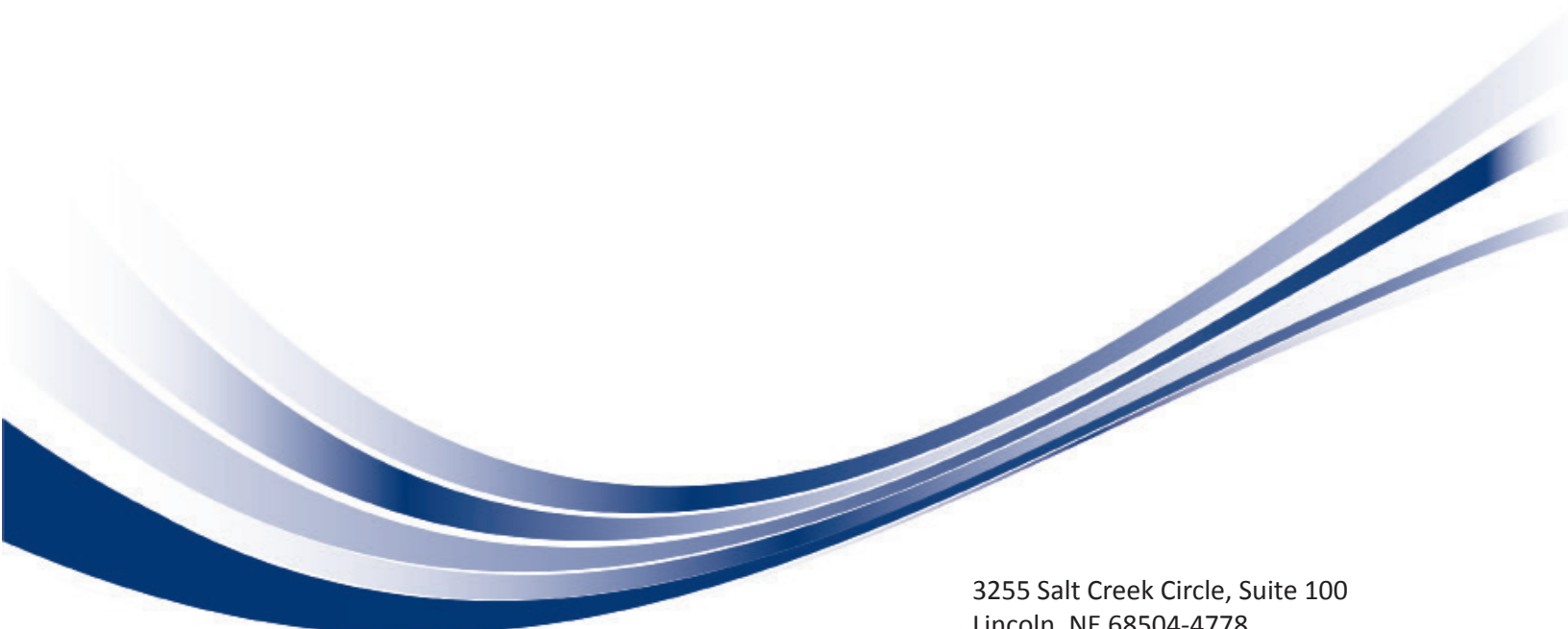




The influential voice of Nebraska's hospitals

Glossary of Health Care Terms & Acronyms

2013 Edition

A decorative graphic consisting of several overlapping, curved bands of blue and white, creating a wave-like effect that flows from the bottom left towards the top right of the page.

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A

AA

Anesthesiologist assistant

AAHC

American Accreditation Healthcare Commission (formerly Utilization Review Accreditation Commission)

AAHP

American Association of Health Plans

AAHSA

American Association of Homes and Services for the Aging

AAMC

Association of American Medical Colleges

AAP

American Academy of Pediatrics

AAPCC

Average adjusted per capita cost

AARC

American Association of Respiratory Care

AARP

American Association of Retired Persons

ABN

Advance beneficiary notice

ACC

American College of Cardiology

Access

The patient's ability to obtain health services. Measures of access include the location of health facilities and their hours of operation, travel time and distance to health facilities, availability of medical services, including scheduled appointments with health professionals and cost of care.

Accountable Care Organization (ACO)

A network of health care providers that together manages and coordinates care for patient along the continuum of care. The network receives a single payment for all care provided to a patient and is held accountable for the quality and cost of care. Part of the federal health reform bill, ACOs can be comprised of health care professionals and hospitals with the goal of increasing quality and reducing costs in exchange for increased reimbursement.

Accounts Receivable

Assets arising from the provision of services or the sale of goods or services furnished to patients.

Accreditation

Certification that an organization meets the reviewing organization's standards.

ACE

Acute care episode

ACHE

American College of Healthcare Executives

ACIP

Advisory Committee on Immunization Practices

ACLF

Assisted care living facility

ACOG

American College of Obstetricians and Gynecologists

ACPE

American College of Physician Executives

ACR

Adjusted community rate

ACS

American College of Surgeons

Activities of Daily Living (ADLs)

A measure of independent-living ability based on capacity of an individual to bathe, dress, use the toilet, eat and move across a small room without assistance and used to determine the need for nursing home and other care.

Actuarial Equivalent

A health benefit plan that offers similar coverage to a standard benefit plan. Actuarially equivalent plans will not necessarily have the same premiums, cost having requirements or even benefits. However, the expected spending by insurers for the different plans will be the same.

Actuary

An accredited insurance mathematician trained in the science of loss contingencies, investments, insurance accounting, premiums, managed care risks and service utilization who calculates premium rates, reserves and dividends.

Acuity

Degree or severity of illness.

Acute Care

Generally refers to inpatient hospital care of a short duration (typically less than 30 days) as opposed to ambulatory care or long-term care for the chronically ill.

ADA

Americans with Disabilities Act
American Diabetes Association

ADC

Average daily census

ADHC

Adult day health care

Adjudication

The administrative procedure used to process a claim for service according to the covered benefit.

Adjusted Admissions

A measure of all patient care activity undertaken in a hospital, both inpatient and outpatient. Adjusted admissions are equivalent to the sum of inpatient admissions and an estimate of the volume of outpatient services. This estimate is calculated by multiplying outpatient visits by the ratio of outpatient charges per visit to inpatient charges per admission.

Adjusted Average Per Capita Cost (AAPCC)

1) Actuarial projections of per capita Medicare spending for enrollees in fee-for-service Medicare. Separate AAPCCs are calculated - usually at the county level - for Part A services and Part B services for the aged, disabled and people with end stage renal disease. Medicare pays risk plans by applying adjustment factors to 95 percent of the Part A and Part B AAPCCs. The adjustment factors reflect differences in Medicare per capita fee-for-service spending related to age, sex, institutional status, Medicaid status and employment status.
(2) A county-level estimate of the average cost incurred by Medicare for each beneficiary in fee for service. Adjustments are made so the AAPCC represents the level of spending that would occur if each county contained the same mix of beneficiaries. Medicare pays health plans 95 percent of the AAPCC, adjusted for the characteristics of the enrollees in each plan.

Adjusted Community Rating

A way of pricing insurance where premiums are not based upon a policyholder's health status, but may be based upon other factors, such as age and geographic location. PPACA requires the use of adjusted community rating, with maximum variation for age of 3:1 and for tobacco use of 1.5:1.

Adjusted Patient Day (APD)

An accounting method for modifying the definition of inpatient days to include outpatient revenues.

Administrative Services Only (ASO)

An arrangement in which a licensed insurer provides administrative services to an employer's health benefits plan (such as processing claims), but doesn't insure the risk of paying benefits to enrollees. In an ASO arrangement, the employer pays for the health benefits.

ADLs

Activities of daily living

Admission

Formal acceptance by a hospital or other inpatient healthcare facility of a patient who is to be provided with room, board and continuous nursing service in the hospital or facility where patients remain at least overnight.

Admitting Privileges

The authorization given to a provider by a healthcare organization's governing board to admit patients into its hospital or healthcare facility to provide patient care. Privileges are based on the provider's license, education, training and experience.

ADN

Associate degree in nursing

ADS

Alternative delivery system

ADT

Admission, discharge and transfer

Adult Day Care/Adult Day Health Care (ADHC)

Programs providing social, recreational or other activities specifically for elderly people who cannot be left alone or do not wish to be left alone during the day while their family members work. It combines day care with certain healthcare services.

Advance Directive

Written instruction recognized under state law relating to the provision of health care when an individual is incapacitated. Advance directives take two forms: living will and durable power of attorney for health care.

Adverse Selection

Adverse selection occurs when a larger proportion of persons with poorer health status enroll in specific plans or insurance options, while a larger proportion of persons with better health status enroll in other plans or insurance options. Plans with a subpopulation with higher than average costs are adversely selected. Plans with a subpopulation with lower than average costs are favorably selected.

AFDC

Aid to Families with Dependent Children

Affordable Care Act (ACA)

Known as the Patient Protection and Affordable Care Act, this federal legislation was passed in March 2010 and contains new health reform provisions.

Affiliation

An agreement, usually formal, between two or more otherwise independent hospitals, programs or providers describing their relationship to each other.

AG

Attorney General

Against Medical Advice (AMA)

The self-discharge of a patient who leaves a healthcare facility against the advice of his or her physician or the medical staff.

Agency for Health Care Policy and Research (AHCPR)

Created by the Omnibus Budget Reconciliation Act of 1989 as a component of the U.S. Public Health Service. AHCPR is responsible for research on quality, appropriateness, effectiveness and cost of health care, and for using this data to promote improvement in clinical practice and the organization, financing and delivery of healthcare.

Aggregate Margin

A margin that compares revenues to expenses for a group of hospitals, rather than a single hospital. It is computed by subtracting the sum of expenses for all hospitals in the group from the sum of revenues and dividing by the sum of revenues.

Aggregate PPS Operating Margin/Aggregate Total Margin

A PPS operating margin or total margin that compares revenue to expenses for a group of hospitals, rather than a single hospital. It is computed by subtracting the sum of expenses for all hospitals in the group from the sum of revenues and dividing by the sum of revenues.

AHCA

American Health Care Association

AHCPR

Agency for Health Care Policy and Research

AHIMA

American Health Information Management Association

AHIP

America's health insurance plan

AHRA

American Healthcare Radiology Administrators

AHRMM

Association for Healthcare Resource & Materials Management (AHA)

AHRQ

Agency for Healthcare Research and Quality

AHS, Inc.

Access Health Systems, Inc.

AIDS

Acquired immunodeficiency syndrome

ALC

Alternate level of care

All-Payer System

A system by which all payers of healthcare bills - the government, private insurers, big companies and individuals - pay the same rates, set by the government, for the same medical service. This system does not allow for cost-shifting.

Allied Health Professionals

Professionally trained and certified non-physician healthcare providers, including nurse practitioners, certified registered nurse anesthetists, respiratory therapists, physicians' assistants and others.

ALOS

Average length of stay

ALP

Assisted living program

ALS

Advanced life support

AMA

American Medical Association

Ambulatory

Describes a patient capable of moving about from place to place, not confined to a bed.

Ambulatory Care

Health services provided on an outpatient basis; usually implies that an overnight stay in a healthcare facility is not necessary.

Ambulatory Patient Classifications (APC)

A system for classifying outpatient services and procedures for purposes of payment. The APC system classifies some 7,000 services and procedures into about 300 procedure groups.

Ambulatory Surgical Center (ASC)

A freestanding facility, often certified by Medicare, that performs certain types of surgical procedures on an outpatient basis.

AMC

Academic medical centers

American College of Healthcare Executives (ACHE)

A professional organization for hospital executives.

American Hospital Association (AHA)

A national professional trade association for hospitals.

American Medical Association (AMA)

The largest national professional association for physicians.

American Nurses Association (ANA)

A professional organization for registered nurses.

AMI

Acute myocardial infarction

Ancillary Services

All hospital services for a patient other than room, board and nursing services. Examples include x-ray, drug and laboratory tests.

Annual Limit

Many health insurance plans place dollar limits upon the claims the insurer will pay over the course of a plan year. PPACA prohibits annual limits for essential benefits for plan years beginning after Sept. 23, 2010.

Antitrust Laws

State and national laws that prohibit healthcare and other providers from price-fixing or developing monopolies that would prevent consumers from having choices in terms of costs and services.

AOA

Administration on Aging

American Osteopathic Association

AONE

American Organization of Nurse Executives

APC

Ambulatory payment classification

APG

Ambulatory patient group

APHA

American Public Health Association

APN

Advanced practice nurse

APDRG

All patient refined diagnosis-related group

Arbitration

The process by which a contractual dispute is submitted to a mutually agreed-on impartial party for resolution. Many managed care plans have provisions for compulsory arbitration (in states where arbitration is allowed) in cases of disputes between providers and plans.

Area Wage Index (AWI)

The Centers for Medicare & Medicaid Services (CMS) adjusts 62 percent to 69 percent of Medicare payments to account for geographic differences in labor and benefit costs. This adjustment is referred to as the area wage index (AWI). To calculate the AWI, CMS takes data reported by hospitals every three years in the occupational mix survey, which collects data on wage amounts and benefit costs of clinical and, to a lesser degree, non-clinical staff.

ARRA

American Recovery and Reinvestment Act of 2009

ASAE

American Society of Association Executives

ASC

Ambulatory surgical center

ASDVS

American Society for Directors of Volunteer Services

ASHE

American Society for Healthcare Engineering

ASHES

American Society for Healthcare Environmental Services

ASHFSA

American Society for Healthcare Food Service Administrators

ASHHRA

American Society for Healthcare Human Resources Administration

ASHRM

American Society for Healthcare Risk Management

ASO

Administrative services organization

Assisted Living Centers

Living arrangements for the elderly and disabled who need assistance with daily living activities, such as dressing, bathing and cooking.

Association Health Plan

Health insurance plans that are offered to members of an association. These plans are marketed to individual association members, as well as small business members. How these plans are structured, who they sell to, and whether they are state-based or national associations determines whether they are subject to state or federal regulations or both, or are largely exempt from regulations. Recent congressional proposals would have loosened regulations on these insurance plans.

ASTC

Ambulatory surgical treatment center

Attending Physician

Physician legally responsible for the care provided a patient in a hospital or other healthcare program. Usually, the physician also is responsible for the patient's outpatient care.

Authorization

A utilization management technique used by managed care organizations to grant approval for the provision of care or services not performed by the primary care physician. Services requiring authorization vary greatly by health plan.

Average Daily Census (ADC)

Average number of inpatients per day over a given time period.

Average Length of Stay (ALOS)

Total number of hospital bed days divided by the number of admissions or discharges during a specified period.

AWP

Average wholesale price

B

Bad Debt

Charges for care provided to patients who are financially able to pay but refuse to do so.

Balance Billing

The practice of medical care providers (such as doctors, hospitals or other medical practitioners) billing the insured for the portion of the bill not paid by the insurer. The practice is prohibited by Medicare and some managed care companies.

Basic DRG Payment Rate

The payment rate a hospital will receive for a Medicare patient in a particular diagnosis-related group. The payment rate is calculated by adjusting the standardized amount to reflect wage rates in the hospital's geographic area (and cost of living differences unrelated to wages) and the costliness of the DRG.

BBA

Balanced Budget Act of 1997

BBRA

Balanced Budget Refinement Act of 1999

BCBS

Blue Cross-Blue Shield Association

Benchmarking

A way for hospitals and doctors to analyze quality data, both internally and against data from other hospitals and doctors, to identify best practices of care and improve quality.

Bending the Curve

Healthcare cost trends in the United States are two to three times greater than inflation and are therefore unsustainable. This popular phrase describes current efforts to promote health and wellbeing as well as a more effective and efficient healthcare delivery system that will thereby slow the growth in healthcare spending.

Beneficiary

Someone who is eligible for or receiving benefits under an insurance policy or plan. The term is commonly applied to people receiving benefits under the Medicare or Medicaid programs.

Beneficiary Liability

The amount beneficiaries must pay providers for Medicare-covered services. Liabilities include copayments and coinsurance amounts, deductibles and balance billing amounts.

Benefit Package

The set of services, such as physician visits, hospitalizations, prescriptions drugs, that are covered by an insurance policy or health plan. The benefit package will specify any cost-sharing requirements for services, limits on particular services and annual or lifetime spending limits.

Best Practices

A term describing organizations' superior performance in their operations, managerial and/or clinical processes.

BHO

Behavioral health organization

Billed Charges

A reimbursement method used mostly by traditional indemnity insurance companies wherein charges for healthcare services are billed on a fee-for-service basis. Fees are based on what the provider typically charges all patients for the particular service.

BIPA

Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000

BME

Board of Medical Examiners

Board-Certified

A term used to describe a physician who has passed an examination given by a medical specialty board and who has been certified as a specialist in that medical area.

BSN

Bachelor of science degree in nursing

Bundled Billing

The practice of charging an all-inclusive package price for all medical services associated with selected procedures (e.g., heart surgery or maternity care) to improve quality and help control costs.

Bundled Service A bundled service combines closely-related specialty and ancillary services for an enrolled group or insured population by a group of associated providers.

Bundled Payment

Bundled payment, also known as episode-based payment, episode payment, episode-of-care payment, case rate, evidence-based case rate, global bundled payment, global payment, package pricing, or packaged pricing, is defined as the reimbursement of health care providers (such as hospitals and physicians) "on the basis of expected costs for clinically-defined episodes of care." It has been described as "a middle ground" between fee-for-service reimbursement (in which providers are paid for each service rendered to a patient) and capitation (in which providers are paid a "lump sum" per patient regardless of how many services the patient receives).

C

Cadillac Tax

The Cadillac Tax is a 40 percent excise tax on healthcare premiums (employer + employee) that is placed on employers for premiums that exceed \$10,200 for individual coverage and \$27,500 for family coverage. The Cadillac Tax is part of the Patient Protection and Affordable Care Act and is slated to go into effect on Jan. 1, 2018.

CAH

Critical access hospital

CAHPS

Consumer Assessment of Healthcare Providers and Systems

CAI

Cooperative accreditation agreement

CAO

Chief administrative officer

CAP

Capitation

College of American Pathologists

Capital

Owners' equity in a business and often used to mean the total assets of a business, although sometimes used to describe working capital (i.e., cash) available for investment or acquisition of goods.

Capital Asset

Depreciable property of a fixed or permanent nature (e.g., buildings and equipment) that is not for sale in the regular course of business.

Capital Costs

Depreciation, interest, leases and rentals, taxes and insurance on tangible assets like physical plant and equipment.

Capital Expense

An expenditure that benefits more than one accounting period, such as the cost to acquire long-term assets.

Capital Structure

The permanent long-term financing of an organization: the relative proportions of short-term debt, long-term debt and owners' equity.

Capitalize

To record an expenditure (e.g., R&D costs) that may benefit a future period as an asset rather than as an expense of the period of its occurrence.

Capitation

(1) Method of payment for health services in which a physician or hospital is paid a fixed amount for each person served, regardless of the actual number or nature of services provided. (2) A method of paying healthcare providers or insurers in which a fixed amount is paid per enrollee to cover a defined set of services over a specified period, regardless of actual services provided. (3) A health insurance payment mechanism that pays a fixed amount per person to cover services. Capitation may be used by purchasers to pay health plans or by plans to pay providers.

Carrier

An insurance company or a health plan that has some financial risk or that manages healthcare benefits.

Case Management

Monitoring and coordinating the delivery of health services for individual patients to enhance care and manage costs; often used for patients with specific diagnoses or who require high-cost or extensive healthcare services.

Case Manager

An experienced professional who works with patients, providers and insurers to coordinate all services deemed necessary to provide the patient with appropriate healthcare.

Case-Mix Index (CMI)

The average DRG weight for all cases paid under PPS. The CMI is a measure of the relative costliness of the patients treated in each hospital or group of hospitals.

Case-Mix Score

A measure of patient acuity reflecting different patients' needs for hospital and long-term care resources. This measure may be based on patients' diagnoses, the severity of their illnesses and their utilization of services. A high case-mix index refers to a patient population more ill than average.

CAT

Computerized axial tomography

Catastrophic Coverage Insurance

A coverage option with limited benefits and a high deductible intended to protect against medical bankruptcy due to an unforeseen illness or injury. These plans are usually geared toward young adults in relatively good health. While catastrophic plans do not generally cover preventive care, catastrophic coverage plans under health reform will be required to exempt some preventive care services from the deductible.

CBO

Congressional Budget Office

CBSA

Core-based statistical area

CC

Complications and co-morbidities

CCI

Correct coding initiative

CCIP

Chronic care improvement program

CCR

Cost-to-charge ratio

CCU

Cardiac care unit

Coronary care unit

CDC

Centers for Disease Control

CDAC

Clinical data abstraction center

CE

Continuing education

Census

Average number of inpatients who receive hospital care each day, including newborns.

Center of Excellence A specialized product line (e.g., neurosciences, cardiac services, or orthopedics) developed by a provider to be a recognized high-quality, high-volume, cost-effective clinical program.

Centers for Disease Control and Prevention (CDC)

A division of the U.S. Public Health Service that takes the lead in analyzing and fighting infectious disease.

Centers for Medicare and Medicaid Services (CMS)

Federal agency (a division of the U.S. Department of Health and Human Services) that administers the Medicare and Medicaid programs and determines provider certification and reimbursement.

Center for Medicare and Medicaid Innovation (the CMS Innovation Center or CMMI)

Fosters health care transformation by finding new ways to pay for and deliver care that improve care and health while lowering costs. The Center identifies, develops, supports, and evaluates innovative models of payment and care service delivery for Medicare, Medicaid and CHIP beneficiaries using an open, transparent and competitive process.

Certificate of Need (CON)

A certificate of need is a legal document required in many state and some federal jurisdictions before proposed acquisitions, expansions, or creations of facilities are allowed. CONs are issued by a federal or state regulatory agency with authority over an area to affirm that the plan is required to fulfill the needs of a community. Certificates of need are necessary for the construction of medical facilities in 35 states and are issued by state health care agencies.

CHA

Catholic Health Association
Center for Health Affairs

CHAMPVA

Civilian health and medical program of the Veteran's Administration

CHAP

Community health accreditation program

Charges

The amount billed by a hospital for services provided. A charge usually includes the costs plus an operating margin. Charges are the posted prices of provider services; however, many payers pay a discounted rate, negotiated rate or government-set rate rather than actual charges.

Charity Care

Free or reduced fee care provided due to financial situation of patients.

CHAUS

Catholic Health Association of the United States

CHF

Congestive heart failure

CHI

Catholic Health Initiatives

Chief Executive Officer (CEO)

The person selected by the governing body to direct overall management of the hospital. The CEO acts on behalf of the board and is sometimes called administrator, executive director, president or similar title.

Chief Financial Officer (CFO)

The person designated by the CEO with the responsibility for the financial operations of the organization.

Chief Medical Officer (CMO) or Chief of Staff

Member of a hospital medical staff who is elected, appointed or employed by the hospital to be the medical and administrative head of the medical staff. Also known as president of the medical staff or medical director.

Chief Nursing Officer (CNO)

CNO is responsible for overseeing and coordinating an organization's nursing department and its daily operations. As the primary spokesperson for nurses, the chief nursing officer also works to align the nursing staff with the mission, values and vision of the organization.

Chief Operating Officer (COO)

Executive administrator under the CEO who has responsibility for hospital operations.

Children's Health Insurance Program (CHIP)

A program enacted within the Balanced Budget Act of 1997 providing federal matching funds to states to help expand healthcare coverage for children under Medicaid or new programs.

Chronic Care

Both medical care and services that are not directly medically related, such as cooking, giving medications and bathing, for those with chronic illnesses.

Chronic Case Management

The coordination of both health care and supportive services to improve the health status of patients with chronic conditions, such as diabetes and asthma. These programs focus on evidence-based interventions and rely on patient education to improve patients' self-management skills. The goals of these programs are to improve the quality of health care provided to these patients and to reduce costs.

Chronic Illness

A condition (e.g., diabetes, emphysema, chronic hypertension or rheumatoid arthritis) that will not improve substantially, lasts a life-time, or recurs and may require long-term care.

CLABSI

Central line-associated bloodstream infection

Claim

Information submitted in writing or electronically by providers to an insurer requesting payment for medical services provided to the beneficiary.

CLIA

Clinical Laboratory Improvement Act

Clinical laboratory improvement amendments

Claims-Made Coverage/Policy

A form of liability coverage for claims made (reported or filed) against an insured party during the policy period irrespective of when the event occurred that caused the claims to be made. Thus, claims made during a previous period in which the policyholder was insured under a claims-made policy would be covered, provided the coverage is continuous with the insurer.

CLASS Act

The community living assistance services and supports program (CLASS) program is designed to expand options for people who become functionally disabled and require long-term services and supports. Adults who meet eligibility criteria would receive a cash benefit that can be used to purchase non-medical services and support necessary to maintain community residence; payments for institutional care are permitted.

Clinical Decision Support

These are computerized tools that incorporate information gathering, as well as monitoring and delivery systems, to ensure optimal decision-making on the part of the treating clinician. They assist physicians and other providers at the point of care to follow evidence-based guidelines and improve healthcare outcomes.

Closed Formulary

A list restricting the number and type of drugs covered by a pharmacy benefits management program or managed care plan.

CLT

Clinical laboratory technologist

CME

Continuing medical education

CMG

Case-mix group

CMHC

Community mental health center

CMI

Case mix index

CMP

Civil monetary penalty

CMS

Centers for Medicare and Medicaid Services

CNA

Certified nurse aide

CNM

Certified nurse midwife

CNO

Chief nursing officer

CNP

Certified nurse practitioner

CNS

Clinical nurse specialist

COB

Coordination of benefits

COBRA Coverage

When employees lose their jobs, they are able to continue their employer-sponsored coverage for up to 18 months through the Consolidated Omnibus Budget Reconciliation Act of 1985. Under the original legislation, individuals were required to pay the full premium to continue their insurance through COBRA. The American Recovery and Reinvestment Act provides a temporary subsidy of 65 percent of the premium cost for the purchase of COBRA coverage to people who lost their jobs between Sept. 1, 2008, and May 31, 2010.

Code of Federal Regulations

A codified collection of regulations issued by various departments, bureaus and agencies of the federal government and promulgated in the Federal Register.

Coinsurance

Amount a health insurance policy requires the insured to pay for medical and hospital services, after payment of a deductible.

Community Accountability

The responsibility of providers in a network to document to members their progress toward specific community health goals and their maintenance of specific clinical standards.

Community Benefits

Activities initiated by not-for-profit hospitals to benefit the hospital's community. Community benefits are evolving standards defined by the Internal Revenue Service (IRS) to determine the tax-exempt status of not-for-profit healthcare organizations.

Community Health Center

A local, community-based ambulatory healthcare program, also known as a neighborhood health center, organized and funded by the U.S. Public Health Service to provide primary and preventive health services, particularly in areas with scarce health resources and/or special-needs populations. Some are sponsored by local hospitals and/or community foundations.

Community Health Needs Assessment

Technique for developing a profile of community health that measures factors inside and outside the traditional medical service and public health definitions and practices. Needs assessments identify gaps in healthcare services; special targeted populations; health problems in the community; barriers to access to healthcare services and estimate projected future needs.

Community Rating

A method for setting premium rates for health insurance plans under which all policy holders are charged the same premium for the same coverage. "Modified community rating" generally refers to a rating method under which health insuring organizations are permitted to vary premiums based on specified demographic characteristics (e.g. age, gender, location), but cannot vary premiums based on the health status or claims history of policy holders.

Comparative Effectiveness Research

A field of research that analyzes the impact of different options for treating a given condition in a particular group of patients. These analyses may focus only on the medical risks and benefits of each treatment or may also consider the costs and benefits of particular treatment options.

Co-morbidity

A preexisting patient condition that, linked to a principal diagnosis, causes an increase in length of stay by at least one day in approximately 75 percent of cases.

Computerized Physician Order Entry (CPOE)

Computerized Physician Order Entry (CPOE) is the electronic entry of medical practitioner instructions for services, tests, and treatments of patients into a computerized system that relays the orders to the appropriate party such as a hospital pharmacist or blood-draw lab. These systems can be used for care orders, prescriptions, lab tests and radiological orders.

CON

Certificate of need

Concurrent Review

Managed care technique in which a managed care firm continuously reviews the charts of hospitalized patients for length of stay and appropriate treatment.

Conditions of Participation (CoP)

CMS federal health and safety requirements ensuring high quality care for all patients. Hospitals and CAHs must meet these conditions to participate in the Medicare and Medicaid programs.

Confidentiality

(1) Restriction of access to data and information to individuals who have a need, reason and permission for such access. (2) An individual's right, within the law, to personal and informational privacy, including his or her healthcare records.

Consumer-Directed Health Plans

Consumer-directed health plans seek to increase consumer awareness about health care costs and provide incentives for consumers to consider costs when making health care decisions. These health plans usually have a high deductible accompanied by a consumer-controlled savings account for health care services. There are two types of savings accounts: Health Savings Accounts (HSAs) and Health Reimbursement Arrangements (HRAs).

Consumer Price Index (CPI)

Measure of inflation encompassing the cost of all consumer goods and services.

Consumer Price Index, Medical Care Component Measure of inflation encompassing the cost of all purchased healthcare services.

Continuous Quality Improvement (CQI)

An approach to organizational management that emphasizes meeting (and exceeding) consumer needs and expectations, use of scientific methods to continually improve work processes, and the empowerment of all employees to engage in continuous improvement of their work process.

Continuum of Care

Comprehensive set of services ranging from preventive and ambulatory services to acute care to long-term and rehabilitative services. By providing continuity of care, the continuum focuses on prevention and early intervention for those who have been identified as high risk and provides easy transition from service to service as needs change.

Contractual Adjustment

A bookkeeping adjustment to reflect uncollectible differences between established charges for services to insured persons and rates payable for those services under contracts with third-party payers.

Contractual Allowances

Negotiated discounts on hospital or other provider-established charges paid by third-party payers or the government.

COO

Chief operating officer

Coordination of Benefits (COB)

Agreement between health plans and insurers to avoid the same services being paid for more than once.

Co-Op Plan

A health insurance plan that will be sold by member-owned and operated non-profit organizations through Exchanges when they open in 2014. PPACA provides grants and loans to help Co-Op plans enter the marketplace.

CoP

Conditions of Participation

Co-payment (Copay)

Cost-sharing arrangement in which an insured person pays a specified charge for a specified service. The insured is usually responsible for payment at the time the health care is rendered. Typical copayments are fixed or variable flat amounts for physician office visits, prescriptions or hospital services.

Core-Based Statistical Area (CBSA)

Official term for a functional region in an urban center of at least 10,000 people based on standards published by the Office of Management & Budget.

CORF

Comprehensive outpatient rehabilitative facility

Cost Accounting

An accounting system arriving at charges by healthcare providers based on actual costs for services rendered.

Cost Center

A business or organizational unit of activity or responsibility that incurs expenses.

Cost Containment

A set of strategies aimed at controlling the level or rate of growth of healthcare costs. These measures encompass a myriad of activities that focus on reducing over-utilization of health services, addressing provider reimbursement issues, eliminating waste and increasing efficiency in the healthcare system.

Cost-Sharing

A feature of health plans where beneficiaries are required to pay a portion of the costs of their care. Examples of costs include co-payments, coinsurance and annual deductibles.

Cost Shifting

Increasing revenues from some payers to offset losses or lower reimbursement from other payers, such as government payers and the uninsured.

Cost-to-Charge Ratio

A cost-finding measure derived from applying the ratio of third-party payer charges to total charges against the total operating costs in a hospital operating department.

Countercyclical

Medicaid is a countercyclical program in that it expands to meet increasing need when the economy is in decline. During an economic downturn, more people become eligible for and enroll in the Medicaid program when they lose their jobs and their access to health insurance. As enrollment grows, program costs also rise.

Coverage Limits

A health insurance plan has been able dictate the maximum number of dollars spent on benefits per individual/family/policy, and these restrictions come in two forms — annual and lifetime.

Covered Lives

The total number of people in a health plan or the people covered by an insurer.

Covered Services

Specific healthcare services and supplies for which payers provide reimbursement under the terms of the applicable contract (Medicaid, Medicare, group contract, or individual subscriber contract).

CPE

Certified public expenditures

CPHA

Commission on Professional and Hospital Activities

CPI

Consumer price index

CPOE

Computerized physician order entry

CPR

Cardiopulmonary resuscitation

CPT

Current procedural terminology

CQI

Continuous quality improvement

Credentialing and Privileging

Process by which hospitals determine the scope of practice of practitioners providing services in the hospital. The criteria for granting privileges or credentialing are determined by the hospital and include individual character, competence, training, experience and judgment.

Critical Access Hospital (CAH)

Designated within the Medicare rural hospital flexibility program as a limited service rural, not-for-profit or public hospital that provides outpatient and short-term inpatient hospital care on an urgent or emergency basis and is a part of a rural health network. Medicare reimburses CAHs at a rate of 101 percent of their costs.

CRNA

Certified registered nurse anesthetist

CSR

Continuous survey readiness

CT

Computerized tomography

Culture of Health

This is an ideological transformation of an organization's culture that passively accepts rising, unsustainable healthcare costs to a proactive entity that encourages the holistic wellbeing of each of its employees. Such organizations integrate the health status of their workforce into their mission and vision statements and require all of their employees to be accountable for their health.

Current Assets

Assets that are expected to be turned into cash within one year (e.g., accounts receivable).

Current Liabilities

Obligations that will become due and payable with cash within one year.

Current Procedural Terminology (CPT)

Coding system for physician services developed by the American Medical Association; basis of the HCPCS coding system.

Current Ratio

A financial ratio designed to measure liquidity based on the relationship or balance between current assets and current liabilities.

Custodial Care

Basic long-term care, also called personal care, for someone with a terminal or chronic illness.

Customary Charge

One of the screens previously used to determine a physician's payment for a service under Medicare's customary, prevailing and reasonable payment system. Customary charges were calculated as the physician's median charge for a given service over a prior 12-month period.

CY

Calendar year

D

DC

Doctor of chiropractic

DCI

Duplicate coverage inquiry

DDS

Doctor of dental surgery

Deductible

A feature of health plans in which consumers are responsible for healthcare costs up to a specified dollar amount. After the deductible has been paid, the health insurance plan begins to pay for healthcare services. Under health reform, beginning in 2014, deductibles for new plans sold in the small group insurance market will be limited to \$2,000 for individual policies and \$4,000 for family policies.

Deemed Status

A hospital is “deemed qualified” to participate in the Medicare program if it is accredited by the Joint Commission, thus avoiding the need for a duplicative Medicare accreditation survey.

Defensive Medicine

Health care under which providers order more test than necessary to protect themselves from potential lawsuits by patients. Defensive medicine is said to be a major reason healthcare costs are so high, particularly under fee-for-service medicine.

Demonstration Projects

These are federally funded efforts to test and evaluate care delivery, cost reduction, health improvement, and payment reform models. The goal of these projects is to develop new, effective methodologies for care and payment, which can be expanded to a broader, perhaps national, scope. The Affordable Care Act has several funded pilots dealing with innovations such as the bundled payment model and programs for chronically ill Medicare beneficiaries using home-based teams. Note that demonstration project opportunities have been ongoing for years and are not solely tied to recent legislation.

Denial

The refusal by a third-party payer to reimburse a provider for services, or a refusal to authorize payment for services prospectively. Denials are generally issued on the basis that a hospital admission, diagnostic test, treatment or continued stay is inappropriate, according to a set of guidelines.

Dependent

A member of a health plan by virtue of a family relationship with the member who has the health plan coverage.

Depreciation

The amortization of the cost of a physical asset (plant, property, and equipment) over its useful life. Annual depreciation is the amount charged each year as expense for such assets as buildings, equipment and vehicles. Accumulated depreciation is the total amount of depreciation of the hospital’s financial books. Funded depreciation refers to setting aside and investing the accumulated depreciation so monies can be used for replacement and renovation of assets.

DHS

Designated health service

Diagnosis-Related Groups (DRGs)

Method of reimbursing providers based on the medical diagnosis for each patient. Hospitals receive a set amount, determined in advance, and based on the length of time patients with a given diagnosis are likely to stay in the hospital.

Direct Contracting

Agreement between a hospital and a corporate purchaser for the delivery of healthcare services at a certain price. A third party may be included to provide administrative and financial services.

Directors and Officers (D&O)

Liability Coverage Insurance protection for directors and officers of corporations against suits or claims brought by shareholders or others alleging that the directors and/or officers acted improperly in some manner in the conduct of their duties. This coverage does not extend to dishonest acts.

Discharge Planning

Evaluation of patients' medical needs in order to arrange for appropriate care after discharge from an inpatient setting.

Discharges

The number of patients who leave an overnight medical care facility (usually a hospital but occasionally an extended care facility).

Disease Management

The process in which a physician or clinical team coordinates treatment and manages a patient's chronic disease (such as asthma or epilepsy) on a long-term, continuing basis, rather than providing single episodic treatments. Assists in providing cost-effective healthcare using preventive methods, such as diet, medication and exercise for a patient with heart disease.

Disproportionate Share Hospital (DSH) Payments

Adjustment A payment adjustment under Medicare's prospective payment system or under Medicaid for hospitals that serve a relatively large volume of low-income patients.

DMD

Doctor of medical dentistry

DME

Durable medical equipment

DMO

Disease management organization

DMS

Diagnostic medical sonographers

DNR

Do not resuscitate

DO

Doctor of osteopathy

DOJ

U.S. Department of Justice

Donut Hole

A gap in prescription drug coverage under Medicare Part D, where beneficiaries enrolled in Part D plans pay 100 percent of their prescription drug costs after their total drug spending exceeds an initial coverage limit until they qualify for catastrophic coverage.

DOS

Date of service

DPM

Doctor of podiatric medicine

DPR

Drug price review

DPT

Doctor of Physical Therapy

DRA

Deficit Reduction Act

DRG

Diagnosis-related group

Drug Enforcement Administration (DEA)

The federal agency that licenses individuals to prescribe medications.

Drug Formulary

List of prescription drugs covered by an insurance plan or used within a hospital. A positive formulary lists eligible products while a negative one lists exclusions. Some insurers will not reimburse for prescribed drugs not listed on the formulary; others may have limited reimbursement for non-formulary drugs.

DSH

Disproportionate share hospital

Dual Eligibles

A term used to describe an individual who is eligible for Medicare and for some level of Medicaid benefits.

DUR

Drug utilization review

Durable Medical Equipment (DME)

Equipment that is primarily and customarily used to serve a medical purpose, can withstand repeated use, and is appropriate for use in the home, like hospital beds, walkers, wheel chairs and oxygen tents.

Durable Power of Attorney for Health Care

Allows an individual to designate in advance another person to act on his/her behalf if he/she is unable to make a decision to accept, maintain, discontinue or refuse any healthcare services.

DVS

Director of volunteer services

DVT

Deep vein thrombosis

E

EACH

Essential access community hospital

EAH

Essential access hospital

EAP

Employee assistance program

EAPG

Enhanced ambulatory patient group

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services

One of the services that states are required to include in their basic benefits package for all Medicaid-eligible children under age 21. EPSDT services include periodic screenings to identify physical and mental conditions, as well as vision, hearing, and dental problems. Services also include follow-up diagnostic and treatment services to correct conditions identified during a screening, without regard to whether the state Medicaid plan covers those services for adult beneficiaries.

Early Retiree Reinsurance Program

The Early Retiree Reinsurance Program (ERRP) is a temporary \$5 billion program established by the Patient Protection and Affordable Care Act. Its purpose is to help businesses and unions cover the healthcare costs of Medicare-ineligible early retirees, their spouses, and other dependents. It provides 80 percent of claims costs for benefits between \$15,000 and \$90,000 starting with the 2010 calendar year.

ECF

Extended care facility

Economic Credentialing

The use of economic criteria unrelated to quality of care or professional competency in determining an individual's qualifications for initial or continuing hospital medical staff membership or privileges.

ED

Emergency department

EDI

Electronic data interchange

EEG

Electroencephalogram

EHR

Electronic health record

EIP

Early intervention program

EKG (or ECG)

Electrocardiogram

Elective

A healthcare procedure that is not an emergency and that the patient and doctor plan in advance, such as knee replacement.

Electronic Health Record (EHR)

An electronic health record contains personal health information. Only authorized doctors, nurses and staff can create, view and update these records. An electronic health record should meet the technical rules that ensure it can be shared between, for example, hospitals, doctors' offices and clinics.

Emergency Medical Services System (EMS)

A system of personnel, facilities, and equipment administered by a public or not-for-profit organization delivering emergency medical services within a designated geographic area.

Emergency Medical Treatment and Active Labor Act (EMTALA)

Known as the "antidumping" provision under COBRA, this law requires that all patients who come to the emergency department of a hospital must receive an appropriate medical screening exam, regardless of ability to pay, and be stabilized if they are to be transferred to another facility.

Emergency Preparedness Plan

A process designated to manage the consequences of natural disasters or other major emergency disruptions to the ability to provide care and treatment.

Employee Benefit Survey

Survey of employers administered by the U.S. Bureau of Labor Statistics to measure the number of employees receiving particular benefits, such as health insurance, paid sick leave and paid vacations.

Employee Retirement Income Security Act (ERISA)

Legislation enacted in 1974 to protect workers from the loss of benefits provided through the workplace. ERISA does not require employers to establish any type of employee benefit plan, but contains requirements applicable to the administration of the plan when a plan is established. The requirements of ERISA apply to most private employee benefit plans established or maintained by an employer, an employee organization or both.

Employer Health Care Tax Credit

An incentive mechanism designed to encourage employers, usually small employers, to offer health insurance to their employees. The tax credit enables employers to deduct an amount, usually a percentage of the contribution they make toward their employees' premiums, from the federal taxes they owe. These tax credits are typically refundable so they are available to non-profit organizations that do not pay federal taxes.

Employer Mandate

A requirement that employers pay part or all of their employees' health insurance premiums. Under an employer mandate, employees get their health insurance through their company rather than buying it individually or having the government pay for it in a tax-based or single-payer system.

Employer Pay-or-Play

An approach that would require employers to offer and pay for health benefits on behalf of their employees, or to pay a specified dollar amount or percentage of payroll into a designated public fund.

Enrollment

- (1) The total number of covered person (i.e., the enrolled group) in a health plans.
- (2) The process by which a health plan signs up individuals and groups for membership.

Entitlement Program

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.

EOB

Explanation of benefits

EPA

Environmental Protection Agency

Episode of Care

The collection of all medical and pharmaceutical services rendered to a patient for a given illness, disease or injury, across all settings of care (inpatient, outpatient, ambulatory) and across providers, for the duration of that illness.

EPO

Exclusive provider organization

E-prescribing

According to the Centers for Medicare and Medicaid, e-prescribing is, “a prescriber’s ability to electronically send an accurate, error-free and understandable prescription directly to a pharmacy from the point-of-care.” Studies have demonstrated that replacing handwritten prescriptions with this electronic transmission greatly reduces medication errors.

EPSDT

Early periodic screening diagnosis and treatment program

ER

Emergency room

ERISA

Employee Retirement Income Security Act

Essential Benefits

PPACA requires all health insurance plans sold after 2014 to include a basic package of benefits including hospitalization, outpatient services, maternity care, prescription drugs, emergency care and preventive services among other benefits. It also places restrictions on the amount of cost-sharing that patients must pay for these services.

Ethics Committee

Multi-disciplinary group that convenes for the purpose of staff education and policy development in areas related to the use and limitation of aggressive medical technology; acts as a resource to patients, family, staff, physicians and clergy regarding healthcare options surrounding terminal illness and assisting with living wills.

Evidence-Based Medicine

Much of the care delivered today has been simply based on expert opinion. Evidence-Based Medicine’s (EBM)’s charge is to deliver care that has strong scientific validation. Ideally this term refers to the synthesis of individual, first-hand clinical experience with evidence garnered by external systematic research to create best practices in care delivery. It involves the interested clinician or organization asking a specific care question and then proceeding to systematically review published research to find practices backed by concrete data.

Exchange

PPACA creates new “American Health Benefit Exchanges” in each state to assist individuals and small businesses in comparing and purchasing qualified health insurance plans. Exchanges will also determine who qualifies for subsidies and make subsidy payments to insurers on behalf of individuals receiving them. They will also accept applications for other health coverage programs such as Medicaid and CHIP.

Exclusive Contract

An agreement that gives a physician or physician group the right to provide all administrative and clinical services required for the operation of a hospital department and precludes other physicians from practicing that specialty in that institution for the period of the contract.

Expanded Coverage

A significant goal of the Affordable Care Act is near universal coverage.

To accomplish this, a mandate requiring most U.S. citizens and legal residents to have health insurance is included. There are individual regulations that support this initiative by:

- Expanding Medicaid coverage
- Removing bans on coverage of individuals with pre-existing conditions
- Setting required groundwork for the formation of state-based health insurance exchanges
- Supplying assistance for individuals to procure insurance
- Expanding coverage of dependents up to age 26

Experience Rating

A method of setting premiums for health insurance policies based on the claims history of an individual or group. Experience rating will be prohibited under the health reform law beginning in 2014.

Explanation of Benefits (EOB)

A statement mailed to a member or covered insured explaining how and why a claim was or was not paid; the Medicare version is called an explanation of Medicare benefits.

Extended Care Facility (ECF)

A hospital unit for treatment of inpatients who require convalescent, rehabilitative or long-term skilled nursing care.

External Review

The review of a health plan’s determination that a requested or provided health care service or treatment is not or was not medically necessary by a person or entity with no affiliation or connection to the health plan. PPACA requires all health plans to provide an external review process that meets minimum standards.

F

FACHE

Fellow in the American College of Healthcare Executives

FACMPE

Fellow in the American College of Medical Practice Executives

FAH

Federation of American Hospitals

False Claims Act

A Civil War-era federal law provided for prosecution of fraud against the U.S. government. The U.S. Department of Justice (DOJ) misused it in 1997 and 1998 to make widespread claims of fraud against hospitals for Medicare billing errors, threatening immediate prosecution if settlement payments were not paid to the government. Under pressure, the DOJ later issued new False Claims Act guidelines that better differentiated billing errors from substantial evidence of international fraud and provided hospitals with relief.

Family Practitioner/Practice Physician (FP)

A doctor who specializes in the care and treatment of all family members, including adults and children. These physicians can perform a wide range of services, including delivering babies, but usually do not perform surgeries.

FDA

U.S. Food and Drug Administration

FDO

Formula-driven overpayment

Federal Employee Health Benefits Program (FEHBP)

A program that provides health insurance to employees of the U.S. federal government. Federal employees choose from a menu of plans that include fee-for-service plans, plans with a point of service option, and health maintenance organization plans. There are more than 170 plans offered; a combination of national plans, agency-specific plans, and more than 150 HMOs serving only specific geographic regions. The various plans compete for enrollment as employees can compare the costs, benefits, and features of different plans.

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.

Federal Poverty Level (FPL)

The amount of income determined by the U.S. 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.

Fee-For-Service

(1) Is the most prevalent payment mechanism for physicians. It is reimbursing the provider whatever fees he or she charges on completion of a specific service. (2) A method of paying healthcare providers for individual medical services rendered, as opposed to paying them salaries or capitated payments. (3) Type of payment used by some health insurers that pays providers for each service after it has been delivered.

FEHBP

Federal employee benefits health plan

Fee Schedule

Maximum dollar amounts that are payable to healthcare providers. Medicare has a fee schedule for doctors who treat beneficiaries. Insurance companies have fee schedules that determine what they will pay under their policies.

FEMA

Federal Emergency Management Agency

FFP

Federal financial participation

FFS

Fee-for-service

FFY

Federal fiscal year

FHA

Farmers Home Administration
Federal Housing Administration

FI

Fiscal intermediary

FICA

Federal Insurance Contribution Act

Fiscal Year

A 12-month period for which an organization plans the use of its funds, such as the federal government's fiscal year (October 1 to September 30). Fiscal years are referred to by the calendar year in which they end; for example, the federal fiscal year 1998 began October 1, 1997. Hospitals can designate their own fiscal years, and this is reflected in differences in time periods covered by the Medicare cost reports.

Fixed Costs

Costs, such as rent and utilities, that do not vary with the output or activity of an organization.
Flexible Benefits An employer-administered program allowing employees to select and trade between health care and other benefits based on their specific needs. Also called cafeteria benefits.

FMAP

Federal medical assistance percentage

FOIA

Freedom of Information Act

Formulary

The list of drugs covered fully or in part by a health plan.

FQHC

Federally qualified health center

FSA

Flexible spending account

FTC

Federal Trade Commission

Full-time Equivalent Personnel (FTE)

Refers to employees; total FTE personnel is calculated by dividing the hospital's total number of paid hours by 2080, the number of annual paid hours for one full-time employee.

FY

Fiscal year

G

GA

General assistance

Gainsharing

Is an incentive program focused on improving operating results, typically implemented at the group or organizational level.

GAO

Government Accountability Office

Gatekeeper

The person in a managed care organization who decides whether or not a patient will be referred to a specialist for further care. Physicians, nurses and physician assistants all function as gatekeepers.

Generics

Drugs that have the same chemical equivalents as a brand-name drug and are typically less expensive. Generic equivalents are often prescribed as a cost-saving alternative.

Global Payments (Global Capitation)

Global payments (global capitation) are fixed payments for which providers are given a pre-specified amount per patient (dependent on demographic data and other considerations) for a time period such as a month or a year. This payment schema places the burden of risk on the provider who will be responsible for delivering comprehensive acute, chronic and preventive care during that time period for that all-inclusive payment.

GME

Graduate medical education

Governance

The legal authority and responsibility for the public health system.

Governing Body

The legal entity ultimately responsible for hospital policy, organization, management and quality of care. Also called the governing board, board of trustees, commissioners or directors. The governing body is accountable to the owners(s) of the hospital, which may be a corporation, the community, local government or stockholders.

GPO

Group purchasing organization

Graduate Medical Education (GME)

The period of medical training that follows graduation from medical school; commonly referred to as internship, residency and fellowship training. GME payments are made to reimburse hospitals for the cost of providing residencies for medical graduates. Effective July 1, 2011, the federal reform law redistributes 65% of the nation's unused residency slots.

Grandfathered Plan

A health plan that an individual was enrolled in prior to March 23, 2010. Grandfathered plans are exempted from most changes required by PPACA. New employees may be added to group plans that are grandfathered, and new family members may be added to all grandfathered plans.

Gross Domestic Product (GDP)

The total current market value of all goods and services produced domestically during a given period; differs from the gross national product by excluding net income that residents earn abroad.

Group Health Insurance

The most common type of health insurance in the United States. The majority of health insurance is offered through businesses, union trusts, or other groups and associations. For insurance purposes, most groups are composed of full-time employees.

Group Practice

Provision of medical services by three or more physicians formally organized to provide medical care, consultation, diagnosis and/or treatment through the joint use of equipment and personnel. The income from the medical practice is distributed in accordance with methods determined by members of the group. Group practices have a single-specialty or multi-specialty focus.

Guarantee Issue/Renewal

Requires insurers to offer and renew coverage, without regard to health status, use of services or pre-existing conditions. This requirement ensures no one will be denied coverage for any reason. Beginning in 2014, the health reform law will require guarantee issue and renewability.

Guaranteed Renewability

A requirement that health insurers renew coverage under a health plan except for failure to pay premium or fraud. HIPAA requires that all health insurance be guaranteed renewable.

H

HAC

Hospital-acquired condition

HAI

Healthcare-acquired infection

HB

House bill

HBIPS

Hospital-based inpatient psychiatric services

HCAHPS

Hospital Consumer Assessment of Healthcare Providers and Systems

HCAP

Hospital care assurance program

HCBS

Home- and community-based services

HCPCS

Healthcare Common Procedure Coding System

HCUP

Healthcare Cost and Utilization Project

HDHP

High Deductible Health Plan

Health and Human Services (HHS)

The U.S. Department of Health and Human Services, formerly the Department of Health, Education and Welfare.

Health Care Cooperative (Co-op)

A non-profit, member-run health insurance organization, governed by a board of directors elected by its members. Co-ops provide insurance coverage to individuals and small businesses and can operate at state, regional and national levels.

Healthcare-Acquired Conditions (HAC)

Reasonably preventable conditions or events during a stay at a healthcare facility and for which Medicare may refuse payment.

Healthcare Common Procedure Coding System (HCPCS)

A uniform method for healthcare providers and medical suppliers to code professional services, procedures and supplies.

Healthcare Cost and Utilization Project (HCUP)

A family of health care databases and related software tools developed through a Federal-State-Industry partnership to build a multi-state health data system for health care research and decisionmaking. HCUP is sponsored by the Agency for Healthcare Research and Quality (AHRQ).

Healthcare Provider

An individual or institution that provides medical services (e.g., a physician, hospital, laboratory). This term should not be confused with an insurance company that provides insurance.

Health Information Exchange (HIE)

A health information exchange is when hospitals, doctors' offices, and others electronically share health information. The exchange of health information should be done securely, maintaining privacy.

Health Information Exchange and Interoperability

A Health Information Exchange (HIE) is an initiative focused on the electronic exchange of healthcare data between healthcare stakeholders. The exchange typically includes clinical, administrative, and financial data across a medical care and coverage area. Interoperability refers to the ability to connect to two or more disparate systems, for example, a disease registry and a payer claims database, for the sharing of permissible secure information via standardized protocols and exchanges.

Health Information Technology (HIT)

Systems and technologies that enable healthcare organizations and providers to electronically gather, store, and share information.

Health Insurance Exchange/Connector

A purchasing arrangement through which insurers offer and smaller employers and individuals purchase health insurance. State, regional, or national exchanges could be established to set standards for what benefits would be covered, how much insurers could charge, and the rules insurers must follow in order to participate in the insurance market. Individuals and small employers would select their coverage within this organized arrangement.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

(1) A federal law that made many changes in employer-sponsored health plans. The law allows individuals to move from job to job without losing coverage as the result of pre-existing conditions. HIPAA also guarantees access to group coverage for employees in companies with 2 to 50 employees, and established the need to provide patients total access to their care information and have the ability to amend their records. (2) HIPAA includes a medical privacy regulation issued by the U.S. Department of Health and Human Services that

obligates hospitals, doctors and other providers to use a patient's health information only for treatment; obtaining payment for care; and for their own operations, including improving the quality of care they provide to their patients. Healthcare facilities cannot use or disclose a patient's health information in other ways, such as marketing or research, unless they get the patient's written permission before doing so. In addition, providers must inform patients how their health data will be used, establish systems to track disclosure of patient information, and permit patients to inspect, copy and request to amend their own health information.

Health Maintenance Organization (HMO)

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

Health Reimbursement Account (HRA)

A tax-exempt account that can be used to pay for current or future qualified health expenses. HRAs are established benefit plans funded solely by employer contributions, with no limits on the amount an employer can contribute. HRAs are often paired with a high-deductible health plan, but are not required to do so.

Health Savings Account (HSA) or Medical Savings Account (MSA)

A health insurance option consisting of a high-deductible insurance policy and tax-advantaged saving account. Individuals 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 pays for most or all costs of covered services once the deductible is met.

HEDIS

Health employer data information set

HFMA

Healthcare Financial Management Association

HHA

Home health agency

HHS

U.S. Department of Health and Human Services

HIAA

Health Insurance Association of America

HIC

Health insuring corporation

HICS

Hospital incident command system

HIDI

Hospital Industry Data Institute

HIE

Health information exchange

High-Deductible Health Plan (HDHP)

Health insurance plans that have higher deductibles (the amount of health care costs that must be paid for by the consumer before the insurance plan begins to pay for services), but lower premiums than traditional plans. Qualified high-deductible plans that may be combined with a health savings account must have a deductible of at least \$1,150 for single coverage and \$2,300 for family coverage in 2009.

High-Risk Pool

State programs designed to provide health insurance to residents who are considered medically uninsurable and are unable to buy coverage in the individual market. As of early 2009, high-risk pools operate in 34 states, but vary by who is eligible, cost sharing requirements, availability of premium subsidies and funding sources.

HIM

Health information management

HIMSS

Healthcare Information & Management Systems Society

HIPAA

Health Insurance Portability and Accountability Act of 1996

HIPC

Health insurance purchasing cooperative

HIT

Health information technology

HITECH

Health Information Technology and Economic and Clinical Health Act

HIV

Human immunodeficiency virus

HMO

Health maintenance organization

Holding Company

A separate entity used to hold a variety of subsidiary groups that often perform related functions but have a distinct corporate identity.

Home and Community-Based Services (HCBS)

Services covering a wide range of needs are available, allowing individuals to remain in their communities and homes. These services include home health care; personal care, providing assistance with bathing, dressing, eating, grooming, toileting, etc.; health support services such as housekeeping, shopping assistance, laundry; respite care (caregiver relief); transportation and other routine household chores as necessary to maintain a consumer's health, safety and ability to remain in the home; home-delivered meals prepared at a central location and delivered to a person's home.

Home Health Care

Provides healthcare services in a patient's home rather than a hospital or other institutional setting. The services provided include nursing care, social services and physical, speech or occupational therapy.

HOP-HAC

Hospital outpatient healthcare-associated condition

HOPD

Hospital outpatient department

Horizontal Integration

A linkage or network of the same types of providers, e.g., a multi-organization system composed of acute care hospitals. It is used as a competitive strategy by some hospitals to control the geographic distribution of health care services.

HOSPAC

Hospital political action committee

Hospice

An organized program of holistic care for the terminally ill that emphasizes caring as opposed to curing, which includes inpatient care, homecare, respite care and family support.

Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)

The HCAHPS survey is the first national, standardized, publicly reported survey of patients' perspectives of hospital care.

Hospital-Physician Alliance (HPA)

A partnership between a hospital and a group of its staff physicians. Such alliances range from an informal sharing of expertise to a more structured arrangement involving computer networking, assistance with physician recruitment and physician practice development.

Hospital Pre-Authorization

Managed care technique in which the insured obtains permission from a managed care organization before entering the hospital for non-emergency care.

Hospitalist

A physician based in a hospital setting responsible for the care and treatment of hospitalized patients.

Hospital Value-Based Purchasing/Pay for Performance

These programs are established to reward providers of care for better results. They require the care-providing organizations have a system of accurate measurements to gauge performance (i.e., a hospital measuring readmission rates). If the organization achieves established goals set by a program sponsor, the organization receives an incentive payment. Organizations can also receive lower remunerations for poor outcomes.

HPP

Health partnership program

HPSA

Health professional shortage area

HQA

Hospital Quality Alliance

HR

House resolution

Human resources

HRA

Health reimbursement account

HRET

Health Resources & Educational Trust

HRSA

Health Resources and Services Administration

HSA

Health savings account

Health service agency

HSDA

Health Services and Development Agency

HVSO

Hospital volunteer services organization

ICD-9-CM

International Classification of Diseases, 9th revision, Clinical Modification. An international system used for reporting vital statistics and mortality coding. Used also as an inpatient and outpatient diagnosis classification system and inpatient procedure classification system.

ICD-10-CM

International Classification of Diseases, 10th revision, Clinical Modification. An international system used for reporting vital statistics and mortality coding. Used also as an inpatient and outpatient diagnosis classification system and an inpatient procedure classification system.

Incurred But Not Reported (IBNR)

An accounting term, means healthcare services have been provided but the bill has not reached the insurer. It allows calculating an insurer's liability and reserve needs. Incurred claims are the legal obligation an insurer has for services that have been provided during a specific period.

Indemnity Insurance

Coverage offered by insurance companies in which individual persons insured are reimbursed for medical expenses by the company. Payments may be made to the individual incurring the expense or, in many cases, directly to providers. Indemnity related only to specific loss incurred by the insured person after the fact.

Independent Payment Advisory Board (IPAB)

A board of 15 members appointed by the President and confirmed by the Senate for six-year terms. The board is tasked with submitting proposals to congress to reduce Medicare spending by specified amounts if the projected per beneficiary spending exceeds the target growth rate. If the board fails to submit a proposal, the secretary of the U.S. Department of Health and Human Services is required to develop a detailed proposal to achieve the required level of Medicare savings. The secretary is required to implement the board's (or secretary's) proposals, unless congress adopts alternative proposals that result in the same amount of savings. The board is prohibited from submitting proposals that would ration care, increase taxes, change Medicare benefits or eligibility, increase beneficiary premiums and cost-sharing requirements, or reduce low-income subsidies under Part D.

Indian Health Services (IHS)

A division of the U.S. Public Health Service that is responsible for providing federal health services for American Indians and Alaska natives.

Indigent Care

Medical care for patients who cannot afford to pay for their care.

Individual Insurance Market

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

Individual Mandate

A requirement that all individuals obtain health insurance. There is an individual mandate to obtain health insurance in the health reform law that applies to all Americans with some hardship and income-based exemptions beginning in 2014.

In-Network Provider

A health care provider (such as a hospital or doctor) that is contracted to be part of the network for a managed care organization (such as an HMO or PPO). The provider agrees to the managed care organization's rules and fee schedules in order to be part of the network and agrees not to balance bill patients for amounts beyond the agreed upon fee.

Inpatient

A patient receiving acute care through admission to the hospital for a stay of longer than 24 hours.
Intensive Care Unit (ICU) A hospital unit for treatment and continuous monitoring of inpatients with life-threatening conditions.

Integrated Healthcare Delivery System

An integrated delivery system (IDS) is a network of healthcare providers and organizations that provide or arrange to provide a coordinated continuum of services. Services provided by an IDS can include a fully equipped community and/or tertiary hospital, home healthcare and hospice services, primary and specialty outpatient care and surgery, social services, rehabilitation, preventive care, and health education.

Internal Medicine Physicians (Internists)

Primary care physicians primarily for adults. Unlike family practice physicians, they normally do not care for children and may perform surgeries.

Internal Review

The review of the health plan's determination that a requested or provided health care service or treatment health care service is not or was not medically necessary by an individual(s) associated with the health plan. PPACA requires all plans to conduct an internal review upon request of the patient or the patient's representative.

Interstate Compact

An agreement between two or more states. PPACA provides guidelines for states to enter into interstate compacts to allow health insurance policies to be sold in multiple states.

Investor-Owned Hospital

A hospital operated by a for-profit corporation in which the profits go to shareholders who own the corporation. Also referred to as a "proprietary or specialty" hospital.

J

JAMA

Journal of the American Medical Association

JAR

Joint Annual Report of Hospitals

JC

Joint Commission

JCR

Joint Commission Resources

Job Lock

The situation where individuals remain in their current job because they have an illness or condition that may make them unable to obtain health insurance coverage if they leave that job. PPACA would eliminate job lock by prohibiting insurers from refusing to cover individuals due to health status.

The Joint Commission (Formerly JCAHO)

An independent, voluntary, not-for-profit accreditation body sponsored by the American College of Physicians, American College of Surgeons, American Hospital Association, American Medical Association, and American Dental Association. The Joint Commission conducts accreditation surveys for hospitals and other healthcare organizations, monitoring the quality of care provided based on standards established by The Joint Commission.

L

LCSW

Licensed clinical social worker

LeadingAge

A professional trade association, the work of LeadingAge is focused on advocacy, leadership development, and applied research and promotion of effective services, home health, hospice, community services, senior housing, assisted living residences, continuing care communities and nursing homes, as well as technology solutions, to seniors, children and others with special needs.

Length of Stay (LOS)

The number of days between a patient's admission and discharge from a hospital. Average length of stay (ALOS) is determined by total discharge days divided by total discharges.

Licensed Practical Nurse (LPN)

A nurse who has completed a practical nursing education program and is licensed by a state to provide routine care under the direction of a registered nurse or physician.

Licensure

A formal process by which a government agency grants an individual the legal right to practice an occupation; grants an organization the legal right to engage in an activity, such as operation of a hospital; and prohibits all other individuals and organizations from legally doing so, to ensure that the public health, safety and welfare are reasonably well-protected.

Lifetime Benefit Maximum

A cap on the amount of money insurers will pay toward the cost of healthcare services over the lifetime of the insurance policy. Lifetime benefits maximums are prohibited under health reform.

Limited Benefits Plan

A type of health plan that provides coverage for only certain specified health care services or treatments or provides coverage for health care services or treatments for a certain amount during a specified period.

LIP

Low-income patient

LISW

Licensed independent social worker

Living Will

Document generated by a person for the purpose of providing guidance about the medical care to be provided if the person is unable to articulate these decisions.

Long-Term Care

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

LOS

Length of stay

LPN

Licensed practical nurse

LSW

Licensed social worker

LTAC

Long-term acute care

LTCF

Long-term care facility

LTCH

Long-term care hospital

LTD

Long-term disability

LUPA

Low utilization payment adjustment

LWDII

Lost work day injury and illness

M

MA

Medical assistance

MAC

Medicare administrative contractor

Magnetic Resonance Imaging (MRI)

Using a scanner, this is a high technology diagnostic procedure used to create cross-sectional images of the body by the use of magnetic fields and radio frequency fields.

Malpractice

Professional misconduct or lack of ordinary skill in the performance of a professional act. A practitioner is liable for damages or injuries. Malpractice requires that the patient proves some injury and the injury was negligently caused.

Managed Care

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

Managed Care Network

A regional or national organization of providers owned by a commercial insurance company or other sponsor (e.g., a managed care plan) and offered to employers and other groups or organizations as either an alternative to, or a total replacement for, traditional indemnity health insurance.

Managed Care Organization (MCO)

A plan or company, such as a health maintenance organization (HMO), preferred provider organization (PPO), or exclusive provider organization, that uses the principles of managed care as a basic part of doing business.

Management Information System (MIS)

A system that produces the necessary information in proper form and at appropriate intervals for the management of a program or other activity. The system ideally measures program progress toward objectives and reports costs and problems needing attention.

Management Service Organization (MSO)

A management entity, either for-profit and wholly owned by a hospital or created via a hospital-physician joint venture. An MSO acquires the tangible assets of a medical group and contracts with the group to provide all facilities, equipment and administrative services for a management fee.

Mandatory Benefits

Certain benefits or services, such as mental health services, substance abuse treatment, and breast reconstruction following a mastectomy, that state-licensed health insuring organizations are required to cover in their health insurance plans. The number and type of these mandatory benefits vary across states.

Marginal Cost

The cost of producing an extra unit of product; a key consideration in pricing and in calculating cost implications of business expansion or contraction.

Market Basket Index Update

An index of the annual change in the prices of goods and services that providers use for producing health services. There are separate market baskets for Medicare's prospective payment system's (PPS's) hospital operating and capital inputs; PPS-excluded facility operating inputs; and skilled nursing facility (SNF), home health agency, and renal dialysis facility operating and capital inputs.

Market Share

In the context of managed care, that part of the market potential that a managed care company has captured; usually market share is expressed as a percentage of the market potential.

MCC

Managed care contractor

MCO

Managed care organization

MCPSS

Medicare contractor provider satisfaction survey

MD

Medical doctor

MDCs

Major diagnosis categories

MDH

Medicare-dependent hospital

MDS

Minimum data set

Meaningful Use

The 2009 Health Information Technology for Economic and Clinical Health Act (HITECH Act) is part of the American Recovery and Reinvestment Act (ARRA) which included funding for Medicare and Medicaid incentives for the ‘Meaningful Use’ (MU) of certified electronic health records (EHRs). The intent of the legislation is to promote the use of EHR technology to improve quality, safety, efficiency and reduce health disparities; engage patients and families in their healthcare; enhance care coordination; support population and public health.

Meaningful Users of EHR Technologies (per HIMSS)

HIMSS recognizes that defining a meaningful user is a complex endeavor. In order for the nation to benefit from the spirit and intent of ARRA, and for physicians to have a reasonable chance of achieving the definition, HIMSS asserts that the requirements must be introduced – and made increasingly stringent – in incremental stages. In the final stage, which must commence in FY15, HIMSS believes the mature definition of “meaningful user of certified EHR technology” includes at least four attributes: A. Utilization of an EHR certified by the Certification Commission for Healthcare Information Technology (CCHIT); B. Demonstrated ability to electronically exchange standardized patient summary data with clinical and administrative stakeholders; C. Demonstrated practice of electronic prescribing; and, D. Demonstrated reporting of quality and patient safety data.

Medicaid

Enacted in 1965 under Title XIX of the Social Security Act, Medicaid is a federal entitlement program that provides health and long-term care coverage to certain categories of low-income Americans. States design their own Medicaid programs within broad federal guidelines. Medicaid plays a key role in the U.S. health care system, filling large gaps in the health insurance system, financing long-term care coverage, and helping to sustain the safety-net providers that serve the uninsured.

Medicaid Integrity Contractors (MIC)

Firms chosen by the Centers for Medicare and Medicaid Services to perform audits, identify overpayments and conduct education on payment integrity and quality of care.

Medicaid Integrity Group (MIG)

The Centers for Medicare and Medicaid Services’ MIG administers the Medicaid integrity program and regularly consults with the Medicaid fraud and abuse technical advisory group.

Medicaid Integrity Program (MIP)

A comprehensive plan established by the Centers for Medicare and Medicaid Services to combat fraud, waste and abuse in the Medicaid program, beginning in fiscal year (FY) 2006.

Medicaid Waivers

Authority granted by the secretary of the U.S. Department of Health and Human Services to allow a state to continue receiving federal Medicaid matching funds even though it is no longer in compliance with certain requirements of the Medicaid statute. States can use waivers to implement home and community-based services programs, managed care, and expand coverage to populations who are not otherwise eligible for Medicaid.

Medical Executive Committee

Generally composed of the elected or appointed officers and chairs of clinical departments or divisions of the medical staff organization.

Medical Group

An organized collection of physicians who have a common business interest through a partnership or some form of shared ownership. Some medical groups consist of a group of physicians representing a single specialty; other groups are made up of physicians from two or more specialties.

Medical Home

A healthcare setting where patients receive comprehensive primary care services; have an ongoing relationship with a primary care provider who directs and coordinates their care; have enhanced access to non-emergent primary, secondary and tertiary care; and have access to linguistically and culturally appropriate care.

Medical Loss Ratio (MLR)

The percentage of premium dollars an insurance company spends on medical care, as opposed to administrative costs or profits. The health reform law requires insurers in the large group market to have an MLR of 85 percent and insurers in the small group and individual markets to have an MLR of 80 percent.

Medical Record

A record kept for each patient containing sufficient information to identify the patient, justify the diagnosis and treatment, and accurately document the results. The purposes of the record are to: (1) serve as the basis for planning and continuity of patient care; (2) provide a means of communication among physicians and other professionals contributing to the patient's care; (3) furnish documentary evidence of the patient's course of illness and treatment; (4) serve as a basis for review, study and evaluation; and (5) provide data for use in research and education. The content of the record is confidential.

Medical Staff Bylaws

The written rules and regulations that define the duties, responsibility and rights of physicians and other health professionals who are part of a facility's medical staff.

Medical Staff Organization

That body which, according to the medical staff standard of the Joint Commission, "include fully licensed physicians, and may include other licensed individuals permitted by law and by the hospital to provide inpatient care services independently in the hospital." These individuals together make up the "organized medical staff."

Medical Underwriting

The process of determining whether or not to accept an applicant for healthcare coverage based on their medical history. This process determines what the terms of coverage will be, including the premium cost, and any pre-existing condition exclusions. Medical underwriting will be prohibited under health reform beginning in 2014.

Medically Indigent

A person who, by current income standards, is not poor, but lacks the financial resources to afford necessary medical services.

Medically Necessary

Those covered services required to preserve and maintain the health status of a member or eligible person in accordance with the area standards of medical practice in the medical community where services are rendered.

Medically Underserved Area (MUA)

A geographic location that has insufficient health resources to meet the medical needs of the resident population.

Medicare

Enacted in 1965 under Title XVII of the Social Security Act, Medicare is a federal entitlement program that provides health insurance coverage to 45 million people, including people age 65 and older, and younger people with permanent disabilities, end-stage renal disease and Lou Gehrig's disease.

Medicare Administrative Contractor (MAC)

The integration of the administration of Medicare Parts A and B from separate oversight of fiscal intermediary (Part A) and carrier (Part B). This integration will allow centralization of information regarding coverage, claims payment, etc.

Medicare Advantage

Referred to as Medicare Part C, the Medicare Advantage program allows Medicare beneficiaries to choose to receive their Medicare benefits through a private insurance plan rather than the traditional fee-for-service program.

Medicare Assignment

An agreement in advance by a physician to accept Medicare's allowed charge as payment in full (guarantees not to balance bill). Medicare pays its share of the allowed charge directly to physicians who accept assignment and provides other incentives under the participating physician and supplier program.

Medicare Cost Report (MCR)

An annual report required of all institutions participating in the Medicare program. The MCR records each institution's total costs and charges associated with providing services to all patients, the portion of those costs and charges allocated to Medicare patients, and the Medicare payments received.

Medicare Fee Schedule

The resource-based fee schedule Medicare uses to pay for physicians' services.

Part A Medicare

Medical hospital insurance (HI) under Part A of Title XVIII of the Social Security Act, which covers beneficiaries for inpatient hospital, home health, hospice and limited skilled nursing facility services. Beneficiaries are responsible for deductibles and copayments. Part A services are financed by the Medicare HI trust fund, which consists of Medicare tax payments.

Part B Medicare

Medicare supplementary medical insurance (SMI) under Part B of Title XVII of the Social Security Act, which covers Medicare beneficiaries for physician services, medical supplies and other outpatient treatment. Beneficiaries are responsible for monthly premiums, copayments, deductibles and balance billing. Part B services are financed by a combination of enrollee premiums and general tax revenues.

Part C Medicare

Medicare supplementary medical insurance (SMI) under Part C of Title XVII of the Social Security Act, which covers Medicare beneficiaries enrolled in the various Medicare + Choice managed care plans.

Part D Medicare

Medicare supplementary medical insurance (SMI) under Part D of Title XVII of the Social Security Act, which covers prescription drugs as enacted by the Medicare Modernization Act of 2006.

Medicare Payment Advisory Commission (MedPAC)

An advisory body of independent experts created by the U.S. Congress to provide guidance on Medicare provider payment issues. The former Prospective Payment Assessment Commission (ProPAC) and Physician Payment Review Commission (PPRC) were merged into the MedPAC at its creation in 1997.

Medicare-Severity DRG's (MS-DRGs)

A refinement of the DRG classification system to more fairly compensate hospitals for treating severely ill Medicare patients by adding more DRGs to account for major complications and co-morbidity.

Medicare-Supplement Policy

A type of health insurance policy that provides benefits for services Medicare does not cover.

Medigap Insurance

Privately purchased individual or group health insurance policies designed to supplement Medicare coverage. Benefits may include payment of Medicare deductibles, coinsurance and balance bills, as well as payment for services not covered by Medicare. Medigap insurance must conform to one of ten federally standardized benefit packages.

MedPAC

Medicare Payment Advisory Commission

MedPAR

Medicare provider analysis and review

Metropolitan Statistical Area (MSA)

A geographic area that includes at least one city with 50,000 or more inhabitants, or a Census Bureau-defined urbanized area of at least 50,000 inhabitants and a total MSA population of at least 100,000.

MFN

Most favored nation

MHPAEA

Mental Health Parity and Addiction Equity Act of 2008

MIC

Medicaid integrity contractor

Mid-Level Practitioner (MLP)

Nurse practitioners, physician assistants, certified nurse midwives, and other non-physicians who can deliver medical care under the sponsorship of a practicing physician.

Minimum Creditable Coverage

The minimum level of benefits that must be included in a health insurance plan in order for an individual to be considered insured.

Minimum Data Set (MDS)

Federally mandated process for clinical assessment of all residents in Medicare or Medicaid certified nursing homes. This process provides a comprehensive assessment of each resident's functional capabilities and helps nursing home staff identify health problems and needs of those who reside in the nursing home. The MDS also is used to measure quality of care and to determine level of payment.

MIP

Medicaid integrity program

MIPPA

Medicare Improvements for Patients and Providers Act of 2008

MMA

Medicare Modernization Act

Medicare Prescription Drug, Improvement & Modernization Act of 2003

MMIS

Medical management information system

MMSEA

Medication, Medicaid & SCHIP Extension Act of 2007

MMWR

Morbidity and mortality weekly report

Morbidity

A measure of disease incidence or prevalence in a given population, location or other grouping of interest.

Mortality

A measure of deaths in a given population, location or other grouping of interest.

MOU

Memorandum of understanding

MPFS

Medicare physician fee schedule

MPH

Master's degree in public health

MRA

Magnetic resonance angiography

MRI

Magnetic resonance imaging

MRSA

Methicillin-resistant *Staphylococcus aureus*

MSA

Medical savings account

Metropolitan statistical area

MSDRG

Medicare severity diagnosis-related group

MSN

Master of science in nursing

Medicare summary notice

MSO

Management service organization

MUA

Medically underserved area

Multispecialty Group

A physician practice environment where diverse fields of medicine may converge to bring patients and purchasers a more unified and comprehensive service package.

MUP

Medically underserved population

N

National Committee for Quality Assurance (NCQA)

A private, not-for-profit organization that assesses and reports on the quality of managed care plans, with the goal of enabling purchasers and consumers of managed healthcare to distinguish among plans based on quality.

National Incident Management System (NIMS)

A federal program established in 2003 to provide a consistent nationwide template to enable organizations to work together when responding to domestic disasters and emergencies.

National Practitioner Data Bank (NPDB)

A computerized data bank maintained by the federal government that contains information on physicians against whom malpractice claims have been paid or certain disciplinary actions have been taken.

NBRC

National Board for Respiratory Care

NBME

National Board of Medical Examiners

NCCMERP

National Coordinating Council for Medication Error Reporting and Prevention

NCD

National coverage determination

NCHS

National Center for Health Statistics

NCHSR

National Center for Health Services Research

NCQA

National Committee for Quality Assurance

NDC

National drug code

NDMS

National disaster medical system

Neonatal

The part of an infant's life from the hour of birth through 27 days, 23 hours and 59 minutes; the infant is referred to as a newborn throughout this period.

Neonatal Intensive Care Unit (NICU)

An intensive care unit specializing in the care of ill or premature newborn infants.

Net Loss Ratio

A measure of a plan's financial stability, derived by dividing its medical costs and other expenses by its income from premiums.

Network

A group of providers, typically linked through contractual arrangements, which provide a defined set of benefits.

NIC

Neonatal intensive care

NIH

National Institutes of Health

NIOSH

National Institute for Occupational Safety and Health

NLRB

National Labor Relations Board

NMT

Nuclear medicine technologist

Nonparticipating Physician

A physician who does not sign a participation agreement and, therefore, is not obligated to accept assignment on all Medicare claims.

Nosocomial Infection

An infection that may be measured by its rate of frequency of occurrence and is acquired by an individual while receiving care or services in a healthcare organization.

Not-For-Profit Hospital

A not-for-profit hospital is owned and operated by a private corporation. Excess of income over expenses is used for hospital purposes rather than returned to stockholders or investors as dividends. Sometimes referred to as a voluntary, tax-exempt or 501 (c) (3) hospital.

NP

Nurse practitioner

NPDB

National practitioner data bank

NPI

National provider identifier

NPSF

National patient safety foundation

NPSP

National patient safety partnership

NQF

National Quality Forum

NRC

Nuclear Regulatory Commission

NRHA

National Rural Health Association

NSQIP

National surgical quality improvement program

Nursing Home

A health facility with inpatient beds and an organized professional staff that provides continuous nursing and other health-related, psychosocial and personal services to patients who are not in an acute phase of illness, but who primarily require continued care on an inpatient basis.

O

OASIS

Outcome and assessment information set

OB-GYN

Obstetrics and gynecology

OBRA

Omnibus Budget Reconciliation Act

OBS

Office-based surgery

Occupancy

The inpatient census, generally expressed as a percentage of total beds which are occupied at any given time.

Occupational Safety and Health Administration (OSHA)

Agency of the U.S. Department of Labor charged with the responsibility of reducing occupational exposure and risk to workers' health and safety. OSHA establishes rules, monitors compliance through inspection and enforces rules through penalties and fines for non-compliant organizations.

Occurrence Coverage

Once the most common type of commercial malpractice insurance, coverage for liability arising from malpractice that occurred while the policy was in effect, regardless of when the claim of potential loss is reported.

OCR

U.S. Office of Civil Rights

OD

Optometry doctor

OHS

U.S. Office of Homeland Security

OIG

Office of Inspector General

OMB

U.S. Office of Management and Budget

Ombudsman

An advocate for quality care and quality of life in nursing homes and assisted living facilities. Ombudsmen identify, investigate and resolve complaints by or on behalf of facility residents. Volunteer and staff ombudsmen serve as independent, unbiased advocates for residents and work with all persons involved to reach acceptable solutions to problems. Ombudsmen work closely with the Texas Department of Aging and Disability Services, the government agency that regulates nursing homes. State and federal laws authorize the nursing home ombudsman program.

Omnibus Budget Reconciliation Act (OBRA)

Congress refers to this as the many tax and budget reconciliation acts. Most of these acts contain language important to managed care, generally in the Medicare market segment.

Open Enrollment Period

A specified period during which individuals may enroll in a health insurance plan each year. In certain situations, such as if one has had a birth, death or divorce in their family, individuals may be allowed to enroll in a plan outside of the open enrollment period.

Open Staff

As applied to the medical staff as a whole, an agreement under which physicians provide administrative and clinical services to a hospital on a non-exclusive basis.

Operating Budget

A financial plan for the expected revenues and expenditures of the day-to-day operations of the hospital.

OPO

Organ procurement organization

OPPS

Outpatient prospective payment system

OR

Operating room

ORHP

Office of Rural Health Policy

OSHA

Occupational Safety and Health Administration

OT

Occupational therapy/therapist

OTC

Over-the-counter

Outcome and Assessment Information Set (OASIS)

Federally mandated process for clinical assessment of individuals receiving home care services paid for by Medicare. The OASIS provides a comprehensive assessment of the person's functional capabilities and needs. It also is utilized to help measure quality of care and determine payment.

Outcomes

The end result of health care that is usually measured in terms of cost, mortality, health status, and quality of life or patient function. Outcome measures are the specific criteria used to determine or describe the outcome.

Outcomes Measurement

The process of systematically tracking a patient's clinical treatment and responses to that treatment using generally accepted outcomes measures or quality indicators.

Outliers

Cases with extremely long lengths of stay (day outliers) or extraordinarily high costs (cost outliers) compared with others classified in the same diagnosis-related group. Hospitals receive additional payment for these cases.

Out-of-Area

A place where the plan will not pay for services or benefits. Out-of-area can refer to geographical location, as well as to benefits or services outside a specific group of providers.

Out-of-Network Provider

A health care provider (such as a hospital or doctor) that is not contracted to be part of a managed care organization's network (such as an HMO or PPO). Depending on the managed care organization's rules, an individual may not be covered at all or may be required to pay a higher portion of the total costs when he/she seeks care from an out-of-network provider.

Out-of-Pocket Limit

The total amount of money, including deductibles, copayments and coinsurance, as defined in the contract that plan members must pay out of their own pockets toward eligible expenses for themselves and/or dependants.

Out-of-Pocket Payments

Cash payments made by a plan member or insured person to the provider in the form of deductibles, coinsurance or copayments during a defined period (usually a calendar year) before the out-of-pocket limit is reached.

Outpatient

A person who receives care without being admitted to the hospital for overnight or a longer stay. The term usually does not designate a person who is receiving services from a physician's office or other program that does not also provide inpatient care.

P

PA

Physician assistant

PAC

Political action committee

PACE

Program of all-inclusive care for the elderly

PAE

Preadmission evaluation

Paid Claims

The funds that health insurance plans pay to providers for approved services rendered. They do not include the patient's portion of those services, such as copayments. Paid claims are only those costs for which the plan is responsible, according to the contract between the provider and plan.

Paid Claims Loss Ratio

The ratio of paid claims to premiums as a measure of a health plan's financial performance.

Partial Capitation

An insurance arrangement where the payment made to a health plan is a combination of a capitated premium and payment based on actual use of services; the proportions specified for these components determine the insurance risk faced by the plan.

Participating Physician or Provider

A physician or other provider who signs a Medicare participation agreement, agreeing to accept assignment on all Medicare claims for one year, or those who are under contract with a health plan to provide services.

Patient-Centered Medical Home

A Patient-Centered Medical Home (PCMH) is a model of care by which a personal primary care physician, who has an ongoing trusted relationship with a patient, provides comprehensive and continuous care with care coordination to meet the patient's multiple care needs including: wellness, risk reduction, preventive services, as well as acute, chronic, and end-of-life care. This model focuses on improving accessibility, comprehensiveness, collaboration, record-keeping, patient safety, and the quality of care for the patients treated within them.

PASRR

Preadmission screening and resident review

Patient Days

Each calendar day of care provided to a hospital inpatient under the terms of the patient's health plan excluding the day of discharge. "Patient days" is a measure of institutional use and is usually stated as the accumulated total number of inpatients (excluding newborns) each day for a given reporting period, tallied at a specific time (e.g., midnight) per 1,000 use rate, or patient days/1,000. Patient days are calculated by multiplying admissions by average length of stay.

Patient Mix

The numbers and types of patients served by a hospital or health program, classified according to their home, socioeconomic characteristics, diagnosis or severity of illness.

Patient Protection and Affordable Care Act (PPACA)

Known as the Affordable Care Act, legislation (Public Law 111-148) signed by President Obama on March 23, 2010. Commonly referred to as the health reform law.

Patient Representative

A person who investigates and mediates patients' problems and complaints in relation to a hospital's services or health plan's coverage. Also called a patient advocate or patient ombudsman.

Patient Registry

To deliver the most appropriate care to specific cohorts within a population, providers are encouraged to keep lists of patients who have common conditions or concerns. These registries can be paper-based or preferably computerized. With these lists, physicians and other providers can institute disease or condition management programs for patients with illness burdens or track others for their completion of appropriate screenings, for example.

Patient Rights

Those rights to which an individual is entitled while a patient. In addition to civil and constitutional rights, they include the right to privacy and confidentiality, the right to refuse treatment, and the right of access to the individual's medical information.

Patient Safety

The domain dedicated to preventing and reducing the harm that may be caused during a patient's interaction with the medical system. This can help improve healthcare outcomes while reducing costs.

Patient Satisfaction Survey

A questionnaire used to solicit the perceptions of patients and then pursues another source of payment (e.g., another plan). Also called pay and chase.

Pay for Performance

A healthcare payment system in which providers receive incentives for meeting or exceeding quality and cost benchmarks. Some systems also penalize providers who do not meet established benchmarks. The goal of pay-for-performance is to improve the quality of care over time.

Payer

Any agency, insurer or health plan that pays for healthcare services and is responsible for the costs of those services, such as Medicare, Medicaid or a third-party payer (ex: Blue Cross Blue Shield).

Payment Bundling

A mechanism of provider payment where providers or hospitals receive a single payment for all of the care provided for an episode of illness, rather than per service. Total care provided for an episode of illness may include both acute and post-acute care.

Payment Integrity

Payment integrity is the process by which the correct payments for the correct covered lives, for the correct services are paid to the correct provider(s). This process involves detecting and minimizing fraud, waste, abuse, and misuse of healthcare dollars.

Payment Rate

The total amount paid for each unit of service rendered by a healthcare provider, including both the amount covered by the insurer and the consumer's cost sharing: sometimes referred to as payment level. Also used to refer to capitation payments to health plans. For Medicare payments to physicians, this is the same as the allowed charge.

PBM

Pharmacy benefits manager

PCCM

Primary care case management

PCMH

Patient-Centered Medical Home

PCN

Primary care network

PCP

Primary care physician

PDL

Preferred drug list

PDN

Private duty nurse

PDS

Patient data system

Peer Review

Evaluation of a physician's performance by other physicians, usually within the same geographic area and medical specialty.

Peer Review Organization (PRO)

(1) An organization contracting with CMS to review the medical necessity and the quality of care provided to Medicare beneficiaries; formerly called Utilization and Quality Control Peer Review Organization. (2) An organization that contracts with CMS to investigate the quality of health care furnished to Medicare beneficiaries and to educate beneficiaries and providers. PROs also conduct limited review of medical records and claims to evaluate the appropriateness of care provided.

PEPM

Per employee per month

PEPPER

Program for evaluating payment patterns electronic report

Per Diem Cost

Refers to hospital or other inpatient institutional costs per day or for a day of care. Hospitals occasionally charge for their services on the basis of a per diem rate derived by dividing their total costs by the number of inpatient days of care given.

Per Diem Payments

Fixed daily payments that do not vary with the level of services used by the patient. This method generally is used to pay institutional providers, such as hospitals and nursing facilities.

Per Member Per Month (PMPM)

The amount of money a health plan or provider receives per person every month. It is a way of calculating income and levels of payment. Also called per subscriber per month (PSPM) or per contract per month (PCPM).

Performance Measure

A quantitative tool (e.g., rate, ratio, index, percentage) that indicates an organization's performance in relation to a specified process or outcome. This can be a comparative indicator, such as a benchmark.

Personal Health Record (PHR)

A personal health record contains individual electronic health information. It is controlled and managed by an individual. A personal health record should meet the technical rules that ensure it can be shared between, for example, hospitals, doctors' offices and clinics.

PET

Positron emission tomography

PharmD

Doctor of pharmacy

PHI

Personal health information

PHO

Physician hospital organization

PHP

Partial hospitalization program

Prepaid health plan

Physician Assistant (PA)

A specially trained and licensed health professional that, under the supervision of a physician, performs certain medical procedures previously reserved to a physician.

Physician Credentialing

Originally, referred only to the process of verifying that a physician had the appropriate credentials (medical, education, training, licenses, etc.) to practice in the hospital. Today, the term refers more broadly to the entire process, delegated by the board to the medical staff, of medical staff appointment, reappointment and delineation of clinical privileges. The board has ultimate accountability for physician credentialing.

Physician Extender

A health professional, such as a nurse or health educator, who works with patients to make the patient's time with the physician more efficient and productive.

Physician/Hospital Organization (PHO)

(1) A structure in which a hospital and physicians - both in individual and group practices - negotiate as an entity directly with insurers. (2) An organization that contracts with payers on behalf of one or more hospitals and affiliated physicians. The PHO also may undertake utilization review, credentialing and quality assurance. Physicians retain ownership of their own practices, maintain significant business outside the PHO, and typically continue in their traditional style of practice.

PIP

Periodic interim payment

PMPM

Per member per month

POA

Present on admission

Portability of Coverage

Rules allowing people to obtain coverage as they move from job to job or in and out of employment. Individuals changing jobs are guaranteed coverage with the new employer without a waiting period. In addition, insurers must waive any pre-existing condition exclusions for individuals who were previously covered within a specified time period. Portable coverage can also be health coverage that is not connected to an employer, allowing individuals to keep their coverage when they have a change in employment.

POS

Point-of-service

Positron Emission Tomography (PET)

An imaging technique that tracks metabolism and responses to therapy used in cardiology, neurology and oncology. Particularly effective in evaluating brain and nervous system disorders.

PPACA

Patient Protection and Affordable Care Act

PPO

Preferred provider organization

PPS

Prospective payment system

PQRI

Physician quality reporting initiative

Practice Guidelines

Systematically developed statements on medical practices that assist a practitioner in making decisions about appropriate health care for specific medical conditions. Managed care organizations frequently use these guidelines to evaluate appropriateness and medical necessity of care. Also called practice parameters.

Practice Pattern

The manner in which an individual provider uses medical resources to treat patients. Increasingly, managed care organizations and hospitals are monitoring physician practice patterns in an attempt to lower utilization of medical services.

Pre-Admission Screening and Resident Review (PASRR)

Government mandated two-phase screening and assessment process for nursing home applicants to and residents of Medicaid certified nursing homes. The PASRR is designed to identify and ensure delivery of appropriate services and placements for people with disabilities.

Pre-existing Condition

An illness or medical condition for which a person received a diagnosis or treatment within a specified period of time prior to becoming insured. Health care providers can exclude benefits for a defined period of time for the treatment of medical conditions that they determine to have existed within a specific period prior to the beginning of coverage.

Pre-existing Condition Exclusion

The period of time that an individual receives no benefits under a health benefit plan for an illness or medical condition for which an individual received medical advice, diagnosis, care or treatment within a specified period of time prior to the date of enrollment in the health benefit plan. PPACA prohibits pre-existing condition exclusions for all plans beginning January 2014.

Preferential Discounts

Reimbursements to healthcare providers from insurance companies and other payers based on negotiated discounts off of providers' regular charges.

Preferred Provider Organizations (PPO)

(1) Are somewhat similar to IPAs and HMOs in that the PPO is a corporation that receives health insurance premiums from enrolled members and contracts with independent doctors or group practices to provide care. However, it differs in that doctors are not prepaid, but they offer a discount from normal fee for service charges. (2) A health plan with a network of providers whose services are available to enrollees at a lower cost than the services of non-network providers. PPO enrollees may self-refer to any network provider at any time.

Premium

The money paid for insurance. Often, both employers and employees pay a premium. There are different kinds of premiums. A per-person premium is a fixed amount of money paid by employers and employees for insurance. A wage-based premium is a percentage of payroll paid by employers and employees for insurance.

Premium Subsidies

A fixed amount of money or a designated percentage of the premium cost that is provided to help people purchase health coverage. Premium subsidies are usually provided on a sliding scale based on an individual's or family's income.

Prepayment

A method of providing the cost of healthcare services in advance of their use.

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).

Preventive Health Care

Health care that aims to prevent disease and illness before it occurs and concentrates on keeping patients well.

Price Transparency

The process of collecting and reporting health care cost, performance and quality data in a format that can be accessed by consumers to make a decision based on quality and cost of health care services at a variety of outlets and is intended to improve the delivery of services and ultimately improve the health care system as a whole.

Primary Care

A basic level of health care provided by the physician from 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. Traditionally, primary care physicians are family physicians, internists, gynecologists and pediatricians.

Primary Care Provider or Primary Care Physician (PCP)

Healthcare professional capable of providing a wide variety of basic health services. Primary care providers include practitioners of family, general or internal medicine; pediatricians and obstetricians; nurse practitioners; midwives; and physician's assistants in general or in family practice.

Principal Diagnosis

An ICD-9-CM diagnosis established after study as being chiefly responsible for occasioning the admission of a patient to the hospital for care. Also referred to as the principal inpatient diagnosis (PID).

Prior Authorization

A cost-control procedure that requires a service or medication to be approved in advance by the doctor and/or the insurer. Without prior authorization, the health plan or insurer will not pay for the test, drug or services.

Private Inurement

When a 501 (c)(3), tax exempt business operates in such a way as to provide more than incidental financial gain to a private individual, a practice that can jeopardize that business's tax-exempt status.

Private Practice A traditional arrangement wherein physicians are not employees of any entity and generally treat a variety of patients in terms of their payment sources.

Privileges

The right to provide medical or surgical care services in the hospital, within well-defined limits, according to an individual's professional license, education, training, experience and current clinical competence.

Hospital privileges must be delineated individually for each practitioner by the board based on a medical staff recommendation. It also is referred to as medical staff privileges.

PRO

Peer review organization

Product Lines

Groups of related business activities. A hospital's product line might be as broad as cardiac care or surgical care, or as specific as care by DRG or product code.

Productivity

The relationship between service input and output. Typically productivity measures for labor costs include FTEs per patient day, FTEs per admission and FTEs per bed.

Professional Liability Insurance

The insurance physicians purchase to help protect themselves from the financial risks associated with medical liability claims.

Profitability

A financial ratio that measures the earning power and earning record of a corporation.

ProPAC

Prospective Payment Assessment Commission

Prospective Payment

A method of payment for healthcare services in which the amount of payment for services is set prior to the delivery of those services and the hospital (or other provider) is at least partially at risk for losses or stands to gain from surpluses that accrue in the payment period.

Prospective Payment System (PPS)

A method of payment by which rates of payments to providers for services to patients are established in advance for the upcoming fiscal year.

Prosthetics-Orthotics

The evaluation, fabrication and custom fitting of artificial limbs and orthopedic braces.

Protocols

Standards or practices developed to assist healthcare providers and patients to make decisions about particular steps in the treatment process.

Provider

A hospital or healthcare professional who provides healthcare services to patients. May also be an entity (e.g. hospital, nursing home, physician group practice, treatment center, etc.) or a person (physician, nurse, physician's assistant, etc.).

PSC

Program safeguard contractor

PSI

Patient safety indicator

PSO

Patient safety organization

Provider safety organization

Provider-sponsored organization

PsyD

Doctor of psychology

PT

Physical therapy/therapist

Public Health Department/District

Local (county or multi- county) health agency, operated by local government, with oversight and direction from a local board of health, which provides public health services throughout a defined geographic area.

Public Health Service (PHS)

A division of the U.S. Department of Health and Human Services responsible for the health and well-being of the American public by providing services for low-income families and individuals and battling communicable diseases. PHS' responsibility includes environmental health, as well as clinical health services to prevent the spread of disease.

Public Plan Option

A proposal to create a new insurance plan administered and funded by federal or state government that would be offered along with private plans in a newly-created health insurance exchange.

Purchaser

An employer or company that buys health insurance for its employees.

Purchasing Pool

Health insurance providers pool the healthcare risks of a group of people in order to make the individual costs predictable and manageable.

Q

QAPI

Quality assessment and performance improvement

QI

Quality improvement

QM

Quality management

QMB

Qualifying medical bills

Qualified Medicare beneficiary

Qsource

Center for Healthcare Quality

Qualified Health Plan

Refers to insurance plans that have been certified as meeting a minimum benchmark of benefits (i.e. the essential health benefits) under health reform. This will allow consumers to verify that the plan they have purchased will meet at least the minimum requirements of the individual mandate.

Quality Assurance

A formal, systematic process to improve quality of care that includes monitoring quality, identifying inadequacies in delivery of care, and correcting those inadequacies. Monitoring and maintaining the quality of public health services through licensing and discipline of health professionals, licensing of health facilities, and the enforcement of standards and regulations.

Quality Assurance Committee

A committee established by a professional organization or institution to evaluate and/or ensure the quality of care provided to patients. It can function independently on a broad range of topics related to healthcare quality.

Quality of Care

One of the most disputed and least clear-cut healthcare concepts, quality generally includes the appropriateness and medical necessity of care provided, appropriateness of the provider that renders care, clinical expertise of the provider and condition of the physical plant in which services are provided.

Quality Improvement Organization (QIO)

Peer review organizations in every state whose purpose is to review items and services provided to Medicare beneficiaries to determine if services are reasonable and necessary, provided in the appropriate setting and the quality of care is met.

Quality Improvement Program (QIP)

A continuing process of identifying problems in healthcare delivery and testing and continually monitoring solutions for constant improvement. QIP is a common feature of total quality management (TQM) programs. The aim of QIP is the elimination of variations in healthcare delivery through the removal of their causes and the elimination of waste through design and redesign processes.

Quality Indicator

A measure of the degree of excellence of the health care actually provided. Selected quality indicators of patient outcome are mortality and morbidity, health status, length of stay, readmission rate, patient satisfaction, etc.

R

R&D

Research and development

Rate Review

Review by insurance regulators of proposed premiums and premium increases. During the rate review process, regulators will examine proposed premiums to ensure that they are sufficient to pay all claims, that they are not unreasonably high in relation to the benefits being provided, and that they are not unfairly discriminatory to any individual or group of individuals.

Rate Setting

A method of paying healthcare providers in which the federal or state government establishes payment rates for all payers for various categories of health services.

RCA

Root cause analysis

RDRG

Refined diagnosis-related group

Recovery Audit Contractor (RAC)

The recovery audit contractor (RAC) program was created through the Medicare Modernization Act of 2003 (MMA) to identify and recover improper Medicare payments paid to healthcare providers under fee-for-service (FFS) Medicare plans.

Rehabilitation Facility

A facility that provides medical, health-related, social and/or vocational services to disabled persons to help them attain their maximum functional capacity.

Reinstatement

Resumption of coverage under an insurance policy that has lapsed.

Reinsurance

A type of insurance purchased by primary insurers (insurers that provide healthcare coverage directly to policyholders) from other secondary insurers, called re-insurers, to protect against part or all losses the primary insurer might assume in honoring claims of its policyholders. Also known as excess risk insurance.

Relative Value Scale (RVS) An index that assigns weights to each medical service: the weights represent the relative amount to be paid for each service. The RVS used in the development of the Medicare fee schedule consists of three cost components: physician work, practice expense and malpractice expense.

Relative Value Unit (RVU)

The unit of measure for a relative value scale. RVUs must be multiplied by a dollar conversion factor to establish payment amounts.

Rescission

The process of voiding a health plan from its inception usually based on the grounds of material misrepresentation or omission on the application for insurance coverage that would have resulted in a different decision by the health insurer with respect to issuing coverage. PPACA prohibits rescissions except in cases of fraud or intentional misrepresentation of a relevant fact.

Resident (Medical)

A physician in training who participates in an accredited program of graduate medical education sponsored by a hospital.

Respite Care

Temporary relief to people who are caring for elderly or disabled relatives who require 24-hour care; that is, offering them a break from their care-giving activities.

Resource-Based Relative Value Scale (RBRVS)

A fee schedule for physicians used by Medicare reflecting the value of one service relative to others in terms of the resources required to perform the service.

Resource Utilization Groups (RUGs)

A prospective payment system that categorizes long-term care residents into payment groups depending upon his or her care and resource needs. Skilled nursing facilities determine RUGs based upon an assessment of the resident using the minimum data set (MDS).

Restricted Funds

Includes all hospital resources that are restricted to particular purposes by donors and other external authorities. These funds are not available for the financing of general operating activities, but may be used in the future when certain conditions and requirements are met.

Return on Equity (ROE)

After-tax earnings of a corporation divided by its shareholders' equity. Shareholders' equity is determined by deducting total liabilities and intangible assets from total assets.

Return on Investment (ROI)

After-tax income for a specified period of time divided by total assets; a financial tool to measure and relate a corporation's earnings to its total asset base.

RFA

Regulatory Flexibility Act

RFP

Request for proposal

RHC

Regional hospital coordinator

Rural health clinic

RHIO

Regional health information organization

RHQDAPU

Reporting hospital quality data for annual payment update

Risk

The probable amount of loss foreseen by an insurer in issuing a contract. The term also sometimes applies to the person insured or the hazard against which it is insured.

Risk Adjustment

(1) Risk adjustment uses the results of risk assessment in order to fairly compensate plans that, by design or accident, end up with a larger-than-average share of high-cost enrollees. (2) Increases or reductions in the amount of payment made to a health plan on behalf of a group of enrollees to compensate for healthcare expenditures that are expected to be higher or lower than average.

Risk Analysis

The process of evaluating the predicted costs of medical care for a group under a particular health plan. It aids managed care organizations and insurers in determining which products, benefit levels and prices to offer in order to best meet the needs of both the group and plan.

Risk Corridor

A temporary provision in PPACA that requires plans whose costs are lower than anticipated to make payments into a fund that reimburses plans whose costs are higher than expected.

Risk Factor

Behavior or condition which, based on scientific evidence or theory, is thought to directly influence susceptibility to a specific health problem.

Risk Management

The assessment and control of risk within a healthcare facility, including the analysis of possibilities of liability, methods to reduce risk of liability and methods to transfer risk to others or through insurance coverage. Risk management is commonly used to mean a formal program of malpractice reduction.

Risk Pools

State legislatures created programs that group together individuals who cannot get insurance in the private market due to pre-existing medical conditions. Funding for the pool is subsidized through assessments on insurers or through government revenues. Maximum rates are tied to the rest of the market. Risk pools are supposed to disband by 2014, depending on federal healthcare reform.

RMHI

Regional mental health institute

RN

Registered nurse

RPCH

Rural primary care hospital

RRC

Rural referral center

RRT

Rapid response team RT

Radiologic technologist

Respiratory therapist

RUG

Resource utilization group

Rural Health Center

An outpatient facility in a non-urbanized area (per the U.S. Census Bureau) primarily engaged in furnishing physicians and other medical health services in accordance with certain federal requirements designed to ensure the health and safety of the individuals served by the health center. Rural health centers serve areas designated for their shortage of personal health services or a health workforce.

Rural Health Clinic (RHC)

The rural health clinic program was established in 1977 to address an inadequate supply of physicians who serve Medicare and Medicaid beneficiaries in rural areas. The program provides qualifying clinics located in rural and medically underserved communities with payment on a cost-related basis for outpatient physician and certain non-physician services.

Rural Health Network

An organization consisting of at least one critical access hospital and at least one acute care hospital. Its provider participants enter into agreements regarding patient referral and transfer, the development and use of communication systems, and the provision of emergency and non-emergency transportation.

Rural Referral Center

Generally large rural hospitals that Medicare designates to serve patients referred by other hospitals or physicians who are not members of the hospital's medical staff.

RVS

Relative value scale

RY

Rate year

S

Safe Harbor

A set of federal regulations providing safe refuge for certain healthcare business arrangements from the criminal and civil sanction provisions of the Medicare anti-kickback statute prohibiting illegal remuneration.

Safety Net

Health care providers who deliver health care services to patients regardless of their ability to pay. These providers may consist of public hospital systems, community health centers, local health departments, and other providers who serve a disproportionate share of uninsured and low-income patients.

SARS

Severe acute respiratory syndrome

SB

Senate bill

SCH

Sole community hospital

SCHIP

State children's health insurance program

SCIP

Surgical care improvement project

Seamless Care

The experience by patients of smooth and easy movement from one aspect of comprehensive healthcare to another.

Secondary Care

Attention given to a person in need of specialty services, following referral from a source of primary care.

Section 125 Plan

A section 125 plan allows employees to receive specified benefits, including health benefits, on a pre-tax basis. Section 125 plans enable employees to pay for health insurance premiums on a pre-tax basis, whether the insurance is provided by the employer or purchased directly in the individual market.

Self-Insurance

An entity itself assumes the risk of coverage and makes appropriate financial arrangements rather than purchasing insurance from a third party and paying a premium for this coverage.

Sentinel Event

An unexpected occurrence or variation involving death or serious physical or psychological injury, or such a risk to a patient. Serious injury includes loss of limb or function. The event is called “sentinel” because it sounds a warning that requires immediate attention. The Joint Commission is requesting the voluntary reporting of such events by accredited healthcare organizations.

Service Area

The geographic area a health plan serves. Some insurers are statewide or national, while others operate in specific counties or communities.

SFY

State fiscal year

SHCA

Society for Healthcare Consumer Advocacy

SHIP

State health insurance assistant program

SHSMD

Society for Healthcare Strategy & Market Development (AHA)

SIDS

Sudden infant death syndrome

SII

Standards improvement initiative

Single-Payer System

A healthcare system in which a single entity pays for healthcare services. This entity collects healthcare fees and pays for all healthcare costs, but is not involved in the delivery of healthcare.

Skilled Nursing Facility (SNF)

An institution that has a transfer agreement with one or more hospitals, provides primarily inpatient skilled nursing care and rehabilitative services, and meets other specific certification requirements.

Small Group Market

Firms with 2-50 employees can purchase health insurance for their employees through this market, which is regulated by states.

SNF

Skilled nursing facility

Socialized Medicine

A health care system in which the government operates and administers health care facilities and employs health care professionals.

Sole Community Hospital (SCH)

For Medicare purposes, a hospital which is more than 35 miles from any similar hospital and meets other special criteria.

Solo Practice

A medical practice where sole responsibility for practice decisions and management falls to the independent physician.

Solvency

The ability of a health insurance plan to meet all of its financial obligations. State insurance regulators carefully monitor the solvency of all health insurance plans and require corrective action if a plan's financial situation becomes hazardous. In extreme circumstances, a state may seize control of a plan that is in danger of insolvency.

SPD

Summary plan description

Specialist

A physician whose training focuses on a particular area rather than family medicine or general medicine. Specialists work at the secondary level of health care and provide services not all physicians can perform.

Specialty Medical Group (SMG)

A single-specialty group of physicians or a multi-specialty group of physicians.

Sponsorship

A relationship between a religious or other sponsoring organization and a hospital that may set limits on the activities undertaken within the hospital or is intended to further the objectives of the sponsoring organization, but does not involve ownership or other legal relationships.

SPMI

Severely and persistently mentally ill

SSA

Social Security Administration
Social Security Act

SSI

Supplemental security income
Surgical site intervention

ST

Surgical technologist

Staffing Ratio

The total number of hospital full time employees (FTEs) divided by the average daily census.

Standard of Care

In a medical malpractice action, the degree of reasonable skill, care and diligence exercised by members of the same health profession practicing in the same or similar locality in light of the present state of medical or surgical science.

State Children's Health Insurance Program (SCHIP)

A program enacted within the Balanced Budget Act of 1997 providing federal matching funds to states to help expand healthcare coverage for children under Medicaid or new programs.

Subacute Care

A comprehensive inpatient program for those who have experienced a serious illness, injury or disease, but do not require intensive hospital services. The range of services can include infusion therapy, respiratory care, cardiac services, wound care, rehabilitation services, postoperative recovery programs for knee/hip replacements and cancer, stroke and AIDS care.

Supplemental Security Income (SSI)

A federal income support for low-income disabled, aged and blind persons. Eligibility for the monthly cash payments is based on the individual's current status without regard to previous work or contributions.

Support Services

Services other than medical, nursing and ancillary services that provide support in the delivery of clinical services for patient care (e.g., housekeeping, food service and security).

Sustainable Growth Rate (SGR)

Enacted as part of the Balanced Budget Act of 1997, the sustainable growth rate formula determines how much Medicare pays for services that physicians provide. Under the SGR, cumulative Medicare spending on physicians' services is supposed to follow a target path that depends on the rates of growth in physicians' costs, Medicare enrollment and real gross domestic product per person. If spending in a given year exceeds the SGR target for that year, the amounts paid to physicians for each service they provide are supposed to be reduced in the following year to move total spending back towards the target path.

SW

Social worker

Swing-Bed Hospital

A hospital participating in the Medicare swing-bed program. This program allows rural hospitals with fewer than 100 beds to provide skilled post-acute care services in acute care beds. Unused acute care beds that can be “swung” to long-term care beds within the same hospital so the need to build long-term beds can be avoided. Any services provided when the bed is in use as a long-term care bed are paid at long-term care rates.

Swing Beds

Acute care hospital beds that can be used for long-term care, depending on the needs of the patient and community.

T

TAG

Technical advisory group

TANF

Temporary assistance for needy families

Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA)

Legislation that established a target rate of increase limits on reimbursements for inpatient operating costs per Medicare discharge. A facility’s target amount is derived from costs in a base year updated to the current year by the annual allowable rate of increase. Medicare payments for operating costs generally may not exceed the facility’s target amount. These provisions still apply to hospitals and units excluded from PPS.

Tax Credit

A tax credit is an amount that a person/family can subtract from the amount of income tax that they owe. If a tax credit is refundable, the taxpayer can receive a payment from the government to the extent that the amount of the credit is greater than the amount of tax they would otherwise owe.

Tax Deduction

A deduction is an amount that a person/family can subtract from their adjusted gross income when calculating the amount of tax that they owe. Generally, people who itemize their deductions can deduct the portion of their medical expenses, including health insurance premiums, that exceed 7.5% of their adjusted gross income.

Tax Preference for Employer-Sponsored Insurance

Under the current tax code the amount that employers contribute to health benefits are excluded, without limit, from most workers’ taxable income and any contributions made by employees toward the premium cost for health insurance are made on a tax-free basis. In contrast, individuals who do not receive health insurance through an employer may only deduct the amount of their total health care expenses that exceeds 7.5% of their adjusted gross income.

Teaching Hospitals

Hospitals that have accredited physician residency training programs and typically are affiliated with a medical school.

Telemedicine

Technology that allows medical services to be conducted over a great geographic distance (rural areas that lack specialists) by using electronic or other media to transmit images or information.

TEFRA

Tax Equity Fiscal Responsibility Act of 1982

Tertiary Center/Tertiary Care

A large medical care institution (e.g. teaching hospital, medical center or research institution) that provides highly specialized technologic care.

Third-Party Administrator (TPA)

Administration of a group insurance plan by some person or firm other than the insurer or the policyholder.

Third-Party Payer

An organization (private or public) that pays for or insures at least some of the healthcare expenses of its beneficiaries. Third-party payers include Blue Cross/Blue Shield, commercial health insurers, Medicare and Medicaid. The individual receiving the healthcare services is the first party, and the individual or institution providing the service is the second party.

TPA

Third-party administrator

Tissue plasminogen activator

TPL

Third-party liability

TQI

Total quality improvement

Trauma Center

A hospital specifically designed within a region that is equipped and staffed to receive critically ill or injured patients.

Triage

The sorting and allocation of treatment to patients, especially disaster victims, according to a system of priorities designated to maximize the number of survivors.

TRICARE (formerly CHAMPUS)

Insurance program for veterans and civilian dependents of members of the military.

Trustee

A member of a healthcare facility governing body. May be referred to as a director or commissioner.

Tort Reform

Changes in the legal rules governing medical malpractice lawsuits.

Total Margin

A measure that compares total hospital revenue and expenses for inpatient, outpatient and non-patient care activities. The total margin is calculated by subtracting total expenses from total revenue and dividing by total revenue.

Turnover

The rate at which an employer loses staff. Voluntary turnover is when the employee initiates the termination. Some examples of voluntary resignation or termination would be those occurring as a result of a new job, dissatisfaction, personal reasons, retirement or returning to school. Involuntary turnover is when the employer initiates the termination. Some examples of involuntary resignation or termination would be those occurring as of result of absenteeism, conduct, failed to obtain license, reduction in workforce, layoffs or reorganization.

U

UAN

United American Nurses

UB-04

Uniform billing form 2004

UB-92

Uniform billing form of 1992

UCR

Usual, customary and reasonable charges

UDNR

Universal do-not-resuscitate

UIRS

Unusual incident reporting system

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 debts, for which the provider has made an unsuccessful effort to collect payment due from the patient.

Underinsured

A descriptive term for people who may have some type of healthcare insurance, such as catastrophic care, but lack coverage for ordinary healthcare costs.

Underwriting

The process by which an insurance carrier examines a person's medical history and decides whether it will issue coverage.

Uninsurable

Those persons an insurance company does not want to insure, usually because of bad health.

Uninsured

Individuals who do not have health insurance coverage of any type. Over 80 percent of the uninsured are working adults and their family members, of which over 25 percent are children under 18. The uninsured usually earn too much to qualify for public assistance, but too little to afford coverage.

Universal Access

The right and ability to receive a comprehensive, uniform and affordable set of confidential, appropriate and effective health services.

Universal Coverage

A system that provides health coverage to all Americans. A mechanism for achieving universal coverage (or near-universal coverage) under several current health reform proposals is the individual mandate. Single payer proposals would also provide universal coverage.

UNOS

United Network for Organ Sharing

Unrestricted Funds

Includes all hospital resources not restricted to particular purposes by donors or other external authorities. All of the hospital's resources are available for the financing of general operating activities.

UR

Utilization review

URAC

Utilization Review Accreditation Commission

Urgent Care Center

A freestanding emergency care facility that may be sponsored by a hospital, physician(s) or corporate entity. Sometimes referred to as a minor emergency facility or surgery center.

USP

United States Pharmacopeia

Usual, Customary and Reasonable Charge (UCR)

The cost associated with a healthcare service that is consistent with the going rate for identical or similar services within a particular geographic area. Reimbursement for out-of-network providers is often set at a percentage of the usual, customary and reasonable charge, which may differ from what the provider actually charges for a service.

Utilization

Patterns of use for a particular medical service, such as hospital care or physician visits.

Utilization Management (UM) or Utilization Review (UR)

(1) The review of services delivered by a healthcare provider or supplier to determine whether those services were medically necessary; may be performed on a concurrent or retrospective basis. (2) The review of services delivered by a healthcare provider to evaluate the appropriateness, necessity and quality of the prescribed services. The review can be performed on a prospective, concurrent or retrospective basis.

V

VA

Veterans Administration

Value-Based Insurance Design

Recent studies demonstrate that health outcomes can be influenced by a patient's insurance coverage and benefit policy. Therefore it is possible to design insurance packages that improve outcomes and add value. An example of this involves identifying effective clinical practices and reducing the financial barriers associated with those treatments and services encouraging greater adherence with care protocols.

Value-Based Purchasing (VBP)

A Centers for Medicare and Medicaid Services initiative to reimburse providers for care to Medicare beneficiaries based on quality performance (a pay-for-performance program).

VAP

Ventilator-associated pneumonia

Variable Cost

Any cost that varies with output or organizational activity (e.g., labor and materials).

Vertical Integration

A healthcare system that provides a range or continuum of care such as: outpatient, acute hospital, long-term, home or hospice care (multi-institutional system or horizontal integration).

W

Waiting Period

A period of time that an individual must wait either after becoming employed or submitting an application for a health insurance plan before coverage becomes effective and claims may be paid. Premiums are not collected during this period.

Waiver

A provision in a health insurance policy in which specific medical conditions a person already has are excluded from coverage.

Webinar

A conference with audio portion via telephone and visual materials accessible through a web-based virtual meeting. This type of program can be fully interactive.

Wellness Programs

Educational and other programs designed to inform individuals about healthy lifestyles and direct them to programs and facilities that encourage and support these behaviors. Employers may initiate these programs as part of larger efforts to control healthcare costs, reduce absenteeism and strengthen employee relations.

WHO

World Health Organization

WIC

Women and infant children program

Workers' Compensation (WC)

Workers' compensation law is governed by statutes in every state. Specific laws vary with each jurisdiction, but key features are consistent. An employee is automatically entitled to receive certain benefits when an employee suffers an occupational disease or accidental personal injury arising out of and in the course of employment.

Working Capital

A company's amount of capital available for spending. Detailed as part of the statement of cash flow and the balance sheet, it is current assets less current liabilities.

Y

Young Adult Health Plan

Health plans designed to meet the needs of young adults. These plans tend to offer lower premiums in exchange for high deductibles and/or limited benefit packages.

Z

ZPIC

Zone program integrity contractor

Other Important Acronyms

AAHAM	American Association of Healthcare Administrative Management
AONE	American Organization of Nurse Executives
BRVN	Blue River Valley Healthcare Network
CHI	Catholic Health Initiatives - Nebraska
CIMRO-NE	CIMRO of Nebraska
COMS	Clinical Outcomes Measurement System
CHPN	Community Health Partners of Nebraska
FACHE	Fellow, American College of Healthcare Executives
FHFMA	Fellow, Healthcare Financial Management Association
HFMA	Healthcare Financial Management Association
HHA	Heartland Health Alliance
HHEG	Heartland Healthcare Executive Group
HIPDB	Healthcare Integrity and Protection Data Bank
HEN	Hospital Engagement Network
MAHA	Mid-America Hospital Alliance
NAHCHA	Nebraska Association of Home and Community Health Agencies
NAHQRS	Nebraska Association for Healthcare Quality Risk and Safety
NALA	Nebraska Assisted Living Association
NAOHN	Nebraska Association of Occupational Health Nurses
NeAMSS	Nebraska Association of Medical Staff Services
NANA	Nebraska Association for Nurse Anesthetists
NCCHA	Nebraska Conference of Catholic Health Facilities
NCFN	Nebraska Center for Nursing
NCPDP	National Council for Prescription Drug Programs
NCPS	Nebraska Coalition for Patient Safety
NDA	Nebraska Dental Association and Nebraska Dietetic Association
DHHS	Nebraska Department of Health & Human Services
NENA	Nebraska Emergency Nurses Association
NEAPHI	Nebraska Educational Alliance for Public Health Impact
NFPA	National Fire Prevention Association
NHCA	Nebraska Health Care Association
NeHII	Nebraska Health Information Initiative
NHCA	Nebraska Health Care Association
NHIMA	Nebraska Health Information Management Association
NHIS	Nebraska Health Information System
NHM	Nebraska Healthcare Marketers

NHPCA	Nebraska Hospice and Palliative Care Association
NHA	Nebraska Hospital Association
NHA LI	Nebraska Hospital Association Leadership Institute
NHA PDC	Nebraska Hospital Association Policy Development Committee
NHAREF	Nebraska Hospital Association Research & Education Foundation
NICN	Nebraska Infection Control Network
NeLN	Nebraska League for Nursing
NMA	Nebraska Medical Association
NeMPHA	Nebraska Minority Public Health Association
NNA	Nebraska Nurses Association
NOA	Nebraska Optometric Association
NONL	Nebraska Organization of Nurse Leaders
NOTA	Nebraska Occupational Therapy Association
NPA	Nebraska Pharmacists Association and Nebraska Psychological Association
NPTA	Nebraska Physical Therapy Association
NeRHA	Nebraska Rural Health Association
NSCLS	Nebraska Society for Clinical Laboratory Service
NSHE	Nebraska Society for Healthcare Educators
NSSWLHC	Nebraska Society for Social Work Leaders in Healthcare
NSRT	Nebraska Society of Radiological Technologists
NSHE	Nebraska Society of Healthcare Engineers
NSSNA	Nebraska State Student Nurses Association
NE SNIP	Nebraska Strategic National Implementation Process
NUIHC	Nebraska Urban Indian Health Coalition, Inc.
NICHE	Nurses Improving Care for Healthsystem Elders

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