South Dakota
Association of Healthcare Organizations

Health Care Glossary

Terms and Abbreviations

The South Dakota Association of Healthcare Organizations (SDAHO) is pleased to provide you with this resource that has been specifically designed for health care facility trustees/board members, legislators and members of the media. The *SDAHO Health Care Glossary - Terms and Abbreviations* was created to help you better understand the complex and confusing world of health care. We hope you find this resource tool useful.

The South Dakota Association of Healthcare Organizations would like to thank The Kaiser Family Foundation for assistance in compiling this collection of helpful health care terms and abbreviations.

A

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

Accountable Care Organization (ACO)
Part of the federal health reform bill, ACOs can be comprised of health care professionals and hospitals with the goal of increasing quality and reducing costs in exchange for increased reimbursement.

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

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

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

Acuity
Degree or severity of illness.

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

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.

Adjusted Patient Day (APD)
An accounting method for modifying the definition of inpatient days to include outpatient revenues.

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.

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.

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

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

Affordable Care Act (ACA)
Also known as the Patient Protection and Affordable Care Act, this federal legislation was passed in March 2010 and contains new health reform provisions.

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

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.

Agency for Health Care Policy and Research (AHCPR)
Created by the Omnibus Budget Reconciliation Act of 1989 as a component of the U.S. Public Health Service. AHCPR is responsible for research on quality, appropriateness,

effectiveness and cost of health care, and for using this data to promote improvement in clinical practice and the organization, financing and delivery of health care.

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)

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

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

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.

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

American Hospital Association (AHA)
A national professional trade association for hospitals.

American Medical Association (AMA)
The largest national professional association for physicians.

American Nurses Association (ANA)
A professional organization for registered nurses.

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.

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

Area Wage Index (AWI)
The Centers for Medicare & Medicaid Services (CMS) adjusts 62 percent to 69 percent of Medicare payments to account for geographic differences in labor and benefit costs. This adjustment is referred to as the Area Wage Index (AWI). To

calculate the AWI, CMS takes data reported by hospitals every three years in the Occupational Mix Survey, which collects data on wage amounts and benefit costs of clinical and, to a lesser degree, non-clinical staff.

Assisted Living Centers 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.

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.

B

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

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

Basic DRG Payment Rate
The payment rate a hospital will receive for a Medicare patient in a particular diagnosis-related group. The payment rate is calculated by adjusting the standardized amount to reflect wage rates in the hospital's geographic area (and cost of living differences unrelated to wages) and the costliness of the DRG. See also Standardized Amount, Diagnosis-Related Groups.

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.

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.

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.

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.

C

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

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

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

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

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

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

Capitation
(1) Method of payment for health services in which a physician or hospital is paid a fixed amount for each person served regardless of the actual number or nature of services provided.

(2) A method of paying 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.

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

Case Management
Monitoring and coordinating the delivery of health services for individual patients to enhance care and manage costs; often used for patients with specific diagnoses or who require high-cost or extensive 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 Score
A measure of patient acuity reflecting different patients' needs for hospital and long term care resources. This measure may be based on patients' diagnoses, the severity of their illnesses, and their utilization of services. A high case-mix index refers to a patient population more ill than average.

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.

Catastrophic Coverage (Insurance)
A coverage option with limited benefits and a high deductible intended to protect against medical bankruptcy due to an unforeseen illness or injury. These plans are usually geared toward young adults in relatively good health. While

catastrophic plans do not generally cover preventive care, catastrophic coverage plans under health reform will be required to exempt some preventive care services from the deductible.

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

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

Centers for Disease Control and Prevention (CDC)
A division of the U.S. Public Health Service that takes the lead in analyzing and fighting infectious disease.

Centers for Medicare and Medicaid Services (CMS)
Federal agency (a division of Health and Human Services) that administers the Medicare and Medicaid programs and determines provider certification and reimbursement.

Certified Health Plan
A managed health care plan, certified by the Health Services Commission and the Office of the Insurance Commissioner to provide coverage for the Uniform Benefits Package to state residents.

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.

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

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 life-time, or recurs and may require long-term care.

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

Claims-Made Coverage/Policy
A form of liability coverage for claims made (reported or filed) against an insured party during the policy period irrespective of when the event occurred that caused the claims

to be made. Thus, claims made during a previous period in which the policyholder was insured under a claims-made policy would be covered, provided the coverage is continuous with the insurer.

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

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

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. Under the original legislation, individuals were required to pay the full premium to continue their insurance through COBRA. The American Recovery and Reinvestment Act provides a temporary subsidy of 65% of the premium cost for the purchase of COBRA coverage to people who lost their job between September 1, 2008 and May 31, 2010.

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

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

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

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

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.

Consumer Price Index (CPI)
Measure of inflation encompassing the cost of all consumer goods and services.

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

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.

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.

Coordination of Benefits (COB)
Agreement between health plans and insurers to avoid the same services being paid for more than once.

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

Core Based Statistical Area (CBSA)
Official Term for a functional region based around an urban center of at least 10,000 people based on standards published by the Office of Management & Budget

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

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

Cost Containment
A set of strategies aimed at controlling the level or rate of growth of health care costs. These measures encompass a myriad of activities that focus on reducing overutilization of health services, addressing provider reimbursement issues, eliminating waste, and increasing efficiency n the health care system.

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

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

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 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. *(Also see physician credentialing)*

Critical Access Hospital (CAH)
Designated within the Medicare Rural Hospital Flexibility Program as a limited service rural, not-for-profit, or public hospital that provides outpatient and short-term inpatient hospital care on an urgent or emergency basis and is a part of a rural health network. Medicare reimburses CAH's at a rate of 101% of their costs. There are 38 CAH's in SD.

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

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

Current Procedural Terminology (CPT)
Coding system for physician services developed by the American Medical Association; basis of the HCPCS coding system.

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

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

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

D

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

Deemed Status
A hospital is "deemed qualified" to participate in the Medicare program if it is accredited by the Joint Commission for the Accreditation of Healthcare Organizations (JCAHO), thus avoiding the need for a duplicative Medicare accreditation survey.

Defensive Medicine
Health care under which providers order more test than necessary to protect themselves from potential lawsuits by patients. Defensive medicine is said to be a major reason 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.

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, and based on the length of time patients with a given diagnosis are likely to stay in the hospital.

Direct Contracting
Agreement between a hospital and a corporate purchaser for the delivery of 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).

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.

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

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.

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

Durable Medical Equipment (DME)
Equipment that is primarily and customarily used to serve a medical purpose, can withstand repeated use, and is

appropriate for use in the home, like hospital beds, walkers, wheel chairs and oxygen tents.

Durable Power of Attorney for Health Care
Allows an individual to designate in advance another person to act on his/her behalf if he/she is unable to make a decision to accept, maintain, discontinue or refuse any health care services. (see Advance Directive)

E

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

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

Electronic Health Record (EHR)
An electronic health record contains personal health information. Only authorized doctors, nurses, and staff can create, view, and update these records. An electronic health record should meet the technical rules that ensure that it can be shared between, for example, hospitals, doctors' offices, and clinics. Also Electronic Medical Records (EMR).

Emergency Medical Services (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 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.

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

Enrollment
(1) The total number of covered person (i.e., the enrolled group) in a health plans.

(2) The process by which a health plan signs up individuals and groups for membership.

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.

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.

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

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

Extended Care Facility (ECF)
A hospital unit for treatment of inpatients who require convalescent, rehabilitative, or long-term skilled nursing care.

F

False Claims Act
Also called the "Lincoln Law" is an American federal law that imposes liability on persons and companies (typically federal contractors) who defraud governmental programs. The law includes a "qui tam" provision that allows people who are not affiliated with the government to file actions on behalf of the government (informally called "whistleblowing"). Persons filing under the Act stand to receive a portion (usually about 15–25 percent) of any recovered damages. Claims under the law have typically involved health care, military, or other government spending programs.

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 Medical Assistance Percentage (FMAP)
The statutory term for the federal Medicaid matching rate—i.e., the share of the costs of Medicaid services or administration that the federal government bears

Federal Poverty Level (FPL)
The amount of income determined by the 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 fees him or her 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.

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.

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.

G

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

Gatekeeper
The person in a managed care organization who decides whether or not a patient will be referred to a specialist for

further care. Physicians, nurses and physician assistants all function as gatekeepers.

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

Governance
The legal authority and responsibility for the public health system.

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

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

Group Practice
Provision of medical services by three or more physicians formally organized to provide medical care, consultation, diagnosis and/or treatment through the joint use of equipment and personnel. The income from the medical practice is

distributed in accordance with methods determined by members of the group. Group practices have a single-specialty or multi-specialty focus.

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

H

Healthcare-Acquired Conditions (HAC)
"Reasonably preventable" conditions or events during a stay at a health care facility and for which Medicare may refuse payment.

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

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

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 Information Exchange (HIE)
Health Information Exchange is when hospitals, doctors' offices, and others share health information electronically. The exchange of health information should be done securely, maintaining privacy.

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

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. Health care facilities cannot use or disclose a patient's health information in other ways, such as marketing or research, unless they get the patient's written permission before doing so. In addition, providers must inform patients how their health data will be used, establish systems to track disclosure of patient information, and permit patients to inspect, copy and request to amend their own health information.

Health Maintenance Organization (HMO)
A managed care plan that integrates financing and delivery of a comprehensive set of 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 Savings Account (HSA) or Medical Savings Account (MSA)
A health insurance option consisting of a high-deductible insurance policy and tax-advantaged saving account. Individuals pay for their own health care up to the annual deductible by withdrawing from the savings account or paying out of pocket. The insurance policy pays for most or all costs of covered services once the deductible is met.

Healthcare Common Procedure Coding System (HCPCS)
A uniform method for healthcare providers & medical suppliers to code professional services, procedures & supplies.

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

Home 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.

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

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.

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

Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)
The HCAHPS survey is the first national, standardized, publicly reported survey of patients' perspectives of hospital care.

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

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

I

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

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

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

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

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

Indian Health Services (IHS)
A division of the U.S. Public Health Service that is

responsible for providing federal health services for American Indians and Alaska natives.

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

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

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

Intensive Care Unit (ICU)
A hospital unit for treatment and continuous monitoring of inpatients with life-threatening conditions.

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 or specialty" hospital.

J

The Joint Commission (Formerly JCAHO)
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.

K

L

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

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

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

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

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

Living Will
Document generated by a person for the purpose of providing

guidance about the medical care to be provided if the person is unable to articulate these decisions. See Advance Directive

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.

M

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 ratio frequency fields.

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

Managed Care Organization (MCO)
A plan or company, such as an HMO, PPO, or exclusive provider organization, that uses the principles of managed care as a basic part of doing business.

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

Market Basket Index Update
An index of the annual change in the prices of goods and services that providers use for producing health services. There are separate market baskets for Medicare's prospective payment system's (PPS's) hospital operating and capital inputs; PPS-excluded facility operating inputs; and 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 provide medical coverage for low-income families and individuals.

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

Medicaid Integrity Group (MIG)
The Centers for Medicare and Medicaid Services' MIG administers the Medicaid Integrity Program and regularly consults with the Medicaid Fraud and Abuse Technical Advisory Group.

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

Medicaid Waivers
Authority granted by the Secretary of 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 who are not otherwise eligible for Medicaid.

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

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

Medical Home
A 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 non-emergent primary, secondary, and tertiary care; and have access to linguistically and culturally appropriate care.

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

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 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 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 will be prohibited under health reform beginning in 2014.

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

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

Medically Underserved Area (MUA)
A geographic location that has insufficient health resources to meet the medical needs of the resident population.

Medicare
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 Administrative Contractor (MAC)
The integration of the administration of Medicare Parts A and B from separate oversight of Fiscal Intermediary (Part A) and Carrier (Part B). This integration will allow centralization of information regarding coverage, claims payment, etc.

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

Medicare Assignment
An agreement in advance by a physician to accept Medicare's Allowed charge as payment in full (guarantees not to balance

bill). Medicare pays its share of the allowed charge directly to physicians who accept assignment and provides other incentives under the Participating Physician and Supplier Program.

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

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

- **Part A Medicare**
  Medical Hospital Insurance (HI) under Part A of Title XVIII of the Social Security Act,

- which covers beneficiaries for inpatient hospital, home health, hospice, and limited skilled nursing facility services. Beneficiaries are responsible for deductibles and copayments. Part A services are financed by the Medicare HI Trust Fund, which consists of Medicare tax payments.

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

- **Part C Medicare**
  Medicare Supplementary Medical Insurance (SMI) under Part C of Title XVII of the Social Security Act, which covers Medicare beneficiaries enrolled in the

various Medicare + Choice managed care plans.

- **Part D Medicare**
  Medicare Supplementary Medical Insurance (SMI) under Part D of Title XVII of the Social Security Act, which covers prescription drugs as enacted by the Medicare Modernization Act of 2006.

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

Medicare-Severity DRG's (MS-DRGs)
A refinement of the DRG Classification System to more fairly compensate hospitals for treating severely ill Medicare patients by adding more DRGs to account for major complications and co-morbidity.

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

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

Metropolitan Statistical Area (MSA)
A geographic area that includes as 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.

Midlevel Practitioner (MLP)
Nurse Practitioners, Physician Assistants, Certified Nurse Midwives, and other non-physicians who can deliver medical

care under the sponsorship of a practicing physician.

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

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.

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.

N

National Committee for Quality Assurance (NCQA)
A private, not-for-profit organization that assesses and reports on the quality of managed care plans, with the goal of enabling purchasers and consumers of managed health care to distinguish among plans based on quality.

National Incident Management System (NIMS)
A federal program established in 2003 to provide a consistent nationwide template to enable organizations to work together when responding to domestic disasters and emergencies.

National Practitioner Data Bank (NPDB)
A computerized data bank maintained by the federal government that contains information on physicians against whom malpractice claims have been paid or certain disciplinary actions have been taken.

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

Neonatal Intensive Care Unit (NICU)
An intensive care unit specializing in the care of ill or premature newborn infants.

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

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

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 who's excess of income over expenses is used for hospital purposes rather than returned to stockholders or investors as dividends. Sometimes referred to as a "voluntary, tax-exempt, or 501 (c) (3) hospital."

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.

Ombudsman
An advocate for quality care and quality of life in nursing homes and assisted living facilities. Ombudsmen identify, investigate and resolve complaints by or on behalf of facility residents. Volunteer and staff ombudsmen serve as independent, unbiased advocates for residents and work with all persons involved to reach acceptable solutions to problems.

Omnibus Budget Reconciliation Act (OBRA)
Congress refers to this as the many tax and budget reconciliation acts. Most of these acts contain language important to managed care, generally in the Medicare market segment.

Open 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.

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.

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

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

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

Outpatient
A person who receives care without being admitted to the hospital for overnight or 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.

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

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

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

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

Patient Protection and Affordable Care Act (PPACA)
Also known as the Affordable Care Act, this federal legislation was passed in March 2010 and contains new health reform provisions.

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 short, easily administered questionnaire that provides health care facilities with information and insight on their patients' view of the services they provide. Health care facilities can use survey results to design and track quality improvement over time, as well as compare themselves to other health care providers.

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.

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

Payer
Any agency, insurer, or health plan that pays for 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 Bundling
A form of provider payment where providers or hospitals receive a single payment for all of the care provided for an episode of illness, rather than per service rendered. Total care provided for an episode of illness may include both acute and post-acute care. The health reform law establishes pilot programs in Medicare and Medicaid to pay a bundled payment for episodes of care involving hospitalizations.

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.

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.

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

Per Diem Payments
Fixed daily payments that do not vary with the level of services used by the patient. This method generally is used to pay institutional providers, such as hospitals and nursing facilities. (See also Capitation.)

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).

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

Physician Credentialing
Originally, referred only to the process of verifying that a physician had the appropriate credentials (medical, education, training, licenses, etc.) to practice in the hospital. Today, the term refers more broadly to the entire process, delegated by

the board to the medical staff, of medical staff appointment, reappointment, and delineation of clinical privileges. The board has ultimate accountability for physician credentialing.

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

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

Physician/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.

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

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

Practice Guidelines
Systematically developed statements on medical practices that assist a practitioner in making decisions about appropriate health care for specific medical conditions. Managed care

organizations frequently use these guidelines to evaluate appropriateness and medical necessity of care. Also called practice parameters.

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

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

Pre-existing Condition
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.

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

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

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

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

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

Primary Care
A basic level of health care provided by the physician from whom an individual has an ongoing relationship and who knows the patient's medical history. Primary care services emphasize a patient's general health needs such as preventive services, treatment of minor illnesses and injuries, or identification of problems that require referral to specialists. Traditionally, primary care physicians are family physicians, internists, gynecologists and pediatricians.

Primary Care Provider or Primary Care Physician (PCP)
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-10-CM diagnosis established after study as being chiefly responsible for occasioning the admission of a patient to the hospital for care. Also referred to as the principal inpatient diagnosis (PID).

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

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

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

Privileges
The right to provide medical or surgical care services in the hospital, within well-defined limits, according to an individual's professional license, education, training, experience, and current clinical competence. Hospital privileges must be delineated individually for each practitioner by the board based on a medical staff recommendation**.** It is also referred to as 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)
A method of payment by which rates of payments to providers for services to patients are established in advance for the upcoming fiscal year.

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

Protocols
Standards or practices developed to assist 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 Department/District
Local (county or multi- county) health agency, operated by

local government, with oversight and direction from a local board of health, which provides public health services throughout a defined geographic area.

Public Health Service (PHS)
A division of the U.S. Department of Health an 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.

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.

Q

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

Quality Assurance (QA)
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 Organization (QIO)
Peer review organizations in every state whose purpose is to review items and services provided to Medicare beneficiaries to determine if services are reasonable and necessary, if they are provided in the appropriate setting and if the quality of care is met. The South Dakota QIO is the South Dakota Foundation for Medical Care.

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 (QI)
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.

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

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.

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

Reinstatement
Resumption of coverage under an insurance policy that has lapsed.

Reinsurance
A type of insurance purchased by primary insurers (insurers that provide 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 Scale (RVS)
An index that assigns weights to each medical service: the weights represent the relative amount to be paid for each service. The RVS used in the development of the Medicare Fee Schedule consists of three cost components: physician work, practice expense, and malpractice expense. See

Malpractice Expense, Medicare Fee Schedule. Physician Work, Practice Expense, Resource-Based Relative Value Scale.

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.

Resource Utilization Groups (RUGs)
A prospective payment system that categorizes long term care residents into a payment groups depending upon his or her care and resource needs. Skilled nursing facilities determine RUGs based upon an assessment of the resident using the Minimum Data Set (MDS).

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

Return on Equity (ROE)
After-tax earnings of a corporation divided by its shareholders' equity. Shareholders' equity is determined by

deducting total liabilities and intangible assets from total assets.

Return on Investment (ROI)
After-tax income for a specified period of time 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
(1) Risk Adjustment uses the results of risk assessment in order to fairly compensate plans that, by design or accident, end up with a larger-than-average share of high-cost enrollees.

(2) Increases or reductions in the amount of payment made to a health plan on behalf of a group of enrollees to compensate for 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.

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

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.

Rural Health Clinic (RHC)
The Rural Health Clinic Program was established in 1977 to address an inadequate supply of physicians who serve Medicare and Medicaid beneficiaries in rural areas. The program provides qualifying Clinics located in rural and medically underserved communities with payment on a cost-related basis for outpatient physician and certain non-physician services.

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.

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.

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.

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.

Skilled Nursing Facility (SNF)
An institution that has a transfer agreement with one or more hospitals, provides primarily inpatient skilled nursing care and

rehabilitative services, and meets other specific certification requirements.

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

Sole Community Hospital (SCH)
For Medicare purposes, a hospital which is more than 35 miles from any similar hospital, and meets other special criteria.

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

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

Specialty Medical Group (SMG)
A single-specialty group of physicians or a multi-specialty group of physicians.

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

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

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

State Children's Health Insurance Program (SCHIP)
A program enacted within the Balanced Budges Act of 1997 providing federal matching funds to states to help expand health care coverage for children under Medicaid or new programs.

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

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

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

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

Swing-Bed Hospital
A hospital participating in the Medicare swing-bed program. This program allows rural hospitals with fewer than 100 beds

to provide skilled post-acute care services in acute care beds. Unused acute care beds that can be "swung" to long-term care beds within the same hospital so that the need to build long-term beds can be avoided. Any services provided when the bed is in use as a long-term care bed are paid at long-term care rates.

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

T

Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA)
Legislation that established target rate of increase limits on reimbursements for inpatient operating costs per Medicare discharge. A facility's target amount is derived from costs in a base year updated to the current year by the annual allowable rate of increase. Medicare payments for operating costs generally may not exceed the facility's target amount. These provisions still apply to hospitals and units excluded from PPS. (See also Excluded Hospitals and Units)

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

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

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.

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 health care facility governing body. May also be referred to as a director or board member.

Tort Reform
Changes in the legal rules governing medical malpractice lawsuits.

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

Turnover
The rate at which an employer loses staff.

1) Voluntary turnover is when the employee initiates the termination. Some examples of “voluntary resignation” or termination would be those occurring as a result of new job, dissatisfaction, personal reasons, retirement or returning to

school.

2) Involuntary turnover is when the employer initiates the termination. Some examples of "involuntary resignation" or termination would be those occurring as of result of: absenteeism, conduct, failed to obtain license, reduction in workforce, layoffs or reorganization.

U

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.

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.

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 surgery center.

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 of physician visits.

Utilization Management (UM) or Utilization Review (UR)
(1) 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

Value-Based Purchasing (VBP)
A Centers for Medicare and Medicaid Services initiative to

reimburse providers for care to Medicare beneficiaries based on quality performance (a pay-for-performance program).

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 or hospice care. (multi-institutional system or horizontal integration).

W

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

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

Wellness Programs
Educational and other programs designed to inform individuals about 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.

Z

Glossary of Hospital and Health-related Acronyms

Compiled by the South Dakota Association of Healthcare Organizations

A

AAFP..... American Academy of Family Physicians

AAHSA ..... American Association of Homes and Services for the Aging (Now called LeadingAge)

AAMC..... Association of American Medical Colleges

AAP ..... American Academy of Pediatrics

AAPCC..... adjusted average per capita cost

AARP ..... American Association of Retired Persons

ABA..... American Bar Association

ABIM..... American Board of Internal Medicine

ACA…….. Affordable Care Act of 2010

ACCME..... Accreditation Council on Continuing Medical Education

ACE ..... Association for Continuing Education

ACHE ..... American College of Healthcare Executives

ACA..... Accountable Care Act

ACO..... Accountable Care Organization

ACOHA..... American College of Osteopathic Hospital Administrators

ACP ..... American College of Physicians

ACS ..... American College of Surgeons

ACU..... ambulatory care unit

ADC..... average daily census

ADL..... activities of daily living

ADR..... adverse drug reaction

ADS ..... alternate delivery systems

AFL-CIO ..... American Federation of Labor-Congress of Industrial Organizations

AGPA ..... American Group Practice Association

AHA ..... American Hospital Association

AHAPAC..... American Hospital Association Political Action Committee

AHAS ..... Allied Healthcare Association Services LLC

AHCA..... American Health Care Association

AHCPR..... Agency for Health Care Policy and Research

AHEC ..... Area Health Education Center

AHHA ..... Association of Home Health Agencies

AHIP..... America's Health Insurance Plans

AHLA ..... American Health Lawyers Association

AHP ..... accountable health plan

AHPA ..... American Health Planning Association

AHRQ..... Agency for Healthcare Research and Quality

AHS ..... American Healthcare Systems

AIDS..... Acquired Immune Deficiency Syndrome

ALOS..... average length of stay

AMA..... against medical advice

AMA..... American Medical Association

AMCRA ..... American Medical Care and Review Association

AMHO..... Association of Managed Health Care Organizations

ANA ..... American Nurses Association

ANSI..... American National Standards Institute

AOA ..... American Osteopathic Association

AOHA ..... American Osteopathic Hospital Association

AONE..... American Organization of Nurse Executives

A/P..... accounts payable

APA ..... American Psychological Association

APC ..... ambulatory patient classifications

APD ..... adjusted patient day

APG ..... ambulatory patient group

APHA ..... American Protestant Hospital Association and American Public Health Association

APIC..... Association for Professionals in Infection

APS Corp..... Associated Purchasing Services Corporation

A/R ..... accounts receivable

ARRA..... American Recovery and Reinvestment Act of 2009

ARRT ..... American Registry of Radiologic Technologists

ASAE..... American Society of Association Executives

ASC ..... Ambulatory Surgical Center

ASCP ..... American Society of Chemical Pathologists

ASHBEAMS . American Society of Hospital-based Emergency Air Medical Services

ASHCSP..... American Society for Hospital Central Service Personnel

ASHE..... American Society for Healthcare Engineering

ASHMM..... American Society for Healthcare Materials Management

ASHP..... American Society of Health-Systems Pharmacists

ASHPR..... American Society for Hospital Public Relations

ASHRM..... American Society for Hospital Risk Managers (AHA)

ASO..... Administrative Services Only

AWI..... Area Wage Index

B

BBA ..... Balanced Budget Act of 1997

BCBS..... Blue Cross and Blue Shield

BLS..... Bureau of Labor Statistics

BME ..... Board of Medical Examiners

BP ..... blood pressure

BQA..... Bureau of Quality Assurance

BSN ..... Bachelor of Science in Nursing

C

C-Suite..... chief executive staff

CAE..... Certified Association Executive

CAH..... Critical Access Hospital

CAT ..... computerized axial tomography

CBISA ..... Community Benefit Inventory for Social Accountability

CBO..... Congressional Budget Office

CCH..... Commerce Clearing House

CCHIT ..... Certification Commission for Health Information Technology

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

CFR ..... Code of Federal Regulations

CHA..... Catholic Health Association

CHAD…….. Community HealthCare Association of the Dakotas

CHAMPUS.... Civilian Health and Medical Program of the Uniformed Services

CHAUS..... Catholic Health Association of the United States

CHC..... community health center

CHE..... Certified Healthcare Executive

CHI ..... consolidated health information

CHIN ..... Community Health Information Network

CHIO ..... Community Health Information Organization

CHIP..... Children's Health Insurance Program

CIO ..... chief information officer

CIP..... critical infrastructure protection

CLASS..... Community Living Assistance Services and Supports (Program)

CLIA..... Clinical Laboratory Improvement Act

CLT ..... clinical laboratory technician

CMI ..... case mix index

CME ..... continuing medical education

CMO..... chief medical officer

CMS..... Centers for Medicare and Medicaid Services

CNM..... certified nurse midwife

CNO..... chief nursing officer

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

CPA ..... Certified Public Accountant

CPHQ ..... Certified Professional in Healthcare Quality

CPI..... consumer price index

CPR ..... cardiopulmonary resuscitation

CPRS ..... computerized patient record system

CPT..... current procedural terminology

CQI ..... continuous quality improvement

CR..... change request

CRNA ..... chief registered nurse anesthetist

CT ..... computerized tomography

CY ..... Calendar Year

D

D&O ..... directors' and officers' liability coverage

DEA..... Drug Enforcement Administration

DHHS ..... Department of Health and Human Services

DHPF..... Division of Health Policy and Finance

DHS ..... Department of Homeland Security

DME ..... director of medical education

DME ..... durable medical equipment

DNR..... do not resuscitate order

DO ..... doctor of osteopathy (physician)

DOA ..... dead on arrival

DOD ..... Department of Defense

DOJ..... Department of Justice

DOL..... Department of Labor

DOS ..... date of service

DRA..... Deficit Reduction Act

DRG..... diagnosis related group

DSA ..... digital subtraction angiography

DSH ..... disproportionate share hospital

DSS..... decision support system

Dx ..... diagnosis

E

ECF..... extended care facility

ECU ..... environmental control unit

ED..... emergency department

EDI ..... electronic data interchange

EDP ..... electronic data processing

EDS ..... electronic data systems

EEG ..... electroencephalogram

EEOC..... Equal Employment Opportunity Commission

EHR ..... electronic health records

EHRVA ..... Electronic Health Record Vendors Association

EKG/ECG..... electrocardiogram

E&M ..... evaluation and management

eMAR ..... electronic medication administration record

EMG ..... electromyogram

EMPI ..... enterprise master person index

EMR ..... electronic medical record

EMRAM..... EMR Adoption Model

EMS..... emergency medical services

EMT..... emergency medical technologist

EMTALA ..... Emergency Medical Treatment and Active Labor Act

EOB..... Explanation of Benefits

EOMB ..... Explanation of Medicare Benefits

EOP ..... emergency operation plan

EP ..... emergency preparedness

EPA ..... Environmental Protection Agency

ePHR ..... electronic personal health record

EPO ..... exclusive provider organization

EPSDT..... early and periodic screening, diagnosis and treatment (services)

ER..... emergency room

ERISA ..... Employee Retirement Income Security Act 1994

ESRD..... end stage renal disease

F

FACHE..... Fellow of the American College of Healthcare Executives

FAH..... Federation of American Hospitals

FAHS..... Federation of American Health Systems

FASB..... Financial Accounting Standards Board

FCC ..... Federal Communications Commission

FCE..... functional capacity evaluation

FCRA..... Fair Credit Reporting Act

FDA ..... Food and Drug Administration

FEC..... freestanding emergency center

FEMA..... Federal Emergency Management Agency

FFS ..... fee for service

FFY..... Federal Fiscal Year

FI ..... fiscal intermediary

FLEX ..... Medicare Rural Hospital Flexibility Program

FMAP ..... federal medical assistance percentage

FMG ..... foreign medical graduate

FOIA..... Freedom of Information Act

FP..... family practitioner (physician)

FPL ..... federal poverty level

FQHC ..... federally qualified health center

FRA ..... federal reimbursement allowance

FTC..... Federal Trade Commission

FTE..... full-time equivalent

FY..... Fiscal Year

FYE ..... Fiscal Year Ending

G

GAAP ..... generally accepted accounting principles

GAO ..... Government Accounting Office

GDP ..... gross domestic product

GHAA ..... Group Health Association of America

GI..... gastrointestinal

GME ..... graduate medical education

GNP ..... gross national product

GPHA ..... Great Plains Health Alliance

H

HAC..... Health Acquired Condition

HAI ..... Hospital Acquired Infection

HCAHPS ..... Hospital Consumer Assessment of Healthcare Providers and Systems

HCBS..... Home and Community Based Services

HCFA ..... Health Care Financing Administration

HCPCS ..... Healthcare Common Procedure Coding System

HCQIA ..... Health Care Quality Improvement Act

HCW..... health care worker

HEDIS ..... health plan employer data and information set

HFMA ..... Healthcare Financial Management Association

HH ..... home health

HHA ..... home health agency

HHS ..... U.S. Department of Health and Human Services

HHS/ASPR .... U.S. Department of Health and Human Services Assistant Secretary for Preparedness Response

HIAA ..... Health Insurance Association of America

HICS ..... Hospital Incident Command System

HIDI..... Hospital Industry Data Institute

HIE ..... health information exchange

HIMSS..... Health Information and Management Systems Society

HINN ..... Hospital Issued Notice of Noncoverage

HIO..... Health Information Organization

HIPAA..... Health Insurance Portability and Accountability Act of 1996

HIT ..... health information technology

HITECH ..... Health Information Technology for Economic and Clinical Health

HITPC ..... Health Information Technology Policy Committee

HMBI..... hospital market basket index

HMO..... health maintenance organization

HPSA..... Health Professional Shortage Area

HRET..... Hospital Research and Educational Trust (AHA)

HSP..... health service plan

HVA ..... hazard vulnerability assessment

I

IBNR ..... incurred but not reported

IAB ..... Industrial Accident Board

ICCU ..... intensive coronary care unit

ICD-9-CM ..... International Classification of Disease, 9th Edition, Clinical Modification

ICD-10-CM ... International Classification of Disease, 10th Edition, Clinical Modification

ICN ..... internal control number

ICU ..... intensive care unit

IDS..... integrated delivery system

IG..... Inspector General

IHF..... International Hospital Federation

IME..... independent medical evaluation

IOM ..... Institute of Medicine

IP ..... inpatient

IPAB..... Independent Payment Advisory Board

IPPS..... Inpatient Prospective Payment System

IRF..... inpatient rehabilitation facility

IRS..... Internal Revenue Service

IS ..... information system

IT ..... information technology

ITV ..... interactive televideo

IV..... intravenous

J

JCAHO ..... Joint Commission on Accreditation of Healthcare Organizations (now known as The Joint Commission)

JCC ..... Joint Conference Committee

K

L

LA..... LeadingAge

LDR..... labor and delivery room

LOL ..... limitation of liability

LOS ..... length of stay

LPN ..... licensed practical nurse

LTC ..... long-term care

LTCU..... long-term care unit

M

MA..... Medicare Advantage

MAC..... maximum allowable costs

MAC..... Medicare Administrative Contractor

MCI ..... mass casualty incident

MCO..... managed care organization

MD..... doctor of medicine

MDP ..... medical disclosure panel

MEC ..... medical executive committee

MedPAC..... Medicare Payment Advisory Commission

MGCRB..... Medicare Geographic Classification Review Board

MHA..... Master of Healthcare Administration (degree)

MIC ..... Medicaid Integrity Contractor

MIG ..... Medicaid Integrity Group

MIP..... Medicaid Integrity Program

MIPPA..... Medicare Improvement for Patients and Provider Act

MLP..... midlevel practitioner

MLR ..... medical loss ratio

MMA ..... Medicare Modernization Act

MMI..... maximum medical improvement

MPH ..... Master of Public Health (degree)

MRI ..... magnetic resonance imaging

MSA ..... medical savings account

MSA ..... metropolitan statistical area

MSN ..... Medicare Summary Notice

MSO ..... management service organization

MSP ..... Medicare Secondary Payer

MU..... meaningful use

N

NACH..... National Association of Children's Hospitals

NAHQ ..... National Association of Healthcare Quality

NAIC ..... National Association of Insurance Commissioners

NAMSS ..... National Association of Medical Staff Service Professionals

NCHS ..... National Center for Health Statistics

NCN..... National Commission on Nursing

NCQA..... National Committee for Quality Assurance

NDC..... National Drug Code

NECPA..... National Energy Conservation Act (Title III)

NFRA ..... Nursing Facility Federal Reimbursement Allowance

NGA ..... National Governors' Association

NHI..... National Health Insurance

NHIN ..... National Health Information Network

NICU ..... neonatal intensive care unit

NIH..... National Institutes of Health

NIMS ..... National Incident Management Systems

NLRB ..... National Labor Relations Board

NP..... Nurse Practitioner

NPI..... National Provider Identifier

NPDB ..... National Practitioner Data Bank

NPRM..... Notice of Proposed Rule-making

NRHA..... National Rural Health Association

NQF..... National Quality Forum

NWRO..... National Welfare Rights Organization

O

OASIS ..... Outcome Assessment and Information Set

OB-GYN..... obstetrics and gynecology

OBRA..... Omnibus Budget Reconciliation Act

OIG..... Office of Inspector General

OMB..... Office of Management and Budget

ONC..... Office of the National Coordinator for Health Information Technology (also ONCHIT)

OP..... outpatient

OPPS ..... outpatient prospective payment system

OR ..... operating room

OSA..... optional segregated account

OSHA ..... Occupational Safety and Health Administration

OT..... occupational therapy/occupational therapist

OTC..... over-the-counter

P

P4P..... pay for performance

P&L ..... profit and loss

PA..... physician assistant

PAC ..... Political Action Committee

PAT ..... pre-admission testing

PCCM..... primary care case management

PCN ..... primary care network

PCP..... primary care physician

PDP..... prescription drug plan

PDR ..... Physician's Desk Reference

PET..... positron emission tomography

PFS ..... patient financial services

PHIX..... Public Health Information Exchange

PHO ..... physician hospital organization

PHR ..... personal health record

PHS..... public health service

PiHQ..... Partners in Healthcare Quality

PIP ..... Periodic Interim Payment (Medicare)

PML..... Provider Monitor Listing (Medicaid)

POS..... point of service plans

PPACA ..... Patient Protection and Affordable Care Act of 2010

PPE ..... personal protective equipment

PPO..... preferred provider organization

PPP ..... Preferred Provider Plan

PPRC ..... Physician Payment Review Commission

PPS ..... prospective payment system

PRO ..... peer review organization

ProPAC..... Prospective Payment Assessment Commission

PRRB..... Provider Reimbursement Review Board

PSN..... provider sponsored network

PSO..... provider sponsored organization

PSRO ..... Professional Standards Review Organization

PT ..... physical therapy/physical therapist

PTA ..... physical therapy assistant

Q

QA ..... quality assurance

QHI..... Quality Health Indicators

QI..... quality improvement

QIO..... Quality Improvement Organization

R

R&D ..... research and development

RAC..... recovery audit contractors

RAD..... radiation absorbed dose

RBRVS..... resource-based relative value scale

REC ..... regional extension center

RFP..... request for proposal

RHIA ..... registered health information administrator

RHIO ..... regional health information organization (often interchangeable with HIE)

RHIT..... registered health information technologist

RHQDAPU.... Reporting Hospital Quality Data for Annual Payment Update

RN ..... registered nurse

ROA..... return on assets

ROI ..... return on investment

RPB ..... Regional Policy Board

RPB6 ..... Regional Policy Board 6 (AHA)

RPh ..... registered pharmacist

RT..... respiratory therapy/respiratory therapist

RUG..... resource utilization group

RVU..... Relative Value Unit

Rx ..... prescription

S

SAD ..... self-administered drugs

SCU ..... special care unit

SDAHO ..... South Dakota Association of Healthcare Organizations

SEC..... Securities and Exchange Commission

SHAEF ..... State Hospital Association Executives' Forum

SHARE..... Shared Hospital Activities and Regional Efforts

SHSMD ..... Society for Healthcare Strategy and Market Development

SICU..... surgical intensive care unit

SIDS ..... sudden infant death syndrome

SLP ..... speech language pathologist

SMSA ..... standard metropolitan statistical area

SNF..... skilled nursing facility

SPECT ..... single photon emission computed tomography

SSA..... Social Security Administration

SSI ..... social security income

T

TEFRA ..... Tax Equity and Fiscal Responsibility Act of 1982

The Alliance .. The Health Alliance of MidAmerica

TPA ..... third-party administrator

TTD ..... temporary total disability

U

UB-92 ..... Uniform Billing X 1992 Version

UHI..... Universal Health Insurance

UR ..... utilization review

URC..... utilization review coordinator

V

VA ..... Veterans Administration

VBP ..... Value-Based Purchasing

VHA ..... previously the Voluntary Hospitals of America (now simply VHA)

W

WI..... Wage Index

Y

YTD..... year to date

Z

ZPIC ..... Zone Program Integrity Contractor

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