Georgia Health Initiative

Glossary

(A companion to
Insights on Medicaid in Georgia)

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Glossary

Aged, Blind, and Disabled (ABD) Medicaid	A Georgia Medicaid program for individuals who are 65 years or older, legally blind, or disabled, provided they meet financial eligibility criteria. Coverage is provided for health services including doctors' visits, hospital care, and needed medical equipment.
Affordable Care Act (ACA)	A federal statute enacted in 2010 and designed to increase the quality, affordability, and availability of health insurance. It aims to reduce the number of uninsured Americans, expand Medicaid, create health insurance exchanges, and establish regulations to prevent insurance companies from denying coverage based on pre-existing conditions.
Alternative Benefit Plans (ABPs)	State-tailored Medicaid programs designed to meet the needs of specific population groups or geographic areas, offering flexibility in how services are delivered. Note: Georgia does not currently have ABPs.
American Rescue Plan Act (ARPA)	Enacted in 2021, it provided economic relief to Americans, including unemployment benefits and health insurance subsidies. It aimed to support recovery from the financial impacts of the COVID-19 pandemic.
Beneficiary	An individual who is eligible and enrolled in a health insurance plan and receives benefits through the policy. Beneficiaries can fall under private health insurance, Medicare, and or Medicaid. Under Medicaid, an individual must be enrolled to be a beneficiary.
Centers for Medicare and Medicaid Services (CMS)	A federal agency within the U.S. Department of Health and Human Services responsible for overseeing Medicare, Medicaid, CHIP, and the Health Insurance Marketplace. It ensures these programs provide access to affordable healthcare.
Certified Community Behavioral Health Center (CCBHC)	Provides accessible, coordinated, and comprehensive behavioral healthcare. These centers ensure individuals receive the care they need for mental health and substance use issues through coordinated care.
Children's Health Insurance Program (CHIP)	An insurance program that provides low-cost health coverage to children in families who are uninsured, low income, or that earn too much money to qualify for Medicaid but not enough to buy private insurance. Children who are eligible for Medicaid are not eligible for CHIP. States have the option to administer CHIP through their medical programs and or a separate program. Georgia's CHIP program is called PeachCare for Kids®.
Comprehensive Support Waiver Program (COMP)	Under the Medicaid waiver program, COMP provides funding to individuals with developmental disabilities to assist families in covering the cost of necessary services. It supports those who require help with daily activities and other specialized care.

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Continuous Eligibility	A provision that allows states to ensure individuals can retain health insurance coverage under federal Medicaid law, even if their circumstances change (e.g., income or family status), which might otherwise make them ineligible. Children who are enrolled in Medicaid can remain eligible for a continuous period of 12 months.
Copayment or Copay	A fixed dollar amount of money that a recipient of Medicaid must pay out of pocket for a covered healthcare service, typically at the time of the visit. Copay or copayment are common in health insurance plans and can vary depending on the type of service (e.g., doctor's visits, prescriptions, emergency care) and the specifics of the policy.
Cost Sharing	Refers to the portion of healthcare expenses that an insured person must pay, such as deductibles, copayments, and coinsurance. It is designed to share the financial responsibility between the insurer and the individual.
Demonstrations	Under the Social Security Act, the Secretary of Health and Human Services has the authority to approve demonstration projects aimed at advancing the goals of Medicaid programs. This authority allows the Secretary to waive certain provisions of the Medicaid law, giving states the flexibility to design and enhance their programs.
Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services	Required by federal law in basic benefit packages, these services provide comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. Periodic screening services include screenings that identify vison, hearing, and dental problems, as well as physical and mental conditions. Diagnostic and treatment services include correcting conditions identified during early or periodic screenings.
Federal Medical Assistance Percentage (FMAP)	The percentage of Medicaid costs that the federal government pays to each state, varying by state and based on economic factors. Its overall purpose is to help states cover the cost of Medicaid services.
Federal Poverty Level (FPL)	A measure set by the federal government to determine income-based eligibility for various federal assistance programs, including Medicaid, the Supplemental Nutrition Assistance Program (SNAP), and health insurance subsidies. It is the working definition for poverty and is adjusted annually for inflation. It is published by the department of Health and Human Services as poverty guidelines.
Fee-For-Service (FFS)	A delivery model for Medicaid services where members may choose from any provider within an approved network who contract directly with the state agency. When a member receives services that are covered by Medicaid, the provider bills Medicaid directly and gets paid an established rate associated with the delivery of that service.

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Georgia Pathways to Coverage ("Pathways") Program	Launched on July 1, 2023, Pathways offers Medicaid coverage to eligible Georgians ages 19-64 who have a household income up to 100% of the FPL and complete qualifying activities (such as employment, on-the-job-training, higher education, etc.) for at least 80 hours per month.
Health Insurance	A contract arrangement between the insurer and the individual, where an insurer is required to pay some or all the individual's health care expenses through a premium.
Home and Community-Based Services (HCBS)	Provide opportunities through the Department of Health and Human Services (HHS) for Medicaid beneficiaries to receive services in their own homes or communities rather than institutions.
Managed Care Model	Under the managed care system, this model contracts states with Managed Care Organizations to administer healthcare services. These organizations aim to help patients balance quality care with cost control. There are three health delivery systems in the managed care model: health maintenance organizations (HMO), preferred provider organizations (PPO), and point of service (POS) plans.
Managed Care Organizations (MCOs)	MCOs are health plans or companies contracted by the state Medicaid agency to deliver coverage while managing costs through coordinated care approaches. These organizations provide comprehensive benefit packages, and payment is risk-based to optimize patient outcomes and control healthcare spending.
Medicaid	A joint federal and state program that provides free or low-cost health coverage to individuals and families with low income and limited resources, offering a broad range of services such as hospital care, doctor visits, prescription drugs, and long-term care. Primarily serving vulnerable populations, including children, pregnant women, the elderly, and people with disabilities.
Medicaid Unwinding/ Redetermination	The process by which states begin reviewing individuals from Medicaid after the end of the continuous coverage requirement. The Centers for Medicare & Medicaid Services (CMS) gives states up to 12 months for an unwinding period in which renewals are initiated for all enrollees.
Medicare	A federal health insurance program primarily for individuals aged 65 and older with set standards for costs and coverage. Medicare also covers 65 years or younger individuals with disabilities or specific conditions.
New Options Waiver (NOW)	A Medicaid waiver program that offers home and community-based services for people with intellectual disabilities or developmental disabilities. It provides services and support to allow them to remain living in their own or caretaker home, enabling independent living and participation in society and the community.

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Out-of-Pocket Maximum	The highest amount an individual will have to pay for covered healthcare services within a policy year, after which the insurer covers 100% of additional costs. This cap includes deductibles, copayments, and coinsurance and is designed to protect policyholders from extreme healthcare costs in a given year.
Payer	An organization or insurer responsible for paying for healthcare services. They may include government programs like Medicaid or private health insurance companies.
Premiums	The regular payments made to an insurance company by the policyholder in exchange for health coverage or other forms of insurance. Premiums are paid on a monthly, quarterly, or annual basis, and the amount can vary depending on factors like the type of insurance, the level of coverage, and the insured person's health status or age.
Private Health Insurance	A type of health coverage purchased from private insurers, either through an employer or independently, that helps cover health care costs, including doctor's visits, hospital care, and medications.
Social Determinants of Health (SDOH)	The conditions in which people are born, grow, live, work, and age, which may affect outcomes. These determinants include socioeconomic status, neighborhood and built environment, access to education, employment opportunities, and the availability of healthcare. This may also be referred to as Health-Related Social Needs (HRSN).
State-based Exchange (SBE)	A state-run marketplace where individuals and small businesses can purchase health insurance plans. It provides infrastructure, support, and information specific to the state's health insurance options. States can establish SBEs through declaration letters to the Department of Health and Human Services.
Tricare	An insurance program that provides coverage for active duty, retired uniformed service members, and their families. It offers medical, dental, and prescription coverage as part of military service benefits.
Waivers	Exceptions or permissions granted by the federal government under the discretion of the Secretary of Health and Human Services (HHS) to allow states Medicaid program design flexibility. All states operate at least one or more Medicaid waivers and can use waivers to offer specialized benefit packages, make policy changes to respond to public health emergencies, or to extend coverage to certain groups.

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