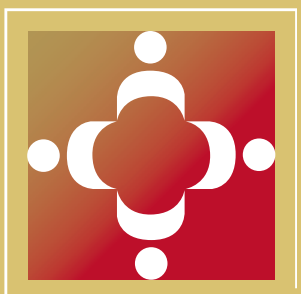
Pocket Guide to Health Care Terms



South Carolina Institute of Medicine & Public Health

The Pocket Guide to Health Care Terms is produced by the South Carolina Institute of Medicine & Public Health as a resource in understanding the numerous terms and acronyms that are part of ongoing health care discussions.

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Access – A patient's ability to obtain appropriate health care services. The ease of access is determined by components such as availability of insurance, the location of health care facilities, transportation, hours of operation, affordability and cost of care.

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

Acute Care – Medical services provided to treat an illness or injury, usually over a short period of time.

Affordable Care Act (ACA) – See Patient Protection and Affordable Care Act

Aged, Blind, Disabled (ABD) – A Medicaid designation that assists with medical expenses for indigent South Carolinians who are aged 65 years or older, blind or disabled (as classified by the Social Security Administration for an adult or

child).

Aid to Families with Dependent Children (AFDC) – A federally supported, state-administered program established by the Social Security Act of 1935 that provides financial support for children under the age of 18 (and their caretakers) who have been deprived of parental support or care because of the parent's death, continued absence from the home, unemployment, or physical or mental illness.

BabyNet – South Carolina's interagency system (led by DHEC) of early intervention services for families who have infants and toddlers (up to 3 years of age).

Behavioral Health, Behavioral Health Care – A state of mental/emotional being and/or choices and actions that affect wellness. Behavioral health problems include substance abuse or misuse, alcohol and drug addiction, serious psychological distress, suicide, and mental and substance use disorders. The term is also used to describe the service systems related to prevention, treatment and recovery.

Best Chance Network – A program that provides free screening for breast and cervical cancer to eligible South Carolina residents. Women diagnosed with breast or cervical cancer may qualify for free health coverage through Medicaid for treatment of their condition.

Birth Outcomes Initiative (BOI) – A collaborative effort led by the South Carolina Department of Health and Human Services (SC DHHS), South Carolina Hospital Association, March of Dimes, Blue Cross Blue Shield of South Carolina and over 100 stakeholders to improve the health outcomes for newborns not only in the Medicaid program but throughout the state's population.

Capitation – A method of paying for health care services under which providers receive a set payment for each person or "covered life" instead of receiving payment based on the number of services provided or the costs of the services rendered as in a fee-for-service model.

Care Coordination & Case Management – A system that supports information-sharing across providers, patients,

types and levels of service, sites and time frames. The goal of coordination is to ensure that patients' needs and preferences are achieved and that care is efficient and of high quality. Care coordination is most needed by persons who have multiple needs that cannot be met by a single clinician or by a single clinical organization and which are ongoing, with their mix and intensity subject to change over time.

Carve Out – Refers to a service not covered in a health insurance contract or plan. The service is usually reimbursed according to a different arrangement or rate formula than those services specified in an insurance plan.

Centers for Disease Control and Prevention (CDC) – A federal agency (based in Atlanta) within the US Department of Health and Human Services that serves as the central point for consolidation of disease control data, health promotion and public health programs.

Centers for Medicare and Medicaid Services (CMS) – A federal agency within the US Department of Health and Human Services that directs Medicare, Medicaid and the

State Children's Health Insurance Program.

Certificate of Need (CON) – A certificate issued by a governmental body to an individual or organization proposing to construct or modify a health facility, or to offer a new or different health service. The CON program is designed to promote cost containment, prevent unnecessary duplication of health care facilities and services, guide the establishment of health facilities and services which best serve public needs and ensure that high quality health services are provided.

Children's Health Insurance Program (CHIP) – Provides federal matching funds for states to spend on health coverage for uninsured children. 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.

Chronic Diseases – A long-lasting illness or sickness that can be controlled but not cured and is not passed from person to person. Examples include heart disease, stroke and diabetes.

Co-Pay, Co-Payment – 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).

Community Health Center (CHC) – An ambulatory health care program usually serving a geographic area which has scarce or nonexistent health services or a population with special health needs. CHCs attempt to coordinate federal, state and local resources into a single organization capable of delivering both health and related social services to a defined population. While such a center may not directly provide all types of health care, it usually takes responsibility to arrange all medical services needed by its patient population.

Community Health Worker (CHW) – Trained health workers who come from the communities they serve which aids in building trust and vital relationships with the residents of the community. This peer-to-peer relationship enables the CHWs to be effective links between their own communities and systems of care.

Continuity of Care – The process by which the patient and the physician are cooperatively involved in ongoing health care management toward the goal of high quality, cost-effective medical care.

Consolidated Omnibus Budget Reconciliation Act (COBRA) – A federal law that requires employers to offer continued health insurance coverage to employees who have had their health insurance coverage terminated. Employees often must pay for the full cost of the coverage.

Cost-Shifting – Charging one group of patients more in order to make up for lack of payment or underpayment by others. Most commonly, charging privately insured patients more in order to make up for losses due to uncompensated or indigent care or lower payments from other payers.

Coverage Gap – In states that did not chose to expand Medicaid under the ACA, individuals whose income is above current Medicaid eligibility criteria but below the federal poverty level do not qualify for assistance in the Marketplace nor for Medicaid and are said to be in

the coverage gap.

Data Warehouse – A specific database (or set of databases) containing information from many sources that are linked by a common subject (e.g., a health plan member).

Deductible – A feature of health plans in which consumers are responsible for health care costs up to a specified dollar amount. After the deductible has been paid, the health insurance plan begins to pay for health care services.

Disease Management – An effort to improve patient outcomes and lower costs by organizing managed care initiatives around patients with a particular disease or condition.

Disenrollment – The process or end result of a termination of insurance coverage.

Disproportionate Share Hospital Program (DSH) – A federal program that works to increase health care access for the poor. Hospitals that treat a "disproportionate" number of Medicaid and other indigent

patients qualify for higher Medicaid payments based on the hospital's estimated uncompensated cost of services to the uninsured.

Donut Hole – A common term for the gap in Medicare Part D prescription drug coverage that occurs when a Medicare beneficiary surpasses the prescription drug coverage limit and is financially responsible for the entire cost of prescription drugs until the expense reaches the catastrophic coverage threshold. The donut hole is gradually closing due to provisions in the ACA and will be eliminated in 2020.

Dual Eligible – When someone is eligible for two health insurance plans, referring most often to Medicare and Medicaid as dual coverage.

Electronic Health Record (EHR)/Electronic Medical Record (EMR) – A computerized system providing real-time patient data access and evaluation in a medical care setting.

Emergency Medical Services (EMS) –

A system of health care professionals, facilities and equipment providing emergency care.

Emergency Medical Treatment and Labor Act (EMTALA) – A federal act passed in 1986 pertaining to emergency medical situations. EMTALA requires hospitals to provide emergency treatment to individuals, regardless of insurance status and ability to pay.

Employee Assistance Program (EAP) – Workplace programs designed to help identify, educate, rehabilitate and return the physically or emotionally impaired individual to their job. These programs may include helping employees gain access to health, legal and social services or to control specific conditions (e.g., chemical dependency, gambling, hypertension, stress).

Employee Retirement Income Security Act (ERISA) – A federal law that exempts self-insured health plans from state laws governing health insurance, including contribution to risk pools, prohibitions against disease discrimination and other state health reforms.

Employer Mandate – The requirement that all employers above a minimum size provide a standard level of health insurance benefits to their employees.

Evidence-Based Medicine (EBM) – An approach to medical therapy that employs the current, best clinical data in making decisions about the care of individual patients.

Family Medical Leave Act (FMLA) – A federal law passed in 1993 requiring that private employers with 50 or more employees (and public employers of any size) allow employees to take leave to care for ill family members and to return to substantially similar employment conditions following the leave.

Federal Medical Assistance Percentage (FMAP) – The statutory term for the federal Medicaid matching rate (i.e., the share of the costs of Medicaid services or administration that the federal government bears). In the case of covered services, FMAP varies from 50 to 76 percent depending upon a state's per capita income; on average, across all states, the federal government pays 57 percent of the costs of Medicaid. SC's FMAP has historically

been around 70 percent.

Federal Poverty Level (FPL) – The amount of income determined by the US Department of Health and Human Services to provide a bare minimum for food, clothing, transportation, shelter and other necessities. The level varies according to family size. In 2014, the FPL for an individual is $11,670, and for a family of four is $23,850.

Federally Qualified Health Center (FQHC) – A health center in a medically underserved area that is eligible to receive cost-based Medicare and Medicaid reimbursement and allows for the direct reimbursement of nurse practitioners, physician assistants and certified nurse midwives.

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.

Formulary – A list of prescription drugs covered by a prescription drug plan or another insurance plan offering prescription drug

benefits. Also called a preferred drug list.

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

Health in All Policies – An approach to improving the health of all people by incorporating health considerations into decision-making across sectors and policy areas.

Health Information Technology (HIT) – Systems and technologies that enable health care organizations and providers to gather, store and share information electronically.

Health Insurance Exchange – A mechanism that creates a single marketplace for the buying and selling of private health insurance.

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 Maintenance Organization (HMO) – A managed care plan that integrates financing and delivery of a comprehensive set of health care services to an enrolled population. HMOs may contract with, directly employ or own participating health care providers. Enrollees are usually required to choose from among these providers and in return have limited co-payments. Providers may be paid through capitation, salary, per diem or pre-negotiated fee-for-service rates.

Health Professional Shortage Area (HPSA) – A geographic area, population

group or medical facility that the US Department of Health and Human Services determines to be served by too few health professionals of particular specialties.

Health Resources and Services Administration (HRSA) – A federal agency within the US Department of Health and Human Services that is the primary agency for improving access to health care by strengthening the health care workforce, building healthy communities and achieving health equity.

Health Savings Account (HSA) – A savings account used in conjunction with a high-deductible health insurance policy that allows users to save money tax-free against medical expenses.

Healthy Connections – The name of South Carolina's Medicaid program.

Healthy Connections Prime – A program for seniors 65 and older with Medicare and Medicaid. The program is a demonstration project through Healthy Connections Medicaid and the federal government (Medicare).

Healthy Outcomes Plan (HOP) – Plan that supports participating hospitals advancing service delivery models to coordinate care for chronically ill, uninsured, high utilizers of emergency department (ED) services.

High Deductible Health Plan (HDHP) – An inexpensive health insurance plan that generally does not pay for the first several thousand dollars of health expenses (i.e., the deductible) but will generally cover medical care after the amount is met.

High-Risk Pool – A subsidized health insurance pool organized federally or by individual states as a source of coverage for individuals who have been denied health insurance because of a medical condition or whose premiums are significantly higher than the average due to health status or claims experience.

Home and Community-Based Services (HCBS) – Any care or services provided in a person's place of residence or in a non-institutional setting located in the immediate community. HCBS may include home health care, adult day care/day treatment, medical services or other supportive interventions.

Home Health Agency – An organization that provides medical, therapeutic or other health services in patients' homes.

Hospice or Hospice Care – Facility or program providing care for the terminally ill. Hospice care involves a team-oriented approach that addresses the medical, physical, social, emotional and spiritual needs of the patient. Hospice also provides support to the patient's family or caregiver.

Indigent Medical Care – Care given by health care providers to patients who are unable to pay for treatment or services.

Integrated Care – The systematic coordination of general and behavioral health care to improve health outcomes.

Level of Care – Amount of assistance required by individuals which may determine their eligibility for programs and services.

Long-Term Care (LTC)/Long-Term Services and Supports (LTSS) – Ongoing health and social services provided for indi-

viduals who need assistance on a continuing basis because of physical, cognitive or mental disability or condition. Services can be provided in an institution, the home or the community, and include formal services provided by professionals or agencies as well as informal services provided by family or friends.

Managed Care – Method of organizing and financing health care services which emphasizes cost-effectiveness and coordination of care. Managed care organizations receive a fixed amount of money per client/member per month, no matter how much care a member needs during that month.

Managed Care Organization (MCO) – An organization that provides programs designed to control access to inpatient and ambulatory health services, to ensure the medical necessity of the proposed service and the delivery of the service at the most efficient and cost effective level of care consistent with high quality. Accountable Care Organizations (ACO), Health Maintenance Organizations (HMO) and Preferred Provider Organizations (PPO) are examples of types of MCOs.

Maternal and Child Health (MCH) – Focuses on the improvement of public health delivery systems for women, children and their families through advocacy, education and research.

Medicaid – A health insurance program, funded jointly by federal and state goverments and managed by the states, that provides medical coverage to qualified low-income individuals in need of health and medical care. The program is subject to broad federal guidelines, with states determining the benefits covered and methods of administration.

Medical Loss Ratio (MLR) – The fraction of revenue from an insurance plan's premiums that pays for medical services.

Medical Savings Account (MSA) – A health insurance option consisting of a high-deductible insurance policy and a tax-advantaged savings account. Individuals would pay for their own health care up to the annual deductible by withdrawing from the savings account or paying out of pocket. The insurance policy would pay for most or all

costs of covered services once the deductible is met.

Medicare – A federal health insurance program for older adults and people with disabilities regardless of financial status. It consists of two separate but coordinated programs: hospital insurance (Part A) and supplementary medical insurance (Part B). It also includes a separate drug coverage program administered by the private sector (Part D).

Morbidity – The extent of illness, injury or disability in a defined population. It is usually expressed in general or specific rates of incidence (new cases) or prevalence (total cases).

National Institutes of Health (NIH) – A part of the US Department of Health and Human Services, NIH is the nation's medical research agency.

Partners for Healthy Children Program – The South Carolina Medicaid program for low income children under the age of 19.

Patient Centered Medical Home (PCMH) – A health care delivery model whereby patient treatment is coordinated through their primary care physician to ensure they receive the necessary care when and where they need it, in a manner they can understand. The core functions of primary health care include comprehensive, patient-centered, coordinated care with accessible services and ongoing quality and safety improvements.

Patient Protection and Affordable Care Act (PPACA or ACA) – A comprehensive federal law passed in 2010 that includes numerous health-related provisions and health insurance reforms.

Patient Self-Determination Act (PSDA) – A federal law passed in 1990 that requires health care facilities to determine if new patients have a living will and/or durable power of attorney for health care and take patients' wishes into consideration in developing their treatment plans.

Per Member Per Month (PMPM) – A unit of measure representing the dollar amount

paid by insurance or Medicaid to a provider (hospital or health care worker) each month for each person for whom the provider is responsible for providing services.

Pharmaceutical Assistance Program – A program to provide pharmaceutical coverage to those who cannot afford or have difficulty obtaining prescription drugs.

Pharmacy Benefit Manager (PBM) – A company under contract with managed care organizations, self-insured companies and government programs for pharmacy network management, drug utilization review, outcomes management and disease management.

Population Health – The health outcomes of a group of individuals, including the distribution of such outcomes within the group, that are influenced by multiple determinants of health, including medical care, public health, genetics, behaviors, social and environmental factors.

Portability – A concept describing that an individual changing jobs would be guaran-

teed health coverage with the new employer without a waiting period or having to meet additional deductible requirements.

Pre-Existing Condition – A physical or mental condition of an individual which is known to the individual before an insurance policy is issued.

Preferred Drug List (PDL) – A list of prescription drugs which are covered by a health plan or other payer (e.g., Medicaid). Also called a formulary.

Preferred Provider Organization (PPO) – A health care delivery system that contracts with hospitals and physicians to provide services at discounted fees to members. Individuals in a PPO may seek care from non-participating providers of medical care but generally are financially penalized for doing so by the loss of the discount and/or subjection to co-payments and deductibles.

Prescription Drug Plan (PDP) – Managed by commercial and private entities, PDPs are a type of managed care. Individuals can use

plan member cards at pharmacies to receive discounts on their prescriptions, provided that the drugs are on the approved/covered lists and members are within the limits of their coverage plan. If an individual has limited income and resources, he or she may get extra help to cover prescription drugs for little or no cost.

Prevention – Actions taken to reduce susceptibility or exposure to health problems (primary prevention), detect and treat disease in early stages (secondary prevention) or alleviate the effects of disease and injury (tertiary prevention).

Preventative/Preventive Care – A pattern of nursing and medical care that focuses on disease prevention and health maintenance. It includes discovery and identification of people at risk of development of specific problems, early diagnosis of disease, and counseling and other necessary interventions to avert a health problem. Screening tests, health education and immunization programs are common examples of preventive care.

Primary Care – A basic level of health care

provided by a licensed health care professional with whom an individual has an ongoing relationship and who knows the patient's medical history. Primary care services emphasize a patient's general health needs such as preventive services, treatment of minor illnesses and injuries or identification of problems that require referral to specialists.

Provider – Individual or organization that provides health care or long-term care services (e.g., doctor, nurse, hospital, physical therapist, home health aide and more). A health care provider may also be a public/community health professional.

Public Health – A broad array of programmatic and policy-related activities that society performs collectively, often in partnership with federal, state and local government entities, to assure the conditions in which people can be healthy. This includes organized community efforts to prevent, identify, preempt and counter threats to the public's health.

Return on Investment (ROI) – The concept of preventing treatable disease through

prevention and public health efforts as a way to generate health care cost savings.

Rural Health Clinic (RHC) – A public or private hospital, clinic or physician practice designated by the federal government and in compliance with the Rural Health Clinics Act. The practice must be located in a medically underserved area or a Health Professional Shortage Area (HPSA) and use physician assistants and/or nurse practitioners to deliver services.

Rural Health Network – Refers to any variety of organizational arrangements to link rural health care providers in a common purpose.

Safety Net – Providers and institutions that provide low cost or free medical care to medically needy, low income or uninsured populations. They include community and migrant health centers, free medical clinics and public hospitals.

Scope of Practice – The range of professional activities that a licensed health care professional can and cannot do to or for a patient

as defined by state boards (e.g., medicine or nursing), statute and regulations. Health care professions with defined scope of practice laws and regulations include chiropractors, emergency medical services, midwifery, nursing, pharmacists and physicians.

Self-Insured Group Health Plan – Plan set up by employers who set aside funds to pay their employees' health claims. Self-insured plans are regulated by the US Department of Labor, not by the South Carolina Department of Insurance.

Skilled Nursing Care – Daily nursing and rehabilitative care that can be performed only by or under the supervision of skilled medical personnel.

Small Business Health Options Program (SHOP) – Established by the ACA, a health insurance exchange that in 2014 is available to employers with 50 or fewer full-time equivalent (FTE) employees. Starting in 2016, all SHOPs will be open to employers with up to 100 FTEs.

Social Determinants of Health – The circumstances, in which people are born, grow up, live, work and age and the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies, education and politics.

South Carolina Department of Alcohol and Other Drug Abuse Services (SC DAODAS) – State agency charged with ensuring the provision of quality services to prevent or reduce the negative consequences of substance use and addictions.

South Carolina Department of Health and Environmental Control (SC DHEC) – State agency charged with protecting public health, coastal resources and the state's land, air and water quality.

South Carolina Department of Health and Human Services (SC DHHS) – State agency that manages the Medicaid program.

South Carolina Department of Mental Health (SC DMH) – State agency that

provides mental health services to South Carolinians.

South Carolina Information Exchange (SCIEx) – Statewide information highway that allows participating health care providers to view a patient's medical history, including medications, diagnoses and procedures. It is not a data warehouse, but a secure network, where providers use certified technology to share the information they need for better outcomes.

Substance Abuse and Mental Health Services Administration (SAMHSA) – The agency within the US Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation and to make substance use and mental disorder information, services and research more accessible.

Supplemental Security Income (SSI) – A federal cash assistance program for low-income elderly, blind and disabled individuals who have little or no income for basic needs. States may use SSI income limits to establish Medicaid eligibility.

Telemedicine – Specifically defined form of video conferencing that can provide medical consultation (e.g., psychiatry) to patients living in remote locations or otherwise underserved areas.

Temporary Assistance for Needy Families (TANF) – A program that provides cash benefits to low income families with children. When you qualify for TANF, you generally also qualify for Medicaid.

Trauma System – An organized, coordinated effort in a defined geographic area that delivers the full range of emergency care to all injured patients and is integrated with the local public health system.

Triple Aim Model – A framework focused on improving the individual experience of health care, improving the health of populations and reducing the per capita costs of health care for populations.

Underinsured – People with public or private insurance policies that do not cover all necessary health services, resulting in out-of-

pocket expenses that often exceed their ability to pay.

Uninsured – People who lack public or private health insurance.

United States Department of Health and Human Services (US DHHS) – The US government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves. Many US DHHS-funded services, including Medicaid, are provided at the local level by state or county agencies or through private-sector grantees.

Utilization – A commonly examined pattern or rate of use of a single service or type of service (e.g., hospital care, physician visits and prescription drugs). Utilization is typically expressed in rates per unit of population at risk for a given period (e.g., the number of annual admissions to a hospital per 1,000 persons over age 65).

Value-Based Purchasing (VBP) – Links health care payment more directly to the quality of care provided. VBP is a strategy that can help to transform the current payment system by rewarding providers for delivering high quality, efficient clinical care.

Waiver – An application, when approved by CMS, that allows states to test innovative ways to deliver and pay for health care services that are not typically covered by Medicaid. Common waiver types include those that allow states to obtain program flexibility, develop managed care systems or provide long-term care services in home and community-based settings.

Youth Risk Behavior Surveillance System (YRBSS) – Monitors priority health risk behaviors that contribute to the leading causes of death, disability and social problems among youth and adults in the United States. The national YRBS is conducted every two years during the spring semester and provides data representative of 9th through 12th grade students in public and private schools throughout the United States.

Acronym Appendix

ABD:	Aged, Blind, Disabled
ACA:	Affordable Care Act (Patient Protection and)
ACO:	Accountable Care Organization
ADRC:	Aging and Disability Resource Center
AFDC:	Aid to Families with Dependent Children
BOI:	Birth Outcomes Initiative
BRFSS:	Behavioral Risk Factor Surveillance System
CDC:	Centers for Disease Control and Prevention
CHC:	Community Health Center
CHIP:	Children's Health Insurance Program
CMS:	Centers for Medicare and Medicaid Services
CHW:	Community Health Worker
COBRA:	Consolidated Omnibus Budget Reconciliation Act
CON:	Certificate of Need
DSH:	Disproportionate Share Hospital Program
EAP:	Employee Assistance Program

EBM:	Evidence-Based Medicine
EHR/EMR:	Electronic Health Record/ Electronic Medical Record
EMS:	Emergency Medical Services
EMTALA:	Emergency Medical Treatment and Labor Act
ERISA:	Employee Retirement Income Security Act
FFS:	Fee-for-Service payment model
FMAP:	Federal Medical Assistance Percentage
FMLA:	Family Medical Leave Act
FPL:	Federal Poverty Level
FQHC:	Federally Qualified Health Center
HCBS:	Home and Communty-Based Services
HDHP:	High Deductible Health Plan
HIA:	Health Impact Assessment
HIT:	Health Information Technology
HIPAA:	Health Insurance Portability and Accountability Act
HMO:	Health Maintenance Organization
HOP:	Healthy Outcomes Plan
HPSA:	Health Professional Shortage Area

HRSA:	Health Resources and Services Administration
HSA:	Health Savings Account
LTC/LTSS:	Long-Term Care/Long-Term Services and Supports
MCH:	Maternal and Child Health
MLR:	Medical Loss Ratio
MSA:	Medical Savings Account
NIH:	National Institutes of Health
PBM:	Pharmacy Benefit Manager
PCMH:	Patient Centered Medical Home
PCP:	Primary Care Provider
PDL:	Preferred Drug List
PDP:	Prescription Drug Plan
PMPM:	Per Member Per Month
PPACA:	Patient Protection and Affordable Care Act
PPO:	Preferred Provider Organization
PSDA:	Patient Self-Determination Act
RHC:	Rural Health Clinic
ROI:	Return on Investment
SAMHSA:	Substance Abuse and Mental Health Services Administration
SC DAODAS:	SC Department of Alcohol

	and Other Drug Abuse Services
SC DHEC:	SC Department of Health and Environmental Control
SC DHHS:	SC Department of Health and Human Services
SC DMH:	SC Department of Mental Health
SCIEx:	South Carolina Information Exchange
SHOP:	Small Business Health Options Program
SSI:	Supplemental Security Income
TANF:	Temporary Assistance for Needy Families
US DHHS:	United States Department of Health and Human Services Prescription Drug Plan
YRBSS:	Youth Risk Behavior Surveillance System
VBP:	Value-Based Purchasing

The South Carolina Institute of Medicine & Public Health (IMPH) is an independent entity serving as a convener around the important health issues in our state. IMPH also serves as a provider of evidence-based information. The mission of IMPH is to collectively inform policy to improve health and health care. For more information on IMPH publications, initiatives and events, please visit www.imph.org.

South Carolina Institute of
Medicine & Public Health
1301 Gervais Street, Suite 300
Columbia, SC 29201
Email: info@imph.org
Phone: 803-576-5850
Web: www.imph.org