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***GLOSSARY OF
COMMONLY USED
HEALTH CARE TERMS
AND
ACRONYMS***

A

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

access An individual's ability to obtain appropriate health care services. Barriers to access can be financial (insufficient monetary resources), geographic (distance to providers), organizational (lack of available providers) and sociological (e.g., discrimination, language barriers). Efforts to improve access often focus on providing/improving health coverage.

accident insurance A policy that provides benefits for injury or sickness directly resulting from an accident.

accreditation A process whereby a program of study or an institution is recognized by an external body as meeting certain predetermined standards. For facilities, accreditation standards are usually defined in terms of physical plant, governing body, administration, and medical and other staff. Accreditation is often carried out by organizations created for the purpose of assuring the public of the quality of the accredited institution or program. The State or Federal governments can recognize accreditation in lieu of, or as the basis for licensure or other mandatory approvals. Public or private payment programs often require accreditation as a condition of payment for covered services. Accreditation may either be permanent or may be given for a specific period of time.

activities of daily living (ADL) An index or scale which measures a patient's degree of independence in bathing, dressing, using the toilet, eating, and moving from one place to another.

actuary A person trained in the insurance field who determines policy rates, reserves

and dividends, as well as conducted other statistical studies.

acute care Medical treatment rendered to individuals whose illnesses or health problems are of short-term or episodic nature. Acute care facilities are those hospitals that mainly serve persons with short-term health problems.

acute disease A disease characterized by a single episode of a relatively short duration from which the patient returns to his/her normal or previous state of level of activity. While acute diseases are frequently distinguished from chronic diseases, there is no standard definition or distinction. It is worth noting that an acute episode of a chronic disease (for example, an episode of diabetic coma in a patient with diabetes) is often treated as an acute disease.

adjusted average per capita cost (AAPCC) The basis for HMO or CMP (Competitive Medical Plan) reimbursement under Medicare-risk contracts. The average monthly amount received per enrollee is currently calculated at 95 percent of the average costs to deliver medical care in the fee-for-service sector.

adjusted community rate (ACR) An HMO's estimate of the premium it would charge to Medicare beneficiaries if these beneficiaries were enrolled as commercial enrollees and not covered by Medicare. The ACR is intended to gauge the appropriateness of CMS's (Center for Medicare and Medicaid Services) reimbursements to plans. If CMS's payment is higher than a plan's ACR, the plan is required by law to provide the difference to Medicare enrollees through lower premiums or higher benefits or to return it to the Medicare program (see also Medicare+Choice).

administrative costs Costs the insurer incurs for utilization review, insurance marketing, medical underwriting, agents'

commissions, premium collection, claims processing, insurer profit, quality assurance activities, medical libraries, and risk management.

Administrative Services Organization (ASO) An arrangement under which an insurance carrier or an independent organization will, for a fee, handle the administration of claims, benefits and other administrative functions for a self-insured group.

adverse selection A tendency for utilization of health services in a population group to be higher than average. From an insurance perspective, adverse selection occurs when persons with poorer-than-average health status apply for, or continue, insurance coverage to a greater extent than do persons with average or better health expectations.

affiliated provider A health care professional or facility that is part of the Managed Care Organization's (MCO) network and has a contractual arrangement to provide services to the MCO's covered members.

affiliation agreement An agreement (usually formal) between two or more otherwise independent entities or individuals that defines how they will relate to each other. Affiliation agreements between hospitals may specify procedures for referring or transferring patients from one facility to another, joint faculty and/or medical staff appointments, teaching relationships, sharing of records or services, or provision of consultation between programs.

Agency for Health Care Policy and Research (AHCPR) The Agency's primary goal is to enhance the quality, appropriateness and effectiveness of health care services by conducting and sponsoring credible and timely research. It is the federal government's focal point for health services research, AHCPR's predecessor, the

National Center for Health Services Research and Health Care Technology Assessment. AHCPR is now AHRQ Agency for Healthcare Research and Quality www.ahrq.gov

The Agency for Healthcare Research and Quality's (AHRQ) mission is to improve the quality, safety, efficiency, and effectiveness of health care for all Americans. Information from AHRQ's research helps people make more informed decisions and improve the quality of health care services. AHRQ was formerly known as the Agency for Health Care Policy and Research.

aggregate The maximum amount of money an insurance company will pay on an insured's policy per year, regardless of the number of claims.

Aid to Families with Dependent Children (AFDC) A state-based federal cash assistance program for low-income families. In all states, AFDC reciprocity may be used to establish Medicaid eligibility.

all patient diagnosis related groups (APDRG) An enhancement of the original DRGs (diagnosis related groups), designed to apply to a population broader than that of Medicare beneficiaries, who are predominately older individuals. The APDRG set includes groupings for pediatric and maternity cases as well as of services for HIV- related conditions and other special cases.

allowable costs Charges for services rendered or supplies furnished by a mental health professional that qualify as covered expenses.

all payer contract An arrangement allowing for payment of health services delivered by a contracted clinician regardless of product type (e.g., HMO, PPO, indemnity) or revenue source (e.g., premium or self-funded)

all-payer system A system in which prices for health services and payment methods are the same, regardless of who is paying. For instance, in an all-payer system, federal or state government, a private insurer, a self-insured employer plan, an individual or any other payer could pay the same rates. The uniform fee bars health care providers from shifting costs from one payer to another. *See cost shifting.*

allied health personnel Specially trained and licensed (when necessary) health workers other than physicians, dentists, optometrists, chiropractors, podiatrists, and nurses. The term has no constant or agreed-upon detailed meaning; sometimes used synonymously with paramedical personnel, sometimes meaning all health workers who perform tasks that must otherwise be performed by a physician, and at other times referring to health workers who do not usually engage in independent practice.

allowable costs Items or elements of an institution's costs that are reimbursable under a payment formula. Both Medicare

and Medicaid reimburse hospitals on the basis of only certain costs. Allowable costs may exclude, for example, luxury accommodations, costs that are not reasonable expenditures that are unnecessary for the efficient delivery of health services to persons covered under the program in question, or depreciation on a capital expenditure that was disapproved by a health-planning agency.

alternative delivery systems A phrase used to describe all forms of health care delivery except traditional fee-for-service, private practice and inpatient hospitalization. The term may also include HMOs, PPOs, IPAs, and other systems of providing health care.

American Association of Health Plans (AAHP) The trade organization that represents managed care organizations (HMOs and PPOs).

ambulatory care All types of health services that are provided on an outpatient basis, in contrast to services provided in the home or to persons who are inpatients. While many inpatients may be ambulatory, the term ambulatory care usually implies that the patient must travel to a location to receive services that do not require an overnight stay. *See also ambulatory setting and outpatient.*

ambulatory setting A type of institutional organized health setting in which health services are provided on an outpatient basis. Ambulatory care settings may be either mobile (when the facility is capable of being moved to different locations) or fixed (when the person seeking care must travel to a fixed service site).

amendment A formal document changing the provisions of an insurance policy signed jointly by the insurance company and by the policyholder or his authorized representative *See also endorsement.*

ancillary services Supplemental services, including laboratory, radiology, physical therapy and inhalation therapy, which are provided in conjunction with medical or hospital care.

annual out of pocket maximum The most you will have to pay in any given year for all services received under an insurance policy. This amount includes co-payments, coinsurance and deductibles. If you exceed this amount, the insurance company will pay all other expenses for the remainder of that year.

antitrust A legal term encompassing a variety of efforts on the part of government to assure that sellers do not conspire to restrain trade or fix prices for their goods or services in the market.

any willing provider laws Laws that require managed care plans to contract with all health care providers that meet their terms and conditions.

appropriateness Appropriate health care is care for which the expected health benefit exceeds the expected negative consequences by a wide enough margin to justify treatment.

Area Health Education Center (AHEC) An organization or organized system of health and educational institutions whose purpose is to improve the supply, distribution, quality, use and efficiency of health care personnel in specific medically underserved areas. AHEC's objectives are to educate and train the health personnel specifically needed by the underserved areas and to decentralize health workforce education, thereby increasing supply and linking the health and educational institutions in scarcity areas.

assignment A process in which a Medicare beneficiary agrees to have Medicare's share of the cost of a service paid directly ("assigned") to a doctor or other provider,

and the provider agrees to accept the Medicare approved charge as payment in full. Medicare pays 80 percent of the cost and the beneficiary 20 percent, for most services. *See participating physician.*

authorization The process of receiving approval from an insurance company for a specific service from a specific provider before you get that service. *See referral.*

average manufacturer price (AMP) The price at which the manufacturer sells drugs to purchasers. There is an AMP for wholesalers and an AMP for pharmacies. For sales to wholesalers, AMP represents the Wholesale Acquisition Cost after all discounts. For sales directly to pharmacies, AMP represents the price pharmacies pay for drugs after all the discounts they receive.

average wholesale price (AWP) The AWP is the price that pharmaceutical manufacturers suggest that wholesalers charge retail pharmacies. Manufacturers generally offer lower prices or rebates to favored customers that have purchasing power, such as large insurance companies or governments, meaning that those customers pay significantly less than the AWP.

avoidable hospital condition Medical diagnosis for which hospitalization could have been avoided if ambulatory care had been provided in a timely and efficient manner.

B

bad debt Income lost to a provider because of failure of patients to pay amounts owed. Bad debt may sometimes be recovered by increasing charges to paying patients. Some cost-based reimbursement programs reimburse certain bad debt. The impact of the loss of revenue from bad debt may be partially offset for proprietary institutions by the fact that income tax is not payable on income not received.

balance billing In Medicare and private fee-for-service health insurance, the practice of billing patients for charges that exceed the amount that the health plan will pay. Under Medicare, the excess amount cannot be more than 15 percent above the approved charge. *See approved charge and participating physician.*

Balanced Budget Act of 1997 (BBA) 1) created the Children's Health Insurance Program, which expanded coverage to poor children not covered under Medicaid; 2) added a new part to Medicare, called Medicare+Choice, which includes an array of private health plan options among which beneficiaries may choose; 3) gave states greater authority to structure their Medicaid programs, including the authority to mandatorily enroll beneficiaries without a waiver from HHS; and 4) added new beneficiary protections to both Medicaid and Medicare.

basic health services Benefits that all federally qualified HMOs must offer, as defined under Subpart A, 100.112 of the federal HMO regulations.

beneficiary An individual who receives benefits from or is covered by an insurance policy or other health care financing program.

benefit cap A dollar limit placed on the assistance that can be provided to an

individual in a given time period, which is usually one year.

benefit package A group of guaranteed services provided by a health plan to its members.

benefits The health care services provided under terms of a contract by an MCO or other benefits administrator.

Blue Cross plan A non-profit, tax-exempt insurance plan providing coverage for hospital care and related services. (the individual plans should be distinguished from their national association, the Blue Cross Association.) Historically, the plans were largely the creation of the hospital industry and designed to provide hospitals with a stable source of revenue. A Blue Cross plan should be a nonprofit community service organization with a governing body whose membership includes a majority of public representatives.

Blue Shield plan A nonprofit, tax-exempt insurance plan, which provides coverage for physicians' services. Blue Shield coverage is sometimes sold in conjunction with Blue Cross coverage, although this is not always the case.

board certified Status granted a medical specialist who completes a required course of training and experience (residency) and passes an examination in his/her specialty. Individuals who have met all requirements except examination are referred to as "board eligible."

Boren Amendment Part of the Medicaid law, known by the name of its principle Congressional sponsor. It provides that state payment for hospitals and nursing facilities must be reasonable and adequate to meet the costs incurred by efficiently and economically operated facilities to provide care and services meeting state and federal standards.

bulk-purchasing programs Single or multi-state programs that combine various groups or programs—such as state employees, the Medicaid program, the pharmacy assistance program—to create a larger group that can negotiate better drug prices from manufacturers. Bulk-purchasing programs may include people without prescription drug insurance.

C

capital Fixed or durable non-labor inputs or factors used in the production of goods and services, the value of such factors, or the money specifically allocated for their acquisition or development. Capital costs include, for example, the buildings, beds and equipment used in the provision of hospital services. Capital assets are usually thought of as permanent and durable as distinguished from consumable such as supplies.

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

capital expenditure review A review of proposed capital expenditures of hospitals and/or other health facilities to determine the need for, and appropriateness of, the proposed expenditures. The review is done by a designated regulatory agency and has a sanction attached which prevents or discourages unneeded expenditures.

capitation A method of payment for health services in which an individual or institutional provider is paid a fixed amount for each person served, without regard to the

actual number or nature of services provided to each person in a set period of time. Capitation is the characteristic payment method in certain health maintenance organizations. It also refers to a method of Federal support of health professional schools. Under these authorizations, each eligible school receives a fixed payment, called a “capitation grant” from the Federal government for each student enrolled.

care management A process by which providers work to improve the quality of care by analyzing variations in and outcomes for current practice in the care of specific health conditions. An intervention (quality improvement) is designed to reduce the variations in care, optimize the use of generalists and specialists, and to measure and improve the outcome, while reducing costs if possible.

carrier A private organization, usually an insurance company that finances health care.

carve in A model of delivering and financing healthcare services in which mental health and/or substance abuse services are provided under the same delivery system as physical health care; the integration of behavioral health care with physical health care.

carve out Regarding health insurance, an arrangement whereby an employer eliminates coverage for a specific category of services (e.g., vision care, mental health/psychological services and prescription drugs) and contracts with a separate set of providers for those services according to a predetermined fee schedule or capitation arrangement. Carve out may also refer to a method of coordinating dual coverage for an individual.

carve-out service A “carve-out” is typically a service provided within a standard benefit package but delivered exclusively by a designated provider or group. Mental health

services are a typical carve-out within many insurance plans.

case management The monitoring and coordination of treatment rendered to patients with specific diagnosis or requiring high-cost or extensive services.

case manager A clinician who works with consumers, providers and insurers to coordinate services.

case-mix A measure of the mix of cases being treated by a particular health care provider that is intended to reflect the patients' different needs for resources. Case mix is generally established by estimating the relative frequency of various types of patients seen by the provider in question during a given time period and may be measured by factors such as diagnosis, severity of illness, utilization of services and provider characteristics.

catastrophic health insurance Health insurance that provides protection against the high cost of treating severe or lengthy illnesses or disability. Generally such policies cover all, or a specified percentage of, medical expenses above an amount that is the responsibility of another insurance policy up to a maximum limit of liability.

catchment area A geographic area defined and served by a health program or institution, such as a hospital or community mental health center that is delineated on the basis of such factors as population distribution, natural geographic boundaries and transportation accessibility. By definition, all residents of the area needing the services of the program are usually eligible for them, although eligibility may also depend on additional criteria.

categorically needy Persons whose Medicaid eligibility is based on their family, age or disability status. Persons not falling into these categories cannot qualify, no matter how low their income. The Medicaid

statute defines over 50 distinct population groups as potentially eligible, including those for whom coverage is mandatory in all states and those that may be covered at a state's option. The scope of covered services that states provide to the categorically needy is much broader than the minimum scope of services for the other, optional groups receiving Medicaid benefits. *See medically needy.*

Centers for Disease Control and Prevention (CDC) The Centers for Disease Control and Prevention, based in Atlanta, Georgia is charged with protecting the nations' public health by providing direction in the prevention and control of communicable and other diseases and responding to public health emergencies. Within the U.S. Public Health Service, CDC is the agency that led efforts to prevent such diseases as malaria, polio, small pox, toxic shock syndrome, Legionnaire's disease, and more recently, acquired immunodeficiency syndrome (AIDS), and tuberculosis. CDC's responsibilities evolve as the agency addressed contemporary threats to health, such as injury, environmental and occupational hazards, behavioral risks and chronic diseases.

Centers for Medicare and Medicaid Services (CMS) CMS is the new name for the agency within the U. S. Department of Health and Human Services (HHS) that oversees Medicare and Medicaid. Formerly known as the Health Care Financing Administration (HCFA).

certificate The formal document received by an employee that describes the specific benefits covered by the policyholder's health care contract with the insurer. The certificate contains co-payment and/or deductible requirements, specific coverage details, exclusions, and the responsibilities of both the certificate holder and the insurance company.

Certificate of Need (CON) A certificate issued by a governmental body to an individual or organization proposing to construct or modify a health facility, acquire major new medical equipment, modify a health facility, or offer a new or different health service. Such issuance recognizes that a facility or service, when available, will meet the needs of those for whom it is intended. CON is intended to control expansion of facilities and services by preventing excessive or duplicate development of facilities and services.

certification The process by which a governmental or nongovernmental agency or association evaluates and recognizes an individual, institution, or educational program as meeting predetermined standards. One so recognized is said to be “certified.” It is essentially synonymous with accreditation, except that certification is usually applied to individuals, and accreditation to institutions. Certification programs are generally nongovernmental and do not exclude the uncertified from practice as do licensure programs.

CHAMPUS (Civilian Health and Medical Program of the Uniformed Services) A Department of Defense program supporting private sector care for military dependents.

chronic care Care and treatment rendered to individuals whose health problems are of a long-term and enduring nature. Rehabilitation facilities, nursing homes and mental hospitals may be considered chronic care facilities.

chronic disease A disease which has one or more of the following characteristics: is permanent, leaves residual disability; is caused by nonreversible pathological alteration, requires special training of the patient for rehabilitation, or may be expected require a long period of supervision, observation or care.

clinic A facility, or part of one, devoted to diagnosis and treatment of outpatients. “Clinic” is irregularly defined. It may either include or exclude physicians’ offices; may be limited to describing facilities that serve poor or public patients; and may be limited to facilities which graduate or graduate medical education is done.

clinical criteria Criteria by which managed care organizations (MCOs) decide whether a specific treatment setting is the appropriate level of care for a given consumer.

closed access A managed health care arrangement in which covered persons are required to select providers only from the plan’s participating providers. Also called an Exclusive Provider Organization (EPO).

CMS Center for Medicare and Medicaid Services (formerly CHFA the Health Care Financing Administration)

COBRA (Consolidated Omnibus Budget Reconciliation Act of 1986) This federal law allows employees (and their dependents) who had health insurance coverage through their employer to purchase and continue the coverage under certain circumstances for a limited period of time after their employment ends.

coinsurance A cost-sharing requirement under a health insurance policy. It provides that the insured party will assume a portion or percentage of the costs of covered services. The health insurance policy provides that the insurer will reimburse a specified percentage of all, or certain specified, covered medical expenses in

excess of deductible amounts payable by the insured. The insured is then liable for the remainder of the costs until their maximum liability is reached.

community-based care The blend of health and social services provided to an individual or family in their place of residence for the purpose of promoting, maintaining, or restoring health or minimizing the effects of illness and disability.

Community Health Accreditation Program (CHAP) Similarly to JCAHO, CHAP is a national, private, not-for profit agency that accredits home health care organizations. CHAP is a subsidiary of the National League of Nursing. CHAP establishes guidelines for the operation of home health agencies.

community health center An ambulatory health care program (defined under Section 330 of the Public Health Service Act) usually serving a catchment area that has scarce or nonexistent health services or a population with special health needs; sometimes known as “neighborhood health center.” Community health centers attempt to coordinate Federal, State and local resources in a single organization capable of delivering both health and related social services to a defined population.

While such a center may not directly provide all types of health care, it usually takes responsibility to arrange all health care services needed by its patient population. *See also Federally Qualified Health Center or FQHC*

Community Health Management Information Systems (CHMIS) An automated communication network supporting the transfer of clinical and financial information, currently under development with the support of the John A. Hartford Foundation.

Community Mental Health Center (CMHC) An entity that provides

comprehensive mental health services (principally ambulatory), primarily to individuals residing or employed in a defined catchment area.

community rating A method of calculating health plan premiums using the average cost of actual or anticipated health services for all subscribers within a specific geographic area. The premium does not vary for different groups or subgroups of subscribers on the basis of their specific claims experience.

community rating by class (class rating) (CRC) For federal qualified HMOs, the Community Rating by Class (CRC) adjustment of community-rated premiums on the basis of such factors as age, sex, family size, marital status and industry classification. These health plan premiums reflect the experience of all enrollees of a given class within a specific geographic area, rather than the experience of any one employer.

Community Medical Plan (CMP) A state-licensed entity, other than a federally qualified HMO, that signs a Medicare Risk Contract and agrees to assume financial risk for providing care to Medicare eligible on a prospective, prepaid basis.

comprehensive medical A health insurance policy designed to cover a broad range of hospital, doctor and other related services (for example, lab or radiology services).

Consumer Price Index (CPI) A measurement of inflation at the consumer level. Many state programs use the CPI as a measure of changes in consumer buying power and increase the level of benefit provided through pharmacy assistance programs to reflect those changes. The Bureau of Labor Statistics within the Department of Labor tracks the CPI.

continuing medical education (CME) Formal education obtained by a health

professional after completing his/her degree and full-time postgraduate training. For physicians, some states require CME (usually 50 hours per year) for continued licensure, as do some specialty boards for certification.

continuum of care The availability of a broad range of treatment services so that care can be flexible and customized to meet a consumer's needs.

contract The formal legal document, also known as the "policy," that describes the agreement between the policyholder and the insurance carrier. This document contains the specific responsibilities of the policyholder and the insurance carrier in relation to the benefits provided under the contract.

contract discounts An economic incentive offered to consumers to encourage them to use providers belonging to a group or organization preferred by a health plan. Usually, the out-of-pocket expenses incurred by the patient are reduced.

coordination of benefits (COB) Procedures used by insurers to avoid duplicate payments for losses insured under more than one insurance policy. A coordination of benefits, or "nonduplication," clause in either policy prevents double payment by making one insurer the primary payer, and assuring that not more than 100 percent of the cost is covered. Standard rules determine which of two or more plans, each having COB provisions, pay its benefits in full and which becomes the supplementary payer on a claim.

co-payment or co-pay A form of cost sharing in which a fixed amount of money is paid by the insured for each health care service provided.

cost-benefit analysis An analytic method in which a program's cost is compared to the program's benefits for a period of time,

expressed in dollars, as an aid in determining the best investment of resources. For example, the cost of establishing an immunization service might be compared with the total cost of medical care and lost productivity that will be eliminated as a result of more persons being immunized. Cost-benefit analysis can also be applied to specific medical tests and treatments.

cost cap A predetermined ceiling, above which costs are not reimbursed. Providers are only reimbursed for their costs up to the cost limit; providers assume the risk for any costs above the limit. Note that "cost caps" are not the same as "capitation"—the two terms are often confused and used interchangeably when, in fact, their meanings are completely different.

cost center An accounting device whereby all related costs attributable to some "financial center" within an institution, such as department or program are segregated for accounting or reimbursement purposes.

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

cost contract An arrangement between a managed health care plan and CMS under Section 1876 or 1833 of the Social Security Act, under which the health plan provides health services and is reimbursed its costs. The beneficiary can use providers outside the plan's provider network.

cost sharing Any provision of a health insurance policy that requires the insured individual to pay some portion of medical expenses. The general term includes deductibles, co-payments and coinsurance.

cost shifting The condition that occurs when health care providers are not reimbursed or not fully reimbursed for providing health care so charges to those who pay must be increased. This typically results from providing health care to the medically indigent or Medicare patients.

covered expenses Hospital, medical and other health care expenses incurred by consumers that entitle them to a payment of benefits under a health insurance policy.

covered services Health care services covered by an insurance plan.

credentialing The recognition of professional or technical competence. The credentialing process may include registration, certification, licensure, professional association membership, or the award of a degree in the field. Certification and licensure affect the supply of health personnel by controlling entry into practice and influence the stability of the labor force by affecting geographic distribution, mobility, and retention of workers. Credentialing also determines the quality of personnel by providing standards for evaluating competence and by defining the scope of functions and how personnel may be used.

Critical Access Hospital (CAH) Created by Congress in the Balanced Budget Act of 1997, the CAH program is designed to support limited-service hospitals located in rural areas. To be designated a CAH, a hospital must be located in a rural area, provide 24-hour emergency care services, have an average patient length of stay of 96 hours or less, be more than 35 miles from a hospital or another CAH or more than 15 miles in areas with mountainous terrain or

only secondary roads **OR** certified by the State as being a “necessary provider” of healthcare services to residents in the area.

Current Procedural Terminology, fourth edition (CPT-4) A manual that assigns five-digit codes to medical services and procedures to standardize claims processing and data analysis.

customary charge One of the factors determining a physician’s payment for a service under Medicare. Calculated as the physician’s median charge for that service over a prior 12-month period.

customary, prevailing and reasonable (CPR) Current method of paying physicians under Medicare. Payment for a service is limited to the lowest of (1) the physician’s billed charge for the service, (2) the physician’s customary charge for the service, or (3) the prevailing charge for that service in the community. Similar to the Usual, Customary, and Reasonable system used by private insurers.

D

daily care Medicare and Medicaid rules limit the amount of service a home health agency can provide. In order to qualify for these home care benefits a patient must be in need of “intermittent” as opposed to daily, 24-hour care. Medicare usually defines intermittent care as care needed five times a week or less.

deductible The amount of loss or expense that must be incurred by an insured or otherwise covered individual before an insurer will assume any liability for all or part of the remaining cost of covered services. Deductibles may be either fixed-dollar amounts or the value of specified services (such as two days of hospital care or one physician visit). Deductibles are usually tied to some reference period over which they must be incurred, e.g., \$100 per calendar, benefit period, or spell of illness.

defined benefit Funding mechanisms for pension plans that can also be applied to health benefits. Typical pension approaches include: (1) pegging benefits to a percentage of an employee's average compensation over his/her entire service or over a particular number of years; (2) calculation of a flat monthly payment; (3) setting benefits based upon a definite amount for each year of service, either as a percentage of compensation for each year of service or as a flat dollar amount for each year of service.

defined contribution Funding mechanism for pension plans that can also be applied to health benefits based on a specific dollar contribution, without defining the services to be provided.

deinstitutionalization Policy that calls for the provision of supporting care and treatment for medically and socially dependent individuals in the community rather than an institutional setting.

dental insurance A contract that reimburses an insured for some or all of the costs of caring for teeth, oral surgery and gums.

developmental disability A severe, chronic disability which is attributable to a mental or physical impairment or combination of mental and physical impairments; is manifested before the person attains age 22; is likely to continue indefinitely; results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity of independent living, economic self-sufficiency; and reflects the person's needs for a combination and sequence of special, interdisciplinary or generic care treatments or services that are of lifelong or extended duration and are individually planned and coordinated.

Diagnosis Related Groups (DRGs)
Groupings of diagnostic categories drawn from the International Classification of

Diseases and modified by the presence of a surgical procedure, patient age, presence or absence of significant comorbidities or complications, and other relevant criteria. DRGs are the case-mix measure used in Medicare's prospective payment system.

direct contracting A contractual relationship in which health services are provided by a provider or group of providers contracting directly with an employer or public sector client. Finances go directly from an employer or the public system to the provider without passing through a middle entity, such as managed care organization or third party insurance carrier.

disability Any limitation of physical, mental or social activity of an individual as compared with other individuals of similar age, sex and occupation. Frequently refers to limitation of a person's usual or major activities, most commonly vocational. There are varying types (functional, vocational, learning), degrees (partial, total) and durations (temporary, permanent) of disability. Public programs often provide benefits for specific disabilities, such as total and permanent.

disability insurance A type of insurance that provides the policyholder with replacement income when he or she is unable to perform the major duties of his or her regular occupation, or an occupation for which the policyholder is qualified by reason of education, training or experience.

discharge The release of a patient from a provider's care, usually referring to the date at which a patient checks out of a hospital.

discounted fee for service A contracted payment rate that is discounted from the provider's customary fee. This agreement may be between the Managed Care Organization (MCO) and the provider or between the consumer and the provider.

disenrollment The process of voluntary or involuntary termination of coverage. Voluntary termination includes a member quitting because s/he prefers to leave. Involuntary termination includes a member leaving the plan because of switching jobs or when the plan terminates a member's coverage against a member's will.

disease May be defined as a failure of the adaptive mechanisms of an organism to counteract adequately, normally or appropriately to stimuli and stresses to which it is subjected, resulting in a disturbance in the function or structure of some part of the organism. This definition emphasizes that disease is multifactorial and may be prevented or treated by changing any or a combination of the factors. Disease is a very elusive and difficult concept to define, being largely socially defined.

dispensing fee A transaction fee that pharmacists charge to process and fill a prescription.

Disproportionate Share Hospital (DSH) Adjustment (pronounced "dish") Medicare makes special payments to hospitals that treat a disproportionately high share of low-income patients. The DSH payment

adjustment was designed to compensate hospitals that treat a greater proportion of low-income persons. Such patients were believed to incur higher-than-average costs, so hospitals that served many of them would likely encounter greater costs for their Medicare patients than would other facilities. These hospitals often have higher uncompensated care costs and fewer patients with private insurance than other hospitals. In recent years, DSH payments have been increasingly viewed as serving the broader purpose of ensuring continued access to hospital care for Medicare beneficiaries and low-income populations.

drug formulary A listing of prescription medications that are preferred or required for use within a health plan. Often, the medications tend to be the cheapest rather than the most effective. A plan that has adopted an open or voluntary formulary allows coverage for both formulary and non-formulary medications. A plan that has adopted a closed, select or mandatory formulary limits coverage to those drugs in the formulary unless an exception is made through a prior authorization process.

drug treatment protocols Documents that outline the clinical decision-making processes related to prescribing drugs. Protocols typically include a detailed clinical decision-making tree and generally recommend initiating therapy with the **lowest-cost alternative**.

drug utilization review (DUR) Review of physician prescribing, typically used to control costs and monitor quality of care. DUR programs are based on prescribing information collected electronically. They can be used prospectively to alert pharmacists when a patient might be taking drugs that could adversely interact. They can be used retrospectively to review physician prescribing practices.

dually eligible To be eligible for health benefits under the federal Medicare program

and the federal/state Medicaid programs simultaneously.

durable medical equipment Prescribed medical equipment (e.g., wheelchair, respirator) that can be used for an extended period of time.

E

Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) A program mandated by law as part of the Medicaid program. The law requires that all states have in effect a program for eligible children under age 21 to ascertain their physical or mental defects and to provide such health care treatments and other measures to correct or ameliorate defects and chronic conditions discovered. The State programs also have active outreach components to inform eligible persons of the benefits available to them, to provide screening and, if necessary, to assist in obtaining appropriate treatment.

effectiveness The net health benefits provided by a medical service or technology for typical patients in community practice settings.

efficacy The net health benefits achievable under ideal conditions for carefully selected patients.

electronic claim A digital representation of a medical bill generated by a provider or by the provider's billing agent for submission using telecommunications to a health insurance payer.

electronic data interchange (EDI) The mutual exchange of routine information between businesses using standardized, machine-readable formats.

emergency medical services (EMS) Services utilized in responding to the perceived individual need for immediate

treatment for medical, physiological, or psychological illness or injury.

Employee Retirement Income Security Act (ERISA) A Federal act, passed in 1974 that established new standards and reporting/ disclosure requirements for employer-funded pension and health benefit programs. To date, self-funded health benefit plans operating under ERISA have been held to be exempt from state insurance laws.

encounter A contract between an individual and the health care system for a health care service or set of services related to one or more medical conditions.

endorsement A formal document that changes the provisions of an insurance policy. *See also amendment.*

Enrollment The total number of covered persons in a health plan. The term also refers to the process by which a health plan signs up groups and individuals for membership or the number of enrollees who sign up in any one group.

epidemic A group of cases of a specific disease or illness clearly in excess of what one would normally expect in particular geographic area. There is no absolute criterion for using the term epidemic; as standards and expectations change, so might the definition of an epidemic, e.g., an epidemic of violence.

epidemiology The study of the patterns of determinants and antecedents of disease in human populations. Epidemiology utilizes biology, clinical medicine and statistics in an effort to understand the etiology (causes) of illness and/or disease. The ultimate goal of the epidemiologist is not merely to identify underlying causes of a disease but to apply findings to disease prevention and health promotion.

exclusions Specific conditions or circumstances listed in the policy that the health insurer will not pay for.

exclusive provider arrangement (EPA) An indemnity or service plan that provides benefits only if care is rendered by the institutional and professional providers with which it contracts (with some exceptions for emergency and out-of-area services).

Exclusive Provider Organization (EPO)
See *closed access*.

exclusivity clause A clause in a contract which prohibits healthcare providers from participating in more than one MCO (Managed Care Organization) network.

expenditure target (ET) A mechanism to adjust fee updates (for the fees themselves) based on how actual expenditures in an area compare to a target for those expenditures.

expense Funds actually spent or incurred providing goods, rendering services, or carrying out other mission related activities during a period. Expenses are computed using accrual accounting techniques that recognize costs when incurred and revenues when earned and include the effect of accounts receivables and accounts payable on determining annual income.

experience rating A method of adjusting health plan premiums based on the historical utilization data and distinguishing characteristics of a specific subscriber group.

explanation of benefits (EOB) The statement sent to an insured by the health plan listing services provided, the amount billed and the payment made.

External Quality Review Organization (EQRO) States are required to contract with an entity that is external to and independent of the State and its managed care contractors

to perform an annual review of the quality of services.

F

family practice A form of specialty practice in which physicians provide continuing comprehensive primary care within the context of the family unit.

favorable selection A tendency for utilization of health services in a population group to be lower than expected or estimated.

federal poverty level (FPL) Guidelines established by the U.S. Department of Health and Human Services that are used to determine an individual's or family's eligibility for various federal and non-federal programs. Federal poverty thresholds vary by family size and, to a small extent, location (Alaska and Hawaii have higher rates than the 48 contiguous states and the District of Columbia). In 2004, in the contiguous United States, the federal poverty level is \$9,310 for an individual and \$12,490 for a family of two and \$18,850 for a family of four.

Federal Medicaid Managed Care Waiver Program The process by which states obtain permission to implement managed care programs for their Medicaid or other categorically eligible beneficiaries.

federal qualification A status defined by the HMO Act, conferred by HCFA after conducting an extensive evaluation of the HMO's organization and operations. An organization must be federally qualified or be designated as a CMP (competitive medical plan) to be eligible to participate in Medicare cost and risk contracts. Likewise, an HMO must be federally qualified or State plan defined to participate in the Medicaid managed care program.

federal supply schedule (FSS) The price available to all federal government

purchasers. FSS prices are intended to equal or better the prices manufacturers charge their “most favored” non-federal customers under comparable terms.

Federally Qualified HMO An HMO that has satisfied certain federal qualifications pertaining to organizational structure, provider contracts, health service delivery information, utilization review/quality assurance, grievance procedures, financial status, and marketing information as specified in Title XIII of the Public Health Service Act.

Federally Qualified Health Center (FQHC) A federal payment option that enables qualified providers in Medically Underserved Areas (MUA/MUP) to receive cost-based Medicare and Medicaid reimbursement and allows for the direct reimbursement of nurse practitioners, physician assistants and certified nurse midwives. Federal legislation creating the FQHC category was enacted in 1989. *See also CHC*

fee-for-service Method of billing for health services under which a physician or other practitioner charges separately for each patient encounter or service rendered; it is the method of billing used by the majority of U.S. physicians. Under a fee-for-service payment system, expenditures increase if the fees themselves increase, if more units of service are provided, or if more expensive services are substituted for less expensive ones. This system contrasts with salary, per capita, or other prepayment systems, where the payment to the physician is not changed with the number of services actually used.

fee schedule An exhaustive list of physician services in which each entry is associated with a specific monetary amount that represents the approved payment level for a given insurance plan.

fiduciary Relating to, or founded upon, a trust or confidence. A fiduciary relationship

exists where an individual or organization has an explicit or implicit obligation to act in behalf of another person or organization’s interests in matters that affect the other person or organization. A physician has such a relation with his/her patient, and a hospital trustee has one with a hospital.

fiscal intermediary A private organization, usually an insurance company, that has a contract with CMS to process claims under Parts A of Medicare.

fiscal soundness The requirement that managed care organizations have sufficient operating funds, on hand or available in reserve, to cover all expenses associated with services for which they have assumed financial risk. This term also refers to an MCO’s (Managed Care Organization) ability to remain solvent.

formulary A list of drugs covered by a health plan or pharmacy assistance program. In some cases, the payers will only cover formulary drugs. More commonly, non-formulary drugs are available to consumers, but the consumer must pay a higher co-payment (see “Tiered Formulary”).

freedom of choice A Medicaid provision that requires states to allow recipients the freedom to choose providers. States can seek CMS Section 1915 and 1115 waivers of the freedom of choice requirement.

fully capitated A stipulated dollar amount established to cover the cost of all health care services delivered to a person.

G

gag clause A clause within a contract that restricts the ability of a provider to discuss treatment options with a consumer that may benefit the consumer but are not covered by the health plan.

gatekeeper The primary care practitioner in managed care organizations that determine

whether the presenting patient needs to see a specialist or requires other non-routine services. The goal is to guide the patient to appropriate services while avoiding unnecessary and costly referrals to specialists.

general practice A form of practice in which physicians without specialty training provide a wide range of primary health care services to patients.

generalists Physicians who are distinguished by their training as not limiting their practice by health condition or organ system, who provide comprehensive and continuous services, and who make decisions about treatment for patients presenting with undifferentiated symptoms. Generalists typically include family practitioners, general internists and general pediatricians, and many believe it also includes Obstetrician-Gynecologists.

generic drug A drug product that is no longer covered by patent protection and thus may be produced and/or distributed by many firms.

global budgeting A method of hospital cost containment in which participating hospitals must share a prospectively set budget. Method for allocating funds among hospitals may vary but the key is that the participating hospitals agree to an aggregate cap on revenues that they will receive each year. Global budgeting may also be mandated under a universal health insurance system.

global fee A total charge for a specific set of services, such as obstetrical services that encompass prenatal, delivery and post-natal care.

grace period The period of time after a premium becomes due in which you can still pay for the insurance and keep it in force. Vermont law requires health insurers to provide at least 14 days' notice before canceling a policy because you failed to

make the payment by the regular due date. If you pay within the 14-day period, the company cannot cancel the policy.

Graduate Medical Education (GME)

Medical education after receipt of the Doctor of Medicine (MD) or equivalent degree, including the education received as an intern, resident (which involves training in a specialty) or fellow, as well as continuing medical education. CMS partly finances GME through Medicare direct and indirect payments.

grievance procedure Defined process in a health plan for consumers or health care providers to use when there is disagreement about a plan's services, billing, or general procedures.

group-model HMO An HMO that pays a medical group a negotiated, per capita rate, which the group distributes among its physicians often under a salaried arrangement. (See "Health Maintenance Organization" and "Staff—Model HMO").

group or network HMO An HMO that contracts with one or more independent group practices to provide services to its members.

group practice A formal associate of three or more physicians or other health professionals providing health services. Income from the practice is pooled and redistributed to the members of the group according to some prearranged plan (often, but not necessarily, through partnership). Groups vary a great deal in size, composition and financial arrangements.

guaranteed eligibility A defined period of time (3-6 months) that all patients enrolled in prepaid health programs are considered eligible for Medicaid, regardless of their actual eligibility for Medicaid. A State may apply to HCFA for a waiver to incorporate this into their contracts.

guaranteed issue Requirement that health plans offer coverage to all businesses or individual who wish to purchase coverage, during some period each year.

guaranteed renewable policy A health insurance policy that must be continued in force, and must be renewed regularly, if the premium is paid on time.

guidelines Systematic sets of rules for choosing among alternate drug therapies. *Treatment* guidelines, or protocols, generally require that the drug therapy with the fewest side effects (often the oldest and cheapest therapy) be tried first, before more potent therapies are recommended. *Administrative* guidelines generally focus more on cost and may require that the least expensive therapy be used first; only if that fails should more expensive therapies be used.

H

handicapped As defined by Section 504 of the Rehabilitation Act of 1973, any person who has a physical or mental impairment that substantially limits one or more major life activity, has a record of such impairment, or is regarded as having such an impairment.

health The state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. It is recognized, however, that health has many dimensions (anatomical, physiological, and mental) and is largely culturally defined. The relative importance of various disabilities will differ depending upon the cultural milieu and the role of the affected individual in that culture. Most attempts at measurement have been assessed in terms of morbidity and mortality.

Health Care Financing Administration (HCFA) The government agency within the Department of Health and Human Services that directs the Medicare and Medicaid programs (Titles XVIII and XIX of the

Social Security Act) and conducts research to support those programs. (The agency has been renamed CMS—Centers for Medicare and Medicaid Services)

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 that “provides” insurance.

Health Insurance Portability and Accountability Act (HIPAA) A federal law to help workers maintain coverage when they change jobs. Limits the ability of plans to refuse to pay for “pre-existing conditions.” Additionally, privacy and security provisions regulate personal health information and electronic transactions. Covered entities under HIPAA include most health plans, health care clearing houses and those health care providers who conduct certain financial and administrative transactions electronically.

health education Any combination of learning opportunities designed to facilitate voluntary adaptations of behavior (in individuals, groups or communities) conducive to health.

health facilities Collectively, all physical plants used in the provision of health services; usually limited to facilities built for the purpose of providing health care, such as hospitals and nursing homes. They do not include an office building that includes a physician’s office. Health facility classifications include: hospitals (both general and specialty), long-term care facilities, kidney dialysis treatment centers and ambulatory surgical facilities.

health insurance Financial protection against the medical care costs arising from disease or accidental bodily injury. Such insurance usually covers all or part of the medical costs of treating the disease or

injury. Insurance may be obtained on either an individual or a group basis.

Health Plan Employer Data and Information Set (HEDIS) The Health Plan Employer Data and Information Set is a set of performance measures developed to access the quality of managed care across public and private sectors. It is a product of the National Committee on Quality Assurance.

Health Insuring Organization (HIO) An entity that contracts on a prepaid, capitated risk basis to provide comprehensive health services to recipients.

health insurance purchasing cooperatives (HIPCs) Public or private organizations that secure health insurance coverage for the workers of all member employers. The goal of these organizations is to consolidate purchasing responsibilities to obtain greater bargaining clout with health insurers, plans and providers, to reduce the administrative costs of buying, selling and managing insurance policies. Private cooperatives are usually voluntary associations of employers in a similar geographic region who band together to purchase insurance for their employees. Public cooperatives are established by state governments to purchase insurance for public employees, Medicaid beneficiaries and other designated populations.

Health Maintenance Organization (HMO) An entity with four essential attributes: (1) an organized system providing health care in a geographic area, which accepts the responsibility to provide or otherwise assure the delivery of (2) an agreed-upon set of basic and supplemental health maintenance and treatment services to (3) a voluntarily enrolled group of persons and (4) for which services the entity is reimbursed through a predetermined fixed, periodic prepayment made by, or on behalf of, each person or family unit enrolled. The payment is fixed without regard to the

amounts of actual services provided to an individual enrollee. Individual practice associations involving groups or independent physicians can be included under the definition.

Health Manpower Shortage Area (HMSA) An area or group that the U.S. Department of Health and Human Services designates as having an inadequate supply of health care providers. HMSAs can include: (1) an urban or rural geographical area, (2) a population group for which access barriers can be demonstrated to prevent members of the group from using local providers, or (3) medium and maximum-security correctional institutions and public or non-profit private residential facilities.

health personnel Collectively, all persons working in the provision of health services, whether as individual practitioners or employees of health institutions and programs whether or not professionally trained, and whether or not subject to public regulation. Facilities and health personnel are the principal health resources used in producing health services.

health plan An organization that provides a defined set of benefits including private and governmental plans, high-risk pools and HMOs.

Health Plan Employer Data and Information Set (HEDIS) National Committee for Quality Assurance *See above*

health policy An insurance contract consisting of a defined set of benefits. See health insurance.

Health Professional Shortage Area (HPSA) A federal designation of shortage similar to the MUA/MUP. An area can be designated as a HPSA based on the ratio of clinical service providers to the population of a specific geographic area or of a special population within a geographic area. A health care organization in a HPSA is

eligible to have the services of health care professionals who receive loan forgiveness or scholarships through the National Health Service Corps.

health promotion Any combination of health education and related organizational, political and economic interventions designed to facilitate behavioral and environmental adaptations that will improve or protect health.

Health Resources and Services

Administration (HRSA) One of eight agencies of the U.S. Public Health Service, HRSA has responsibility for addressing resource issues relating to access, equity and quality of health care, particularly to the disadvantaged and underserved. HRSA provides leadership assures the support and delivery of primary health care services, particularly in underserved areas and the development of qualified primary care health professionals and facilities to meet the health needs of the nation. HRSA focuses on support of states and communities in their efforts to plan, organize and delivery primary health care, as well as strengthen the overall public health system.

health service area (HSA) Geographic area designated on the basis of such factors as geography, political boundaries, population and health resources, for the effective planning and development of health services.

health status The state of health of a specified individual, group or population. It may be measured by obtaining proxies such as people's subjective assessments of their health; by one or more indicators of mortality and morbidity in the population, such as longevity or maternal and infant mortality; or by sing the incidence or prevalence of major diseases (communicable, chronic or nutritional). Conceptually, health status is the proper outcome measure for the effectiveness of a

specific population's medical care system, although attempts to relate effects of available medical care to variations in health status have proved difficult.

Health Systems Agency (HSA) A health planning agency created under the National Health Planning and Resources Development Act of 1974. HSAs were usually nonprofit private organizations and served defined health service areas as designated by the States.

Hill-Burton Coined from the names of the principal sponsors of the Public Law 79-725 (the Hospital Survey and Construction Act of 1946); this program provided Federal support for the construction of modernization of hospitals and other health facilities. Hospitals that have received Hill-Burton funds incur an obligation to provide a certain amount of charity care.

hold-harmless A contractual requirement prohibiting a provider from seeking payment from an enrollee for services rendered prior to a health plan solvency.

holism Refers to the integration of mind, body and spirit of a person and emphasizes the importance of perceiving the individual (regarding physical symptoms) in a "whole" sense. Holism teaches that the health care system must extend its focus beyond solely the physical aspects of disease and particular organ in question, to concern itself with the whole person and the interrelationships between the emotional, social, spiritual, as well as physical implications of disease and health.

home health care Health services rendered in the home to the aged, disabled, sick or convalescent individuals who do not need institutional care. The services may be provided by a visiting nurse association (VNA) home health agency, county public health department, hospital, or other organized community group and may be specialized or comprehensive. The most

common types of home health care are the following—nursing services; speech, physical, occupational and rehabilitation therapy; homemaker services; and social services.

homebound Medicare eligibility definition that sometimes restricts coverage. In order to be eligible for certain Medicare services, the law requires that a physician certify the client is confined to his/her home.

home health care Health services rendered in the home to the aged, disabled, sick or convalescent individuals who do not need institutional care. The services may be provided by a visiting nurse association (VNA), home health agency, county public health department, hospital or other organized group and may be specialized or comprehensive. The most common types of home health care services include nursing services; speech, physical and occupational therapy; homemaker services; and social services.

horizontal integration Merging of two or more firms at the same level of production in some formal, legal relationship. See vertical integration.

hospice A program that provides palliative and supportive care for terminally ill patients and their families, either directly or on a consulting basis with the patients' physician or another community agency. Originally a medieval name for a way station of crusaders where they could be replenished, refreshed and care for, hospice is used here for an organized program of care for people going through life's "last station." The whole family is considered the unit of care, and care extends through their period of mourning.

hospital An institution whose primary function is to provide inpatient diagnostic and therapeutic services for a variety of medical conditions, both surgical and nonsurgical. In addition, most hospitals

provide some outpatient services, particularly emergency care. Hospitals may be classified by length of stay (short term or long term), as teaching or non-teaching, by major type of service (psychiatric, tuberculosis, general and other specialties, such as maternity, pediatric or ear, nose and throat), and by type of ownership or control (federal, state or local government; for-profit and nonprofit). The hospital system is dominated by the short-term, general, nonprofit community hospital, often called a voluntary hospital.

hospital affiliation A contract between an HMO and a hospital in which the hospital agrees to provide inpatient benefits to HMO members according to terms negotiated and a (usually discounted) payment schedule.

I

incidence In epidemiology, the number of cases of disease, infection or some other event having their onset during a prescribed period of time in relation to the unit of population in which they occur. Incidence measures morbidity or other events as they happen over a period of time. Examples include the number of accidents occurring in a manufacturing plant during a year in relation to the number of employees in the plant, or the number of cases of mumps occurring in a school during a month in relation to the number of pupils enrolled in the school. It usually refers only to the number of new cases, particularly of chronic diseases.

incurred but not reported (IBNR) Claims that have not been reported to the insurer as of some specific date for services that have been provided. The estimated value of these claims is a component of an insurance company's current liabilities.

indemnity Health insurance benefits provided in the form of cash payments rather than services. An indemnity insurance

contract usually defines the maximum amounts that will be paid for covered services.

independent practice association (IPA) An organized form of prepaid medical practice in which participating physicians remain in their independent office settings, seeing both enrollees of the IPA and private-pay patients. Participating physicians may be reimbursed by the IPA on a fee-for-service basis or a capitation basis.

indigent care Health services provided to the poor or those unable to pay. Since many indigent patients are not eligible for federal or state programs, the costs that are covered by Medicaid are generally recorded separately from indigent care costs.

individual (nongroup) insurance Health insurance bought directly by an individual not eligible for group coverage through an employer or association.

inlier A patient whose course or cost of treatment resembles those of most other patients in a diagnosis-related group.

in-network A provider, hospital, pharmacy or other facility is “in network” when it has contractually accepted the health insurance company’s terms and conditions for payments of services.

inpatient A person who has been admitted at least overnight to a hospital or other health facility (which is therefore responsible for his/her room and board) for the purpose of receiving diagnostic treatment or other health services.

insolvency A legal determination occurring when a managed care plan no longer has the financial reserves or other arrangements to meet its contractual obligations to patients and subcontractors.

institution for mental disease A facility of more than 16 beds in which at least 50

percent of the residents have a primary diagnosis of a mental illness at the time of admission. IMDs cannot receive Medicaid services for persons ages 22-64.

institutional health services Health services delivered on an inpatient basis in hospitals, nursing homes, or other inpatient institutions. The term may also refer to services delivered on an outpatient basis by departments or other organizational units of, or sponsored by, such institutions.

instrumental activities of daily living An index or scale that measures a patient’s degree of independence in aspects of cognitive and social functioning including shopping, cooking, doing housework, managing money and using the telephone.

insured A participant in a health care plan who makes up part of the plan’s enrollment. Insureds may be the subscriber, the subscriber’s spouse, or other eligible dependents. In managed care plans, often called “member.”

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

integrated services network (ISN) A network of organizations usually including hospitals and physician groups, that provides or arranges to provide a coordinated continuum of services to a defined population and is held both clinically and fiscally accountable for the outcomes of the populations served.

interim payment system (IPS) The Medicare home care payment system that started in October 1998 and was replaced October 2000 by the Prospective Payment System (PPS). IPS replaced the former fee-for-service system. Under IPS agencies were

paid either on a per visit basis, or cost per year for their patients, whichever is less.

intermediate care facility (ICF) An institution that is licensed under State law to provide on a regular basis, health-related care and services to individuals who do not require the degree of care or treatment that a hospital or skilled nursing facility is designed to provide. Public institutions for care of the mentally retarded or people with related conditions are also included in the definition. The distinction between “health-related care and services” and “room and board” has often proven difficult to make but is important because ICFs are subject to quite different regulations and coverage requirements than institutions, which do not provide health-related care and services.

international medical graduate (IMG) A physician who graduated from a medical school outside of the United States, usually Canada. U.S. citizens who go to medical school abroad are classified as international medical graduates just as are foreign-born persons who are not trained in a medical school in this country. U.S. citizens represent only a small portion of the IMG group.

intervention strategy A generic term used in public health to describe a program or policy designed to have an impact on an illness or disease. Hence a mandatory seat belt law is an intervention designed to reduce automobile-related fatalities.

J

Joint Commission on Accreditation of Healthcare Organizations (JCAHO) A national private, nonprofit organization whose purpose is to encourage the attainment of uniformly high standards of institutional medical care. Establishes guidelines for the operation of hospitals and other health facilities and conducts survey and accreditation programs.

K

Katie Beckett children Disabled children who qualify for home care coverage under a special provision of Medicaid, named after a girl who remained institutionalized solely to continue Medicaid coverage.

L

large group insurance Health insurance provided to employer or association groups of 51 or more persons.

legal reserves The minimum reserve that a company must keep to meet future claims and obligations as they are calculated under the state insurance code. The reserve amount is usually determined by an actuary.

license/licensure Permission granted to an individual or organization by a competent authority, usually public, to engage lawfully in a practice, occupation or activity. Licensure is the process by which the license is granted. It is usually granted on the basis of examination and/or proof of education rather than on measures of performance. A license is usually permanent but may be conditioned on annual payment of a fee, proof of continuing education or proof of competence.

lifetime benefit maximum The total amount an insurance company will pay for health care services over your lifetime. If the cost of the benefits you receive since enrolling in a plan exceeds this amount, your coverage ends and no additional services will be covered.

limited benefit policy An insurance policy that provides benefits only for certain specific diseases or accidents.

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

lock-in A contractual provision by which members are required to receive all their care from the network health care providers except in cases of urgent or emergency need.

long-term care A set of health care, personal care and social services required by persons who have lost, or never acquired, some degree of functional capacity (e.g., the chronically ill, aged, disabled or retarded) in an institution or at home, on a long-term basis. The term is often used more narrowly to refer only to long-term institutional care such as that provided in nursing homes, homes for the retarded and mental hospitals. Ambulatory services such as home health care, which can also be provided on a long-term basis, are seen as alternatives to long-term institutional care.

long-term care insurance This type of insurance is designed to help pay for some or all long-term care costs, including care in a nursing home, adult day care facility or at home. Benefits are paid when the insured person needs assistance with activities of daily living, or when the insured person suffers from a cognitive impairment.

M

Managed Behavioral Healthcare Organization (BHO) An MCO (Managed Care Organization) that specializes in the management, administration, and/or provision of behavioral healthcare benefits.

managed care Health care financing/delivery systems that coordinate the use of services by its members to contain costs and improve quality. These systems have arrangements (employment or contractual) with selected physicians, hospitals and others to provide services and include incentives for members to use network providers.

Managed Care Organization (MCO) A system of health service delivery and financing that coordinates the use of health services by its members, designates covered health services, provides a specific provider network, and influences use of medical care services.

managed care plan A health plan that uses managed care arrangements and has a defined system of selected providers that contract with the plan. Enrollees have a financial incentive to use participating providers that agree to furnish a broad range of services to them. Providers may be paid on a pre-negotiated basis. (See also “Health Maintenance Organization,” “Point of Service Plan,” and “Preferred Provider Organization.”)

magnetic resonance imaging (MRI) This relatively new form of diagnostic radiology is a method of imaging body tissues that uses the response or resonance of the nuclei of the atoms of one of the bodily elements, typically hydrogen or phosphorus, to externally applied magnetic fields.

malpractice Professional misconduct or failure to apply ordinary skill in the performance of a professional act. A practitioner is liable for damages or injuries caused by malpractice. For some professions like medicine, malpractice insurance can cover the costs of defending suits instituted against the professional and/or any damages assessed by the court, usually up to a maximum limit. To prove malpractice requires that a patient demonstrate some injury and that the injury be caused by negligence.

managed care The body of clinical, financial and organizational activities designed to ensure the provision of appropriate health care services in a cost-efficient manner. Managed care techniques are most often practiced by organizations and professionals that assume risk for a

defined population (e.g., health maintenance organizations).

management services organization The management services organization provides administrative and practice management services to physicians. An MSO may typically be owned by a hospital, hospitals or investors. Large group practices may also establish MSOs to sell management services to other physician groups.

mandate A state or federal statute or regulation that requires coverage for certain health care services.

maximum allowable actual charge (MAAC) A limitation on billed charges for Medicare services provided by nonparticipating physicians. For physicians with charges exceeding 115 percent of the prevailing charge for nonparticipating physicians, MAACs limit increases in actual charges to 1 percent a year. For physicians whose charges are less than 115 percent of the prevailing, MAACs limit actual charge increases so they may not exceed 115 percent.

McCarran-Ferguson Act A 1945 Act of Congress exempting insurance business from federal commerce laws and delegating regulatory authority to the states.

Medicaid (Title XIX) A federally aided, state-operated and administered program that provides medical benefits for certain indigent or low-income persons in need of health and medical care. The program, authorized by Title XIX of the Social Security Act, is basically for the poor. It does not cover all of the poor, however, but only persons who meet specified eligibility criteria. Subject to broad federal guidelines, states determine the benefits covered, program eligibility, rates of payment for providers, and methods of administering the program.

medical audit Detailed retrospective review and evaluation of selected medical records by qualified professional staff. Medical audits are used in some hospitals, group practices, and occasionally in private, independent practices for evaluating professional performance by comparing it with accepted criteria, standards, and current professional judgment. A medical audit is usually concerned with the care of a given illness and is undertaken to identify deficiencies in that care in anticipation of educational programs to improve it.

medically indigent Persons who cannot afford needed health care because of insufficient income and/or lack of adequate health insurance.

medical management information system (MMIS) A data system that allows payers and purchasers to track health care expenditure and utilization patterns.

medical necessity The eligibility requirements for Medicaid, Medicare or third party insurers to qualify for specific healthcare interventions.

medical savings account (MSA) An account in which individuals can accumulate contributions to pay for medical care or insurance. Some states give tax-preferred status to MSA contributions, but such contributions are still subject to federal income taxation. MSAs differ from Medical reimbursement accounts, sometimes called flexible benefits of Section 115 accounts, in that they need not be associated with an employer. MSAs are not currently recognized in federal statute.

medically needy Persons who are categorically eligible for Medicaid and whose income, less accumulated bills, are below income limits for the Medicaid program.

medically underserved area/population (MUA/MUP) MUAs and MUPs are

geographic areas and population groups that have inadequate access to primary health care, as determined by a federally approved formula. Areas seeking MUA designation must be consistent throughout the defined service area in terms of distance from population centers, characteristics of its population, and geographic barriers to access. The criteria for an MUP focus on the needs of specific population groups within a geographic area.

Medicare (Title XVIII) A U.S. health insurance program for people aged 65 and over for persons eligible for social security disability payments for two years or longer, and for certain workers and their dependents who need kidney transplantation and dialysis. Monies from payroll taxes and premiums from beneficiaries are deposited in special trust funds for use in meeting the expenses incurred by the insured. It consists of two coordinated programs: hospital insurance (Part A) and supplementary medical insurance (Part B).

Medicare + Choice A program created by the Balanced Budget Act of 1997 to replace the existing system of Medicare risk and cost contracts. Beneficiaries have the choice during an open season each year to enroll in a Medicare+Choice plan or to remain in traditional Medicare. Medicare+Choice plans may include coordinated care plans (HMOs, PPOs or plans offered by provider-sponsored organizations); private fee-for-service plans; or plans with medical savings accounts.

Medicare approved charge The amount Medicare approves for payment to a physician. Typically, Medicare pays 80 percent of the approved charge and the beneficiary pays the remaining 20 percent. Physicians may bill beneficiaries for the additional amount (not balance) not to exceed 15 percent of the Medicare approved charge. See balance billing.

Medicare risk contract An agreement by an HMO or competitive medical plan to accept a fixed dollar reimbursement per Medicare enrollee, derived from costs in the fee-for-service sector, for delivery of a full range of prepaid health services.

Medigap insurance (Medicare Supplement Policy) 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.

mental health services Comprehensive mental health services, as defined under some state laws and federal statutes, include: inpatient care, outpatient care, day care and other partial hospitalization and emergency services; specialized services for the mental health of children; specialized services for the mental health of the elderly; consultation and education services; assistance to courts and other public agencies in screening catchment area residents; follow-up for catchment area residents discharged from mental health facilities or who would require inpatient care without such halfway house services; and specialized programs for the prevention, treatment and rehabilitation of alcohol and drug abusers.

Mental Health Statistics Improvement Program (MHSIP) A project, funded and coordinated through the U.S. Center for Mental Health Services, in which a group of individuals, organizations, state government agencies and associates are working to improve information management capacity to support decision making in meeting the needs of persons with mental health disorders. The goal of MHSIP is to implement uniform, integrated mental health data collection systems.

mental illness All forms of illness in which psychological, emotional, or behavioral disturbances are the dominating feature. The term is relative and variable in different cultures, schools of thought and definitions. It includes a wide range of types and severities.

morbidity The extent of illness, injury or disability in a defined population. The rate, incidence or prevalence of disease.

mortality Death. Used to describe the relation of deaths to the population in which they occur. The mortality rate (death rate) expresses the number of deaths in a unit of population within a prescribed time and may be expressed as crude death rates (e.g., total deaths in relation to total population during a year) or as death rates for specific diseases and, sometimes, for age, sex or other attributes (e.g., number of deaths from cancer in white males in relation to the white male population during a given year).

multiple employer trust (MET)

Arrangement through which two or more employers can provide benefits, including health coverage, for their employees. Arrangements formed by associations of similar employers were exempt from most state regulations. Redefined as a MEWA by the Multiple Employer Welfare Arrangement Act of 1982.

multiple employer welfare arrangement

(MEWA) As defined in 1983 Erlenborn ERISA (Employee Retirement Income Security Act) Amendment, an employee welfare benefit plan or any other arrangement providing any of the benefits of an employee welfare benefit plan to the employees of two or more employers. MEWAs that do not meet the ERISA definition of employee benefit plan and are not certified by the U.S. Department of Labor may be regulated by states. MEWAs that are fully insured and certified must only meet broad state insurance laws regulating reserves.

N

National Committee for Quality

Assurance (NCQA) A national organization founded in 1979 composed of 14 directors representing consumers, purchasers and providers of managed health care. It accredits quality assurance programs in prepaid managed health care organizations develops and coordinates programs for assessing the quality of care and service in the managed care industry.

National Health Services Corps (NHSC)

A program administered by the U.S. Public Health Service that places physicians and other providers in health professions shortage areas by providing scholarship and loan repayment incentives. Since 1970, the Corps members have worked in community health centers, migrant centers, and Indian health facilities and in other sites targeting underserved populations.

network An affiliation of providers through formal and informal contracts and agreements. Networks may contract externally to obtain administrative and financial services.

network model HMO A health care model in which the HMO contracts with more than one physician group or IPA, and may contract with single and multi-specialty groups that work out of their own facilities. The network may or may not provide care exclusively for the HMO's members.

nurse An individual trained to care for the sick, aged or injured. A nurse can be defined as a professional qualified by education and authorized by law to practice nursing. There are many different types, specialties and grades of nurses.

nurse practitioner A registered nurse qualified and specially trained to provide primary care, including primary health care in homes and in ambulatory care facilities, long-term care facilities and other health

care institutions. Nurse practitioners generally function under the supervision of a physician but not necessarily in his/her presence. They are usually salaried rather than reimbursed on a fee-for-service basis, although the supervising physician may receive fee-for-service reimbursement for their services.

nursing home Includes a wide range of institutions that provide various levels of maintenance and personal or nursing care to people who are unable to care for themselves and who have health problems that range from minimal to very serious. The term includes freestanding institutions, or identifiable components of other health facilities that provide nursing care and related services, personal care and residential care. Nursing homes include skilled nursing facilities and extended care facilities, but not boarding homes.

O

occupancy rate A measure of inpatient health facility use, determined by dividing available bed days by patient days. It measures the average percentage of a hospital's beds occupied and may be institution-wide or specific for one department or service.

occupational health services Health services concerned with the physical, mental and social well-being of an individual in relation to his/her work environment and the adjustment of individuals to their work. The term applies to more than the safety of the workplace and includes health and job satisfaction. In the U.S. the principal Federal statute concerned with occupational health is the Occupational Safety and Health Act administered by the Occupational Safety and Health Administration (OSHA) and the National Institute of Occupational Safety and Health (NIOSH).

Olmstead Decision U.S. Supreme Court 1999 decision interpreting ADA anti-discrimination provisions which led the federal government to direct State Medicaid authorities to provide services in the most integrated setting appropriate for those in or at risk of institutionalization. Each state is required to develop an Olmstead plan with the active involvement of individuals with disabilities.

Ombudsman A person responsible for investigating and seeking to resolve consumer complaints.

open access A term describing a consumer's ability to self-refer for specialty care. Open access arrangements allow a consumer to see a participating provider without a referral from a gatekeeper. All called open panel.

open enrollment A method for assuring that insurance plans, especially prepaid plans, do not exclusively select good risks. Under an open enrollment requirement, a plan must accept all who apply during a specific period each year.

open enrollment period A period during which consumers have an opportunity to select among health plans, usually without evidence of insurability or waiting periods.

organized delivery system (ODS) See integrated services network (ISN).

out-of-network Any provider, hospital, pharmacy or other facilitator who has not contracted with the health insurance plan to provide services to the plan's members.

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

outcome The consequence of an intervention on a patient.

outcome measurement A process of systematically measuring individual or collective response to treatment services typically focusing on functioning issues.

outcomes research Research on measures of changes in patient outcomes, that is, patient health status and satisfaction resulting from specific interventions. Attributing changes in outcomes to care requires distinguishing the effects of care from the effects of the many other factors that influence patients' health and satisfaction.

outlier A hospital admission requiring either substantially more expense or a much longer length of stay than average. Under DRG (diagnosis related groups) reimbursement, outliers are given exceptional treatment (subject to peer review and organizational review).

outline of coverage The document given to each health plan member that summarizes the benefits, co-payment, coinsurance, deductibles, and other requirements for obtaining services covered by the health plan that are listed in full detail in the contract.

outpatient A patient who is receiving ambulatory care at a hospital or other facility without being admitted to the facility.

P

participating provider A provider who has agreed to accept a certain level of payment from an indemnity plan for treating the plan's insureds. The provider may be a hospital, pharmacy, other facility or a physician who has contractually accepted the terms and conditions as set forth by the health plan. Insureds may not be required to

use participating providers, but usually pay more if they do not.

passive intervention Health promotion and disease prevention initiatives that do not require the direct involvement of the individual (e.g., water system fluoridation programs) are termed "passive." Most often these types of initiatives are government sponsored.

patient origin study A study generally undertaken by an individual health program or health planning agency, to determine the geographic distribution of the residences of the patients served by one or more health programs. Such studies help define catchment and medical trade areas and are useful in locating and planning the development of new services.

peer review Generally, the evaluation by practicing physicians or other professionals of the effectiveness of services ordered or performed by other members of the profession (peers). Frequently, peer review refers to the activities of the Professional Review Organizations, and also to review of research by other researchers.

Peer Review Organization (PRO) An organization that contracts with CMS to investigate the quality of health care furnished to Medicare beneficiaries, to educate beneficiaries and medical providers, and to conduct a limited review of medical records and claims to evaluate the appropriateness of care provided.

personal needs allowance (PNA) The amount of an institutionalized Medicaid beneficiary's own money that can be withheld each month from Social Security and other retirement income sources to pay for personal incidentals. The minimum PNA is \$30 per month/per individual.

pharmacy assistance subsidy programs State-funded programs that provide prescription drug insurance coverage. Most

programs focus on low-income seniors; some are opened to all Medicare beneficiaries. Generally, programs only cover individuals without any other drug insurance.

pharmacy assistance discount programs

State programs that give members a discount on prescription drug purchases. These programs do not insure individuals against the cost of drugs.

Pharmacy Benefit Managers (PBMs)

Companies that manage pharmacy benefits under contract on behalf of payers (e.g., state Medicaid or pharmacy assistance programs, self-insured employers). PBMs can be stand-alone companies or a division of a larger insurance company, such as Aetna or Blue Cross. PBMs typically use a variety of clinical and administrative procedures to reduce pharmacy costs.

physician assistant (PA) Also known as a physician extender, a PA is a specially trained and licensed or otherwise credentialed individual who performs tasks, which might otherwise be performed by a physician, under the direction of a supervising physician.

physician-hospital organization (PHO) A legal entity formed by a hospital and a group of physicians to further mutual interests and to achieve market objectives. A PHO generally combines physicians and a hospital into a single organization for the purpose of obtaining payer contracts. Doctors maintain ownership of their practices and agree to accept managed care patients according to the terms of a professional services agreement with the PHO. The PHO serves as a collective negotiating and contracting unit. It is typically owned and governed jointly by a hospital and shareholder physicians.

Physician Payment Review Commission (PPRC) Congress created the Physician Payment Review Commission in 1986 to

advise it on reforms of the methods used to pay physicians under the Medicare program. The Commission has conducted analyses of physician payment issues and worked closely with the Congress to bring about comprehensive reforms in Medicare physician payment policy. Its recommendations formed the basis of 1989 legislation that created the RBRVS (resource-based relative value scale), a resource-based fee schedule limiting the amount physicians may charge patients.

Point of Service (POS) Plan A health insurance benefits program in which subscribers can select between different delivery systems (i.e., HMO, PPO and fee-for-service) when in need of health care services, rather than making the selection between delivery systems at time of open enrollment at place of employment. Typically, the costs associated with receiving care from HMO providers are less than when care is rendered by PPO or non-contracting providers.

portability Requirement that health plans guarantee continuous coverage without waiting periods for persons moving between plans.

practice guidelines Systematically developed statements on medical practice that assist physicians and other professionals with developing appropriate health care plans for specific conditions.

preadmission certification A process under which admission to a health institution is reviewed in advance to determine need and appropriateness and to authorize length of stay consistent with norms for the evaluation.

preauthorization The requirement of some health care plans that an insured obtain the plan's approval for certain services before the service can be received and paid for by the company.

preexisting condition A medical condition developed prior to issuance of a health insurance policy. Some policies exclude coverage of such conditions for a period of time or indefinitely.

preexisting condition exclusion A contractual limitation or exclusion of benefits for a pre-existing condition.

Preferred Drug List (PDL) The purpose of a PDL is to assure that clinically appropriate benefits are available to eligible beneficiaries at the most reasonable cost available. It consists of drug classes that have been selected for clinical, utilization, and/or cost reasons. VT Medicaid's PDL is reviewed and approved by the DUR Board. The List, though, is not a representation of all drugs covered in all of Vermont's publicly funded programs. Coverage is dependent on the program.

Preferred Provider Arrangement (PPA) Selective contracting with a limited number of health care providers, often at reduced or pre-negotiated rates of payment.

Preferred Provider Organization (PPO) Formally organized entity generally consisting of hospital and physician providers. The PPO provides health care services to purchasers usually at discounted rates in return for expedited claims payment and a somewhat predictable market share. In this model, consumers have a choice of using PPO or non-PPO providers; however, financial incentives are built in to benefit structures to encourage utilization of PPO providers.

premium The amount paid to an insurance company in exchange for providing coverage for a specified period of time under a contract. Premiums are usually paid for a one-month period, but can be on an annual or quarterly basis.

prepaid group practice plan A plan by which specified health services are rendered

by participating physicians to an enrolled group of persons, with a fixed periodic payment made in advance by (or on behalf of) each person or family. If a health insurance carrier is involved, then the plan is a contract to pay in advance for the full range of health services to which the insured is entitled under the terms of the health insurance contract. A Health Maintenance Organization (HMO) is an example of a prepaid group practice plan.

prepaid health plan (PHP) An entity that either contracts on a prepaid, capitated risk basis to provide services that are not risk-comprehensive services, or contracts on a non-risk basis. Additionally, some entities that meet the above definition of HMOs are treated as PHPs through special statutory exemptions.

prepayment Usually refers to any payment to a provider for anticipated services (such as an expectant mother paying advance for maternity care). Sometimes prepayment is distinguished from insurance as referring to payment to organizations which, unlike an insurance company, take responsibility for arranging for, and providing, needed services as well as paying for them (such as health maintenance organizations, prepaid group practices and medical foundations).

prescription drug (Rx) A drug available to the public only upon prescription written by a physician, dentist or other practitioner licensed to do so.

prevailing charge One of the factors determining a physician's payment for a service under Medicare, set at a percentile of customary charges of all physicians in the locality.

prevalence The number of cases of disease, infected persons or persons with some other attribute, present at a particular time and in relation to the size of the population from which it is drawn. It can be a measurement of morbidity at a moment in time, e.g., the

number of cases of hemophilia in the country as of the first of the year.

preventive medicine Care that has the aim of preventing disease or its consequences. It includes health care programs aimed at warding off illnesses (e.g., immunizations), early detection of diseases (e.g., Pap smears), and inhibiting further deterioration of the body (e.g., exercise of prophylactic surgery). Preventive medicine developed following discovery of bacterial disease and was concerned in its early history with specific medical control measures taken against the agents of infectious diseases. Preventive medicine is also concerned with general preventive measures aimed at improving the healthfulness of the environment. In particular, the promotion of health through altering behavior, especially using health education, is gaining prominence as a component of preventive care.

primary care Basic or general health care focused on the point at which a patient ideally first seeks assistance from the medical care system. Primary care is considered comprehensive when the primary provider takes responsibility for the overall coordination of the care of the patient's health problems, be they biological, behavioral or social. The appropriate use of consultants and community resources is an important part of effective primary care. Such care is generally provided by physicians but is increasingly provided by other personnel such as nurse practitioners or physician assistants.

primary care case management (PCCM) The use of a primary care physician to manage the use of medical or surgical care. PCCM programs usually pay for all care on a fee-for-service basis.

primary care physician A generalist physician who provides comprehensive services, as opposed to a specialist.

Typically includes internists, family practitioners, and pediatricians.

primary care provider (PCP) The provider that serves as the initial interface between the member and the health care system. The PCP is usually a physician, selected by the member upon enrollment, who is trained in one of the primary care specialties who treats and is responsible for coordinating the treatment of members assigned to his/her plan.

prior authorization A cost-control procedure which an insurer requires a service or medication to be approved in advance for coverage.

prospective payment Any method of paying hospitals or other health programs in which amounts or rates of payment are established in advance for a defined period (usually a year). Institutions are paid these amounts regardless of the costs they actually incur. These systems of payment are designed to introduce a degree of constraint on charge or costs increases by setting limits on amounts paid during a future period. In some cases, such systems provide incentives for improved efficiency by sharing savings with institutions that perform at lower than anticipated costs. Prospective payment contrasts with the method of payment originally used under Medicare and Medicaid (as well as other insurance programs) where institutions were reimbursed for actual expenses incurred.

Prospective Payment Assessment Commission (ProPAC) In 1983, the Congress created the Prospective Payment Assessment Commission to advise the secretary of the Department of Health and Human Services on Medicare's *diagnosis related group- (DRG)* based prospective payment system. The director of the Office of Technology Assessment appoints its members. The commission's main responsibilities include recommending an appropriate annual percentage change in

DRG payments; recommended needed changes in the DRG classification system and individual DRG weights; collecting and evaluating data on medical practices, patterns and technology; and reporting on its activities.

prospective payment system (PPS) The payment system for home care, which began October 1, 2000, replaced the Interim Payment System (IPS). Under PPS, agencies are paid a single payment per person, per 60-day episode.

protected health information Individually identifiable health information that has been received or created by a HIPAA covered entity.

provider Hospital or licensed health care professional or group of hospitals or health care professionals that provide health care services to patients. May also refer to medical supply firms and vendors of durable medical equipment.

provider service organization (PSO) See Provider Sponsored Network (PSN) and Physician-Hospital Organization (PHO).

provider sponsored network (PSN) Formal affiliations of providers, organized and operated to provide an integrated network of health care providers with which third parties, such as insurance companies, HMOs or other health plans, may contract for health care services to covered individuals. Some models of integration include Physician Hospital Organizations (PHO) and Management Service Organizations (MSO).

public health The science of dealing with the protection and improvement of community health by organized community effort. Public health activities are generally those that are less amenable to being undertaken by individuals or which are less effective when undertaken on an individual basis and do not typically include direct

personal health services. Public health activities include: immunizations; sanitation; preventive medicine, quarantine and other disease control activities; occupational health and safety programs; assurance of the healthfulness of air, water and food; health education; epidemiology and others.

purchasing organization See health insurance purchasing cooperative (HIPC).

Q

Qualified Medicare Beneficiaries (QMB) Individuals eligible for Medicare Part A with incomes at or below the federal poverty level who do not have resources exceeding twice the level allowed under SSI (Supplemental Security Income). State Medicaid agencies are required to pay the cost of Medicare Part A and Part B premiums, deductibles, and co-insurance for Qualified Medicare Beneficiaries.

quality assurance (QA) A formal methodology and set of activities designed to access the quality of services provided. Quality assurance includes formal review of care, problem identification, corrective actions to remedy any deficiencies and evaluation of actions taken.

quality assurance plan A formal set of managed care plan activities used to review and affect the quality of services provided. Quality assurance includes quality assessment and corrective actions to remedy any deficiencies identified in the quality of direct patient, administrative, and support services.

Quality Assurance Reform Initiative (QARI) A process developed by the Health Care Financing Administration to develop a health care quality improvement system for Medicaid managed care plans.

quality of care Can be defined as a measure of the degree to which delivered health services meet established professional

standards and judgments of value to the consumer. Quality may also be seen as the degree to which actions taken or not taken maximize the probability of beneficial health outcomes and minimize risk and other untoward outcomes, given the existing state of medical science and art. Quality is frequently described as having three dimensions: quality of input resources (certification and/or training of providers); quality of the process of services delivery (the use of appropriate procedures for a given condition); and quality of outcome of service use (actual improvement in condition or reduction of harmful effects).

quality improvement (QI) Includes the functions listed under quality assurance, plus direct system enhancements on an ongoing basis.

R

random audit The first level of audit of a home care agency by Medicare. If Medicare finds more than 10 percent “errors,” a more intensive focused audit is likely to follow.

rate band The allowable variation in insurance premiums as defined in state regulations. Acceptable variation may be expressed as a ratio from highest to lowest (e.g., 3:1) or as a percent from the community rate (e.g., +/- 20%). Usually based on risk factors such as age, gender, occupation or residence.

rate review Review by a government or private agency of a hospital’s budget and financial data, performed for the purpose of determining the reasonableness of the hospital rates and evaluating proposed rate increases.

referral The process of sending a patient from one practitioner to another for health care services. Health plans may require that designated primary care providers authorize a referral for coverage of specialty services.

rehabilitation The combined and coordinated use of behavioral, medical, social, educational and vocational measures for training or retraining individuals disabled by disease, trauma or injury to the highest possible level of functional ability. Several different types of rehabilitation are distinguished: vocational, social, psychological, medical and educational.

reimbursement The process by which health care providers receive payment for their services. Because of the nature of the health care environment, providers are often reimbursed by third parties who insure and represent patients.

reinsurance The resale of insurance products to a secondary market thereby spreading the costs associated with underwriting.

report card A report presented on quality of health services designed to inform patients and health care purchasers of practitioner and organizational performance.

resource-based relative value scale (RBRVS) Established as part of the Omnibus Reconciliation Act of 1989, Medicare payment rules for physician services was altered by establishing an RBRVS fee schedule. This payment methodology has three components: a relative value for each procedure, a geographic adjustment factor and a dollar conversion factor.

respite care Patient care provided intermittently in the home or institution in order to provide temporary relief to the family home caregiver.

retrospective reimbursement Payment made after-the-fact for services rendered on the basis of costs incurred by the facility. See also prospective payment.

riders Optional coverage for benefits not covered in a base policy, purchased for an

additional premium. Riders may contain co-payments or deductibles that differ from the base policy. Some of the more common riders cover prescription drugs and durable medical equipment.

risk Responsibility for paying for or otherwise providing a level of health care services based on an unpredictable need for these services.

risk adjustment A process by which premium dollars are shifted from a plan with relatively healthy enrollees to another with sicker members. It is intended to minimize any financial incentives health plans may have to select healthier than average enrollees. In this process, health plans that attract higher risk providers and members would be compensated for any differences in the proportion of their members that require high levels of care compared to other plans.

risk assessment The statistical method by which plans and policymakers estimate the anticipated claims cost of enrollees. This estimation attempts to identify and measure the presence of direct causes and risk factors which, based on scientific evidence or theory, are through to directly influence the level of a specific health problem.

risk-bearing entity An organization that assumes financial responsibility for the provision of a defined set of benefits by accepting prepayment for some or all of the cost of care. A risk-bearing entity may be an insurer, a health plan or self-funded employer; or a PHO (Provider Health Organization) or other form of PSN (Provider Sponsored Network).

risk contract A contract payment methodology that requires the delivery of specified covered services to consumers as medically necessary in return for a fixed monthly payment rate from the private or public sector client. The MCO (Managed Care Organization) is then liable for those

contractually offered services without regard to cost.

risk pool A defined account to which revenues and expenses are posted. A risk pool attempts to define expected claim liabilities and required funding to support such claims.

risk pooling The process of combining risk for all groups into one risk pool.

risk-selection Any situation in which health plans differ in the health risk associated with their enrollees because of enrollment choices made by the plans or enrollees. The problem of risk-selection is especially troublesome in the Medicare HMO context. Currently, evidence suggests that Medicare HMOs enroll healthier Medicare beneficiaries, resulting in excess federal payments to this population. Without better risk-adjustment payments, Medicare HMOs will have incentives to either enroll healthier beneficiaries or to deny services to high-cost enrollees.

risk sharing The distribution of financial risk among parties furnishing a service. For example, if a hospital and a group of physicians from a corporation provide health care at a fixed price, a risk-sharing arrangement would entail both the hospital and the group being held liable if expenses exceed revenues.

Rule 10 Quality assurance and consumer protections for Vermont managed care plans established by the State of Vermont Department of Banking, Insurance, Securities and Health Care Administration (BISHCA).

rural health network Refers to any of a variety of organizational arrangements to link rural health care providers in a common purpose.

rural health clinic (RHC) a clinic located in a non-urbanized, medically underserved

area. An RHC must also: Employ a midlevel practitioner 50 percent of the time the clinic is open; Provide routine diagnostic and laboratory services; Establish arrangements with providers and suppliers to furnish medically necessary services not available at the clinic; and Provide first response emergency care.

S

screening The use of quick procedures to differentiate apparently well persons who have a disease or a high risk of disease from those who probably do not have the disease. It is used to identify high-risk individuals for more definitive study or follow-up. Multiple screening (or multiphasic screening) is the combination of a battery of screening tests for various diseases performed by technicians under medical direction and applied to large groups of apparently well persons.

secondary opinions/second opinion In cases involving non-emergency or elective surgical procedures, the practice of seeking judgment of another physician in order to eliminate unnecessary surgery and contain the cost of medical care.

secondary care Services provided by medical specialists who generally do not have first contact with patients (e.g., cardiologist, urologists, dermatologists). In the U.S., however, there has been a trend toward self-referral by patients for these services, rather than referral by primary care providers. This is quite different from the practice in England, for example, where all patients must first seek care from primary care providers and are then referred to secondary and/or tertiary providers, as needed.

secondary prevention Early diagnosis, treatment and follow-up. Secondary prevention activities start with the assumption that illness is already present

and that primary prevention was not successful and the goal is to diminish the impact of disease or illness through early detection, diagnosis and treatment. For example, blood pressure screening, treatment and follow-up programs.

Section 1931 The category of Medicaid that covers low-income families. Established in 1996 as part of the federal welfare reform law, Section 1931 provides Medicaid eligibility for families that, in the past, have been eligible for Medicaid as a result of their eligibility for the Aid to Families with Dependent Children (AFDC) program and for other families that meet income and resource limits established by states. Section 1931 also allows states to define income and resources in ways that, in effect, increase Medicaid eligibility levels for families.

service area The geographic area serviced by a health plan hospital or other provider organization, as approved by state regulatory agencies and/or detailed in a certificate of authority.

Section 1115 Medicaid Waiver Section 1115 of the Social Security Act grants the secretary of Health and Human Services broad authority to waive certain laws relating to Medicaid for the purpose of conducting pilot, experimental or demonstration projects that are “likely to promote the objectives” of the program. Section 1115 demonstration waivers allow states to change provisions of the Medicaid programs, including: eligibility requirements, the scope of services available, the freedom to choose to participate in a plan, the method of reimbursing providers and the statewide application of the program.

Section 1915 Medicaid Waiver Section 1915(b) waivers allow states to require Medicaid recipients to enroll in HMOs or other managed care plans in an effort to control costs. The waivers allow states to: implement a primary care case management

system; additional benefits in exchange for savings resulting from recipients' use of cost-effective providers; and limit the providers from whom beneficiaries can receive non-emergency treatment. The waivers are granted for two years, with two-year renewals. Often referred to as a "freedom-of-choice waiver."

self-funding/self-insurance An employer or group of employers sets aside funds to cover the cost of health benefits for their employees. Benefits may be administered by the employer(s) or handled through an administrative service only agreement with an insurance carrier or third-party administrator. Under self-funding, it is generally possible to purchase stop-loss insurance that covers expenditures above a certain aggregate claim level and/or covers catastrophic illness or injury when individual claims reach a certain dollar threshold.

service period Period of employment that may be required before an employee is eligible to participate in an employer-sponsored health plan, most commonly one to three months.

severity of illness A risk prediction system to correlate the "seriousness" of a disease in a particular patient with the statistically "expected" outcome (e.g., mortality, morbidity, efficiency of care). Most effectively, severity is measured at or soon after admission, before therapy is initiated, giving a measure of pretreatment risk.

shadow pricing Within a given employer group, pricing of premiums by HMO(s) based upon the cost of indemnity insurance coverage, rather than strict adherence to community rating or experience rating criteria.

shared services The coordinated, or otherwise explicitly agreed upon, sharing of responsibility for provision of medical or nonmedical services on the part of two or

more otherwise independent hospitals or other health programs. The sharing of medical services might include an agreement that one hospital provide all pediatric care needed in a community and no obstetrical services while another provide obstetrics and no pediatrics. Examples of shared nonmedical services would include joint laundry or dietary services for two or more nursing homes.

skilled nursing facility (SNF) A nursing care facility participating in the Medicaid and Medicare programs that meets specified requirements for services, staffing and safety.

small-group market The insurance market for products sold to groups that are smaller than a specified size, typically employer groups. The size of groups included usually depends on state insurance laws and thus varies from state to state, with 50 employees the most common size.

Social Security Disability Insurance (SSDI) The portion of Social Security that pays monthly benefits to disabled workers under the age of 65 and their dependents. To be eligible for SSDI, individuals must have contributed a minimum of 40 quarters into the Security System. SSDI recipients (but not their dependents) automatically become eligible for Medicare after a two-year waiting period.

sole community hospital (SCH) A hospital that (1) is more than 50 miles from any similar hospital, (2) is 25-to-50 miles from a similar hospital and isolated from it at least one month a year as by snow, or is the exclusive provider of services to at least 75 percent of its service area populations, (3) is 15-to-25 miles from any similar hospital and is isolated from it at least one month a year, or (4) has been designed as an SCH under previous rules. The Medicare DRG (Diagnosis Related Groups) program makes special optional payment provisions for SCHs, most of which are rural, including

providing that their rates are permanently so that 75 percent of their payment is hospital specific and only 25 percent is based on regional DRG rates.

solo practice Lawful practice of a health occupation as a self-employed individual. Solo practice is by definition private practice but is not necessarily general practice or fee-for-service practice (solo practitioners may be paid by capitation, although fee-for-service is more common). Solo practice is common among physicians, dentists, podiatrists, optometrists and pharmacists.

specialist A physician, dentist or other health professional who is specially trained in a certain branch of medicine or dentistry related to specific services or procedures (e.g., surgery, radiology, pathology); certain age categories of patients (e.g., geriatrics); certain body systems (e.g., dermatology, orthopedics, cardiology); or certain types of diseases (e.g., allergy, periodontics). Specialists usually have advanced education and training related to their specialties.

spend down The amount of expenditures for health care services, relative to income, that qualifies an individual for Medicaid in states that cover categorically eligible, medically indigent individuals. Eligibility is determined on a case-by-case basis.

Staff—Model HMO An HMO in which physicians practice solely as employees of the HMO and usually are paid a salary. (See “Group Model HMO” and “Health Maintenance Organization.”)

State Children’s Health Insurance Program (SCHIP) The federal block grant program established in 1997 through Title XXI of the Social Security Act. SCHIP provides funds to states to establish a health insurance program for targeted low-income children in families with income below 200 percent of the federal poverty level (FPL). States can: (1) expand Medicaid to cover children at higher incomes, (2) create a new

health insurance program for children, or (3) do both. The program is financed with federal and state funds, with the federal government paying a greater share than it pays for the state’s regular Medicaid program. Each state has a different SCHIP program.

stop-loss insurance A form of health insurance for a health plan or self-funded employer that provides protection from medical expense claims over a certain limit each year.

student rider A rider that extends coverage for children beyond the usual age limit if the children are enrolled as full-time students. The rider will include the new age limit for coverage of the students.

subscriber The person responsible for payment of premiums or whose employment is the basis for eligibility for membership in a health plan.

substance abuse A maladaptive pattern of frequent and continued usage of a substance—a drug or medicine—that results in significant problems, such as failing to meet major obligations and having multiple legal, social, family, health, work or interpersonal difficulties.

Substance Abuse and Mental Health Services Administration (SAMHSA) The mission of SAMHSA is to provide through the U.S. Public Health Service, a national focus for the federal effort to promote effective strategies for the prevention and treatment of addictive and mental disorders. SAMHSA is primarily a grant making organization, promoting knowledge and scientific state-of-the-art practice. SAMHSA strives to reduce barriers to high quality, effective programs and services for individuals who suffer from, or are at risk for, these disorders, as well as for their families and communities.

Supplemental Security Income (SSI) A federal cash assistance program for low-income aged, blind and disabled individuals established by Title XVI of the Social Security Act. States may use SSI income limits to establish Medicaid eligibility.

T

Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) The Federal law that created the current risk and cost contract provisions under which health plans contract with CMS.

technology assessment A comprehensive form of policy research that examines the technical, economic and social consequences of technological applications. It is especially concerned with unintended, indirect, or delayed social impacts. In health policy, the term has come to mean any form of policy analysis concerned with medical technology, especially the evaluation of efficacy and safety.

telemedicine The use of telecommunications (i.e., wire, radio, optical or electromagnetic channels transmitting voice, data and video) to facilitate medical diagnosis, patient care, and/or distance learning.

tertiary care Services provided by highly specialized providers (e.g., neurologists, neurosurgeons, thoracic surgeons, intensive care units). Such services frequently require highly sophisticated equipment and support facilities. The development of those services has largely been a function of diagnostic and therapeutic advances attained through basic and clinical biomedical research.

tertiary prevention Prevention activities that focus on the individual after a disease or illness has manifested itself. The goal is to reduce long-term effects and help individuals better cope with symptoms.

therapeutic substitution Replacement of one drug with another drug from the same

therapeutic class that the Food and Drug Administration (FDA) has determined to be “bioequivalent” (same active ingredient with the same absorption rate). This includes substitution of a brand name for a brand name or substitution of a generic drug for a brand name. Generally, this results in prescribing the less costly compound.

third-party payer Any organization, public or private that pays or insures health or medical expenses on behalf of beneficiaries or recipients. An individual pays a premium for such coverage in all private and in some public programs; the payer organization then pays bills on the individual’s behalf. Such payments are called third-party payments and are distinguished by the separation among the individual receiving the service (the first party), the individual or institution providing it (the second party) and the organization paying for it (third party).

third-party administrator (TPA) A fiscal intermediary, a person or an organization that serves as another’s financial agent. A TPA processes claims, provides services and issues payments on behalf of certain private, federal and state health benefit programs or other insurance organization.

tiered formulary Use of multiple co-payment rates for formulary drugs, designed to encourage use of the least expensive alternative. Typically, tiered formularies have either two or three co-payment tiers. A three-tiered formulary generally features a generic co-payment, preferred brand co-payment, and non-preferred brand or off-formulary co-payment.

Title XVIII (Medicare) The title of the Social Security Act that contains the principal legislative authority for the Medicare program and therefore a common name for the program.

Title XIX (Medicaid) The title of the Social Security Act that contains the principal legislative authority for the Medicaid

program and therefore a common name for the program.

U

uncompensated care Service provided by physicians and hospitals for which no payment is received from the patient or from third party payers. Some costs for these services may be covered through cost shifting. Not all uncompensated care results from charity care. It also includes bad debts from persons who are not classified as charity cases but who are unable or unwilling to pay their bill.

underinsured People with public or private insurance policies that do not cover all necessary health care services, resulting in out-of-pocket expenses that exceed their ability to pay.

uninsured People who lack public or private health insurance.

usual, customary and reasonable (UCR) fees The use of fee screens to determine the lowest value of physician reimbursement based on: (1) the physician's usual charge for a given procedure, (2) the amount customarily charged for the service by other physicians in the area (often defined as a specific percentile of all charges in the community), and (3) the reasonable cost of services for a given patient after medical review of the case.

utilization Use; commonly examined in terms of patterns or rates of use of a single service or type of service, e.g., hospital care, physician visits, prescription drugs. Use is also expressed in rates per unit of population at risk for a given period.

utilization management the process of evaluating the medical necessity, appropriateness and efficiency of health care services against established guidelines and criteria.

utilization review (UR) Evaluation of the necessity, appropriateness and efficiency of the use of health care services, procedures and facilities. In a hospital, this includes review of the appropriateness of admissions, services ordered and provided, length of stay and discharge practices, both on a concurrent and retrospective basis. Utilization review can be done by a peer review group or a public agency.

V

vertical integration Organization of production whereby one business entity controls or owns all states of the production and distribution of goods or services.

VIPER A Vermont law that requires continuation of coverage for people who leave employer groups with 20 or less employees. This law requires employers to offer those employees the option to continue their group health care coverage for up to six months.

vital statistics Statistics relating to births (natality), deaths (mortality), marriages, health and disease (morbidity). Vital statistics for the United States are published by the National Center for Health Statistics.

W

waiting period A set period of time that an employer may make a new employee wait before enrolling in the company's health care plan. The health insurance policy cannot impose a waiting period, but the employer may.

wellness A dynamic state of physical, mental and social well-being; a way of life which equips the individual to realize the full potential of his/her capabilities and to overcome and compensate for weaknesses; a lifestyle that recognizes the importance of nutrition, physical fitness, stress reduction and self-responsibility. Wellness has been

viewed as the result of four key factors over which an individual has varying degrees of control: human biology, environment, health care organization (system) and lifestyle.

wholesale acquisition price The factory charge, before discounts to wholesalers.

wrap around coverage A continuum of benefits designed around an individual enrollee's treatment needs.