmental Transfer (IGT): Transfer of funds among or between different levels of government, including state-owned or operated health care providers, local governments, and non-state-owned or operated health care providers. The term is most often used in Medicaid, where transfers of governmental funds to the state Medicaid agency are used as the non-federal share to draw down federal matching funds for allowable Medicaid expenditures. States also use IGTs as the non-federal share to draw down federal matching funds for Medicaid Disproportionate Share Hospital payments.

Knox-Keene: Knox-Keene Health Care Service Plan Act of 1975, which provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a violation of the Act a crime.

Lock-In: Refers to the period of time an individual is required to, or agrees to, remain registered with a particular provider or group of providers, or remain enrolled in a particular health care plan.

Long-term care services and supports (LTSS): A set of health care, personal care and social services required by persons who have lost, or never acquired, some degree of functional capacity (e.g., the chronically ill, aged, disabled or intellectually disabled) in an institution or at home, on a long-term basis. The term is often used more narrowly to refer only to long-term institutional care such as that provided in nursing homes, homes for the intellectually disabled, and mental hospitals. Ambulatory services such as home health care, which can also be provided on a long-term basis, are seen as alternatives to long-term institutional care.

Low Income Health Program (LIHP): Provides the option of Section 1115 Waiver funds to counties who wish to establish a program for uninsured individuals ineligible for Medi-Cal. For participating counties, the LIHP pays for half of the cost of covering

adults ages 19-64 with incomes at or below 200% FPL. The other half is paid by counties, and there is no state general fund contribution.

Managed care: Any form of health plan that initiates selective contracting to channel patients to a limited number of providers and that requires utilization review to control unnecessary use of health services.

Managed Care Organization (MCO): A health care organization, such as a HMO or PPO, that contracts to provide medical services to a group of enrollees in exchange for capitated monthly premiums. Payments to physicians and other practitioners in HMOs are often lower than fee-for-service payments. Medicare Advantage includes HMOs, PPOs and regional PPOs.

Managed Risk Medical Insurance Board (MRMIB): An independent state Board charged with reducing the numbers of uninsured in California. Currently, MRMIB administers the Healthy Families Program, the Major Risk Medical Insurance Program (MRMIP), Access for Infants and Mothers Program, and the Pre-Existing Condition Insurance Plan.

Mandate: Used in two senses in health policy discussions. (1) Employer or individual mandate, in which a government body imposes a requirement on some employers to help pay for insurance coverage for their workers (and perhaps their families), and/or on certain individuals to obtain coverage. (2) State mandate, a requirement imposed by states on insurance companies to include, as part of any health insurance policy they sell, coverage for a specific service, such as well baby care, or provider, such as psychologists or optometrists.

Means Testing: Determining eligibility for government benefits based on an individual's lack of means, as measured by income and/or assets. Under current Medicaid eligibility guidelines, means-testing may differ for different eligibility groups. The Medicare Prescription Drug Improvement and Modernization Act of 2003 introduced a form of means-testing in Medicare, which now sets higher premiums for higher-income seniors and provides more generous drug benefits to lower-income beneficiaries.

Medicaid (Title XIX): A federally aided, State-operated and administered program which provides medical benefits for certain indigent or low-income persons in need of health and medical care. The program, authorized by Title XIX of the Social Security Act, is basically for the poor. It does not cover all of the poor, however, but only persons who meet specified eligibility criteria. Subject to broad federal guidelines, states determine the benefits covered, program eligibility, rates of payment for providers, and methods of administering the program.

Medical Loss Ratio (MLR): The ratio of money paid out by an insurer for claims, divided by premiums collected for a particular type of insurance policy. Low loss ratios indicate that a small proportion of premium dollars was paid out for benefits, while a high loss ratio indicates that a high percentage of the premium dollars was paid out for

benefits. The ACA sets minimum medical loss ratios for health plans effective Jan. 1, 2011.

Medi-Cal Expansion: As part of the ACA, states were provided the option to expand their Medicaid program (known as Medi-Cal in California) to cover nearly all non-disabled adults under age 65 with household incomes at or below 133% of FPL as of January, 2014. The current law excludes low-income childless adults from Medicaid eligibility and mandates coverage for the following principal eligibility groups: pregnant women and children under age 6 with family incomes at or below 133% FPL, children ages 6 through 18 with family incomes at or below 100% FPL, parents and caretaker relatives who meet the financial eligibility requirements for the Temporary Assistance for Needy Families (TANF) program (cash assistance) program, and elderly and disabled individuals who qualify for Supplemental Security Income benefits based on low income and resources.

Medi-Cal Managed Care (MCMC): Under the traditional Medi-Cal fee-for-service arrangement, health care providers are reimbursed for every service they provide and do not assume financial risk. Under Medi-Cal managed care, the Department of Health Care Services reimburses health care plans on a capitated basis (a per-person, per-month payment) regardless of the number of services, if any, a Medi-Cal beneficiary receives. The contracting health plans, in return, assume financial risk, in that it may cost them more or less money than the capitated amount paid to them to deliver the necessary care.

Medically indigent: People who cannot afford needed health care because of insufficient income and/or lack of adequate health insurance.

Medically necessary, **medical necessity, medical necessary services**: Services or supplies which meet the following tests: they are appropriate and necessary for the symptoms, diagnosis, or treatment of the medical condition; they are provided for the diagnosis or direct care and treatment of the medical condition; they meet the standards of good medical practice within the medical community in the service area; they are not primarily for the convenience of the plan member or a plan provider; and they are the most appropriate level or supply of service which can safely be provided.

Medicare: Federal health insurance program for virtually all persons age 65 and older, and permanently disabled persons under age 65, who qualify by receiving Social Security Disability Insurance.

Mental Health Parity (MHP): A set of state and federal laws requiring health plans to provide equal benefits for mental health care under the same terms and conditions applied to other medical conditions.

Modified Adjusted Gross Income (MAGI): A methodology for calculating income as defined by the Internal Revenue Code of 1986. Starting January 1, 2014, eligibility for Medicaid for most individuals, as well as for CHIP, will be determined using methodologies that are based on MAGI, resulting in simplified eligibility determinations.

Eligibility for advance payments of premium tax credits for the purchase of private insurance coverage through Affordable Insurance Exchanges will also use MAGI .

Multiple Employer Welfare Arrangement (MEWA): A MEWA is a type of group purchasing arrangement for small businesses, self-employed individuals, and people with seasonal jobs, such as agricultural workers. The law allows only MEWAs that filed an application by November 1995 to be eligible for licensing, which means no new MEWAs can be licensed in California. MEWAs provide an alternative to traditional coverage by allowing employers to band together in order to purchase health insurance or self-insure health benefits.

Office of Statewide Health Planning and Development (OSHPD): A California state-level office created in 1978 to provide an enhanced understanding of the structure and function of its healthcare delivery systems. OSHPD is the leader in collecting data and disseminating information about California's healthcare infrastructure, promoting an equitably distributed healthcare workforce, and publishing valuable information about healthcare outcomes. OSHPD also monitors the construction, renovation, and seismic safety of hospitals and skilled nursing facilities and provides loan insurance to facilitate the capital needs of California's not-for-profit healthcare facilities.

Open enrollment: A method for assuring that insurance plans, especially prepaid plans, do not exclusively select good risks. Under an open enrollment requirement, a plan must accept all who apply during a specific period each year.

Optional Benefits: A series of benefits states may elect to cover as part of their Medicaid program, as opposed to those which must be covered by any state participating in the federal Medicaid program. These include, but are not limited to prescription drugs, physical therapy, podiatry, dental services, optometry, hospice, and home and community based services.

Out-of-Pocket (OOP): Health care costs, such as deductibles, co-payments, and co-insurance that are not covered by insurance. Out-of-pocket costs do not include premium costs.

Patient-Centered Medical Home (PCMH): An approach to providing comprehensive primary care for individuals through creating a setting that facilitates partnerships between individual patients and their personal health care provider. This approach to care is aided by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

Pay for Performance: A method of paying health care providers differing amounts based on their performance on measures of quality and efficiency. Payment incentives can be in the form of bonuses or financial penalties.

Payment Reform: A broad umbrella term that encompasses efforts to change how health care is paid for in order to better align fiscal incentives and patient outcomes.

Per Capita Cap: A policy proposal typically discussed in the context of federal Medicaid funding, under which the federal government would no longer cover a fixed share of each state's overall Medicaid costs but instead would limit each state to a fixed dollar amount per beneficiary.

Pre-Existing Condition: A physical or mental condition of an individual which is known to the individual before an insurance policy is issued. Insurers may choose not to cover treatment for such a condition, at least for a period, may raise rates because of it, or may deny coverage altogether.

Preferred Provider Organization (PPO): A managed care organization which contracts with selected providers at negotiated or discounted rates and which generally pays providers on a fee-for-service basis. Typically, PPO coverage offers wider choice of providers than most HMOs. PPO premiums and cost sharing, including deductibles and copayments are generally higher (especially for out of network providers) than HMOs as a result of that freedom of choice.

Preventive medicine: Care which has the aim of preventing disease or its consequences. It includes health care programs aimed at warding off illnesses (e.g., immunizations), early detection of disease (e.g., Pap smears), and inhibiting further deterioration of the body (e.g. exercise or prophylactic surgery).

Primary Care/Primary Care Provider (PCP): Care at "first contact" with the health care system, including an array of non-specialist services provided by physicians, nurse practitioners, or physician's assistants - more simply, the care that most people receive for most of their problems that bother them most of the time.

Programs of All-Inclusive Care for the Elderly (PACE): The PACE model of care provides a comprehensive medical/social service delivery system using an interdisciplinary team approach in a PACE Center that provides and coordinates all needed preventive, primary, acute and long-term care services. Services are provided to older adults who would otherwise reside in nursing facilities. The PACE model affords eligible individuals to remain independent and in their homes for as long as possible.

Prospective payment: Any method of paying hospitals or other health programs in which amounts or rates of payment are established in advance for a defined period (usually a year). Institutions are paid these amounts regardless of the costs they actually incur.

Provider: A general term to describe health care providers such as physicians, nurses, psychologists, chiropractors, etc.

Qualified Health Plan: Under the ACA, starting in 2014, an insurance plan that is certified by an Exchange, 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 Exchange in which it is sold. (See also essential health benefits)

Rating: The process of evaluating, or underwriting, a group or individual to determine a health insurance premium rate relative to the financial risk of needing health care the person or group presents. Key components of the rating formula include age, sex, location and plan design.

Rating Bands: Amounts by which insurance rates for a specific class of insured individuals may vary. All states have laws regulating insurer rating practices, and many states periodically update these laws with small group market reform proposals to restrict or loosen allowable variations.

Reimbursement: The process by which health care providers receive payment for their services. Because of the nature of the health care environment, providers are often reimbursed by third parties who insure and represent patients.

Reinsurance: The resale of insurance products to a secondary market thereby spreading the costs associated with underwriting.

Risk: The chance or possibility of loss. For example, physicians may be held at risk if hospitalization rates exceed agreed upon thresholds. Potential financial liability, particularly with respect to who or what is legally responsible for that liability. With insurance, the patient and insurance company share risk but the company's risk is limited by the policy's dollar limitations. In HMOs, the patient is at risk only for copayments and the cost of non-covered services. The HMO, however, with its income fixed, is at risk for whatever volume of care is entailed, however costly it turns out to be. Providers may also bear risk if they are paid a fixed amount (capitation) by the HMO. The sharing of risk is often employed as a utilization control mechanism within the HMO setting. Risk is also defined in insurance terms as the possibility of loss associated with a given population.

Risk Adjustment: The way that payments to health plans are changed to take into account a person's health status. A system of adjusting rates paid to managed care providers to account for the differences in beneficiary demographics, such as age, gender, race, ethnicity, medical condition, geographic location, at-risk population (i.e. homeless), etc. A process by which premium dollars are shifted from a plan with relatively healthy enrollees to another with sicker members. It is intended to minimize any financial incentives health plans may have to select healthier than average enrollees. In this process, health plans that attract higher risk providers and members would be compensated for any differences in the proportion of their members that require high levels of care compared to other plans. In the private insurance market, risk adjustment is a corrective tool designed to re-orient the incentives for health plans and enrollees,

reducing the negative consequences of enrolling high-risk users by compensating plans according to the health risk of plans' enrollees.

Safety net: The network of providers and institutions which provide low cost or free medical care to medically needy, low income, or uninsured populations. The health care safety net can include (but is not limited to) individual practitioners, public and private hospitals, academic medical centers, and smaller clinics or ambulatory care facilities.

Scope of Practice: Delineates what a profession does and places limits upon the functions persons within a profession may lawfully perform. It determines the procedures, actions, and processes that are permitted for the licensed individual. The scope of practice is limited to that which the law allows for specific education and experience, and specific demonstrated competency. Each state has laws, licensing bodies, and regulations that describe requirements for education and training, and define scope of practice.

Section 1115 Medicaid Waiver: The Social Security Act grants the Secretary of the federal Health and Human Services Agency broad authority to waive certain laws relating to Medicaid for the purpose of conducting pilot, experimental or demonstration projects which are "likely to promote the objectives" of the program. Section 1115 demonstration waivers allow states to change provisions of their Medicaid programs, including: eligibility requirements, the scope of services available, the freedom to choose a provider, a provider's choice to participate in a plan, the method of reimbursing providers, and the statewide application of the program. Health plans and capitated providers can seek waivers through their state intermediaries.

Seniors and Persons with Disabilities (SPDs): Seniors who are 65 years or older and persons with disabilities who have physical or mental impairments that meet the requirements for Social Security or Supplemental Security Income benefits in Medi-Cal are considered SPDs. About 1.2 million SPDs also enrolled in Medicare are referred to as "dual eligibles." SPDs without Medicare coverage are known as Medi-Cal-only SPDs.

Single Payer Health Care: A proposed reorganization of the health care system, either at the national or state level, which would designate one entity (usually the government) to function as the central purchaser of health care services. Canadian provinces operate health insurance coverage for residents under this system.

Skilled Nursing Facility (SNF): An institution that offers skilled services similar to those given in a hospital, such as intravenous injections and physical therapy given by professional staff, to aid rehabilitation following hospitalization of patients who have been discharged. SNFs differ from nursing homes or nursing facilities, which are intended primarily to support elderly and disabled individuals in the tasks of daily living (custodial care). Medicare does not cover custodial care in nursing homes; however, Medicare does cover skilled nursing care, rehabilitation and associated custodial care in SNFs. Medicaid covers care in all Medicaid-certified nursing facilities.

Small Group Market: The insurance market for products sold to groups that are smaller than a specified size, typically employer groups. The size of groups included usually depends on state insurance laws and thus varies from state to state, with 50 employees the most common size, and typically ranging from 2 to 99 members.

State Children's Health Insurance Program (Title XXI): A program enacted by Congress in 1997 that provides federal matching funds for states to spend on health coverage for uninsured kids. The program is designed to reach uninsured children whose families earn too much money to qualify for Medicaid but are too poor to afford private coverage. Congress initially authorized CHIP for a 10-year period that expired at the end of September 2007. CHIP was reauthorized and enlarged early in 2009. The bill, signed on February 4, 2009, increases CHIP funding by about $32 billion through 2013 to cover an additional 4 million children. The ACA requires states to maintain existing income eligibility levels for children in CHIP (and Medicaid) until 2019 and extends funding for CHIP through 2015. Beginning in 2015, states will receive a 23 percentage point increase in the percentage of CHIP funding paid by the federal government, up to a cap of 100 percent.

State Plan Amendment (SPA): A State Plan is a contract between a state and the federal government describing how that state administers its Medicaid program. It gives an assurance that a state abides by federal rules and may claim federal matching funds for its Medicaid program activities. The state plan sets out groups of individuals to be covered, services to be provided, methodologies for providers to be reimbursed and the administrative requirements that states must meet to participate. States frequently send a SPA to CMS for review and approval. There are many reasons why a state might want to amend their state plan. For example, the state may wish to implement changes required by Federal or state law, Federal or state regulations, or court orders.

Telehealth, Telemedicine, Telehealth, E-Health, Health Information Technology (HIT): The use of telecommunications (i.e., wire, internet, radio, optical or electromagnetic channels transmitting text, x-ray, images, records, voice, data or video) to facilitate medical diagnosis, patient care, patient education and/or medical learning. Professional services given to a patient through an interactive telecommunications system by a practitioner at a distant site. Many rural areas are finding uses for telehealth and telemedicine in providing oncology, home health, radiology and psychiatry services, among others. Telehealth services have been used between providers, to provide supervision of one another and to provide evaluation of patients. Medicaid and Medicare provide some limited reimbursement for certain services provided to patients via telecommunication. Telehealth is likely to serve greater purposes and populations in the future.

Tertiary Care: Health care services provided by highly specialized providers such as neurosurgeons, thoracic surgeons, and intensive care units. These services often require highly sophisticated technologies and facilities.

Triple Aim: A framework developed by the Institute for Healthcare Improvement (IHI) that describes an approach to optimizing health system performance. It is grounded in the belief that new health care system designs must be developed to simultaneously pursue three dimensions which comprise the "Triple Aim":

1) Improving the patient experience of care (including quality and satisfaction);
2) Improving the health of populations; and
3) Reducing the per capita cost of health care.

Uncompensated Care: Care rendered by hospitals or other providers without payment from the patient or a government-sponsored or private insurance program. It includes both charity care, which is provided without the expectation of payment, and bad debt, for which the provider has made an unsuccessful effort to collect payment due from the patient.

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

Uninsurables: High-risk uninsured persons whose medical condition(s) precludes them from buying health insurance.

Uninsured: People who lack public or private health insurance.

Underwriting: In insurance, the process of selecting, classifying, analyzing and assuming risk according to insurability. The insurance function bearing the risk of adverse price fluctuations during a particular period. Analysis of a group that is done to determine rates or to determine whether the group should be offered coverage at all.

Utilization review (UR): Refers to the overall process a health plan uses to control costs. UR involves "prior authorization" (decisions made before costs are incurred) and can also include the analysis health plans undertake to determine whether too much care is being provided by certain doctors (health plans review provider "economic profiles" to determine which providers have provided the most costly care).