

The background of the cover features a soft-focus photograph of several books stacked together. The spines of the books are visible, showing various colors like blue, red, and yellow, and some have letters such as 'D' and 'C' printed on them.

Health Care ABCs

Terminology and Acronyms for Hospital Trustees

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Glossary of General Health Care Terms

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A

Academic Medical Center

A group of related institutions including a teaching hospital or hospitals, a medical school and its affiliated faculty practice plan, and other health professional schools.

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 Health Plan (AHP)

A plan that would offer a nationally defined package of specified benefits and provide consumers with a report card on the quality and services offered by the plan.

Accountable Health Partnership

An organization of doctors and hospitals which provides care for people organized into large groups of purchasers.

Accounting Perspectives (Evaluation)

Perspectives underlying decisions on which categories of goods and services to include as costs or benefits in an analysis.

Accounts Receivable

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

Accreditation

The process whereby a health care organization is evaluated and determined to meet the quality-of-care standards established by an accrediting body (e.g. The Joint Commission and the National Committee for Quality Assurance).

Accreditation Survey

The process used to evaluate whether a health services organization meets specified standards for accreditation.

Accrual

A technique for determining medical costs for enrollees over a set period so that money can be set aside in a claims reserve to be used for medical costs incurred during that period. Revenues recognized as services are rendered independent of when payment is received.

Accrual Accounting

A descriptive accounting method that recognizes revenues as services are rendered, independent of the time when cash is actually received.

ACHE

American College of Healthcare Executives. A professional organization for hospital executives.

Acquisition

The purchase of all or substantially all the assets of a corporation (such as a hospital) by cash, other compensation, asset exchange, or gift of majority voting control.

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Acquisition Costs

Varied marketing costs within health plans primarily related to the acquisition of subscriber contracts.

Activities of Daily Living (ADL)

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.

Activity-Based Costing (ABC)

Activity-based costing defines costs in terms of an organization's processes or activities and determines costs associated with significant activities or events. ABC relies on the following three step process: Activity mapping, which involves mapping activities in an illustrated sequence; Activity analysis, which involves defining and assigning a time value to activities; and Bill of activities, which involves generating a cost for each main activity.

Activity-based Management (ABM)

Activity-based Management...supports operations by focusing on the causes of costs and how costs can be reduced. It assesses cost drivers that directly affect the cost of a product or service, and uses performance measures to evaluate the financial or nonfinancial benefit an activity provides. By identifying each cost driver and assessing the value the element adds to the health care enterprise, ABM provides a basis for selecting areas that can be changed to reduce costs.

Actual Charge

One of the factors determining a physician's payment for a service under Medicare; equivalent to the billed or submitted charge.

Actuarial Analysis

A means of measuring the statistical probability of the risk of events occurring, such as illness, injury, disability, hospitalization, or death.

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.

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.

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 that 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. See Medicare Risk Contract, U.S. Per Capita Cost.

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Adjusted Patient Day (APD)

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

Administrative Costs

The costs assumed by a health care organization, insurer, or managed care plan for managing health services, including claim processing, billing, marketing, member services, provider relations, and other overhead expenses.

Admission

Formal acceptance by hospital or other inpatient health care 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.

Administrative Services Only (ASO)

Applies to larger employers who self-insure health coverage for their employees. The employer usually contracts with a third party to provide administrative services, such as claims processing and claims communications.

Admitting Privileges

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

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 health care services.

Adverse Drug Reaction

A negative physical reaction or complication caused by the use of medication(s).

Affiliation

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

Against Medical Advice (AMA)

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

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. (See also PPS Inpatient Margin, PPS Operating, Margin, and Total Margin.)

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. (See also PPS Operating Margin and Total Margin.)

AHA

American Hospital Association. A national professional trade association for hospitals.

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Alliance

A formal organization or association owned by shareholders or controlled by members that works on behalf of the common interests of its individual members in the provision of services and products and in the promotion of activities and ventures.

Allied Health Professionals

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

Allowable Expenses

The necessary, customary and reasonable expenses than an insurer will cover.

Allowed Charge

The amount Medicare approves for payment to a physician. Typically, Medicare pays 80 percent of the approved charge and the beneficiary pays the remaining 20 percent. The allowed charge for a nonparticipating physician is 95 percent of that for a participating physician. Nonparticipating physicians may bill beneficiaries for an additional amount above the allowed charge. See Balance Billing, Participating Physician and Supplier Program.

Alternative Delivery System

Provision of health services in settings that are more cost-effective than an inpatient, acute-care hospital, such as skilled and intermediary nursing facilities, hospice programs, and in-home services.

AMA

American Medical Association. The largest national professional association for physicians.

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 health care 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.

ANA

American Nurses Association. A professional organization for registered nurses.

Ancillary Services

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

Antitrust Laws

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

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Any Willing Provider

Any health care provider that complies with an insurer's preferred provider terms and conditions may apply for and shall receive designation as a preferred provider.

APD

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

Appropriateness Review

A methodology in which individual cases are evaluated for clinical appropriateness and for medical necessity of surgical and diagnostic procedures. The review usually consists of comparing clinical data to medical criteria.

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.

Assessment

The regular collection, analysis and sharing of information about health conditions, risks, and resources in a community. The assessment function is needed to identify trends in illness, injury, and death, the factors which may cause these events, available health resources and their application, unmet needs, and community perceptions about health issues.

Assisted Living Facilities

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

Attending Physician

Physician legally responsible for the care provided a patient in a hospital or other health care program. Usually the physician is also 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.

Auxilian

A member of a hospital's auxiliary who may or may not serve as an in-service volunteer at the hospital.

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.

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B

Bad Debt

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

Bed Conversion

Reallocation of beds from one type of care (e.g., acute care) to another (long-term care).

Bed Days

The total number of days of hospital care (excluding the day of discharge) provided to the insured or plan member. Bed days, also called hospital days, discharge days, or patient days, are used to measure hospital utilization and are generally reported in "days per 1,000 plan members per year."

Benchmarking

The process of continually measuring products, services, and practices against major competitors or industry leaders to create normative or comparative standards (benchmarks).

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

Services covered by a health insurance plan and the financial terms of such coverage, including cost sharing and limitations on amounts of services. See Cost Sharing.

Best Practices

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

Billed Charges

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

Biomedical ethics

A term used to describe philosophical questions involving morals, values, and ethics in the provision of health care.

Birthing Rooms

Homelike hospital-based combination labor and delivery units in which new mothers and fathers can participate in the childbirth process.

Block Grants

A program funding approach wherein the federal government makes lump-sum grants to states, which are then responsible for determining beneficiary eligibility, managing the program, and contributing matching funds.

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.

Board Eligible

The term referring to the period when a physician may take a specialty board examination for certification after graduating from a board-approved medical school, completing an accredited training program, and practicing for a specified length of time.

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.



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 Expenditure Review

An internal or regulatory evaluation of a health care facility's planned capital expenditures (e.g., buildings and equipment) to determine their necessity and appropriateness.

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.

Capital Structure (Leverage)

Measure of the extent to which debt financing is employed by a corporation; the mix of long-term debt and equity employed by a corporation for permanent, long-term financing needs.

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 health care 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. (See also Bundling, Fee for Service, Per Diem, and Rate Setting.) (3) A health insurance payment mechanism which 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. See Medicare Risk Contract, Medicare+Choice.

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Caps

Maximum allowable limits placed on revenue or rates by federal or state government.

Carrier

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

Carve-Out Coverage

Carve-out refers to an arrangement where some benefits (e.g., mental health) are removed from coverage provided by an insurance plan, but are provided through a contract with a separate set of providers. Also, carve-out may refer to a population subgroup for which separate health care arrangements are made.

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 health care 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 health care.

Case Mix

A measure of patient acuity reflecting different patients' needs for hospital 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.

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. See also DRG.

Case-Mix Severity

Level of illness or disability within a particular case-mix grouping.

Case Rate

A reimbursement model that established a flat admission rate for all the services associated with all care immediately before and after diagnosis of a condition.

Catastrophic Insurance

(1) Insurance that protects the insured against all or a percentage of costs not covered by other insurance or prepayment plans or incurred under specified circumstances. (2) Insurance in excess of specified dollar or benefit amounts or limits.

Catchment Area

Geographic area defined and served by a hospital and delineated on the basis of such factors as population distribution, natural geographic boundaries, or transporting accessibility.

Census

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

Center of Excellence (COE)

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.

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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 Health and Human Services) that administers the Medicare and Medicaid programs and determines provider certification and reimbursement.

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.

Chemical Dependency

Alcohol or drug addiction. Services that fight these addictions are called chemical dependence services or substance abuse services.

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 some similar title.

Chief Financial Officer (CFO)

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

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 Operating Officer (COO)

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

Children's Health Insurance Program (CHIP)

Insurance program enacted in 1997 that is jointly funded by state and Federal government that provides health insurance to low-income children and, in some states, pregnant women in families who earn too much income to qualify for Medicaid but cannot afford to purchase private health insurance coverage. States have the option of administering CHIP through their Medicaid programs or through a separate program (or a combination of both). The federal government matches state spending for CHIP but federal CHIP funds are capped.

Chronic Care

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

Chronic Illness

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

Churning

The practice of a provider seeing a patient more often than is medically necessary, primarily to increase revenue through an increased number of services. Churning may also apply to any performance-based reimbursement system where there is a heavy emphasis on productivity (in other words, rewarding a provider for seeing a high volume of patients, whether through fee for service or through an appraisal system that pays a bonus for productivity).

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Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)

A health plan that serves the dependents of active-duty military personnel and retired military personnel and their dependents. Retired military personnel over age 65 use Medicare instead of CHAMPUS.

Claim

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

Claims Review

The method by which an enrollee's health care service claims are reviewed before reimbursement is made. Review involves a routine examination of a submitted claim to determine eligibility, coverage of services, and plan liability.

Clinical Department

In departmentalized hospitals, the medical staff organization is subdivided into major divisions such as medicine, surgery, obstetrics-gynecology, pediatrics, family medicine/primary care. Each clinical department has a chief or chair and is responsible for setting and monitoring standards of professional and personal conduct of physicians within those departments.

Clinical Pathway

A treatment regimen agreed to by a consensus of clinicians. Only essential elements – components that directly affect care – are part of the clinical pathway.

Clinical 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

Closed Staff

A hospital's medical staff that accepts no new applicants or a physician or physician group that exclusively provides under contract all the administrative and clinical services required for operation of a hospital department.

Code Creep

The practice of billing for more intensive services than were actually provided for which a higher payment is received.

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.

Coding

A mechanism for identifying and defining physician or hospital services. See Current Procedural Terminology (CPT) or DRG.

Coinurance

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

Commercial Carriers

For-profit, private insurance carriers (e.g. Aetna, Prudential) offering health and other types of coverage.

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Community

The geographic, demographic, or socioeconomic designation of a health care organization's service area.

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 health care organizations.

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 health care services; identify special targeted populations; identify health problems in the community; identify barriers to access to health care services and estimate projected future needs.

Community Health Center

A local, community-based ambulatory health care 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.

Comorbidity

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.

Comprehensive Outpatient Rehabilitation Facility (CORF)

A hospital-based outpatient facility providing a full range of rehabilitative services.

Computerized Axial Tomography (CT or CAT)

Diagnostic equipment that produces cross-sectional images of the head and body.

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.

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 health care records.

Consolidation

Unification of two or more corporations by dissolution of existing ones and creation of a single new corporation.

Consortium

A formal voluntary alliance of institutions for a specific purpose, functioning under a common set of bylaws or rules. Unless otherwise proscribed, each member controls its own assets.

Consumer Price Index (CPI)

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

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Consumer Price Index, Medical Care Component

Measure of inflation encompassing the cost of all purchased health care services.

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.

Continuing Care Retirement Communities (CCRC)

A residential setting for retirees offering a range of services from independent living to assisted living and sometimes nursing home care.

Continuing Education (CE)

Education beyond initial professional preparation that is relevant to the type of care delivered. Such education provides current knowledge relevant to an individual's field of practice or service responsibilities and may be related to findings from performance-improvement activities.

Continuing Medical Education (CME)

Continuing education related to the current practices of physicians.

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.

Contract Management

Daily management of an organization under contract by another organization, wherein the managed organization retains legal responsibility and ownership of the facility's assets and liabilities and the managing organization typically reports directly to the managed organization's board or owners.

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.

Conversion

(1) A major change that a hospital undertakes, such as the conversion from not-for-profit or the conversion of an acute care facility to ambulatory care, and usually entailing a complete change of mission after a new line of business or service displaces a core activity. (2) A reference to the transfer of a plan member covered under a group contract (such as a contract with a larger employer) to coverage under an individual contract without evidence of medical insurability after termination of the group coverage.

Copayment (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.

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Cost Accounting

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

Cost-Benefit Analysis

A method comparing the costs of a project to the resulting benefits, usually expressed in monetary value.

Cost Center

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

Cost Containment

Control or reduction of inefficiencies in the consumption, allocation, or production of health care services that contribute to higher than necessary costs. (Inefficiencies in consumption can occur when health services are inappropriately utilized; inefficiencies in allocation exist when health services could be delivered in less costly settings without loss of quality; and, inefficiencies in production exist when the costs of producing health services could be reduced by using a different combination of resources.)

Cost Finding

Determining how much it actually costs to provide a given service – usually requiring a cost-accounting system or a retrospective cost study.

Cost Sharing

A general term referring to payments made by health insurance enrollees for covered services. Examples of cost sharing include deductibles, coinsurance, and copayments. See Balance Billing, Coinsurance, Copayment, Deductible.

Cost Shifting

Phenomenon occurring in the U.S. health care system in which providers are inadequately reimbursed for their costs and subsequently raise their prices to other payers in an effort to regroup costs. Low reimbursement rates from government health care programs often cause providers to raise prices for medical care to private insurance carriers or self-pay patients.

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.

Covered Lives

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

Covered Services

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

Credentialing. See physician credentialing.

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.

Credentialing Verification Organization (CVO)

An independent organization that confirms the professional credentials of providers for a managed care organization rather than requiring the providers to provide this information independently.

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.

Critical Pathway

A health care management tool based on clinical consensus on the best way to treat a disease or use a procedure and designed to reduce variations in health care procedures.

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.

D

Days Per Thousand

A standard unit of hospital utilization measurement that refers to the annualized use (in days) of hospital or other institutional care for each 1,000 covered lives.

Death Rate (Hospital-Based)

Number of deaths of inpatients in relation to the total number of inpatients over a given period of time.

Deductible

Amount of expense a covered person must pay, typically in a calendar year, before the health plan will make payment for eligible benefits.

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 tests than necessary to protect themselves from potential lawsuits by patients. Defensive medicine is said to be a major reason health care costs are so high, particularly under fee-for-service medicine.

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.

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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 that monies can be used for replacement and renovation of assets.

Diagnosis Related Groups (DRGs)

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

Direct Contracting

Agreement between a hospital and a corporate purchaser for the delivery of health care 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).

Discounted Fee-For-Service

A common risk-sharing payment method similar to fee-for-service except that the amount of money a provider charges for its health services is discounted based on a negotiated amount of percentage that is agreed on between the provider and the health plan.

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 health care using preventive methods, such as diet, medication, and exercise for a patient with heart disease.

Disproportionate Share (DSH) 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.

DRG Creep

The prohibited practice of classifying patients at a higher level of severity in order for a health care provider to receive higher Medicare payments.

Health Care ABCs

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DME

Durable Medical Equipment

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.



ED or ER

Emergency department or emergency room.

Effectiveness

The degree to which care is provided in the correct manner, given the current state of knowledge, to achieve the desired or projected outcome(s).

Efficacy

The degree to which the care of the individual has been shown to accomplish the desired or projected outcome(s).

Efficiency

The relationship between the outcomes (results of care) and the resources used to deliver care.

Elective

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

Eligibility

The status that defines who receives health care services and benefits and for what period of time they qualify to use those benefits.

Eligibility Verification

The process of confirming that a person is a subscriber to a health plan, which, with some insurance plans, means confirming the member's benefit plan and co-payment responsibilities.

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)

Also known as the "antidumping" provision under COBRA, legislation requiring 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 Assistance Programs (EAPs)

Programs under which employers contract with companies to provide alcohol, substance abuse, and other mental health services for their employees if these services are not covered under their employee health care benefits.

Health Care ABCs

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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)

Federal law that regulates various employee benefits, and also exempts from state regulation those companies that manage their own health care benefit plans.

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.

EMS

Emergency medical system. Refers to a systematic, community linkage among hospital trauma centers, ambulance units and other emergency vehicles, personnel trained in emergency medicine, and communications systems so that severely ill or injured persons are transported and treated promptly and appropriately.

Enrollee

A person who is covered by health insurance. See also Beneficiary.

Enrollment

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

Entitlements

Programs in which people receive services and benefits based on some specific criteria, such as income or age. Examples of entitlement programs include Medicaid, Medicare, and veterans' benefits.

Environmental Assessment

A planning method involving identification of the major external factors expected to present opportunities and/or problems over the planning period and an analysis of the operational implication of those factors on the organization.

Environmental Health

An organized community effort to minimize the public's exposure to environmental hazards by identifying the disease or injury agent, preventing the agent's transmission through the environment, and protecting people from the exposure to contaminated and hazardous environments.

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.

Ethics Committee

Multi-disciplinary group which 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 health care options surrounding terminal illness and assisting with living wills.

Exclusions

Medical conditions specified in an insurance policy for which the insurer will provide no benefits.

Excess Capacity

Difference between the number of hospital beds being used for patient care and the number of beds available.

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.

Experience Rating

A system used by insurers to set premium levels based on the insured's past loss experience. For example, rating may be based on service utilization for health insurance or on liability experience for professional liability insurance. An employer whose employees are unhealthy will pay higher rates than another whose employees are healthier.

Experimental Procedure

Health care services or procedures that: (1) public and private health insurance plans believe are not widely accepted as effective by American health care professionals; or (2) have not been scientifically proven to be effective for a particular disease or condition.

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.

F

False Claims Act

A Civil War – era federal law provided for prosecution of fraud against the U.S. government. The 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 intentional 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.

Federal Poverty Level (FPL)

The amount of income determined by the federal Department of Health and Human Services to provide a bare minimum for food, clothing, transportation, shelter, and other necessities. 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 fee he or she charges on completion of a specific service. (2) A method of paying health care 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.

Fee Schedule

Maximum dollar amounts that are payable to health care 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.

First Dollar Coverage

A health insurance policy with no required deductible.

Fiscal Intermediary

An organization that acts as an intermediary between the hospital and a third-party payer. It receives billings from the hospital and makes payments on behalf of the payer for covered services. It is, in turn reimbursed by the third-party payer.

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.

Freestanding Facilities

Health care facilities that are not physically, administratively, or financially connected to a hospital. An example is a freestanding ambulatory surgery center.

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.



Gainsharing

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

General Practitioner (GP)

A doctor who practices general medicine and is involved in primary care.

Generalists

Physicians who are distinguished by their training as not limiting their practice by health condition or organ system, who provide comprehensive and continuous services, and who make decisions about treatment for patients presenting with undifferentiated symptoms. Typically include family practitioners, general internists, and general pediatricians.

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.

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 owner(s) of the hospital, which may be corporation, the community, local government, or stockholders.

Graduate Medical Education (GME)

The period of medical training that follows graduation from medical school; commonly referred to as internship, residency, and fellowship training.

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 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.

H

Health

Defined by the World Health Organization as "a state of complete physical, mental and social well being and not merely the absence of disease or infirmity."

Health Alliance

Organization established to act as a collective purchasing agent for health insurance benefits for individuals and to manage the process of individual health plan choices under managed competition. Health alliances service specific geographic regions. They provide enrollees with information on cost, quality of care and enrollee satisfaction for standard benefits coverage under several plans. Also provide fixed payments to those plans on behalf of enrollees.

Health and Human Services (HHS)

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

Health Care 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 which "provides" insurance.

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. Hospitals 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.

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Health Maintenance Organization (HMO)

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

Health Plan

Network of doctors, hospitals and insurers that provides coverage through contracts negotiated with health alliances.

Health Plan Employer Data and Information Set (HEDIS)

A set of standardized measures of health plan performance. HEDIS allows comparisons between plans on quality, access and patient satisfaction, membership and utilization, financial information, and health plan management. HEDIS was developed by employers, HMOs, and the National Committee for Quality Assurance.

Health Promotion

The process of fostering awareness, influencing attitudes, and identifying alternatives so that individuals can make informed choices and change their behavior in order to achieve an optimum level of physical and mental health.

Health Savings Account (HSA)

See Medical Savings Account.

Health Care Reform

Changes to the overall health care delivery system: its structure, financing, coverage, and services.

Health Care System

Corporate body that owns and/or manages multiple entities including hospitals, long term care facilities, other institutional providers and programs, physician practices and/or insurance functions.

Holding Company

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

Holistic Health

Health viewed from the perspective that the patient is collectively more than the sum of his or her parts; that body, mind, and spirit must be in harmony to achieve optimum health, and, therefore, that a multidisciplinary approach to health care is required.

Home Health Care

Provides health care 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.

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.

Hospice

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

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Hospital Affiliation

Contractual agreement between a health plan and one or more hospitals, such as an agreement for a hospital to provide the inpatient benefits offered by a health plan. May also refer to arrangements between hospitals and other health care financing or provider organizations.

Hospital Alliance

Agreements between hospitals to voluntarily join together on some services to reduce costs and achieve economies of scale.

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. Examples of formal HPA structures include: physician-hospital organizations for managed care contracting, management service organizations for practice management, and integrated delivery systems for development of a broad range of clinical services.

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.

Incentives

Financial rewards built into the health care system to encourage providers or patients to act in a certain way. The doctor's financial incentive in the fee-for-service system is to perform more procedures or services because pay is based on services rendered. In a managed care system with fixed fees, usually paid in advance, the incentive is to do fewer procedures, use fewer specialists, and keep the patient well.

Incidence

The number of new cases of a particular problem or condition that are identified or arise in a specified area during a specified period of time.

Incurred but not reported (IBNR)

An accounting term that means health care services have been provided but the bill has not yet 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.

Incident Report

A written report by either a patient or a staff member that documents any unusual problem, incident, or other situation for which follow-up action is indicated.

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.

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.

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Individual Case Management

The determination by utilization management professionals of individual patients' care (usually high-cost, high-resource intensive care) in order to find the most appropriate and cost-effective course of treatment, even if it involves paying for services not routinely covered by the health plan.

Inpatient

A patient receiving acute care through admission to the hospital for a stay of longer than 24 hours.

Integrated Delivery System (IDS)

An entity that usually includes a hospital, a large medical group, and an insurance vehicle such as an HMO or PPO. Typically, all provider revenues flow through the organization.

Intensity of Service

The quantity and quality of resources used in producing a patient care service, such as a hospital admission or home health visit. Intensity of services reflects, for example, the amount of nursing care, diagnostic procedures, and supplies furnished.

Intensive Care Unit (ICU)

A hospital unit for treatment and continuous monitoring of inpatients with life-threatening conditions.

Intermediate Care Facility (ICF)

A facility that provides nursing, supervisory, and supportive services to elderly or chronically ill patients who do not require the degree of care or treatment that a skilled nursing unit is designed to provide.

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.

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" hospital.

The Joint Commission

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

Joint Venture

A cooperative financial relationship between two parties (e.g., hospital and physician, two hospitals, hospital and HMO) in which each party shares risks and benefits to provide services, products, or both.

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 Facilities

Health care sites that require licenses by the state or federal government to offer health care services.

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.

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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.

Liquidity

Financial ratios that measure the ability of a corporation to meet its short-term liabilities as they come due.

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 the community, and include informal services provided by family or friends as well as formal services provided by professionals or agencies.



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. Previously known as nuclear magnetic resonance NMR.

Malpractice

Professional misconduct or lack of ordinary skill in the performance of a professional act. A practitioner is liable of damages or injuries caused by malpractice insurance that pays for the costs of defending suits instituted against the professional and damages assessed by the court up to maximum limit set in the policy. Malpractice requires that the patient proves some injury and that 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 that 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.

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. Special efforts have been made in the Medicaid program to develop information systems for each state program.

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.

Mandated Benefits

Coverage that states require insurers to include in health insurance policies such as prenatal care, mammography screening and care for newborns.

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.

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Market Basket Index

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 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 for a managed care company has captured; usually market share is expressed as a percentage of the market potential.

Medicaid

Insurance program, funded jointly by the federal and state governments and managed by the states that provides medical coverage for low-income families and individuals.

Medical Executive Committee

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

Medical Foundation

A tax-exempt medical group practice conducting research and offering educational programs.

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 Record

A record kept for each patient containing sufficient information to identify the patient, to justify the diagnosis and treatment, and to document the results accurately. 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 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. Also called a health savings account (HSA).

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 JCAHO, "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 Technology

Includes drugs, devices, techniques, and procedures used in delivering medical care and the support systems for that care.

Health Care ABCs

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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

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

Medicare

The federal health benefit program for people over 65, those eligible for Social Security disability payments, and those who need kidney dialysis or transplants.

Medicare Part A

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.

Medicare Part B

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.

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 and Physician Payment Review Commission (PPRC) were merged into the MedPAC at its creation in 1997.

Medicare-Supplement Policy

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

Merger

Union of two or more organizations by the transfer of all assets to one organization that continues to exist while all others are dissolved.

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 (75,000 in New England).

Midlevel Practitioner (MLP)

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

Mission Statement

A goal statement developed by health care organizations to provide direction and define purposes and objectives of the organization.

Health Care ABCs

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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.

Multidisciplinary Team

An approach to caring for the patient that involves a multidisciplinary team of professionals with the goal of providing comprehensive, integrated care. The team often includes a physician, nurse, and social worker working closely together and, depending on the patient's needs, may also include an occupational, physical, or other therapist and a psychiatrist or psychologist.

Multi-Hospital System

Two or more hospitals owned, leased, contract managed or sponsored by a central organization. They can be either not-for-profit or investor-owned hospitals.

Multi-Institutional System

An organization affiliation among two or more health care organizations. Multi-institutional systems may be vertically or horizontally integrated. The tie among the institutions can be through ownership, lease, contract management, and vertical integration.

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.

**National Association of Insurance Commissioners (NAIC)**

The national group of state officials who regulate insurance practices in each of the states.

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 health care to distinguish among plans based on quality.

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.

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.

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.

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 that is acquired by an individual while receiving care or services in a health care organization.

Not-for-Profit Hospital

A not-for-profit hospital is owned and operated by a private corporation whose 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" hospital.

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

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.

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 nonexclusive basis.

Operating Budget

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

Opportunity Cost

The cost of a lost opportunity; that is, the value given up by using a resource in one way instead of in an alternative, better way.

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 Services

Health care services received by a plan member from a non-contracted provider. Reimbursement is usually lower when a member goes out of the network, and other financial penalties may apply.

Out-of-Pocket Expense

Payments made by an individual for medical services. These may include direct payments to providers as well as payments for deductibles and coinsurance for covered services, for services not covered by the plan, for provider charges in excess of the plan's limits, and for enrollee premium payments.

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 (OOP)

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 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 give inpatient care.

P

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 the plan.

Paid Claims Loss Ratio

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

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 Care Team

A multidisciplinary team organized under the leadership of a physician, with each member of the team having specific responsibilities and the entire team contributing to the care of the patient.

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 Dumping

The refusal to examine, treat, and stabilize any person irrespective of payer/class who has an emergency medical condition or is in active labor or contractions once that person has been presented at a hospital emergency room or emergency department.

Health Care ABCs

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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 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 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.

Patient's 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.

Payer

Any agency, insurer, or health plan that pays for health care 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 Rate

The total amount paid for each unit of service rendered by a health care 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. See Allowed Charge.

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.

Performance Measure

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

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).

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.

Health Care ABCs

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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's Assistant (PA)

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

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 may also 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.

Population Profile

A statistical summary of population-specific health care data used to assess health care delivery.

Portability

An individual's ability to continue health insurance coverage when changing a job or residence without a waiting period or having to meet additional deductible requirements.

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.

Preadmission Certification

Process in which a health care professional evaluates an attending physician's request for a patient's admission to a hospital by using established medical criteria.

Pre-existing Condition

A physical or mental condition that an insured has prior to the effective date of coverage. Policies may exclude coverage for such conditions for a specified period of time.

Preferential Discounts

Reimbursements to health care 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 lower cost than the services of non-network providers. PPO enrollees may self-refer to any network provider at any time. (See also Fee for Service, Health Maintenance Organization, Managed Care, Managed Care Plan, and Point-of-Service Plan.)

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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.

Prepayment

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

Prevalence

Number of existing cases with a particular condition in a specified area at a specified point in time.

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 has as its aim the prevention of disease and illness before it occurs and thus concentrates on keeping patients well.

Prevailing Charge

One of the screens that determined a physician's payment for a service under the Medicare CPR payment system. In Medicare, it was the 75th percentile of customary charges, with annual updates limited by the MEI.

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 Network (PCN)

A group of primary care physicians (PCPs) who share the risk of providing care to members of a managed care plan. The PCP in a primary care network is accountable for the total health care services of a plan member, including referrals to specialists, supervision of the specialists' care, and hospitalization.

Primary Care Provider or Primary Care Physician (PCP)

Health care 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 assistant in general or 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 not-for-profit business operates in such a way as to provide more than incidental financial gain to a private individual, a practice frowned upon by the IRS.

Health Care ABCs

Terminology and Acronyms for Hospital Trustees

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

Prerogatives of individuals to provide medical or other patient care services in the granting institution, within well-defined limits, based on the individual's professional license, experience, competence, ability, and judgment. Also referred to as clinical privileges, medical staff privileges.

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.

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.

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.

Prospective Payment

A method of payment for health care 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)

(1) The Medicare system used to pay hospitals for inpatient hospital services; based on the DRG classification system. (2) Medicare's acute care hospital payment method for inpatient care. Prospective per-case payment rates are set at a level intended to cover operating costs in an efficient hospital for treating a typical inpatient in a given diagnosis-related group. Payments for each hospital are adjusted for differences in area wages, teaching activity, care to the poor, and other factors. Hospitals may also receive additional payments to cover extra costs associated with atypical patients (outliers) in each DRG. (See also Capital Costs, Diagnosis Related Groups, Outliers, and Prospective Payment.)

Protocols

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

Provider

A hospital or health care professional who provides health care 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.).

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.

Purchaser

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

Q

Quality Assessment

An activity that monitors the level of health care (including patient, administrative, and support services) provided to patients and compares it to pre-established criteria for professional performance. The medical record is used as documentation of the care provided.

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 health care quality.

Quality Improvement Program (QIP)

A continuing process of identifying problems in health care 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 health care 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, and so on.

Quality of Care

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

R

Rate Setting

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

Reasonable and Customary Charge

Charge for health care which is consistent with the going rate or charge in a certain geographical area for identical or similar services.

Registry

(1) A database on the incidence of specific diseases, patient demographics, treatment protocols, and treatment outcomes for patients with these diagnoses. (2) An official list of individuals with professional standing and/or credentials in specific health care occupations.

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.

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Reinsurance

A type of insurance purchased by primary insurers (insurers that provide health care 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 Unit (RVU)

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

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.

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 dividend by total assets; a financial tool to measure and relate a corporation's earnings to its total asset base.

Risk

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

Risk Adjustment

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 health care 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 the plan.

Risk Factor

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

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Risk Management

The assessment and control of risk within a health care 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

Legislatively created programs that group together individuals who cannot get insurance in the private market. Funding for the pool is subsidized through assessments on insurers or through government revenues. Maximum rates are tied to the rest of the market.

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 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 by physicians who are not members of the hospital's medical staff.

S

Safe Harbor

A set of federal regulations providing safe refuge for certain health care business arrangements from the criminal and civil sanction provisions of the Medicare Anti-Kickback Statute prohibiting illegal remuneration.

Sanctions

Negative incentives such as withholding of funds or exclusion from a practice or hospital.

Seamless Care

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

Secondary Care

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

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.

Sensitivity

Extent to which the criteria used to identify the target population results in the inclusion of persons, groups, or objects at risk

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 health care organizations.

Health Care ABCs

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Service Area

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

Single Payer

One entity that functions as the only purchaser of health care services.

Single-Specialty Group

Group consisting only of physicians practicing the same specialty.

Skilled Nursing Facility (SNF)

(1) Provides registered nursing services around the clock. (2) 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.

Sole Provider Hospital

A hospital Medicare designates as the only provider of hospital care in its market area. Under the prospective payment system, sole community hospitals benefit from payment provisions intended to ensure their financial viability and access to hospital services for Medicare beneficiaries.

Solo Practice

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

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.

Specific-Purpose Funds

A type of restricted fund that includes all resources restricted by donors to the financing of charity service, educational programs, research projects and other specific purposes other than endowments and plant asset acquisition.

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.

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.

Step-Loss Insurance

An insurance policy designed to reimburse a self-funded arrangement of one or more small employers for catastrophic, excess, or unexpected expenses. Neither the employees nor other individuals are third-party beneficiaries under the policy. Also known as excess risk insurance.

Strategic Planning

A long-range, comprehensive, and structured decision process that ensures logical steps within a time frame for reaching desired goals by the weighing of each decision step against alternative choices.

Subacute Care

Is usually described as a comprehensive inpatient program for those who have experienced a serious illness, injury or disease, but who don't require intensive hospital services. The range of services considered subacute can include infusion therapy, respiratory care, cardiac services, wound care, rehabilitation services, postoperative recovery programs for knee and 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).

Swing Beds

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



Teaching Hospitals

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

Telemedicine

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

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 health care expenses of its beneficiaries. Third-party payers include Blue Cross/Blue Shield, commercial health insurers, Medicare, and Medicaid. The individual receiving the health care services is the first party, and the individual or institution providing the service is the second party.

Total Quality Management (TQM)

A long-term corporate strategy focusing on the continuous improvement of key work processes that ultimately improve products and services, foster efficiency and team involvement, and satisfy the needs and expectations of customers.

Traditional Indemnity Insurance

The traditional type of health insurance in which the insured is reimbursed for covered expenses without regard to choice of provider.

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 hospital governing body. May also 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.

U

Unbundling

The practice of provider billing procedures. It covers hospital utilization for multiple components of service that were previously included in a single fee. For example, if dressing and instruments were included, there will be additional charges for the dressing and instruments.

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 health care insurance, such as catastrophic care, but lack coverage for ordinary health care 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.

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Universal Coverage

A proposal guaranteeing health insurance coverage for all Americans.

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.

Upcode

To bill for a service more intense, extensive, or costly than which was provided.

Urgent Care Center

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

Usual, Customary and Reasonable (UCR)

Amounts charged by health care providers that are consistent with charges from similar providers for the same or nearly the same services in a given area.

Utilization

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

Utilization Management (UM) or Utilization Review (UR)

The review of services delivered by a health care 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 health care 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 **Variable Cost**

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

Vertical Integration

A health care system which provides a range or continuum of care such as outpatient, acute hospital, long-term, home, and hospice care. (see multi-institutional system or horizontal integration).

Volunteer (In-Service)

A person who serves a hospital without financial remuneration and who, under the direction of the volunteer services department or committee, augments but does not replace paid personnel and professional staff.

Vital Signs

Measurements of body temperature, pulse, respiratory rates and blood pressure.

W **Waiver**

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

Wellness Programs

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

Working Capital

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

Glossary of Health Care Reform Terms

Glossary of Health Care Reform Terms

A

Accountable Care Organization (ACO)

A network of health care providers that band together to provide the full continuum of health care services for patients. The network would receive a payment for all care provided to a patient, and would be held accountable for the quality and cost of care. Proposed pilot programs in Medicare and Medicaid would provide financial incentives for these organizations to improve quality and reduce costs by allowing them to share in any savings achieved as a result of these efforts.

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 sharing requirements, or even benefits; however, the expected spending by insurers for the different plans will be the same.

Actuarial Value

The percentage of total average costs for covered benefits that a plan will cover. For example, if a plan has an actuarial value of 70%, on average, you would be responsible for 30% of the costs of all covered benefits. However, you could be responsible for a higher or lower percentage of the total costs of covered services for the year, depending on your actual health care needs and the terms of your insurance policy.

Adverse Selection

People with a higher than average risk of needing health care are more likely than healthier people to seek health insurance. Health coverage providers strive to maintain risk pools of people whose health, on average, is the same as that of the general population. Adverse selection results when the less healthy people disproportionately enroll in a risk pool.

Affordable Care Act

The comprehensive health care reform law enacted in March 2010. The law was enacted in two parts: The Patient Protection and Affordable Care Act was signed into law on March 23, 2010 and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name "Affordable Care Act" is used to refer to the final, amended version of the law.

Aggregate Indemnity

The maximum amount of payment provided by an insurer for each covered service for a group of insured people.

Aid to Families with Dependent Children (AFDC)

A state-based federal assistance program that provided cash payments to needy children (and their caretakers), who met certain income requirements. AFDC has now been replaced by a new block grant program, but the requirements, or criteria, can still be used for determining eligibility for Medicaid.

All-payer System

A proposed health care system in which, no matter who is paying, prices for health services and payment methods are the same. Federal or state government, a private insurance company, a self-insured employer plan, an individual, or any other payer would pay the same rates. Also called Multiple Payer system.

Annual Limit

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

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 businesses 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 regulation, or both, or are largely exempt from regulations. Recent Congressional proposals would have loosened regulations on these insurance plans.

B

Benefits

The health care items or services covered under a health insurance plan. Covered benefits and excluded services are defined in the health insurance plan's coverage documents. In Medicaid or CHIP, covered benefits and excluded services are defined in state program rules.

Biosimilar Biological Products

The generic version of more complicated medications.

Blue Cross/Blue Shield

Non-profit, tax-exempt insurance service plans that cover hospital care, physician care and related services. Blue Cross and Blue Shield are separate organizations that have different benefits, premiums and policies. These organizations are in all states, and The Blue Cross and Blue Shield Association of America is their national organization.

C

Cafeteria Plan

This benefit plan gives employees a set amount of funds that they can choose to spend on a different benefit options, such as health insurance or retirement savings.

Care Coordination

The organization of your treatment across several health care providers. Medical homes and Accountable Care Organizations are two common ways to coordinate care.

Care Guidelines

A set of medical treatments for a particular condition or group of patients that has been reviewed and endorsed by a national organization, such as the Agency for Health care Policy Research.

Catastrophic Health Insurance

Currently, some insurers describe these plans as those that only cover certain types of expensive care, like hospitalizations. Other times insurers mean plans that have a high deductible, so that your plan begins to pay only after you've first paid up to a certain amount for covered services.

Chronic Disease Management

An integrated care approach to managing illness which includes screenings, check-ups, monitoring and coordinating treatment, and patient education. It can improve your quality of life while reducing your health care costs if you have a chronic disease by preventing or minimizing the effects of a disease.

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COBRA

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 (COBRA). Under the original legislation, individuals were required to pay the full premium to continue their insurance through COBRA. The American Recovery and Reinvestment Act (ARRA) provides a temporary subsidy of 65% of the premium cost for the purchase of COBRA coverage to people who have lost their job between September 1, 2008 and December 31, 2009.

Community Rating

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

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.

Competitive Bidding

Open bidding for federal contracts between independent groups that compete for the contract by providing the best bid.

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).

Cooperatives/Co-ops

HMOs that are managed by the members of the health plan or insurance purchasing arrangements in which businesses or other groups join together to gain the buying power of large employers or groups.

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

A person's health care costs are paid by their insurance or by the government.

Creditable Coverage

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

D

Dependent Coverage

Insurance coverage for family members of the policyholder, such as spouses, children, or partners.

Direct Access

The ability to see a doctor or receive a medical service without a referral from your primary care physician.

Disability

A limit in a range of major life activities. This includes activities like seeing, hearing, walking and tasks like thinking and working. Because different programs may have different disability standards, please check the program you're interested in for its disability standards.

Disposable Personal Income

The amount of a person's income that is left over after money has been spent on basic necessities such as rent, food, and clothing.

Disproportionate Share Hospital (DSH) Payments

Payments made by a state's Medicaid program to hospitals that the state designates as serving a "disproportionate share" of low-income or uninsured patients. These payments are in addition to the regular payments such hospitals receive for providing inpatient care to Medicaid beneficiaries. States have some discretion in determining how much eligible hospitals receive. The amount of federal matching funds that a state can use to make payments to DSH hospitals in any given year is capped at an amount specified in the federal Medicaid statute.

Donut Hole, Medicare Prescription Drug

Most plans with Medicare prescription drug coverage (Part D) have a coverage gap (called a "donut hole"). This means that after you and your drug plan have spent a certain amount of money for covered drugs, you have to pay all costs out-of-pocket for your prescriptions up to a yearly limit. Once you have spent up to the yearly limit, your coverage gap ends and your drug plan helps pay for covered drugs again.

Dual Eligibles

A term used to describe an individual who is eligible for Medicare and for some level of Medicaid benefits. Most dual eligibles qualify for full Medicaid benefits including nursing home services, and Medicaid pays their Medicare premiums and cost sharing. For other duals Medicaid provides the "Medicare Savings Programs" through which enrollees receive assistance with Medicare premiums, deductibles, and other cost sharing requirements.



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

As part of the Medicaid program, the law requires that all states have a program for eligible children under age 21 to receive a medical assessment, medical treatments and other measures to correct any problems and treat chronic conditions.

Electronic Health Record/Electronic Medical Records

Computerized records of a patient's health information including medical, demographic, and administrative data. This record can be created and stored within one health care organization or it can be shared across health care organizations and delivery sites.

Emergency

A medical condition that starts suddenly and requires immediate care.

Emergency Room Services

Evaluation and treatment of an illness, injury, or condition that needs immediate medical attention in an emergency room.

Employer Contribution

The contribution is the money a company pays for its employees' health care. Exclusions- Health conditions that are explicitly not covered in an insurance package and that your insurance will not pay for.

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

An approach that would require all employers, or at least all employers meeting size or revenue thresholds, to offer health benefits that meet a defined standard, and pay a set portion of the cost of those benefits on behalf of their employees.

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. The fund would provide a source of financing for coverage for those who do not have employment-based coverage. Currently, two states, Massachusetts and Vermont, and the City of San Francisco impose pay-or play requirements on employers.

Employer Responsibility

Under the Affordable Care Act starting in 2014, if an employer with at least 50 full-time equivalent employees doesn't provide affordable health insurance and an employee uses a tax credit to help pay for insurance through an Exchange, the employer must pay a fee to help cover the cost of the tax credits.

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.

Essential Health Benefits

A set of health care service categories that must be covered by certain plans, starting in 2014. The Affordable Care Act defines essential health benefits to "include at least the following general categories and the items and services covered within the categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care."

Insurance policies must cover these benefits in order to be certified and offered in Exchanges, and all Medicaid State plans must cover these services by 2014.

Starting with plan years or policy years that began on or after September 23, 2010, health plans can no longer impose a lifetime dollar limit on spending for these services. All plans, except grandfathered individual health insurance policies, must phase out annual dollar spending limits for these services by 2014.

The Department of Health and Human Services is working with a number of partners to develop the essential health benefits package. In the fall of 2011, HHS will launch an effort to collect public comment and hear directly from all Americans who are interested in sharing their thoughts on this important issue.

Exchange

A new transparent and competitive insurance marketplace where individuals and small businesses can buy affordable and qualified health benefit plans. Affordable Insurance Exchanges will offer you a choice of health plans that meet certain benefits and cost standards. Starting in 2014, Members of Congress will be getting their health care insurance through Exchanges and you will be able buy your insurance through Exchanges too.

Exclusions

Items or services that aren't covered under your contract for insurance and for which an insurance company won't pay. For example, your policy may not cover pregnancy care or any services related to a pre-existing condition.

Exclusive Provider Organizations (EPO)/Exclusive Provider Arrangement (EPA)

An indemnity or service plan that provides benefits only if those hospitals or doctors with which it contracts provide the medical services, with some exceptions for emergency and out-of-area services.

F

Family and Medical Leave Act (FMLA)

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

Federal Employee Health Benefit 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. In the case of covered services, FMAP varies from 50 to 76 percent depending upon a state's per capita income; on average, across all states, the federal government pays 57 percent of the costs of Medicaid. The American Recovery and Reinvestment Act (ARRA) provides a temporary increase in the FMAP through December 31, 2010.

Federal Poverty Level (FPL) - The federal government's working definition of poverty that is used as the reference point to determine the number of people with income below poverty and the income standard for eligibility for public programs. The federal government uses two different definitions of poverty. The U.S. Census poverty threshold is used as the basis for official poverty population statistics, such as the percentage of people living in poverty. The poverty guidelines, released by the U.S. Department of Health and Human Services (HHS), are used to determine eligibility for public programs and subsidies. For 2008, the Census weighted average poverty threshold for a family of four was \$22,025 and HHS poverty guideline was \$21,200.

Federally Qualified Health Center (FQHC)

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

Flexible Spending Account (FSA)

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

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

Health Care ABCs

Terminology and Acronyms for Hospital Trustees

Formulary

A list of medications that a managed care company encourages or requires physicians to prescribe as necessary in order to reduce costs.

Fully Insured Job-Based Plan

A health plan purchased by an employer from an insurance company.

Gag Clause

A contractual agreement between a managed care organization and a provider that restricts what the provider can say about the managed care company

Gatekeeper

The person in a managed care organization, often a primary care provider, who controls a patient's access to health care services and whose approval is required for referrals to other services or other specialists.

Global Budgeting

A way of containing hospital costs in which participating hospitals share a budget, agreeing together to set the maximum amount of money that will be paid for health care.

Grandfathered

As used in connection with the Affordable Care Act: Exempt from certain provisions of this law.

Grandfathered Health Plan

As used in connection with the Affordable Care Act: A group health plan that was created—or an individual health insurance policy that was purchased—on or before March 23, 2010. Grandfathered plans are exempted from many changes required under the Affordable Care Act. Plans or policies may lose their “grandfathered” status if they make certain significant changes that reduce benefits or increase costs to consumers. A health plan must disclose in its plan materials whether it considers itself to be a grandfathered plan and must also advise consumers how to contact the U.S. Department of Labor or the U.S. Department of Health and Human Services with questions. (Note: If you are in a group health plan, the date you joined may not reflect the date the plan was created. New employees and new family members may be added to grandfathered group plans after March 23, 2010).

Group Model HMO

An HMO that contracts with an independent group practice to provide medical services

Guaranteed Issue/Renewal

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

H **Health Care Benefits**

The specific services and procedures covered by a health plan or insurer.

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.

Health Care Financing Administration (HCFA)

The federal government agency within the Department of Health and Human Services that directs the Medicare and Medicaid programs. HCFA also does research to support these programs and oversees more than a quarter of all health care costs in the United States.

Health Care ABCs

Terminology and Acronyms for Hospital Trustees

Health Care Workforce Development

The use of incentives and recruiting to encourage people to enter into health care professions such as primary care and to encourage providers to practice in underserved areas.

Health Information Technology

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

Health Insurance

Financial protection against the health care costs caused by treating disease or accidental injury.

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. An example of this arrangement is the Commonwealth Connector, created in Massachusetts in 2006.

Health Insurance Purchasing Cooperatives (HIPCs)

Public or private organizations that get health insurance coverage for certain populations of people, combining everyone in a specific geographic region and basing insurance rates on the people in that area.

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 Status

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

High-Cost Excise Tax

Under the Affordable Care Act starting in 2018, a tax on insurance companies that provide high-cost plans. This tax encourages streamlining of health plans to make premiums more affordable.

High Deductible Health Plan

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

High Risk Pool Plan (State)

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

Health Care ABCs

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HIPAA Eligible Individual

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

Home and Community-Based Services (HCBS)

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

Hospital Readmissions

A situation where you were discharged from the hospital and wind up going back in for the same or related care within 30, 60 or 90 days. The number of hospital readmissions is often used in part to measure the quality of hospital care, since it can mean that your follow-up care wasn't properly organized, or that you weren't fully treated before discharge.

Independent Practice Association (IPA)

A group of private physicians who join together in an association to contract with a managed care organization.

Individual Health Insurance Policy

Policies for people that aren't connected to job-based coverage. Individual health insurance policies are regulated under state law.

Individual Mandate

A requirement that all individuals obtain health insurance. A mandate could apply to the entire population, just to children, and/or could exempt specified individuals. Massachusetts was the first state to impose an individual mandate that all adults have health insurance.

Individual Responsibility

Under the Affordable Care Act, starting in 2014, you must be enrolled in a health insurance plan that meets basic minimum standards. If you aren't, you may be required to pay an assessment. You won't have to pay an assessment if you have very low income and coverage is unaffordable to you, or for other reasons including your religious beliefs. You can also apply for a waiver asking not to pay an assessment if you don't qualify automatically.

Insurance Co-Op

A non-profit entity in which the same people who own the company are insured by the company. Cooperatives can be formed at a national, state or local level, and can include doctors, hospitals and businesses as member-owners.

Integrated Provider (IP)

A group of providers that offer comprehensive and coordinated care, and usually provides a range of medical care facilities and service plans including hospitals, group practices, a health plan and other related health care services.

J

Job-Based Health Plan

Coverage that is offered to an employee (and often his or her family) by an employer.

Joint Commission on the Accreditation of Healthcare Organizations (JCAHO)

A national private, non-profit organization that accredits health care organizations and agencies and sets guidelines for operation for these facilities.

L

Lifetime Limit

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

Limitations

A "cap" or limit on the amount of services that may be provided. It may be the maximum cost or number of days that a service or treatment is covered.

Limited Service Hospital

A hospital, often located in a rural area, that provides a limited set of medical and surgical services.

M

Malpractice Insurance

Coverage for medical professionals which pays the costs of legal fees and/or any damages assessed by the court in a lawsuit brought against a professional who has been charged with negligence.

Mandate

Law requiring that a health plan or insurance carrier must offer a particular procedure or type of coverage.

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.

Means Test

An assessment of a person's or family's income or assets so that it can be determined if they are eligible to receive public support, such as Medicaid.

Medicaid Waivers

Authority granted by the Secretary 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 to expand coverage to populations, such as adults without dependent children, who are not otherwise eligible for Medicaid.

Medical Home

A health care 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 nonemergent primary, secondary, and tertiary care; and have access to linguistically and culturally appropriate care.

Medical IRAs

Personal accounts which, like individual retirement plans, allow a person to accumulate funds for future use. The money in these accounts must be used to pay for medical services. The employee decides how much money he or she will spend on health care.

Health Care ABCs

Terminology and Acronyms for Hospital Trustees

Medical Loss Ratio (MLR)

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

Medical Underwriting

The process of determining whether or not to accept an applicant for health care 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

A process used by insurance companies to try to figure out your health status when you're applying for health insurance coverage to determine whether to offer you coverage, at what price, and with what exclusions or limits.

Medicare Advantage (Medicare Part C)

A type of Medicare health plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. Medicare Advantage Plans include Health Maintenance Organizations, Preferred Provider Organizations, Private Fee-for-Service Plans, Special Needs Plans, and Medicare Medical Savings Account Plans. If you're enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan and aren't paid for under Original Medicare. Most Medicare Advantage Plans offer prescription drug coverage.

Medicare Hospital Insurance Tax

A tax under the Federal Insurance Contributions Act (FICA) that is a United States payroll tax imposed by the Federal government on both employees and employers to fund Medicare.

Medicare Part D

A program that helps pay for prescription drugs for people with Medicare who join a plan that includes Medicare prescription drug coverage. There are two ways to get Medicare prescription drug coverage: through a Medicare Prescription Drug Plan or a Medicare Advantage Plan that includes drug coverage. These plans are offered by insurance companies and other private companies approved by Medicare.

Medicare Prescription Drug Donut Hole

Most plans with Medicare prescription drug coverage (Part D) have a coverage gap (called a "donut hole"). This means that after you and your drug plan have spent a certain amount of money for covered drugs, you have to pay all costs out-of-pocket for your prescriptions up to a yearly limit. Once you have spent up to the yearly limit, your coverage gap ends and your drug plan helps pay for covered drugs again.

Medicare Supplements or Medigap

A privately-purchased health insurance policy available to Medicare beneficiaries to cover costs of care that Medicare does not pay. Some policies cover additional costs, such as preventive care, prescription drugs, or at-home care.

Member

The person enrolled in a health plan.

Minimum Essential Coverage

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

N

New Plan

As used in connection with the Affordable Care Act: A health plan that is not a grandfathered health plan and therefore subject to all of the reforms in the Affordable Care Act.

In the individual health insurance market, a plan that your family is purchasing for the first time will generally be a new plan.

In the group health insurance market, a plan that your employer is offering for the first time will generally be a new plan. Please note that new employees and new family members may be added to existing grandfathered group plans – so a plan that is “new to you” and your family may still be a grandfathered plan.

In both the individual and group markets, a plan that loses its grandfathered status will be considered a new plan. A plan loses its grandfathered status when it makes significant changes to the plan, such as reducing benefits or increasing cost-sharing for enrollees.

A health plan must disclose in its plan materials whether it considers itself to be a grandfathered plan and must also advise consumers how to contact the U.S. Department of Labor or the U.S. Department of Health and Human Services with questions.

Non-Contributory Plan

A group insurance plan that requires no payment from employees for their health care coverage.

Nondiscrimination

A requirement that job-based coverage not discriminate based on health status. Coverage under job-based plans cannot be denied or restricted. You also can't be charged more because of your health status. Job-based plans can restrict coverage based on other factors such as part-time employment that aren't related to health status.

Nurse Practitioner

A nurse specialist who provides primary and/or specialty care to patients. In some states nurse practitioners do not have to be supervised by a doctor.

O

Open Enrollment Period

A specified period of time during which people are allowed to change health plans, usually once a year.

Open Panel

A right included in an HMO, which allows the covered person to get non-emergency covered services from a specialist without getting a referral from the primary care physician or gatekeeper.

Outcomes

Measures of the effectiveness of particular kinds of medical treatment. This refers to what is quantified to determine if a specific treatment or type of service works.

P

Patient-Centered Outcomes Research

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

Pay for Performance

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

Health Care ABCs

Terminology and Acronyms for Hospital Trustees

Payment Bundling

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

Percent of Poverty

A term that describes the income level a person or family must have to be eligible for Medicaid.

Plan Year/Policy Year

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

Play or Pay

This system would provide coverage for all people by requiring employers either to provide health insurance for their employees and dependents (play) or pay a contribution to a publicly-provided system that covers uninsured or unemployed people without private insurance (pay).

Point of Service (POS)

A type of insurance where each time health care services are needed, the patient can choose from different types of provider systems (indemnity plan, PPO or HMO). Usually, members are required to pay more to see PPO or non-participating providers than to see HMO providers.

Postnatal Care

Health care services received by a woman immediately following the delivery of her child.

Pre-Authorization

The process where, before a patient can be admitted to the hospital or receive other types of specialty services, the managed care company must approve of the proposed service in order to cover it.

Pre-Existing Condition (Job-Based Coverage)

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

Pre-Existing Condition (Individual Policy)

A condition, disability or illness (either physical or mental) that you have before you're enrolled in a health plan. Genetic information, without a diagnosis of a disease or a condition, cannot be treated as a pre-existing condition. This term is defined under state law and varies significantly by state.

Pre-Existing Condition Exclusion Period (Job-Based Coverage)

The time period during which a health plan won't pay for care relating to a pre-existing condition. Under a job-based plan, this cannot exceed 12 months for a regular enrollee or 18 months for a late-enrollee.

Pre-Existing Condition Exclusion Period (Individual Policy)

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

Health Care ABCs

Terminology and Acronyms for Hospital Trustees

Pre-Existing Condition Insurance Plan (PCIP)

A new program that will provide a health coverage option for you if you have been uninsured for at least six months, you have a pre-existing condition, and you have been denied coverage (or offered insurance without coverage of the pre-existing condition) by a private insurance company. This program will provide coverage until 2014 when you will have access to affordable health insurance choices through an Exchange, and you can no longer be discriminated against based on a pre-existing condition.

Premium Cap

The maximum amount of money an insurance company can charge for coverage.

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.

Premium Tax

A state tax on insurance premiums.

Prepaid Group Practice

A type of HMO where participating providers receive a fixed payment in advance for providing particular health care services.

Private Insurance

Health insurance that is provided by insurance companies such as commercial insurers and Blue Cross plans, self-funded plans sponsored by employers, HMOs or other managed care arrangements.

Provider Payment Rates

The total payment a provider, hospital, or community health center receives when they provide medical services to a patient. Providers are compensated for patient care using a set of defined rates based on illness category and the type of service administered.

Provider-Sponsored Organization (PSO)

Health care providers (physicians and/or hospitals) who form an affiliation to act as insurer for an enrolled population.

Public Health

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

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.

Purchasing Pool

Health insurance providers pool the health care risks of a group of people in order to make the individual costs predictable and manageable. For health coverage arrangements to perform well, the risk pooling should balance low and high risk individuals such that expected costs for the pool are reasonably predictable for the insurer and relatively stable over time.

Q

Qualified Health Plan

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

Quality Improvement Organization (QIO)

An organization contracting with HCFA to review the medical necessity and quality of care provided to Medicare beneficiaries.

R

Rate Review

A process that allows state insurance departments to review rate increases before insurance companies can apply them to you.

Referral System

The process through which a primary care provider authorizes a patient to see a specialist to receive additional care.

Reimbursement

The amount paid to providers for services they provide to patients.

Rescission

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

Rider (Exclusionary Rider)

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

S

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.

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-Insured

A type of insurance arrangement where employers, usually large employers, pay for medical claims out of their own funds rather than contracting with an insurance company for coverage. This puts the employer at risk for its employees' medical expenses rather than an insurance company.

Single Payer System

A health care reform proposal in which health care costs are paid by taxes rather than by the employer and employee. All people would have coverage paid by the government.

Health Care ABCs

Terminology and Acronyms for Hospital Trustees

Small Group Market

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

Socialized Medicine

A health care system in which providers are paid by the government, and health care facilities are run by the government.

Special Enrollment Period

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

Special Health Care Need

The health care and related needs of children who have chronic physical, developmental, behavioral or emotional conditions. Such needs are of a type or amount beyond that required by children generally.

Staff Model HMO

A type of managed care where physicians are employees of the health plan, usually in the health plan's own health center or facility.

Standard Benefit Package

A defined set of benefits provided to all people covered under a health plan.

State Continuation Coverage

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

T

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.

V

Value-Based Purchasing (VBP)

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

W

Waiting Period

The amount of time a person must wait from the date he or she is accepted into a health plan (or from when he or she applies) until the insurance becomes effective and he or she can receive benefits.

Well-Baby and Well-Child Visits

Routine doctor visits for comprehensive preventive health services that occur when a baby is young and annual visits until a child reaches age 21. Services include physical exam and measurements, vision and hearing screening, and oral health risk assessments.

Withhold

A percentage of providers' fees that managed care companies hold back from providers which is only given to them if the amount of care they provide (or that the entire plan provides) is under a budgeted amount for each quarter or the whole year.

Worker's Compensation Coverage

States require employers to provide coverage to compensate employees for work-related injuries or disabilities.

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.



Acronyms

Acronyms

A

AAFP	American Academy of Family Physicians
AAHP	American Association of Health Plans
AAHSA	American Association of Homes and Services for the Aging
AAMC	Association of American Medical Colleges
AAPCC	Adjusted Average Per Capita Cost
AARP	American Association of Retired Persons
ABA	American Bar Association
ABIM	American Board of Internal Medicine
ACCME	Accreditation Council on Continuing Medical Education
ACG	Ambulatory Care Group
ACHE	American College of Healthcare Executives
ACR	Adjusted Community Rating
ACU	Ambulatory Care Unit
ADC	Average Daily Census
ADL	Activities of Daily Living
ADR	Adverse Drug Reaction
AFDC	Aid to Families with Dependent Children
AGPA	American Group Practice Association
AHA	American Hospital Association
AHC	Academic Health Center
AHCA	American Health Care Association
AHCPR	Agency for Health Care Policy and Research (DHHS)
AIDS	Acquired Immune Deficiency Syndrome
AHP	Accountable Health Plan
ALOS	Average Length of Stay
AMA	American Medical Association
AMHO	Association of Managed Health Care Organizations
ANA	American Nurses Association
AOHA	American Osteopathic Hospital Association
AONE	American Organization of Nurse Executives
A/P	Accounts Payable
APC	Ambulatory Patient Classifications
APD	Adjusted Patient Day
APG	Ambulatory Patient Group
A/R	Accounts Receivable
ASC	Ambulatory Surgical Center
BBA	Balanced Budget Act of 1997
BC/BS	Blue Cross and Blue Shield
BLS	Bureau of Labor Statistics
BME	Board of Medical Examiners

B

Health Care ABCs

Terminology and Acronyms for Hospital Trustees

C

BP	Blood Pressure
BSN	Bachelor of Science in Nursing
CAH	Critical Access Hospital
CAT	Computerized Axial Tomography
CBO	Congressional Budget Office
CCN	Community Care Network
CCU	Critical Care Unit
CDC	Centers for Disease Control and Prevention
CE	Continuing Education
CEO	Chief Executive Officer
CFO	Chief Financial Officer
CHF	Congestive Heart Failure
CHIN	Community Health Information Network
CHIP	Children's Health Insurance Program
CICU	Cardiac Intensive Care Unit
CM	Case Management; Case Manager
CME	Continuing Medical Education
CMS	Centers for Medicare and Medicaid Services
CNM	Certified Nurse Midwife
CNS	Clinical Nurse Specialist
COA	Certificate of Authority
COB	Coordination of Benefits
COBRA	Consolidated Omnibus Budget Reconciliation Act
COE	Center of Excellence
COLA	Cost-of-Living Adjustment
CON	Certificate of Need
COO	Chief Operating Officer
COPD	Chronic Obstructive Pulmonary Disease
CORF	Comprehensive Outpatient Rehabilitation Facility
CPA	Certified Public Accountant
CPI	Consumer Price Index
CPR	Cardiopulmonary Resuscitation
CPR	Customary, Prevailing, and Reasonable (fees)
CPT	Current Procedural Terminology
CQI	Continuous Quality Improvement
CRNA	Chief Registered Nurse Anesthetist
CT	Computerized Tomography
CY	Calendar Year
D&O	Directors' and Officers' (liability coverage)
DEA	Drug Enforcement Administration
DHHS	Department of Health and Human Services
DME	Director of Medical Education
DME	Durable Medical Equipment

D

Health Care ABCs

Terminology and Acronyms for Hospital Trustees

E

DNR	Do Not Resuscitate
DO	Doctor of Osteopathy
DOJ	Department of Justice
DOL	Department of Labor
DRG	Diagnosis Related Group
DSH	Disproportionate Share Adjustment
Dx	Diagnosis
ECF	Extended Care Facility
EKG/ECG	Electrocardiogram
ECU	Environmental Control Unit
ED	Emergency Department
EDP	Electronic Data Processing
EDS	Electronic Data System
EEOC	Equal Employment Opportunity Commission
EEG	Electroencephalogram
EMS	Emergency Medical Services
EMT	Emergency Medical Technologist
EMTALA	Emergency Medical Treatment and Active Labor Act
EPA	Environmental Protection Agency
ER	Emergency Room
ERISA	Employee Retirement Income Security Act 1994
FACHE	Fellow of the American College of Healthcare Executives
FAHS	Federation of American Health Systems
FASB	Financial Accounting Standards
FDA	Food and Drug Administration
FFS	Fee For Service
FI	Fiscal Intermediary
FMG	Foreign Medical Graduate
FP	Family Practitioner
FQHC	Federally Qualified Health Center
FTC	Federal Trade Commission
FTE	Full-time Equivalent
FY	Fiscal Year
FYE	Fiscal Year Ending

F

GAAP	Generally Accepted Accounting Principles
GAO	General Accounting Office
GDP	Gross Domestic Product
GI	Gastrointestinal
GME	Graduate Medical Education
GNP	Gross National Product
HEDIS	Health Plan Employer Data and Information Set
HH	Home Health

G

H

Health Care ABCs

Terminology and Acronyms for Hospital Trustees

J-M

N-O

HIAA	Health Insurance Association of America
HIPAA	Health Insurance Portability and Accountability Act of 1996
HMO	Health Maintenance Organization
IBNR	Incurred But Not Reported
ICCU	Intensive Coronary Care Unit
ICF	Intermediate Care Facility
ICU	Intensive Care Unit
IDS	Integrated Delivery System
IG	Inspector General
IME	Indirect Medical Education
IOM	Institute of Medicine
I/P	Inpatient
IPA	Independent Practice Association
IRS	Internal Revenue Service
IS	Information System
IV	Intravenous
JCC	Joint Conference Committee
LOS	Length of Stay
LPN	Licensed Practical Nurse
LTC	Long-term Care
LVN	Licensed Vocational Nurse
MCO	Managed Care Organization
MD	Doctor of Medicine
MEC	Medical Executive Committee
MEDPAC	Medicare Payment Advisory Commission
MHA	Master of Healthcare Administration (degree)
MI	Myocardial Infarction
MLP	Midlevel Practitioner
MOB	Medical Office Building
MPH	Master of Public Health (degree)
MRI	Magnetic Resonance Imaging
MSA	Medical Savings Account
MSA	Metropolitan Statistical Area
MSO	Management Service Organization
NCQA	National Committee for Quality Assurance
NICU	Neonatal Intensive Care Unit
NIH	National Institutes of Health (HHS)
NLRB	National Labor Relations Board
NP	Nurse Practitioner
NPDB	National Practitioner Data Bank
OB-GYN	Obstetrics & Gynecology
OIG	Office of Inspector General (HHS)
OMB	Office of Management and Budget

Health Care ABCs

Terminology and Acronyms for Hospital Trustees

P

Q-R

S-Z

OP	Outpatient
OR	Operating Room
OSHA	Occupational Safety and Health Administration
OT	Occupational Therapy
PA	Physician's Assistant
PAC	Political Action Committee
P&L	Profit and Loss
PET	Positron Emission Tomography
PHO	Physician Hospital Organization
PPO	Preferred Provider Organization
PPS	Prospective Payment System
PRO	Peer Review Organization
PT	Physical Therapy
QA	Quality Assurance
QI	Quality Improvement
R&D	Research and Development
RBRVS	Resource-Based Relative Value Scale
RFP	Request For Proposal
RN	Registered Nurse
ROA	Return on Assets
ROI	Return on Investment
RPh	Registered Pharmacist
RVS	Relative Value Scale
RVU	Relative Value Unit
Rx	Prescription
SEC	Securities and Exchange Commission
SLP	Speech Language Pathologist
SNF	Skilled Nursing Facility
TPA	Third-Party Administrator
UR	Utilization Review
YTD	Year To Date