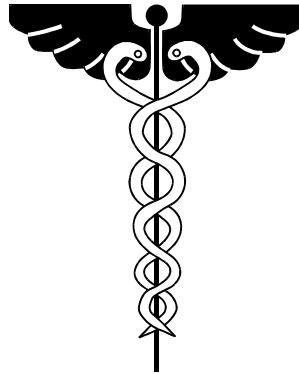


Delaware Healthcare Association Glossary of Health Care Terms and Acronyms



As the health care environment continues to change, the terms associated with health care change also. New laws, as well as new practices require that we continually evaluate the expressions that we use. The [Delaware Healthcare Association](#) has compiled this Glossary of Health Care Terms and Acronyms to provide you with a brief, easy-to-find and easy-to-understand list of health care and legislative terms that can help those in health care as well as the community at large better comprehend the evolving health care delivery system.

The glossary is organized alphabetically with an emphasis on those terms that impact Delaware Healthcare Association members the most. Terms and organizations that are often referred to by acronyms are listed by full name, followed by the acronym. A separate listing of acronyms follows the alphabetical listing of health care terms.

If you would like to recommend additions to the Delaware Healthcare Association's Glossary, send them for consideration to suzanne@deha.org.

DISCLAIMER

The definitions listed here are intended for a general understanding of a health care term. These definitions should not be considered as the complete definition, since many are written in the simplest form to give a general understanding of the term listed.

To look up a health care term such as Actuary, choose the letter that the term begins with below under Alphabetical Glossary. This will take you to the terms beginning with that letter. To look up a health care acronym such as AIDS, choose the letter that the term begins with below under Acronyms. This will take you to all acronyms that begin with that letter.

Alphabetical Listing

[A](#) [B](#) [C](#) [D](#) [E](#) [F](#) [G](#) [H](#) [I](#) [J](#) [K](#) [L](#) [M](#) [N](#) [O](#) [P](#) [Q](#) [R](#) [S](#) [T](#) [U](#) [V](#) [W](#) [X](#) [Y](#) [Z](#)

Acronyms

[A](#) [B](#) [C](#) [D](#) [E](#) [F](#) [G](#) [H](#) [I](#) [J](#) [K](#) [L](#) [M](#) [N](#) [O](#) [P](#) [Q](#) [R](#) [S](#) [T](#) [U](#) [V](#) [W](#) [X](#) [Y](#) [Z](#)

24-Hour Coverage

In general, 24-hour coverage has been proposed as a type of health care system reform that integrates the health coverage and benefits currently offered by public and private insurance programs, state workers' compensation systems, and automobile insurance.

Access

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

Accountable Health Plans (AHP)

Under the Managed Care Act, providers and insurance companies would be encouraged (through tax incentives) to form AHPs, similar to [HMOs](#), [PPOs](#), and other group practices. Accountable health plans would compete on the basis of offering high-quality, low-cost care and would offer insurance and health care as a single product. They would be responsible for looking after the total health of members and reporting medical outcomes in accordance with Federal guidelines.

Accreditation

Approval by an authorizing agency for institutions and programs that meet or exceed a set of pre-determined standards.

Accredited

To meet the standards set by a non-governmental, state or national peer group.

Accrete

The addition of new enrollee to a health plan, usually used in reference to [Medicare](#).

Activities of Daily Living (ADLs)

Activities performed as part of a person's daily routine of self-care such as bathing, dressing, toileting and eating.

Actual Charge	The amount a physician or other provider actually bills a patient for a particular medical service, procedure or supply in a specific instance. The actual charge may differ from the usual, customary, prevailing, and/or reasonable charge.
Actuarial Analysis	The statistical calculations used to determine the managed care company's rates and premiums charged their customers based on projections of utilization and cost for a defined population.
Actuarial Cost of Coverage	The expected dollar value of a health plan's benefits. The method of determining this value may be based entirely on a plan's provisions, or may adjust for the geographic location and demographic characteristics of enrollees, the actual health care utilization level by plan participants, or the type of plan under which the benefits are provided.
Actuarial Soundness	The requirement that the development of capitation rates meet common actuarial principles and rules.
Actuary	A person in the insurance field who decides policy rates and conducts various other statistical studies.
Acute Care	Hospital care given to patients who generally require a stay of up to seven days and that focuses on a physical or mental condition requiring immediate intervention and constant medical attention, equipment and personnel.
Acute Care Bed Need Methodology	A formula used to determine hospital bed needs.
Additional Drug Benefit List	See drug maintenance list.
Adjusted Average Per Capita Cost (AAPCC)	A county-level estimate of the average cost incurred by Medicare for each beneficiary in the fee-for-service system.
Adjusted Community Rating	Community rating impacted by group specific demographics.
Adjusted Payment Rate (APR)	The Medicare capitated payment to risk-contract HMOs . For a given plan, the APR is determined by adjusted county-level AAPCCs to reflect the relative risks of the plan's enrollees.

Administration on Aging (AoA)

The AoA is the principal Federal agency responsible for programs authorized under the Older Americans Act of 1965. The AoA serves as an advocate for older persons at the national level, advises Congress and Federal agencies on the characteristics and needs of older people, and develops programs designed to promote the health and well-being of the older population. AoA provides advice, funding, and assistance to achieve community-based systems of comprehensive social services for older people.

Administrative Costs

Costs related to activities such as utilization review, marketing, medical underwriting, commissions, premium collection, claims processing, insurer profit, quality assurance, and risk management for purposes of insurance.

Administrative Costs Savings

Reductions in expenditures related to changes in the administrative costs associated with the provision of health care coverage and services.

Administrative Loading

The amount added to the prospective actuarial cost of the health care services (pure premium) for administrative, marketing expenses and profit.

Administrative Reform

Reducing paperwork through simplified universal forms or electronic filing and processing of claims.

Administrative Services Only

An agency that delivers administrative services to an employer group. This type of arrangement usually requires the employer to be at risk for the cost of health care services provided.

Administrative Services Organization (ASO)

An entity which only provides administrative services (including claims adjudication, member services, and management information reporting).

Admissions/1000 (APT)

The number of hospital admissions per 1,000 health plan members during a given period.

Adult Day Care

A program of social and health-related services provided during the day in a community group setting. The purpose of the program is to support frail or impaired elderly, or other disabled adults who can benefit from care in a group setting outside the home.

Adult Foster Care (AFC)	An elderly person's placement with another family when independent living is no longer possible, but nursing care is not necessary. Also see family rest residential .
Adult Protective Services (APS)	Social service interventions for impaired adults at risk of abuse, neglect or exploitation.
Advance Directive	A document that patients complete to direct their medical care when they are unable to communicate their own wishes due to a medical condition.
Advanced Medical Directive	See advance directive .
Advanced Nurse Care Practitioner (ANCP)	See Advanced Practice Nurse .
Advanced Practice Nurse (APN)	A registered nurse who is approved by the Board of Nursing to practice nursing in a specified area of advanced nursing practice. APN is an umbrella term given to a registered nurse who has met advanced educational and clinical practice requirements beyond the two to four years of basic nursing education required for all RNs. There are four types: 1. Certified Registered Nurse Anesthetist (CRNA); 2. Clinical Nurse Specialist (CNS); 3. Certified Nurse Practitioner (CNP); and 4. Certified Nurse Midwife (CNM).
Adverse Selection	Among applicants for a given group or individual health insurance program, the tendency for those with an impaired health status, or who are prone to higher-than-average utilization of benefits, to be enrolled in disproportionate numbers in lower deductible plans.
Aftercare	Services following hospitalization or rehabilitation individualized for each patient's needs. Aftercare gradually phases the patient out of treatment while providing follow-up attention to prevent relapse.
Age/Sex Factor	A measurement used in insurance underwriting. It represents the age and sex risk of medical costs of one population relative to another. For example, a group with an age/sex factor of 1.05 would be expected to incur medical costs 5% greater than the average.
Age/Sex Rates (ASR)	Set of rates for a grouping based on age and sex

categories used to calculate premiums. This type of premium structure is often preferred over single and family rating in small groups because it automatically adjusts to demographic changes in the group. Also called table rates.

Agency for Health Care Policy and Research (AHCPR)

A Federal agency within the Public Health Service responsible for research on quality, appropriateness, effectiveness and cost of health care.

Aging in Place

Process allowing seniors to remain in their current residence despite changes in their needs by adjusting the degree and type of services provided. This can occur at home or in a facility offering multiple levels of care.

Aging Network

A highly complex and differentiated system of Federal, State, and local agencies, organizations and institutions which are responsible for serving and/or representing the needs of older persons. The network is involved in service systems development, advocacy, planning, research, coordination, policy development, training and education, administration, and direct service provision. The core structures in the network include the Administration on Aging (AoA), State Units on Aging (SUA), Area Agencies on Aging (AAA), and local service provider agencies.

Aid to Families with Dependant Children (AFDC)

A Federally supported, state-administered program established by the [Social Security Act](#) of 1935 that provides financial support for children under the age of 18 (and their caretakers) who have been deprived of parental support or care because of the parent's death, continued absence from the home, unemployment, or physical or mental illness.

Alien Insurance Company

An insurance company that operates under the laws of another country.

All Patient Diagnosis Related Groups (APDRG)

An enhancement of the original [Diagnostic 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.

All-Payer System	A plan to impose uniform prices on medical services, regardless of who's paying.
Allied Health	General term referring to a variety of non-physician and non-nursing clinicians, practitioners, therapists, technologists and technicians working in the health field.
Allied Health Personnel or Allied Health Professional	Specially trained and often licensed health workers other than physicians, dentists, optometrists, chiropractors, podiatrists, and nurses. The term is sometimes used synonymously with paramedical personal, all health workers who perform tasks that must otherwise be performed by a physician, or health workers who do not usually engage in independent practice.
Allopathic	One of two schools of medicine that treats disease by inducing effects opposite to those produced by the disease. The other school of medicine is osteopathic.
Allowable Costs	Charges for services rendered or supplies furnished by a health care provider, which qualify as covered expenses for insurance purposes.
Allowable Charge	Generic term referring to the maximum fee that a third party will use in determining reimbursement for a given service or supply. An allowable charge may not always be the same as the actual charge.
Alternative Delivery and Financing Systems (ADFS)	See alternative delivery system .
Alternative Delivery Sites	Substitute for traditional inpatient sites for care such as ambulatory care centers, surgicenters, home care, hospice care, or alternative delivery and financing systems such as health maintenance organizations (HMOs), or preferred provider arrangements.
Alternative Delivery System (ADS)	An alternative to traditional inpatient care such as ambulatory care, home health care and same day surgery. Also used as an expression to describe all forms of health care delivery systems other than traditional fee-for-service indemnity health care.

Alternative Levels of Care	Alternatives to traditional acute inpatient care, such as ambulatory care centers, surgicenters, home care, skilled nursing facilities, and hospices.
Am.	Amended. A designation sometimes found before a House or Senate bill number showing that formal changes have been made to an introduced piece of legislation during the legislative process.
Ambulance Restocking	The practice of hospital replenishing certain drugs and supplies used by an ambulance service during transport of a patient to the hospital.
Ambulatory	Able to get from one place to another independently (even if using assistive devices such as manual wheelchairs, canes or walkers).
Ambulatory Care	Care given to patients who do not require overnight hospitalization.
Ambulatory Patient Group (APGS)	A payment system that pays a fixed price for certain types of outpatient procedures.
Ambulatory Setting	An institutional health setting in which organized health services are provided on an outpatient basis, such as surgery center, clinic or other outpatient facility. Ambulatory care settings also may be mobile units of services, e.g., mobile mammography, MRI.
Ambulatory Surgical Center (ASC)	Freestanding centers that perform surgeries which do not require an overnight stay.
Ambulatory Utilization Management	Review prior to service against established standards to determine the medical necessity and appropriateness of the care to be provided in an ambulatory setting. The selection of treatment plans subject to pre-service review may be based upon criteria such as proposed care that would require frequent visits, expensive therapy, an extended course of therapy, or costly technology. Concurrent review would be applied as appropriate.
Amendments	See rider .
American Accreditation Healthcare Commission (AAHC)/URAC	Formerly known as the Utilization Review Accreditation Commission, AAHC/URAC is an

independent not-for-profit corporation which develops national standards for utilization review and managed care organizations.

American Association of Homes and Services for the Aging (AAHSA)

AAHSA represents not-for-profit organizations dedicated to providing high quality health care, housing and services to the nation's elderly. Its membership consists of over 5,000 not-for-profit nursing homes, continuing care retirement communities, senior housing facilities, assisted living and community services. AAHSA organizations serve more than one million older persons of all income levels, creed and races. It serves these members by representing the concerns of not-for-profit organizations that serve the elderly through interaction with Congress and Federal agencies. It also strives to enhance the professionalism of practitioners and facilities through the Certification Program for Retirement Housing professionals, the Continuing Care Accreditation Commission, conferences and programs offered by the AAHSA Professional Development Institute and publications representing current thinking in the long-term care and retirement housing fields.

American College of Healthcare Executives (ACHE)

An international professional society of nearly 30,000 healthcare executives. ACHE is known for its prestigious credentialing and educational programs. ACHE is also known for its journal and magazines as well as groundbreaking research and career development and public policy programs. ACHE's publishing division is a major publisher of books and journals on all aspects of health services management in addition to textbooks for use in college and university courses. Through its efforts, ACHE works toward its goal of improving the health status of society by advancing healthcare management excellence. ACHE headquarters is based in Chicago, IL.

American Health Care Association (AHCA)

A trade association representing nursing homes and long term care facilities in the United States; based in Washington, D.C.

American Hospital Association (AHA)

A national association that represents allopathic and osteopathic hospitals in the United States; based in Washington, D.C. with operational offices

in Chicago.

American Medical Association (AMA)

A national association organized into local and regional societies that represent over 700,000 medical doctors in the United States; based in Chicago.

American with Disabilities Act (ADA)

A Federal law which prohibits employers of more than 25 employees from discriminating against any individual with a disability who can perform the essential functions, with or without accommodations, of the job that the individual holds or wants.

Amount, Duration and Scope

How a [Medicaid](#) benefit is defined and limited in a state's Medicaid plan. Each state defines these parameters, thus state [Medicaid](#) plans vary in what is actually covered.

Ancillary Care

A term used to describe additional services performed related to care, such as lab work, X-ray and anesthesia.

Ancillary Charge

Also referred to as hospital "extras" or miscellaneous hospital charges. They are supplementary to a hospital's daily room and board charge. They include such items as charges for drugs, medicines and dressings; laboratory services; x-ray examinations; and use of the operating room.

Anti-Kickback Statute

A Federal law that prohibits the paying or receiving of remuneration in exchange for the referral of patients or businesses paid by a Federal health care program.

Antitrust

A situation in which a single entity, such as integrated delivery system, controls enough of the practices in any one specialty in a relevant market to have monopoly power (i.e., the power to increase prices).

Any Willing Provider

A term used to describe legislation that requires a health plan to accept on its provider panels every physician, hospital or other practitioner that wants to participate in the health plan's products.

Approved Charge

The maximum fee [Medicare](#) will pay in a given

	area for a covered service.
Approved Health Care Facility or Program	Facility or Program that is licensed, certified or otherwise authorized pursuant to the laws of the state to provide health care and which is approved by a health plan to provide the care described in a contract.
Area Agency on Aging (AAA)	A public or private nonprofit organization designated by the state to develop and administer the area plan on aging within a sub-state geographic planning and service area. AAAs advocate on behalf of older people within the area and develop community-based plans for services to meet their needs. AAAs administer Federal, State, local and private funds through contracts with local service providers. In Delaware the State Unit on Aging also services as the state's sole Area Agency on Aging.
Asset	Medicaid term referring to resources such as savings, stocks, bonds, and certain possessions that are considered in determining financial eligibility.
Assignment of Benefits	A method under which a claimant requests that his/her benefits under a claim be paid to some designated person or institution, usually a physician or hospital.
Assisted Living Facility (ALF)	Home-like residential option that provides personal care and scheduled nursing care as needed.
Assistive Devices or Technology	Any tools that are designed, fabricated, and/or adapted to assist a person in performing a particular task, e.g., cane, walker, shower chair, computer speech recognition, communication device.
Associate Degree in Nursing (AND)	A degree received after completing a two-year nursing education program at a college or university.
At-Risk	Having to assume the financial liability for a loss that occurs when premiums paid are less than the cost of services provided.
Attendant	Term used most often by the disability community to refer to an aide who provides personal assistance in the community. Also see personal care .

Attrition Rate	Disenrollment or fall-out rate expressed as a percentage of total membership. Off-open enrollment terminations are generally due to subscriber's employment or relocation outside of the MCO's service area, and cannot be controlled. Open enrollment terminations are sometimes due to subscriber dissatisfaction and thus may be controllable.
Audiologist	Performs duties directly related to problems and disorders of human communication in the process of speech and hearing
Audit of Provider Treatment	Review of the patient's medical record and charges and claims for services to assure that the services provided were consistent with the patient's diagnosis(es) and that documentation in the medical record supports the submitted charges.
Authorization	As it applies to managed care, authorization is the approval of care, such as hospitalization. Pre-authorization may be required before a patient is admitted or care is given by (or reimbursed to) non-HMO providers.
Auto-Assignment	A term used with Medicaid mandatory managed care enrollment plans. Medicaid recipients who do not specify their choice for a contracted plan within a specified time frame are assigned to a plan by the state. Can also refer to assignment to primary care physicians.
Average Adjusted Per Capita Cost (AAPCC)	Payment rates used by the Health Care Financing Administration to reimburse managed care organizations for care delivered to Medicare enrollees.
Average Cost (or Average Benefit)	The average cost (or benefit) for a unit of output (e.g., one day in a hospital for one patient) is the total cost (or benefit) of the total units of output delivered by the total units of output.
Average Length of Stay (ALOS)	A standard hospital statistic used to determine the average amount of time between admission and discharge for patients in a diagnosis related group (DRG), an age group, a specific hospital or other factors.

Bachelor of Science in Nursing (BSN)	Degree received after completing a four-year college or university program that qualifies a graduate nurse to take a national licensing exam to become a registered nurse.
Balance Bill	The fee amount remaining after patient co-payments.
Balance Billing	A provider's billing of a covered person directly for charges above the amount reimbursed by the health plan (i.e., difference between billed charges and the amount paid). This may or may not be allowed, depending upon the contractual arrangements between the parties.
Balanced Budget Act of 1997	This law made sweeping changes in the Medicare and Medicaid programs. Several of the significant provisions of the BBA were payment reductions to health care providers, new prospective payment systems for health care providers, and reduction of coverage of health care services by the Medicare and Medicaid programs.
Base	A set dollar amount to cover the cost of health care per covered person excluding mental health/substance abuse services, pharmacy and administrative charges.
Base Capitation	A stipulated dollar amount to cover the health care per covered person less mental health/substance abuse services, pharmacy and administrative charges.
Basic Benefits Package	A core set of health benefits that everyone in the country should have either through their employer, a government program, or a risk pool.
Bed Days/1000	The number of inpatient days per 1000 health plan members for a fixed period of time.
Bed Reservation Benefit	In some long-term care policies, a benefit paid to maintain the enrollee's space in a nursing home facility when the enrollee must be hospitalized temporarily.
Behavioral Health Care	Mental services, including services for alcohol and substance abuse.

Benchmarks	Long-range measurable goals that speak to changing conditions. See also Performance Measures , Quality Assurance , Key Indicators , Outcomes .
Beneficiary	A person designated by an insuring organization as eligible to receive insurance benefits.
Benefit	Amount payable by the insurance company to a claimant, assignee, or beneficiary, when the insured suffers a loss covered by the policy.
Benefit Amount	See benefit level .
Benefit Cap	The lifetime dollar or day limitation of an insurance policy.
Benefit Design	Selection of services, providers, and beneficiary obligations to create the scope of coverage.
Benefit Level	The limit or degree of services a person is entitled to receive based on his/her contract with a health plan or insurer.
Benefit Limit	See benefit cap .
Benefit Maximum	See benefit cap .
Benefit Package	Services an insurer, government agency, health plan, or an employer offers under the terms of a contract.
Benefit Payment Schedule	List of the amounts an insurance plan will pay for covered health care services.
Benefit Period	The maximum length of time specified in an insurance product during which benefits will be paid.
Benefit Redesign	Restructuring employee health benefit plans by providing incentives for prudent consumer behavior, such as introducing coverage for treatment in alternative settings; establishing managed care provisions such as pre-admission testing, second surgical opinions and pre-admission certification; establishing alternative financial arrangements, such as creating individual health

accounts; or changing employee premium contribution, co-payment, or deductible levels.

Benefits Tax

A tax all workers would be required to pay based on the value of employer-provided health benefits which exceeds a certain level, or a limit on the tax deduction employers currently take for providing benefits.

Biased Selection

The phenomena whereby individuals or groups with atypical health risks disproportionately enroll in a specific health plan or type of health plan. Favorable selection occurs when a plan's enrollment predominantly consists of above-average health risks, while plans that disproportionately enroll individuals (and groups) of below-average health risks are said to experience adverse selection. Biased selection may be influenced by individual decisions in response to benefit design and plan characteristics as well as by insurer marketing and rating practices.

Billed Claims

The fees or costs for health care services provided to a covered person submitted by a health care provider.

Bio-Medical Engineering Technician

Inspects, repairs, maintains, calibrates and modifies electronic, electrical, mechanical and hydraulic equipment and instruments used in medical therapy and diagnosis, according to schematic and verbal instructions

Block Grant

An intergovernmental transfer of Federal funds to states and local governments for broad purposes such as health, education or community development in general. A block grant holds few requirements for how the money is to be spent, instead offering state and local discretion within general guidelines established by Congress and the executive branch. Annual program plans or applications are normally required. Also see [categorical grant](#) or [formula grant](#).

Blue Cross and Blue Shield Association (BC/BS)

An organization that offers information, consultation, representation and operational services for the Blue Cross and Blue Shield plan members across the country for purposes of providing insurance benefits.

Board and Care	Residential option providing no direct health or personal care services. Also see foster care , rest residential care , family rest residential care , and adult foster care .
Board Certified	A clinician who has passed the national examination in a particular field. Board certification is available for most physician specialties, as well as for many allied medical professions.
Board Eligible	A term used to describe a physician who is eligible to take the specialty board examination by virtue of having graduated from an approved medical school, completed a specific type and length of training and practiced for a specified amount of time.
Boren Amendment	An amendment to OBRA 80 which repealed the requirement that states follow Medicare principles in reimbursing hospitals, nursing facilities and intermediate care facilities for the mentally retarded (ICF/MR) under the Medicaid program. The amendment substituted language which required states to develop payment rates which were "reasonable and adequate" to meet the costs of "efficiently and economically operated" providers (Recently repealed under the Balanced Budget Act.
Boutique Hospital	A limited service hospital designed to provide one medical specialty such as orthopedic or cardiac care.
Bundling Payment or Bundled Payment	The use of a single payment for a group of related services.
Bundled Rate	Payments that represent an amalgamation of services.
Bundled Services	A single comprehensive group of related services. Payments for bundled services have become the norm in recent years and unbundled services are investigated closely by HCFA and other payers for evidence of fraud.
Buy-In	Refers to instances where a state Medicaid program agrees to pay the Medicare premiums and cost

Cafeteria Plan

sharing for members of a specified group. Flexible benefit plan under which the employer provides a range of taxable and nontaxable benefits options from which each eligible employee can make a limited number of selections. Options that may be available to employees through these plans include life insurance, health programs, retirement plans, vacation time, and stock options. Nontaxable benefits can include group term life insurance up to a specified amount of coverage, disability benefits, accident and health benefits, and group legal services to the extent that such benefits are excludable from gross income. A cafeteria plan that includes taxable and nontaxable benefits must meet certain requirements under the Internal Revenue Code. The term "Cafeteria Plan" may also describe a health benefit program that allows employees to select among various cost, coverage, or provider options.

California Public Employees' Retirement System (CalPERS)

A health insurance program available to California's public employees and their dependents that focuses on the maintenance of a large risk pool, the promotion of managed care strategies and a standard benefit package.

Canadian-Style System

A health care financing system based upon the system in place in Canada that provides tax-financed universal coverage with the government as the sole purchaser of services.

Capital Costs

Equipment and physical plant costs, but not consumable supplies. Included in these costs can be interest, leases, rentals, taxes and insurance on physical assets like plant and equipment.

Capitation (CAP)

The payment of a per capita amount for a defined package of health care services. A specific dollar amount per member per month is paid to providers or organizations of providers for which they provide specific services, regardless of the quantity of services necessary to meet the health needs of the defined population.

Care Coordination Benefit

A benefit in newer long-term care policies that pays consultation fees for a professional, such as a registered nurse or a medical social worker, to periodically assess and make recommendations

about the enrollee's care program. The purpose is to adjust services when and if the individual's care needs change. Also called personal care advisor or personal care advocate benefit.

Carrier

An organization acting as an insurer for private plans or government programs.

Carryover

That provision in medical plans that allows individuals who have not satisfied their deductible in a given calendar year to apply expenses incurred in the last quarter of that calendar year to the next year's deductible.

Carve Out

Accessing coverage for a specific type of service through a contract separate from that established with the primary providers.

Case Management

A system for assessing, planning treatment for, referring, and following up on patients in order to ensure the provision of comprehensive and continuous service and the coordination of payment and reimbursement for care.

Case Manager

An experienced health professional that works with patients, providers and insurers to coordinate all services deemed necessary to provide the patient with a plan of medically necessary and appropriate health care. Often used for patients with specific diagnoses or who require high-cost or extensive health care services.

Case Mix (or Case Mix Index)

A measure of relative severity of medical conditions of a hospital's patients.

Case Rate

Flat fee paid for services based on client characteristics (such as diagnosis). For this fee the provider covers all of the services the client requires for a specific period of time. Also called bundled rate, or flat fee-per-case. Very often used as an intermediate step prior to capitation. Also see [diagnostic related groups](#) or [risk adjustment](#).

Cash & Counseling

A joint Federal and Robert Wood Johnson Foundation demonstration program in which cash allowances are given to [Medicaid](#) recipients with disabilities to pay for attendants and other services.

Catastrophic Case	A catastrophic case is any medical condition where total cost of treatment (regardless of payment source) is expected to exceed an amount designated by the HMO contract with the medical group.
Catastrophic Coverage	Insurance protection for extremely high health care costs.
Catastrophic Health Insurance	Health insurance which 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. It is also used to describe those services covered by reinsurance in a capitated program.
Catchment Area	Geographical region where the majority of health care providers customers are located. Also see market area .
Categorical Grant	Federal assistance to State and local governments, institutions, agencies, organizations, and individuals to carry out specified activities in the public's interest. In contrast to "block grants" money is to be spent for a particular purpose or for the benefit of a particular class or group of individuals, such as older persons. Also see block grant or formula grant .
Categorically Related	Persons who are aged, blind, or disabled (as defined under the Supplemental Security Income program - SSI) or a member of a family with dependent children where one parent is absent, incapacitated or unemployed (as defined under the Aid to Families with Dependent Children program - AFDC). Also see categorically eligible .
Center for Health Care Strategies	Established in 1995 as a non-profit, non-partisan policy and resource center affiliated with the Woodrow Wilson School of Public and International Affairs at Princeton University. The Center serves as the National Program Office for two national initiatives of the Robert Wood Johnson Foundation : Medicaid Managed Care Program and Building Health Systems for People with Chronic Illnesses. Also see Robert Wood Johnson Foundation .

Center for Independent Living (CIL)	Federally funded non-profit agencies at the state and community level that advocate for and provide independent living services to persons with disabilities.
Centers for Disease Control (CDC)	An agency within the U.S. Department of Health and Human Services that serves as the central point for consolidation of disease control data, health promotion and public health programs. CDC is also known as the Centers for Disease Control and Prevention, and is based in Atlanta, GA.
Certificate of Authority	A certificate issued by a state government licensing the operation of an HMO .
Certificate of Public Review	Approval by the Delaware Health Resources Board of an application by a health care provider to undertake an activity subject to review under Delaware Statute. Replaced the former Certificate of Need Program.
Certification	Certification is the official authorization for use of services.
Certified Nurse Practitioner	See nurse practitioner .
Certified Nurses Aid	See nurses aid .
Charity Care	Free or reduced fee care provided based on the financial situation of patients.
Cherry Picking	The practice of seeking only healthy customers.
Children's Health Insurance Program (CHIP)	A state administered program funded partly by Federal government which allows states to expand health coverage to uninsured low income children not previously eligible for Medicaid .
Chronic Care	Care and treatment rendered to individuals whose health problems are of a long-term and continuing 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: (1) is permanent, leaves residual disability; (2) is caused by nonreversible

pathological alternation; (3) requires special training of the patient for rehabilitation, or may be expected to require a long period of supervision, observation, or care.

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

A program that provides funds to pay for the treatment in private institutions for members of the uniformed services and their families.

Claim

Information submitted by a provider or covered person to establish that medical services were provided to a covered person, from which processing for payment to the provider or covered person is made.

Claims Audit

Review of health care claims for the purpose of determining the liability of the payer, eligibility of the beneficiary and provider, and the accuracy of the amounts involved.

Claims Review

The method by which an enrollee's health care service claims are reviewed before reimbursement is made. The purpose of this monitoring is to validate the medical appropriateness of the provided service and to be sure the cost of the service is not excessive.

Clearinghouse

An agency that accepts claims from providers and resubmits them to the carrier in the carrier's desired format and to meet the carrier's data requirements.

Clinical Laboratory Improvement Act/Amendments (CLIA)

A Federal law designed to set national quality standards for laboratory testing. The law covers all laboratories that engage in testing for assessment, diagnosis, prevention or treatment purposes.

Closed Access

See [closed panel](#).

Closed Panel

Medical services delivered in the Health Insuring Corporation owned health center or satellite clinic by physicians who belong to a specially formed, but legally separate, medical group that only serves the HIC.

CMP

See competitive medical plan.

Co-Insurance

A cost-sharing requirement under a health insurance policy that provides that the insured will

assume a portion or percentage of the costs of covered services. After the deductible is paid, this provision obligates the subscriber to pay a certain percentage of any remaining medical bills, usually 20 percent.

Co-Morbidity

Presence of a second disease or condition influencing the care or treatment of a patient, and in the hospital setting is expected to increase the length of stay by at least one day for most patients.

Co-Payment

A type of cost-sharing which requires the insured or subscriber to pay a specified flat dollar amount, usually on a per-unit-of-service basis, with the third-party payer reimbursing some portion of the remaining charges.

Code of Federal Regulations

A publication of the Federal government that consists of all regulations of Federal departments and agencies.

Coding

A mechanism for identifying and defining physicians' and hospitals' services. Coding provides universal definition and recognition of diagnoses, procedures and level of care. Coders usually work in medical records departments and coding is a function of billing. Medicare fraud investigators look closely at the medical record documentation which supports codes and looks for consistency. Lack of consistency of documentation can earmark a record as "uncoded" which is considered fraud.

Cognitive Impairment

A loss of mental capacity demonstrated by a person's inability to think, perceive, reason or remember. Such impairment results in a person's inability to care for him or herself without ongoing supervision from another person and is due to a mental or nervous condition with an organic cause.

Cognitive Impairment Reinstatement Provision

A provision in some long-term care policies that allows a policy that has lapsed because the enrollee did not pay the premium to be reinstated for full benefits, if the premiums are paid within six months after the lapse. Typically, the enrollee's physician must certify that the enrollee suffered a cognitive impairment that presumably caused the individual to fail to pay the premium on time.

Commission on Accreditation of Rehabilitation Facilities (CARF)	Nationally recognized independent review organization that accredits disability service organizations.
Commission on Health Care Quality (CHCQ)	National Commission charged with improving health care quality.
Community Based Care	The blend of health and social services provided to an individual or family in their place of residence (or nearby) for the purpose of promoting, maintaining, or restoring health or minimizing the effects of illness and disability.
Community Care Networks	Systems of health care providers organized to provide access to a comprehensive range of personal health services to members of a geographic area. The "network" may act as a health insurance plan offering its services for a specified premium. In this setting, primary care physicians and mid-level professionals are usually used as the entry and referral point for services and a range of services tailored to the needs of the specific community.
Community Health Center (CHC)	An ambulatory health care program usually serving a geographic area which has scarce or nonexistent health services or a population with special health needs (sometimes known as the neighborhood health center). Community Health Centers attempt to coordinate Federal, state, and local resources into a single organization capable of delivering both health and related social services to a defined population. While such a center may not directly provide all types of health care, it usually takes responsibility to arrange all medical services needed by its patient population.
Community Health Information Network (CHIN)	An information network for providers and insurers to record, access and share health information.
Community Health Purchasing Alliance (CHPA)	Established by the Health Care and Insurance Reform Act of 1993. CHPAs are responsible for assisting their members and particularly small employers to be prudent purchasers of health care by analyzing and disseminating data on prices, quality and patient satisfaction. CHPAs annually solicit bids for a variety of state mandated

	insurance products.
Community Integration	Term used in the disability community to refer to an individual's ability to share in community life including physical, cultural and social integration as well as self-determination.
Community Inclusion	See community integration .
Community Nursing Organization (CNO)	A Federal demonstration program that capitates home health and durable medical equipment costs using nurses as care managers.
Community Rating	Method of establishing health insurance premiums on a communitywide rather than group-specific basis. The premium is based on a blend of the average cost of actual and anticipated health services use by all enrollees in a geographic area or industry and does not consider variables such as claims experience, age, sex, or health status of the covered population. Community rating spreads the cost of illness more evenly over the whole community. Federally qualified HMOs must community rate.
Community Rating by Class	Modifies community rating principles to establish different premiums based up the age, sex, marital status, or industry of the individual group. The 1981 amendments to the Federal HMO Act allowed Federally qualified HMOs to community rate by class. Defined under the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) , a competitive medical plan (CMP) resembles a health maintenance organization but is not qualified under the Federal HMO Act ; it must be state-licensed; to be eligible to participate in Medicare , the CMP must be Federally approved.
Comparability	Requirement that the state must ensure that the same Medicaid benefits are available to all people who are eligible. Exceptions include benefits approved under Medicaid waiver programs for special sub populations of Medicaid eligibles.
Competitive Bidding	Comparing one proposal to another based on price, services offered, quality, or other factors. Also refers to the process of offering reduced rates to health plans to obtain exclusive contracts from

payers.

Competitive Medical Plan (CMP)

A mechanism created in [TEFRA](#) to enable organized provider groups, in addition to Federally qualified [HMOs](#), to participate in [Medicare](#); these may be hospitals, medical group practices, [PPOs](#), non-Federally qualified HMOs or other entities that meet certain financial solvency requirements. The CMP must be Federally approved to participate in Medicare.

Complication

A medical condition that arises during treatment and in the hospital setting that is expected to increase the length of stay by at least one day for most patients.

Composite Rate or Rating

Grouping covered individuals from separate health insurance plans into a single group for medical underwriting purposes. For example, a composite rate would be established for all those eligible to participate in a multiple option plan regardless of the delivery and financing coverage elected by the plan participants. The number of covered individuals and the projected number and cost of claims under each plan option are considered.

Comprehensive Major Medical Coverage

A health insurance plan that combines basic health benefits with higher benefit maximums to help cover the costs of major claims. The maximum benefit may range up to \$500,000 or have no limit. This coverage usually includes a deductible and coinsurance.

Comprehensive Outpatient Rehabilitation Facility (CORF)

Medicare term used to designate providers that offer a defined set of outpatient rehabilitation services that can be reimbursed through [Medicare](#).

Computerized Medical Record (CMR)

See [electronic medical record](#).

Computerized Patient Record (CPR)

See [electronic medical record](#).

Concurrent Review

A screening method by which a health care provider reviews a procedure performed or hospital admission authorized by a colleague to assess its necessity.

Congregate Housing

Housing for older and disabled people. Provides for private living quarters and shared eating and

Congregate Meals

living areas.

Program authorized under Title II-C-1 of the Older Americans Act which provides, five or more days a week, a hot or other appropriate meal per day in a group setting. Congregate nutrition programs also include nutrition education and other appropriate services for older people.

Consolidated Omnibus Budget Reconciliation Act (COBRA)

A Federal law that requires employers to offer continued health insurance coverage to employees who have had their health insurance coverage terminated.

Consumer Directed Care

See [participant driven supports](#).

Consumer Directed Services

See [participant driven supports](#).

Consumer Price Index (CPI)

A measure of changes in prices for various commodities. The medical CPI analyzes price changes which have occurred in hospitals, physician services, drugs and other related items.

Continuing Care Accreditation Commission (CCAC)

The nation's only accreditation program for [CCRCs](#). The commission accredits communities meeting strict criteria in the areas of finance, governance and administration, resident life and health care.

Continuing Care Retirement Community (CCRC)

Prepaid long term care plan that provides a continuum of residential options from independent living to nursing home care. Usually requires a substantial entrance fee and monthly charges.

Continuing Medical Education (CME)

The continuing education of practicing physicians through refresher courses, medical journals and texts, educational programs and self-study courses. In some states CME is required for continued licensure.

Continuous Quality Improvement (CQI)

A process to continuously make everything better each day. The initiative is customer focused and requires that processes be analyzed, measured, improved and evaluated on an ongoing basis.

Continuum of Care

A range of clinical services provided to a patient that may reflect the treatment rendered during a single hospitalization or may include care for

multiple conditions spanning the patient's lifetime.

Contractual Allowance

A practice of setting rates that are higher than actual costs to recover unreimbursed costs from government, uninsured, underinsured, and other payers.

Contributory Program

A method of payment for group coverage in which part of the premium is paid by the employee and part is paid by the employer or union.

Convalescent Care

Term often used for short-term custodial care and refers to a "recovery" period after an illness or injury when some assistance may be needed that does not require skilled care.

Conversion

In group health insurance, the opportunity given the insured and any covered dependents to change his or her group insurance to some form of individual insurance, without medical evaluation upon termination of his or her group insurance.

Conversion Factors

The dollar amount that, when multiplied by [Relative Value Scale \(RVS\)](#) unit values, estimate the average cost per service. The unit values vary by medical procedure according to the relative complexity or cognitive value of the different procedures. Conversion factors can be used to measure physician fee levels and they may be by area and the period being used for experience. The term also is used for any factor which is multiplied by a standard value to adjust payments. Also see [relative value scales](#).

Conversion Privilege

See [conversion](#).

Coordination of Benefits

An insurance provision whereby responsibility for primary payment for medical services is allocated among carriers when a person is covered by more than one employer-sponsored health benefit program. This prevents beneficiaries from being reimbursed for more than 100% of allowable charges.

Coordination of Coverage

See [coordination of benefits](#).

Cost-Based Reimbursement

A method of paying hospitals for actual costs incurred by patients. Those costs must conform to

explicit principles defined by third-party payers.

Cost-Benefit Analysis

A comparison of the cost of an action and the economic benefits it produces through elimination of other direct and indirect costs.

Cost Containment

Efforts by purchasers and by providers to control health care costs through mechanisms such as benefit design, pre-admission certification, pre-admission testing, and concurrent review programs; second opinion programs; discharge planning; claims audits, case management, and employee education.

Cost Contract

A formal agreement [with Health Care Financing Administration \(HCFA\)](#) to arrange for the provision of health services to plan members based on reasonable cost or prudent buyer concepts. The plan receives an interim capitated amount derived from an estimated annual budget that may be periodically adjusted during the course of the contract to reflect actual cost experience. The plan's expenses are audited at the end of the contract to determine the final rate the plan should have been paid. The [AAPCC](#) may be a factor in establishing the final payment rate.

Cost Effectiveness

Usually considered as a ratio, the cost effectiveness of a drug or procedure, for example, relates the cost of that drug or procedure to the health benefits resulting from it. In health terms, it is often expressed as the cost per year per life saved or as the cost per quality-adjusted life-year saved.

Cost Management

See [cost containment](#).

Cost Outlier

An individual whose service costs are significantly higher than the average. In Medicare, it refers to a patient who is more costly to treat compared with other patients in a particular diagnosis related group. Also see [day outlier](#).

Cost Reimbursement

Method of provider reimbursement based on actual costs incurred.

Cost Sharing

Financing arrangements whereby the member of a health plan must pay some of the costs to receive care.

Cost Shifting	When rates are set higher than actual costs to recover <u>unreimbursed</u> costs from government, uninsured, underinsured and other payers.
Cost Shifting, Employer	Initiating or increasing employee financial participation in the health benefit cost through premium sharing, co-payments, co-insurance, or deductibles.
Cost Shifting, Medicare	A provision of COBRA , shifting primary coverage for eligible claims from Medicare to employer health plans for employees and their spouses.
Cost Shifting, Provider	Charging some patients, or classes of patients, more than others for the same services in order to recover unreimbursed costs from government and other payers.
Coverage	Promise by a third party to pay for all or a portion of expenses incurred for specified health care services.
Covered Person	An individual who meets eligibility requirements and for whom premium payments are paid for specified benefits of the contractual agreement.
Covered Service	The specified scope of services and the units of each service to be included as benefits under an insurance policy.
Credentialing	The process of reviewing a practitioner's academic, clinical and professional ability as demonstrated in the past to determine if criteria for clinical privileges are met.
Critical Pathway	Standardized specifications for care developed by a formal process that incorporates the best scientific evidence of effectiveness with expert opinion.
Current Procedural Terminology	A coding system used to determine Medicare reimbursement rates.
Custodial Care	The medical or non-medical services, which do not seek to cure, are provided during periods when the medical condition of the patient is not changing, or do not require the continued administration by medical personnel.

Cytotech

Works under the direction of a pathologist screening slides of cell samplings for clues to disease.

Daily Benefit Amount

In a long-term care policy the specific amount of insurance the policy pays for each covered day of long term care as defined in the policy. The enrollee may choose from a wide range of daily benefit amounts and, under some policies, different amounts for different types of care, such as a higher daily benefit for nursing home care and a somewhat lower benefit for home care.

Data Book

See [actuary](#).

Data Base, Health Care

See [health care database](#).

Day Outlier

In Medicare, this refers to a patient with an atypically long length of stay compared with other patients in a particular diagnosis related group. Also see [cost outlier](#).

Death Benefit

In some long-term care policies, a benefit payable to the enrollee's survivors or estate if the enrollee dies before a specified age, often 65 or 70. The benefit amount is a refund of premiums the enrollee paid minus the amount of any benefits the enrollee received while living.

Decision Making Capacity and Incapacity

Decision making capacity is typically defined under state law as the ability of a patient to understand and appreciate the nature and consequences of health care decisions and to make an informed choice. If a person loses this ability, he or she is said to be incapacitated; and if a court determines that a person has become incapacitated, he/she is referred to as being legally incompetent.

Decision Tree

The fundamental analytic tool for decision analysis, is a way of displaying the temporal and logical sequence of a clinical decision problem. Its form highlights tree structural components: The alternative actions that are available to the decision maker; the probabilistic events that follow from and affect these actions, such as clinical information obtained or the clinical consequences revealed; and the outcomes for the patient that are

associated with each possible scenario of actions and consequences.

Decretion

Termination of membership in a [Medicare HMO](#); always the last day of the month.

Deductible

Required out-of-pocket expenditure by the covered individual before the insurer pays towards the allowable charges for a covered service. Deductibles may be specified in dollar amounts or units of service.

Deductible, Leveraging Effect

A component of the insurance premium of "fixed" deductibles upon the price increase for a group medical plan. While premiums generally increase from one policy year to the next, employee-paid deductibles usually remain constant or "fixed." If insurance claims increase while the deductible remains the same between one policy year and the next, an economic adjustment is made in the premium structure to reflect the increase in the cost of the amount of benefits paid in comparison to increases in the total cost of services. Fixed deductibles result in greater inflation in group premiums that the underlying trend in medical care costs. The larger the deductible, the greater the impact on premium inflation the following policy year.

Defensive Medicine

Physician practices solely to reduce risk of a liability claim (e.g., performing diagnostic test of marginal value).

Deficit Reduction Act of 1984 (DEFRA)

Federal law with a number of implications, including the provision that requires companies to give employee spouses over 65 the opportunity to enroll under employer group health plans.

Defined Contribution Coverage

A funding mechanism for health benefits whereby employers make a specific dollar contribution toward the cost of insurance coverage for employees, but make no promises about specific benefits to be covered.

Deinstitutionalization

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

Delaware Healthcare Association

A statewide membership services organization that exists to represent and serve hospitals, health systems, and related health care providers in their role of providing a continuum of appropriate, cost-effective quality care to improve the health of the people of Delaware. The primary role of the Association is to serve as a leader in the promotion of effective change in health services through collaboration and consensus building on health care issues at the State and Federal levels. Based in Dover, DE.

Demand Management

A variety of strategies to reduce utilization of health care services such as telephone health help lines, intended to prevent unnecessary use of medical services. Also used to describe educational programs designed to teach patients about their medical conditions which results in better patient self management and the utilization of fewer health care resources in the long term.

Dependent

An individual who receives health insurance through a spouse, parent, or other family member.

Depth of Benefits or Coverage

Refers to the level of patient cost sharing required under a health insurance plan.

Developmental Disability (DD)

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 of services which are lifelong or extended duration and are individually planned and coordinated.

Diagnostic Guidelines

A practice guideline targeted at evaluating patients with particular symptoms for the presence of diseases that would benefit from intervention. They are also used to guide the screening of asymptomatic patient populations for early stages of disease.

Diagnostic Related Group (DRG)	A hospital classification system that groups patients by common characteristics requiring treatment.
Diagnostic Related Group (DRG) Creep	The illegal practice of manipulating and relabeling case mix into a higher reimbursement group.
Differential	The out-of-pocket (or payroll deduction) difference that an eligible individual may be required to pay.
Direct Access	See self referral .
Direct Contracting	Providing health services to members of a health plan by a group of providers contracting directly with an employer, thereby cutting out the middleman or third party insurance carrier. The provider is usually at full risk in this situation.
Direct Contract HMO	An HMO that contracts with each participating physician directly.
Direct Cost	Costs that are wholly attributable to the service in question, for example, the services of professional and paraprofessional personnel, equipment, and materials.
Direct Spending on Health	The amount directly paid for health insurance premiums by a household, as well as other out-of-pocket expenses for health care services.
Directly Financed Services	Public health care and related social services (often funded by Federal, State and local governments) that are targeted towards the underserved and uninsured populations. They include public hospitals/clinics, Community and Migrant Health Centers, Health Care for the Homeless, and a variety of other grant and appropriations programs.
Disability	As defined by the World Health Organization , a disability (resulting from an impairment) is a restriction or lack of ability to perform an activity in the manner or within the range considered normal for a human being.
Discharge Planning	Services offered by health care facilities prior to discharge to help patients and their families develop an appropriate plan for post-discharge care.

Disclaimer	A qualifying statement. For example, a notice that while a statement may be generally true, there are exceptions.
Discounted Fee-For-Service	An agreed upon rate for service that is usually less than the provider's full fee. This may be a fixed amount per service, or a percentage discount. Providers generally accept such contracts because they represent a means to increase their volume or reduce their chances of losing volume. Also see preferred provider organization or exclusive provider organization .
Disease Management	An effort to improve patient outcomes and lower costs by organizing managed care initiative around patients with a particular disease or condition.
Disenrollment	Terminating coverage with a health plan or insurance. Also see enrollment .
Disproportionate Share	Refers to providers who serve a disproportionately high percentage of low-income, uninsured, or otherwise underserved patients.
Disproportionate Share Hospital (DSH)	A hospital that provides care to a high number of patients who cannot afford to pay and/or do not have insurance.
Do Not Resuscitate (DNR)	An advance directive that patients may make to forego cardiopulmonary resuscitation or other resuscitative efforts (see advance directive).
Doctor of Osteopathy (DO)	A licensed physician who is a graduate from an accredited school of osteopathic medicine.
Domestic Insurance Company	An insurance company that operates under the laws of a specific state.
Domicillary Care	Residential program of the Veterans Administration providing health and social services to ambulatory disabled veterans. Generally involves less intensive care than a skilled nursing facility, but more than independent living.
Drug Formulary	A listing of prescribed drugs covered by an insurance plan or used within a hospital. A positive formulary lists eligible products while a negative one lists exclusions. Some insurers will not

reimburse for prescribed drugs not listed on the formulary; others may have limited reimbursement for non-formulary drugs.

Drug Maintenance List

A catalog of a limited number of prescription medications, as designated by a managed health care organization, commonly prescribed by health care providers for their long-term patient use. This list is usually modified on a regular basis. Also referred to as an additional drug benefit list.

Drug Price Review

A monthly update of drug prices, at average wholesale price, from the American Druggist Blue Book.

Drug Use Evaluation (DUE)

An evaluation of prescribing patterns of physicians to specifically determine the appropriateness of drug therapy. There are three forms of DUE: Prospective (before or at the time of prescription dispensing), concurrent (during the course of drug therapy), and retrospective (after the therapy has been completed).

Drug Utilization Review

An evaluation of prescribing patterns or targeted drug use to specifically determine the appropriateness of drug therapy.

Double Indemnity

Payment of twice the policy's normal benefit in case of loss resulting from specified causes or under specified conditions.

Dual Eligible

A person enrolled in [Medicare](#) and [Medicaid](#).

Duplicate Coverage Inquiry

A request to an insurance company or group plan by another insurance company or plan to determine whether other coverage exists for purposes of coordination of benefits.

Duplication of Benefits

Overlapping or identical coverage of an insured person under two or more health plans, usually the result of contracts with different insurers.

Durable Medical Equipment (DME)

Equipment that can stand repeated use, is primarily and customarily used to serve a medical purpose, it generally is not useful to a person in the absence of illness or injury, and is appropriate for use at home, such as hospital beds, wheelchairs, and oxygen equipment.

Durable Power of Attorney

A document in which competent individuals can select other individuals to make decisions, including health care decisions, for them in the event they become incapacitated.

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

A program which covers screening and diagnostic services to determine physical or mental defects in recipients under age 21, as well as health care and other measures to correct or ameliorate any defects and chronic conditions discovered.

Economic Credentialing

Hospital practice of determining whether to front physicians admitting privileges based on their ability to generate revenues and/or their cost-effectiveness.

EEG Technologist

Performs tests using an EEG machine. Completion of a twelve-month program required.

Electrocardiogram (EKG)

A machine that measures the electrical impulses of the heart and transfers the information gathered to a report that prints out a graph of the patient's heartbeats. Used as a diagnostic tool.

Electroencephalograph (EEG)

A machine that measures the electrical activity of the brain and transfers the information gathered to a report. Used as a diagnostic tool.

Electronic Data Interchange (EDI)

The automated exchange of data and documents in a standardized format. In health care, some common uses of this technology include claims submission and payment, eligibility, and referral authorization.

Electronic Medical Record (EMR)

Computerized system providing real-time data access and evaluation in medical care. Together with clinical workstations and clinical data repository technologies, the EMR provides the mechanism for longitudinal data storage and access. A motivation for healthcare providers to implement this technology derives from the need for medical outcome studies, more efficient care, speedier communication among providers and management of health plans. Also known as computerized patient record or computerized medical record.

Eligibility Date

The defined date a covered person becomes eligible

for benefits under an existing contract.

Eligibility Guarantee

An assurance of reimbursement to the health care provider for services/goods provided to a member who subsequently is found to be ineligible for benefits. Also known as presumptive eligibility.

Eligibility Period

Time following the eligibility date (usually 31 days) during which a member of an insured group may apply for insurance without evidence of insurability. Also, in insurance policies, a period after the onset of an illness or injury during which no benefits are paid, effectively providing for a deductible. Common in long-term care policies, although some insurers offer policies with no elimination period. Sometimes incorrectly called a waiting period.

EKG Technician

Performs a variety of routine, technical duties of limited complexity, involving the use of an electrocardiograph machine and stress EKG machine.

Emergency Medical Services (EMS)

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

Emergency Medical Technician (EMT)

A person certified to provide on-site or in-transit emergency medical treatment.

Emergi-Center

A health care facility whose primary purpose is the provision of immediate, short-term medical care for minor but urgent medical conditions.

Employee Assistance Programs (EAP)

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

Employee Retirement Income Security Act (ERISA)

A Federal law that exempts self-insured health plans from state laws governing health insurance, including contribution to risk pools, prohibitions against disease discrimination, and other state health reforms.

Employer Contribution

The amount an employer contributes toward the

	premium costs of the contract. Employer contributions can be based on dollar amounts, percentages, employment status, length of service, single or family status, or other variables or combinations of the above.
Employer Mandate	The requirement that all employers above a minimum size provide a standard level of health insurance benefits to their employees.
Employment-Based Health Insurance Plan	A group health plan that is sponsored by an employer for its employees and their dependents.
Encounter	A face-to-face meeting between a covered person and a health care provider where services are provided or rendered.
Encounters Per Member Per Year	The number of encounters related to each member on a yearly basis.
End Stage Renal Disease (ESRD)	Kidney condition requiring ongoing treatment. Under Federal law, persons with End Stage Renal Disease are eligible for Medicare payment for chronic hemodialysis.
Endorsements	See rider .
Enrollee	Individuals selecting HMO or PPO coverage are referred to as enrollees, members or beneficiaries.
Enrollment	Purchasing health care coverage from a health plan or insurance. Individuals who purchase coverage are known as enrollees. Also refers to the total number of enrolled covered persons in a health plan. Also see open enrollment , and disenrollment .
Enrollment Broker	Independent organization that assists individuals in choosing and enrolling in a health plan. Also see benefits manager .
Enrollment Protection	See stop-loss and reinsurance .
Enterprise Liability	Legislation that would make hospitals and other health care facilities legally and financially liable for all negligent injuries caused by their medical staffs.
Environmental Protection Agency (EPA)	A Federal and State agency responsible for programs to control air, water and noise pollution,

solid waste disposal and other environmental concerns.

Equal Opportunity Commission (EEOC)

The EEOC was created by the Civil Rights Act of 1964. The purpose of the EEOC is to eliminate discrimination on the basis of race, color, religion, sex, national origin, disability or age in hiring, promoting, firing, wages, testing, training, apprenticeship, and all other terms and conditions of employment.

Essential Community Providers

Those organizations in a community that specialize in serving low income persons or provide unique services that cannot be provided by others. MCOs are sometimes required by public payers to contract with these providers to ensure a comprehensive continuum of care.

Essential Lifestyle Planning (ELP)

See [person centered planning](#).

Evercare

[Medicare](#) managed care demonstration for nursing home residents. A geriatric [Nurse Practitioner](#) acts as a case manager.

Evidence of Insurability

Any statement of proof of a person's physical condition affecting their acceptability for insurance or a health care contract.

Excess Charge

See [balance billing](#).

Exclusions

Clauses in an insurance contract that deny coverage for select individuals, groups, locations, properties, or risks.

Exclusive Provider Organization (EPO)

A form of [PPO](#), in which patients must visit a caregiver who is on its panel of providers. If a visit to an outside provider is made, the EPO will offer limited or no coverage for the office or hospital visit.

Exclusivity Clause

A part of a contract which prohibits a health care provider from contracting with more than one managed care organization.

Expenditure

In the context of health care, monies spent on the acquisition of health care coverage and/or services.

Expenditure Limits

Includes various mechanisms which limit the amounts that may be spent to acquire health care

	coverage and services (e.g., negotiated fee schedules, hospital global operating budgets).
Expenditure Targets	Voluntary or involuntary limits on health care spending. This may refer to spending for specific types of service (e.g., physician care), multiple types of service (e.g., hospital, physician, drugs), or all health care services. Also see global budgets .
Experience Rating	A system where an insurance company evaluates the risk of an individual or group by looking at the applicant's health history.
Explanation of Medicare Benefits (EOMB)	The statement of payment from Medicare ; it shows the amount charged by the provider, the amount approved by Medicare and the amount actually paid by Medicare . It is the statement that is submitted to the insurance company for payment under the Medigap policy. Other insurers sometimes use the term explanation of benefits (EOB) to refer to their own payment statements.
Extended Care Facility	A nursing home-type setting that offers skilled, intermediate, or custodial care.
Extension of Benefits	A provision of many policies which allows medical coverage to be continued past the termination date of the policy for employees not actively at work and for dependents hospitalized on that date. Such extended coverage usually applies only to the specific medical condition that has caused the disability and continues only until the employee returns to work or the dependent leave the hospital.
External Quality Review Organization (EQRO)	See quality improvement organization .
Factored Rating	Community rating impacted by group-specific demographics (also known as adjusted community rating).
False Claims Act	A Federal law that imposes liability for treble damages and fines of \$5,000 to \$10,000 for knowingly submitting a false or fraudulent claim for payment to the Federal government.
Family Medical Leave Act (FMLA)	1993 Federal law requiring that employers of 50 or more (and public employers of any size) allow employees to take leave to care for ill family

members and to return to substantially similar employment conditions following the leave.

Family Rest Residential Care

Residential option in Delaware providing less care than assisted living, usually at the "board and care" level (i.e., no direct health or personal care services) but differs from rest residential in that it is provided in the home of a caregiver. Also known as [adult foster care](#).

Farmers Home Administration (FHA)

A division of the U.S. Department of Agriculture that guarantees hospital mortgages.

Favorable Selection

Strategy that encourages the enrollment of the healthier persons while discouraging the enrollment of sicker persons. Also see [cherry picking](#), [adverse selection](#), and [risk selection](#).

Federal Employee Health Benefit Program (FEHBP)

The health care program for Federal civilian employees. Enrollees can choose among a number of approved private plans, with the Federal government paying a major portion of the cost of the coverage.

Federal Financial Participation (FFP)

That portion paid by the Federal government to states for their share of expenditures for providing [Medicaid](#) services, administering the [Medicaid](#) program, and certain other human service programs.

Federal HMO Act

Federal law regulating [HMOs](#). Under the Federal [HMO](#) act, an entity must have three characteristics to call itself an [HMO](#): (1) an organized system for providing health care or otherwise assuring health care delivery in a geographic area, (2) an agreed upon set of basic and supplemental health maintenance and treatment services, and (3) a voluntarily enrolled group of people.

Federal Medical Assistance Percentage (FMAP)

The percentage of Federal matching dollars available to a state to provide [Medicaid](#) services. FMAP is calculated annually based on a formula designed to provide a higher Federal matching rate to States with lower per capital income. Currently at 50% (minimum FMAP) for Delaware. Also see [Medicaid](#).

Federal Poverty Level (FPL)

Income guidelines established annually by the Federal government. Public assistance programs

Federal Qualified Health Center (FQHC)	usually define income limits in relation to FPL or the Supplemental Security Income (SSI) level. Also see supplemental security income . A Federal payment option that enables qualified providers in medically underserved areas to receive cost-based Medicare and Medicaid reimbursement and allows for the direct reimbursement of nurse practitioners, physician assistants and certified nurse midwives. Many outpatient clinics and specialty outreach services are qualified under this provision.
Federally Qualified HMOs	HMOs that meet certain Federally stipulated provisions aimed at protecting consumers, such as providing a broad range of basic health services, assuring financial solvency and monitoring the quality of care. The application process is administered by HCFA's Office of Prepaid Health Care.
Federal Register	An official publication of the Federal government that provides final and proposed regulations of Federal legislation.
Federation of American Health Systems	A trade association comprised of proprietary or investor-owned hospitals.
Fee Disclosure	Physicians and caregivers discussing their charges with patients prior to treatment.
Fee For Service	A method in which physicians and other health care providers receive a fee for services performed.
Fee HR Service Equivalency	Quantitative measures of the difference between the amount a provider receives from an alternative reimbursement system (e.g., capitation) compared to fee-for-service reimbursement.
Fee Schedule	A comprehensive listing of fees used by either a health care plan or the government to reimburse providers on a fee-for-services basis.
Fee Schedule Payment Area	A geographic area within which payment for a given service under the Medicare Fee Schedule will be equal.

Fellow of American College of Healthcare Executives (FACHE)

A credential awarded by the [American College of Healthcare Executives](#).

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's or organization's interests in matters which affect the other person or organization. This fiduciary is also obligated to act in the other person's best interest with total disregard for any interests of the fiduciary.

Financial Accounting Standards Board (FASB)

The FASB establishes voluntary standards designed to improve the accuracy, relevancy, and usefulness of corporate financial statements. FASB is proposing rules that would require the present employer liability for future retiree health expenditures to be reported in accounting records and financial statements.

Financing

Refers to mechanisms through which money to pay health care providers for the delivery of health care services is delivered.

Fiscal Year (FY)

A 12-month period in which an organization accounts for the use of its funds. The Federal Government's fiscal year (FFY) is October 1 to September 30. The State of Delaware fiscal year (SFY) is from July 1 to June 30. Fiscal years are referred to by the calendar year in which they ended.

First Dollar Coverage

A feature of an insurance plan in which there is no deductible, and therefore the plan's sponsor pays a proportion or all of the covered services provided to a patient as soon as he or she enrolls.

Fiscal Intermediary

A regional administrator of payment/reimbursement for government programs.

Fiscal Note

An analysis by the Legislative Budget Office of the financial impact of proposed state legislation.

Flexible Benefit Plan

A benefit program that offers employees a number of benefit options, allowing them to tailor benefits to their needs.

Food and Drug Administration (FDA)

An agency within the Federal government that is

Foreign Insurance Company

responsible for regulations pertaining to food and drugs sold in the United States.

An insurance company that operates under the laws of another state.

Formula Grant

Federal assistance to local governments in accordance with a distribution formula established by law or regulation. The actual payment is usually based on such factors as: population characteristics, per capita income, substandard housing, or rate of unemployment. Formulas indicate the total of which recipients are entitled if the requirements, regulations or other criteria of law are met. Also see [categorical grant](#) or [block grant](#).

Formulary

The panel of drugs chosen by a hospital or managed care organization that is used to treat patients. Drugs outside of the formulary are not used, unless in rare, specific circumstances.

Foster Care

See [adult foster care](#), [family rest residential](#), or [board and care](#).

Foundation for Accountability (FACCT)

Independent national organization that has developed a quality system similar to [HEDIS](#) that places more emphasis on outcomes, but does not take into account case mix.

Frail Elderly

Senior population with any combination of chronic conditions, dementia or ADL dependencies.

Free Look Provision

An insurance policy provision required by most states, allowing the policy owner to inspect the policy for a specified period of time. If desired the owner may return the policy to the insurer for a refund of the entire premium.

Free Standing Emergency Medical Service Center

A health care facility that is physically separate from a hospital and whose primary purpose is the provision of immediate, short-term medical care for minor but urgent medical conditions. Also called [urgent care](#).

Free Standing Facility

Usually a specialty facility that is not part of a comprehensive care system. For example, a free-standing surgery facility or a free-standing assisted living facility.

Free Standing Outpatient Surgical Center

A health care facility that is physically separate

from a hospital, that provides pre-scheduled, outpatient surgical services. Also called [surgi-center](#) or [ambulatory surgical facility](#).

Freedom of Choice (FOC)

In general, laws that permit enrollees to choose any provider and receive substantial reimbursement from their health plan. Also refers to a Federal [Medicaid](#) rule requiring states to ensure that [Medicaid](#) beneficiaries are free to obtain services from any qualified provider. Exceptions are possible through waivers of [Medicaid](#) and special contract options. Also see [any willing provider](#) and [point of service](#).

Frequency

The number of times a service was provided.

Fringe Benefits

Non-cash benefit, often including health insurance, provided to a worker by an employer.

Full-Time Equivalent (FTE)

A standardized accounting of the number of full-time and part-time employees.

Functionally Disabled

An inability to live independently or to perform [ADLs](#) or [IADLs](#) independently.

Functionally Impaired

See [functionally disabled](#).

Funding level

The amount of revenue required to finance a medical care program. Under an insured program, this is usually premium rate. Under a self-funded program, this amount is usually assessed per expected claim cost, plus stop-loss premium, plus all related fees.

Funding Method

The means by which an employer pays for the employee health benefit plan. The most common methods are 1) prospective and/or retrospective, 2) refunding products, 3) self-funding, and 4) shared risk management.

**Gag-Clause or
Gag-Rule**

A provision in a provider contract with a managed care organization or insurer that prevents providers from discussing all available treatment options or financial incentives provided by the insurer with patients.

Gatekeeper

A primary care physician responsible for overseeing and coordinating all aspects of a

	patient's medical care and pre-authorizing specialty care.
Gatekeeping	The process by which a primary care physician coordinates the use of all services required for a patient's medical care.
General Practitioner	A physician whose practice is based on a broad understanding of all illnesses and who does not restrict his/her practice to any particular field of medicine.
Generic Drug or Substitution	In cases in which the patent on a specific pharmaceutical product expires and drug manufacturers produce generic versions of the original branded product, the generic version of the drug (which is theorized to be exactly the same product manufactured by a different firm) is dispensed even though the original product is prescribed. Some managed care organizations and Medicaid programs mandate generic substitution because of the generally lower cost of generic products.
Geographic Factor	See geographic multiplier .
Geographic Multiplier	A factor used to make geographic adjustments to the Medicare Fee Schedule or any other fee schedule. The term "geographic factor" is also used.
Geriatric Nurse Practitioner	An RN with advanced training in geriatrics. Also see nurse practitioner .
Geriatrics	Medical field specializing in care for the elderly.
Geriatrician	A physician who specializes in the diagnosis and treatment of diseases of older persons.
Gerontology	Social Science field studying the biological, psychological and social aspects of aging.
Global Budgets	Global budgets or expenditure limits are prospectively defined caps on spending for some portion of the health care industry. Several industrialized countries have applied global budgeting in various forms. Many of these systems (e.g., France, Australia, Sweden, and Switzerland) concentrate their global budgets solely on hospital

operating budgets treating capital expenditure outside the annual budget process. Others, including Canada and the United Kingdom, have global budgets that cover both hospital and physician expenditures. Global budgeting in the U.S. as envisioned by most proponents would establish binding targets for permissible growth in the U.S. health care system. Many issues remain unclear, however. In particular, the scope of services to be included (e.g., public vs. private sector programs), and the method for enforcing budget caps (e.g., price controls, premium controls, etc.).

Global Service

A package of clinically related services treated as a unit for purposes of billing, coding, or payment.

Grace Period

A set number of days past the due date of a premium payment during which medical coverage may not be canceled and through which the premium payment may be made.

Graduate Medical Education (GME)

Medical education as an intern, resident or fellow after graduating from a medical school.

Grandfathering

When rules change, current participants remain unaffected and the new rules only apply to new participants.

Greatest Economic Need

The need resulting from an income level at or below the poverty threshold established by the Bureau of the Census. Also see [targeting](#).

Greatest Social Need

The need caused by non-economic factors which include physical and mental disabilities, language barriers, and cultural or social isolation including that caused by racial or ethnic status which restricts an individual's ability to perform normal daily tasks or which threatens his or her capacity to live independently. Also see [targeting](#).

Grievance

The process by which an individual can air complaints and seek remedies.

Grievance Procedure

The process by which a health plan member or participating provider can air complaints and seek remedies.

Group Health Insurance

Health insurance purchased through a group that exists for some purpose other than buying insurance, such as a workplace, labor union, or professional association.

Group Insurance

Any insurance policy or health services contract by which groups of employees (and often their dependents) are covered under a single policy or contract, issued by their employer or other group entity.

Group Model HMO

An **HMO** that contracts with a multi-specialty medical group to provide care for **HMO** members; members are required to receive medical care from a physician within the group unless a referral is made outside the network.

Group Practice Association

A formal arrangement of three or more physicians or other health professionals providing health services. Income is pooled and redistributed to the members of the group according to a prearranged plan.

Group Practice HMO Model

An **HMO** model in which the **HMO** contracts with one or more medical group(s) on a capitation basis for the provision of services. The physicians practice in a common facility and use common staff. Income is pooled and distributed according to an agreed-upon plan.

Group Purchasing Organization (GPO)

An organization that pools purchasers working together to provide larger potential purchases and therefore lower costs.

Guaranteed Issue

The requirement that an insurer or health plan accept everyone, regardless of health, income or age, that applies for coverage and guarantees the renewal of that coverage as long as the premium is paid.

Guaranteed Renewability

The requirement that each insurer and health plan continue to renew health policies purchased by individuals as long as the person continues to pay the premium for the policy.

Habilitation

Programs and activities designed to help individuals maximize their independence.

Health Alliances	Nonprofit agencies that act as the health insurance purchasing agent for consumers under a system of managed competition, organized at either the state or regional level, or by employer groups. These alliances negotiated with provider networks to get the best plan at the lowest cost and would serve defined regions or classes of customers.
Health and Human Services (HHS)	See U.S. Department of Health and Human Services .
Health and Welfare Fund	Health care benefit funds established under provisions of the Taft-Hartley Act, financed through employer and employee contributions, and administered by a board composed equally of representatives from labor and management.
Health Benefits Manager	Independent organization that provides functions to assist enrollees. This may include information, acting as an enrollment broker, handling complaints and grievances etc.
Health Care Coalition	Voluntary alliance of discrete interests sharing the principal objective of improving access to high quality health care services provided in a cost effective manner.
Health Care Data Base	Collection of information on health care episodes, such as utilization, costs, or charges.
Health Care Decision Counseling	Services, sometimes provided by insurance companies or employers, that help individuals weigh the benefits, risks and costs of health care tests and treatments. Unlike case management, health care decision counseling is non-judgmental. The goal of health care decision counseling is to help individuals make more informed choices about their health and medical care needs, and to help them make decisions that are right for the individual's unique set of circumstances. Also see demand management .
Health Care Delivery System	That combination of insurance companies, employer groups, providers of care and government agencies that work together to provide health care to a population.
Health Care Expense, Direct	All direct expenditures associated with promoting, maintaining, and restoring the health of a defined

population. For employers, this frequently includes but is not limited to the design and communication of the benefit plan(s); plan administration; financing the plan(s), which may include medical, dental, vision, and pharmaceutical programs; short and long term disability programs; sick pay; payroll taxes attributable to state and general health programs (e.g., worker's compensation, Medicare, Medicaid; and philanthropy). This may also include expenses for health promotion and wellness activities and on-site medical facilities.

Health Care Financing Administration (HCFA)

An agency within the [U.S. Department of Health and Human Services](#) that is responsible for the administration of the [Medicare](#) and [Medicaid](#) programs.

HCFA Common Procedural Coding System (HCPCS)

Federal coding system for medical procedures. HCPCS includes CPT (Current Procedural Terminology) codes, national alpha-numeric codes and local alpha-numeric codes. The national codes are developed by [HCFA](#) to supplement CPT codes. They include physical services not included in CPT as well as non-physician services such as ambulance, physical therapy and durable medical equipment. The local codes are developed by local Medicare carriers to supplement the national codes. HCPCS codes are 5-digit codes, the first digit a letter followed by four numbers. HCPCS codes beginning with A through V are national; those beginning with W through Z are local. Also see physician's current procedural terminology.

Health Care Prepayment

A health plan with a [Medicare](#) cost contract to provide only [Medicare Part B](#) premiums. Some administrative requirements for these plans are less stringent than those of risk contracts or other cost contracts.

Health Care Prepayment System (HCPP)

A cost contract with [HCFA](#) that prepays a health plan a flat amount per month to provide Medicare-eligible Part B medical services to enrolled members. Members pay premiums to cover the [Medicare](#) coinsurance, deductibles and co-payments, plus any additional non-Medicare covered services that the plan provides. The HCPP does not arrange for [Part A](#) services.

Health Care Provider

An individual or institution that provides medical

services.

Health Care Proxy

A health care proxy is recognized in some states as an alternate method for naming a person to act on one's behalf in health care decision making. In a few states, a health care proxy may be included as part of a living will.

Health Care Reform

Changes in the organization, delivery and financing of health care to improve access, quality and to reduce the cost of care.

Health Insurance

A mechanism to spread the risk of unforeseen expenditures across a broad base to protect the individual from personal expenditures for health care services. Health insurance may be purchased individually or on a group basis. It may be custom designed to cover specific services and procedures and include requirements to control the level of use and payment for these services. An employee health insurance benefit is a nontaxable form of compensation to the employee in lieu of taxable salary or wages, provided through employment.

Various types of insurance, such as accident, disability income, medical expense, dental, vision, hearing, and accidental death and dismemberment may be made available through employment. Benefits may be available to dependents of active employees, retirees, spouses, survivors, and dependents through employment. Benefits for classes of active and retired employees and their dependents need not be uniform. The employer may purchase benefits or the costs may be shared between the employer and employee.

Health Insurance Association of American (HIAA)

A corporate member trade association of health and accident insurance companies; based in Washington, D.C.

Health Insurance Claim Number

The number listed on the beneficiary's [Medicare](#) card consisting of nine digits followed by one or more letters. The nine digits represent the Social Security number of either the beneficiary or their spouse depending upon whose income it is based upon.

Health Insurance Portability and Accountability Act (HIPAA)

The 1996 Federal legislation that makes long-term care insurance premiums tax deductible if non-

Health Insurance Trust Fund

reimbursable medical expenses, including part or all of long-term care premiums, exceed 7.5% of an individual's gross income. HIPPA also excludes long-term care insurance benefits from taxable income. Not all long-term care insurance coverage qualifies for this benefit.

The Federal hospital insurance trust fund is a fund of the Treasury of the United States in which the monies collected from taxes on the annual earnings of employees, employers, and self-employed people covered by [Social Security](#) are deposited. Disbursements from the fund are made to help pay for benefit payments and administrative expenses incurred by the hospital insurance program ([Medicare Part A](#)).

Health Insuring Organization

A hybrid of a state-funded health plan and a health maintenance organization. It is usually a public corporation that pays for medical services provided to recipients in exchange for payment of a premium or subscription charges paid for by the corporation that assumes the underwriting risk.

Health Level Seven (HL7)

An existing formatting and protocol standard, that acts as an interface specification operating at the application level for transmitting health-related data. This standard has largely been used for transmission of data among departments within institutions for orders, clinical observations, test results, etc. Specific parts of HL7 have applicable [CHIN](#) use where such data needs to be transmitted between institutions and systems.

Health Maintenance Organization (HMO)

An entity that offers prepaid, comprehensive health coverage for both hospital and physician services with specific health care providers using a fixed structure or capitated rates.

HMO Lookalike

This is a product where the benefit design looks much like that of an [HMO](#) with coverage for preventative care services and dollar co-payments rather than percentage co-insurance. However, services are not restricted to network providers and there is no primary care physician requirement.

Health Manpower Shortage Area (HMSA)

An area or group which 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

geographic area, (2) a population group for which access barriers can be demonstrated that prevent members of the group from using local providers, or (3) public or non-profit private residential facilities. Also see health professional shortage area.

Health Plan

Various types of managed care plans.

Health Plan Employer Data and Information Sets (HEDIS)

A set of performance measures designed to standardize the way health plans report data to employers. HEDIS measures five major areas of health plan performance: quality, access and patient satisfaction, membership and utilization, finance, and descriptive information on health plan management.

Health Professional Shortage Area (HPSA)

A geographic area, population group, or medical facility that [HHS](#) determines to be served by too few health professionals of particular specialties. Physicians who provide services in HPSAs qualify for the Medicare bonus payments, re-payment of medical school loans or other incentives. Also see health manpower shortage area.

Health Promotion

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

Health Services

The health care services or supplies covered under the plan contract.

Health Services Corporation (HSC)

General term to refer to a provider of an array of health services. Sometimes used in the insurance field to designate organizations that are required to meet special licensure requirements.

Health System

All the services, functions and resources for which the primary purpose is to affect the health of the population.

Healthcare Financial Management Association (HFMA)

The HFMA is the nation's leading personal membership organization for more than 35,000 financial management professionals employed by hospitals, integrated delivery systems, long-term and ambulatory care facilities, managed care

organizations, medical group practices, public accounting and consulting firms, insurance companies, government agencies, and other healthcare organizations. Offices located in Westchester, IL and Washington, DC.

Healthy Start

A Medicaid program that provides health care for pregnant women and children who are at or below a specified level of income and age.

Hill Burton Act

Federal legislation enacted in 1947 to support the construction and modernization of health care institutions.

Hill-Burton Program

Federal program created in 1946 to provide funding for the construction and modernization of health care facilities. Hospitals which receive Hill-Burton funds must provide specific levels of charity care.

Histo-Tech

Cuts and stains vary thin sections of body tissue for microscopic examination by a pathologist.

HMO

See [health maintenance organization](#).

HMO, Closed Panel

Physicians employed or contractually obligated exclusively or primarily to see the patients of an [ADFS](#) health plan.

Hold Harmless

A clause frequently found in managed care contracts, whereby the [HMO](#) and the physician agree not to hold each other liable for malpractice or corporate malfeasance if either of the parties is found to be liable. It may also refer to language that prohibits the provider from billing patients in the event a managed care company becomes insolvent.

Home and Community-Based Services (HCBS)

Programs which provide services in the home or at a convenient location in the community. Commonly these programs provide assistance with meals, transportation or homemaking.

Home and Community Based Waiver

[Medicaid waiver](#) that provides a menu of community long term care services as an alternative to nursing home care. Limited to a specified number of slots in each state. The waiver generally provides a more liberal eligibility level than state plan Medicaid services. Also see

Home Care**Medicaid waivers.**

In contrast with inpatient and ambulatory care, home care is medical care ordinarily administered in the house setting when a patient is not sufficiently ambulatory to make frequent office or hospital visits. With these patients, intravenous therapy for example is administered at the patient's residence, usually by a health care professional. Home care reduces the need for hospitalization and its associated costs.

Home Delivered Meals

A program authorized under Title III-C-2 of the Older Americans Act which provides, five or more days a week, at least one home delivered hot or other appropriate meal per day to older persons who are home bound, lack the capacity to prepare meals independently, or for whom congregate meal facilities are not available.

Home Health

Services performed at an individual's home including a wide range of skilled and non-skilled services, including part-time nursing care, various types of therapy, assistance with activities of daily living and homemaker services such as cleaning and meal preparation. For **Medicare** purpose, this term refers specifically to intermittent, physician-ordered medical services or treatment.

Home Health Agency

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

Home Health Care Agency

See **home health agency**.

Home Medical Equipment

Durable medical equipment prescribed by a physician for use by a patient at home. It is a means of continuing access to health care without remaining in the hospital. Such equipment may help the patient function more independently, it may assist recuperation, or it may be palliative. The equipment may be leased or purchased. These costs may be covered by a health plan.

Homemaker

General term referring to a variety of non-skilled at-home services which may include some minor hands on care such as assistance with dressing and personal care, but also includes shopping, meal preparation, laundry services, housekeeping and similar activities. It is usually provided by

	employees of home health agencies.
Horizontal Integration	Consolidation or merger of organizations that provide similar types of care. Also see vertical integration .
Hospice	A facility or program that is licensed, certified or otherwise authorized by law, which provides supportive care of the terminally ill.
Hospice Care	Care that address the physical, spiritual, emotional, psychological, financial, and legal needs of the dying patient and the family; provided by an interdisciplinary team of professionals and perhaps volunteers in a variety of settings, including hospitals, freestanding facilities, and at home.
Hospital	An institution whose primary function is to provide inpatient diagnostic and therapeutic services for a variety of medical conditions, both surgical and non-surgical. 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 types of services (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 non-profit).
Hospital Affiliation	A contractual relationship between a health insurance plan and one or more hospitals whereby the hospital provides the inpatient benefits offered by the plan.
Hospital Alliance	A group of hospitals that have joined together to improve competitive positions and reduce costs by sharing common services and developing group purchasing programs.
Hospital Insurance Program	The compulsory portion of Medicare which relates to hospital care.
Hospital Market Basket	Components of the overall cost of hospital care.
Hospital Market Basket Index	A statistic of inflation of the overall cost of hospital care.

Hospitalist	A hospital-based internist who can be used to assume management of adult admissions from the primary care physician (PCP) , freeing the PCP to do more office-based work. Hospitalists act as the hospital gatekeeper, to provide a valuable service by assessing the clinical needs of patients presenting to the emergency room and supervising inpatient care for those patients who are more critically ill, thereby reducing hospital inpatient costs.
Housekeeper	Non-skilled environmental services provided in the home including help with housekeeping, laundry, cleaning, shopping and meal preparation. Does not include any hands-on care such as personal care or assistance with activities of daily living.
Housing and Urban Development (HUD)	See U.S. Department of Housing and Urban Development .
Hybrid-Model HMO	A combination of at least two managed care organizational models that are melded into a single health plan. Since its features do not uniformly fit only one type of model, it is called a hybrid.
Impairment	Any loss or abnormality of psychological, physiological, or anatomical structure or function from injury or disease. It represents a deviation from the person's usual biomedical state.
In-Kind Resources	Human, cash or other resources or capability located within an agency, organization or institution as opposed to originating in the outside environment. Often used as a match for other funds. Also see match certain grants .
Incentive Plans	Elements of health benefit plans that emphasize particular types of coverage and therefore serve to promote enrollee use of those benefits.
Incentives	Economic benefits given to providers to motivate efficiency in-patient care management.
Incidence	The number of new cases of a disease in a specified population over a defined period of time.
Incurred but not Reported Expenses (IBNR)	This term refers to a financial accounting of all services that have been performed, but have not yet

been invoiced or recorded.

Incurred Claims

A term that refers to the actual carrier liability for a specified period and includes all claims with dates of services within a specified period, usually called the experience period. Due to the time lag between dates of services and the dates claims payments are actually processed, adjustment must be made to any paid claims data to determine incurred claims.

Indemnity Benefits

Benefits for which the insurance company payment is a fixed dollar amount.

Indemnity Health Plan

Similar to a fee-for-service plan in which the insurer pays for all or part of covered services that the patient chooses to purchase from health care providers.

Indemnity Insurance

Insurance providing a stipulated level of reimbursement for hospital/medical expenses, without regard to the actual expenses incurred during hospitalization.

Indemnity Plans

An insurance policy in which beneficiaries are allowed total freedom to choose their health care providers. Those providers are reimbursed a set fee each time they deliver a service. Reimbursement is usually limited to a percentage of customary and reasonable charges (which may be less than the billed amount). Also see [fee for service](#).

Independent Case Management

Comprehensive professional coordination of the health resources necessary to the support of the patient's diagnosis, treatment, and recovery, facilitating the ability of the patient to function with as much independence as possible through the convergence of physical, psychological, social, functional, and personal services. The case manager may organize services that are more cost-effective and appropriate to the needs of the patient that would not otherwise be covered under a beneficiary's health benefit.

Independent Living

Residential option where no assistance is needed with [ADLs](#) or most [IADLs](#). A senior housing apartment complex is an example of independent living.

Independent Medical Evaluation (IME)

An examination carried out by an impartial health

care provider, generally board certified, for the purpose of resolving a dispute related to the nature and extent of an illness or injury.

Independent Practice Association (IPA)

Organization of physicians who have joined together for purposes of contracting with [HMOs](#), [PPOs](#), or other payers. IPA physicians continue to practice in solo settings or in groups, maintain their offices and regular practices, and usually are reimbursed on a fee-for-service basis. Also called [individual practice association](#).

Indigent Care

See [indigent medical care](#) and [charity care](#).

Indigent Medical Care

Care given by health care providers to patients who are unable to pay for it.

Indirect Costs

The costs that are shared by many services concurrently, for example, maintenance, administration, equipment, electricity, water. Also referred to as [overhead costs](#).

**Individual Case Management
Individual Health Care Account**

See [independent case management](#).
A method of financing health care by giving tax advantage to individuals who establish and maintain personal accounts for health care purposes; similar to an Individual Retirement Account for retirement purposes. Also referred to as [medical savings account](#).

Individual Health Insurance

Health services contract or insurance policy which is purchased by an individual and which covers the individual (and usually the person's dependents) in contrast to a group insurance.

Individual Insurance

Policies purchased without the benefit of group sponsorship that provide protection to the policyholder and/or his family. Sometimes called personal insurance.

Individual Practice Association Model (IPA)

The individual practice association contracts with independent physicians who work in their own private practices, and see fee-for-service patients as well as [HMO](#) enrollees. They are paid by capitation for the HMO patients and by conventional means for their fee-for-service patients. Physicians belonging to the IPA guarantee that the care needed by each patient for

whom they are responsible will fall under a certain amount of money. They guarantee this by allowing the [HMO](#) to withhold an amount of their payments (i.e., usually 20% per year). If, by the end of the year, the physician's cost for treatment falls under the set amount, then the physician receives his entire "withhold fund". If the opposite is true, the HMO can then withhold any part of this amount, at its discretion, from the fund. Essentially, the physician is put "at risk" for keeping down the treatment cost. This is the key to the [HMO's](#) financial viability. Also called independent practice association.

Individual Tax Credits

Instead of employer or government health insurance coverage, all individuals would be required to purchase coverage directly from the insurer of choice. Individuals could participate in a group such as an [Health Insurance Purchasing Cooperative \(HIPC\)](#), where they can pay for their own insurance and receive a refundable tax credit to cover some portion of their health insurance costs. Low-income individuals with no tax liability may receive a voucher to purchase health insurance.

Infant Mortality Rate

Deaths in the first year of life per 1000 births. According to the U.S. General Accounting Office, 50% of these deaths are due to lifestyle factors, 20% due to environmental factors, 20% due to biological factors, and 10% due to inadequate health care.

Inflation Protection

An option offered on some long-term care policies which can increase the maximum daily and lifetime benefits to combat inflation. The protection is generally 5% per year, but varies from policy to policy as to whether the increase is calculated at simple or compound interest.

Inflation Rider

See [inflation protection](#).

Informal Care

Care received at home from friends, neighbors or relatives who are not health care professionals. The vast majority of [LTC](#) services in the home are provided by informal caregivers.

Informal Support Informed Consent

See [informal care](#).
Informed consent is a legal term referring to the

right of individuals to make informed medical treatment decisions. Under State law, informed consent typically includes the right to be told of one's medical condition and prognosis, the risks and benefits associated with a recommended procedure or course of treatment, and the risks and benefits of other available treatment options, including the option of refusing treatment. When a person becomes mentally incapacitated, his or her right to give or withhold informed consent typically passes to the person's legal representative, usually an agent or attorney-in-fact under a durable power of attorney, a court-appointed guardian, or a close family member.

Inlier

A patient whose length of stay or service cost resembles those of most other patients. Also see [outlier](#).

Inpatient

A patient who has been admitted at least overnight to a hospital or other health facility and occupies a hospital bed, crib, or bassinet while under observation, care, and diagnosis.

Inpatient Services

Items and services furnished to a patient staying overnight in a hospital including bed and board, nursing and related services, diagnostic and therapeutic services, and medical or surgical services.

Inside Limits

Provisions that restrict the liability of an insurance plan. Various kinds of maximums can be imposed for specific services within a plan's overall limits. One example would be the limits on services for chemical dependency and mental illness in specific settings.

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.

Institutional Care

Instrumental Activities of Daily Living (IADL)

Usually refers to nursing home or hospital care. Normal day-to-day housekeeping activities such as cooking, cleaning, shopping, etc. with which functionally impaired individuals may need assistance. Also see [activities of daily living](#).

Insurance

Sharing the costs of the risk of incurring losses, whether for health expenses or property and casualty losses, across a base large enough to protect any one entity against the actual costs of an incurred loss. The costs of spreading the risk are assumed to be less than the costs of an actual loss. The insured group or insurance company is at financial risk for assuming the guarantee against loss for the specific instance.

Insurance Market Reform

The goal of most insurance market reform initiatives is to materially change the nature of competition in health insurance markets by prohibiting, or severely limiting, the marketing, rating, and underwriting practices that identify and select the most favorable risks while rejecting the least favorable. Requirements that often accompany insurance market reform proposals include prohibition of experience rating in favor of modified community rating, open enrollment, use of a standard benefit package and elimination of preexisting conditions exclusions. Imposition of such regulations would have the effect of reducing the rate differential among groups, and among competing insurers. However, while premium costs would fall for some groups, they would rise for others.

Insurance Reform

Changing insurance companies' practices that prevent some consumers from obtaining health care coverage. Also see [insurance market reform](#).

Insured Claims Loss Ratio

The result of incurred claims divided by premiums. A defined time period is usually specified.

Insurer

An insurance company, managed care plan, government program, or "self-funded" group responsible for providing coverage.

Insurer HMO

An [HMO](#) whose primary purpose is to provide health insurance and who contracts with independent providers for the health care network.

Integrated Care

An approach used to manage all aspects of health care including primary care, acute care and long term care.

Integrated Delivery System

Collaboration between physicians and hospitals for a variety of purposes. Some models of integration

include physician-hospital organization, management-service organization, group practice without walls, integrated provider organization and medical foundation.

Integrated Provider Network (IPN)

A group of hospitals, physicians and ancillary providers which have joined together to create a system which provides comprehensive health care services through a coordinated, client-centered continuum designed to improve health care services in specified geographic markets also known as an integrated delivery system (IDS) or an integrated delivery and financing system, especially when the organization offers an insurance plan. Also see [community care network](#).

Integrated Services Network (ISN)

See [integrated provider network](#).

Intensive Care Units (ICU)

Highly specialized care requiring sophisticated technologies given to patients who are in danger of disability or death.

Intermediary

The term used for [Medicare](#) contractors who process [Medicare Part A](#) claims.

Intermediate Care

A degree of nursing care evaluation that is less than that provided for skilled nursing care, but greater than that provided for custodial care. This level of care provides a planned, continuous program of nursing care that is preventive or rehabilitative in nature.

Intermediate Care Facility (ICF)

A facility providing an intermediate level of care to individuals who do not require the degree of care and treatment that a hospital or skilled nursing facility is designed to provide, but who do require care above the level of room and board.

Intermediate Care Facility for Mentally Retarded Persons (ICF/MR)

Optional [Medicaid](#) services which provide residential care and services for individuals with developmental disabilities.

Intern

A physician in training in the first year after graduating from medical school. Also see [resident](#).

International Classification of Diseases, 9th Edition (ICD-9)

Widely used classification system employed to codify diseases and medical conditions.

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.
Intractable Pain	Pain for which there is no cure.
Job-Lock	The inability of individuals to change jobs because they would lose crucial health benefits.
Joint Commission on Accreditation of Healthcare Organizations (JCAHO)	Founded in 1951, the JCAHO evaluates and accredits health care organization in the U.S., including hospitals, health plans, and other care organizations that provide home care, mental health care, laboratory, ambulatory care and long-term services.
Joint Venture	A loose form of affiliation, essentially contractual in nature, that preserves the prior legal identity of each party participating in the venture.
Key Indicators	Measures which identify progress is achieving important results. Also see outcomes , performance measures and quality assurance .
Laboratory Supervisor	Provides laboratory services to meet the need of patients as ordered by the medical staff and performed in accordance with accepted standards and practices; directs, supervises, and coordinates functions and activities in any or all divisions of the clinical laboratories; Bacteriology, Blood Bank, Chemistry, Cytology, Hematology, Serology.
Large Case Management	See independent case management .
Least Restrictive Environment	Setting that provides the greatest opportunity for independence while ensuring the safety of the individual.
Legend Drug	Drug that can only be obtained by prescription.
Length of Stay (LOS)	The number of days a patient stays in a hospital or other health care facility.
Level of Care (LOC)	An assessment of the type of care necessary to meet the individual needs of the client. The assessment takes into consideration the client's needs in all aspects of development, level of functioning, and potential to benefit from a

	particular program.
Licensed Practical Nurse (LPN)	Performs a variety of non-professional nursing care duties such as assisting in bathing patients, taking temperatures, blood pressure, pulse and respiration. Records results on charts. Observes patients for reactions to drugs, excessive respiratory rate or any other unusual conditions.
Licensed Social Worker (LSW)	An individual who is licensed by the State to practice social work.
Licensure	The process by which an agency of government (usually state government) grants permission to an individual or organization to engage in a given occupation or business based upon finding that the applicant has attained the competency required to ensure that the public health, safety and welfare will be reasonably well protected.
Life Safety Code	Standards of construction, protection and occupancy that are necessary to minimize danger to life from fire, smoke, fumes, and panic. The Joint Commission on Accreditation of Healthcare Organizations and the Medicaid and Medicare programs require compliance with the code. The code is adopted and published by the National Fire Protection Association and is also known as the NFPA 101.
Lifetime Reserve Days	Hospitalization (Part A) under Medicare from the 91 st day of confinement through the 150 th day. This period of consecutive hospitalization is not renewable; once used, the benefit is gone.
Limiting Coverage	The maximum amounts that a non-participating physician is permitted to charge a Medicare beneficiary for a service. Since 1993 the limiting charge has been set at 115% of the Medicare-allowed charge.
Living Will	A legal document generated by an individual to guide providers on the desired medical care in cases when the individual is unable to articulate his or her own wishes.
Lock-In	A provision that requires that enrollees remain in a health care plan for a specified period of time. See open enrollment .

Long-Term Care	Care given to patients with chronic illnesses and who are required a length of stay longer than 30 days.
Long-Term Care Insurance	A continuum of maintenance and health services provided to the chronically or mentally ill or the disabled on an ongoing basis.
Long Term Care Ombudsman Program (LTCOP)	Program that protects the health, welfare, safety, and rights of residents of long term care facilities. Trained and certified volunteers and professional staff visit long term care facilities, receive and investigate complaints, advocate for residents and mediate disputes.
Long Term Care Options Program (LTCOP)	Minnesota's demonstration program that integrates Medicare and Medicaid funding in a capitated managed care plan covering primary, acute and long term care services for dual eligibles.
Long Term Care Rider	An attachment that may be added to some life insurance and other types of insurance policies to allow some or all of the death benefit or other primary benefit to be used to help pay for long term care costs under situations defined in the policy.
Loss Ratio	The ratio of the total incurred claims made against an insurance policy divided by the total premiums. Loss ratios are used as a method of indicating the amount of benefits returned to policyholders.
Low-Level Radio Active Waste	Waste that has a low intensity of radioactivity, most of which decays to acceptable levels within a few months but a few of which contain radioactivity for hundreds of years.
M/R Coder	Responsible for assigning diagnostic and procedure codes to the records of discharged patients and forwarding reports to insurance and governmental review boards as required. The coder also records and determines other required data such as attending physician, use of intensive care unit, number of consultations and referral source and requests diagnoses from physicians when not recorded.
Maintenance of Benefits (MOB)	Variation of coordination of benefits that allows benefits only up to a maximum allowed had the

enrollee been covered only under one health plan. This approach subtracts charges paid by the primary plan from total eligible expenses, then applies the secondary plan benefits to the remaining costs. Also see coordination of benefits.

Magnetic Resonance Imaging (MRI)

A diagnostic technique that uses radio and magnetic waves, rather than radiation, to create images of body tissue and to monitor body chemistry.

Mail Order Pharmacy

A source for brand name and generic prescription and over-the-counter medicines by mail, usually at lower unit prices than a retail pharmacy.

Major Diagnostic Category (MDC)

A clinically coherent grouping of [ICD-9-CM](#) diagnoses by major organ system or etiology that is used as the first step in assignment of most [diagnosis related groups \(DRGs\)](#). MDCs are commonly used for aggregated DRG reporting.

Malpractice

A dereliction from professional duty or a failure to exercise an accepted degree of professional skill or learning by one (as a physician) rendering professional services which results in injury, loss, or damage. Also an injurious, negligent, or improper practice.

Malpractice Insurance

Insurance purchased by doctors and other providers to cover them against malpractice lawsuits.

Managed Care

Organized programs designed to control access to inpatient and ambulatory health services, to ensure the medical necessity of the proposed service and the delivery of the service at the most efficient and cost effective level of care consistent with high quality. Managed care is essential to the structure of alternative delivery and financing systems, such as health maintenance organizations and preferred provider arrangements. The requirements can also be a component of traditional indemnity or fee-for-service health coverage.

Managed care may include pre-admission or pre-treatment certification, second surgical opinion programs, fee or price negotiation, pre-treatment protocol review, pre-admission testing, continued stay review, discharge planning, and

individual/large case management. Failure to comply with managed care requirements or decisions usually reduces health benefit coverage for claims. The penalties may affect both the patient and the provider(s).

Managed Care Organization (MCO)

An entity which provides or contracts for managed care.

Managed Competition

A series of financial structures and methods used to manage the process by which individuals select health insurance coverage in a competitive market. The goal of managed competition is to encourage cost-conscious consumer choice when individuals select a plan. This, in turn, is intended to strengthen financial incentives for plans to deliver services in the most cost-effective manner. The basic structures of managed competition include a national board which would make decisions affecting benefit design and market rules, "sponsors" which manage the process of individual health insurance choice, and integrated health care delivery networks which provide and manage care. These structures have been termed as a [National Health Board](#), [Health Insurance Purchasing Cooperative \(HIPCs\)](#), and [Accountable Health Partnerships \(AHPs\)](#) in several reform proposals.

Managed Fee-For-Service

An insurance plan that works very much like normal plans except they have specific enforced utilization rules which include, but are not limited to: pre-hospitalization case review, prospective length of stay approvals, second opinions for surgery, current and previous records review, discharge planning and claims audits.

Managed Health Care

See [Managed Care](#).

Managed Health Care Plan

One or more products which (1) integrate financing and management with the delivery of health care services to an enrolled population; (2) employ or contract with an organized provider network which delivers services; (3) between a network or individual provider shares financial risk or has some incentive to deliver quality, cost-effective services; and (4) use an information system capable of monitoring and evaluating patterns of enrollees' use of services and the cost of those services. See health maintenance organization, preferred

provider organization, exclusive provider organization, prepaid health plan, and primary care case management.

Management Guidelines

A practice guideline that covers the evaluation and management of patients who is known to have a particular condition.

Management Services Organization (MSO)

See [administrative services organization](#).

Mandated Benefits

Each state is responsible for the conduct of the insurance business within its boundaries rather than the Federal Government. Each state establishes its requirements for insurance company licensure. A state may establish minimum health insurance policy coverage provisions, such as a specified scope of services and covered providers. A state may require that all insured benefit plans include specific benefits, or both approaches may be used, depending upon the specific coverage under consideration. [ERISA](#) exempts self-insured employers from state mandates.

Mandated Benefits, Federal Preemption

A legislative proposal that would require all employers to provide a minimum health benefit for all permanent employees as a condition of doing business. It would exempt employers meeting the Federal requirements from state mandated benefits.

Mandated Employer Insurance

Employers are required to provide health benefit coverage for their employees.

Mandated Providers

See [essential community providers](#).

Manual Rates

Rates developed based upon the health plan's average claims data and then adjusted for group specific demographics, industry factors, or benefit variations.

Market Area

The targeted geographic area or areas of greatest market potential.

Market-Based Reform

Reliance on competition in the health care market to assure services of acceptable cost and quality to consumers without government mandates or involvement in rate-setting, financing, or administration. Can also refer to the reduction of barriers in the operation of a health care market.

Market Penetration

The part of the total health care market that a managed care company has captured.

**Market Share
Marketplace Medicine**

See [market penetration](#).

An attempt by purchasers to introduce competition for patients among providers and professionals as a cost containment mechanism.

Match Certain Grants

Requirement that the grantee contribute a percentage of the resources necessary for carrying out the grant program. The usual resource is cash (hard match), but some programs accept personal and/or facilities in lieu of cash (soft match). Also see [in-kind resources](#).

Material Safety Data Sheet (MSDS)

The purpose of [OSHA](#) Hazard Communication Standard is to ensure the hazards of all chemical substances and mixtures produced or imported are evaluated and this hazard information is communicated by means of a printed written document called the MSDS. The MSDS must be written in English and contain certain required information including the chemical identity or common name, health hazards, emergency & first aid procedures, and safety precautions.

Maternity-Stay Legislation

Governs the length of hospital stay for a mother and newborn following the newborn's birth. Most maternity-stay legislation follows guidelines jointly established by the American College of Obstetricians and Gynecologists (ACOG) and the American Academy of Pediatrics (AAP) which recommend that a woman and newborn receive a minimum of 48 hours of hospital care following an uncomplicated vaginal delivery and 96 hours of care following a C-section.

Maximum Allowable Charge

The largest dollar amount to which an insurance carrier will apply plan benefits.

Maximum Allowable Costs List (MAC)

A list of prescription medications established by the health plan and distributed to pharmacies, which will be covered at a generic product level.

Maximum Out Of Pocket Costs

A limit on the total amount of co-payments, deductibles and co-insurance that a beneficiary is responsible for paying.

Medicaid (Title XIX)

A joint Federal-State program that pays for medical and other services on behalf of certain groups of low-income persons. See [Social Security Act](#), [categorically needy](#), [medically needy](#), and [Medicaid waivers](#).

The following provisions of the [Social Security Act](#) relate to managed care and long term care:

1902(r)(2) - Section of the [Social Security Act](#) which allows states to use more liberal income and resource methodologies than those used in determining [SSI](#) eligibility as the basis for setting [Medicaid](#) eligibility.

1903(m) - Section of the [Social Security Act](#) which allows State [Medicaid](#) programs to develop risk contracts with [HMOs](#) or comparable entities.

1929 - Section of the [Social Security Act](#) which allows states to provide a broad range of Home and Community Care to functionally disabled individuals as an optional State plan benefit (unpopular because of caps on Federal participation).

Medicaid Management Information System (MMIS)

The reporting system used by [HCFA](#) to gather data on [Medicaid](#) use around the country. Can also refer to state or local [Medicaid](#) information systems.

Medicaid Waivers

An exception to the usual requirements of [Medicaid](#) granted to a state by [HCFA](#). The following numbers refer to the applicable section of the [Social Security Act](#):

1115 - Allows states to waive provisions of [Medicaid](#) law to test new concepts which are consistent with the goals of the Medicaid program. System-wide changes are possible under this provision. Frequently used to establish [Medicaid](#) managed care programs.

1915(b) - Allows state to waive freedom of choice. States may require that beneficiaries enroll in [HMOs](#) or other managed care programs, or select a physician to serve as their primary care case manager.

1915(c) - Allows states to waive various [Medicaid](#) requirements to establish alternative, community-based services for (a) individuals who would otherwise require the level of care provided in a hospital or skilled nursing facility, and/or (b) persons already in such facilities who need assistance returning to the community. Target

Medicaid Prudent Pharmaceutical Purchasing Act (MPPPA)

populations for 1915(c) waivers include older adults, persons with disabilities, persons with mental retardation, persons with chronic mental illness and persons with AIDS. Also known as a 2176 waiver in reference to the relevant section of the [Omnibus Budget Reconciliation Act of 1981](#). *1915(d)* - Similar to 1915(c) waiver except that expenditures for nursing facility and home and community-based services for person 65 years and older cannot exceed a projected amount, determined by taking a base year expenditure (last year before the waiver), and adjusting for inflation. Also eliminates requirements that programs be statewide and be comparable for all target populations. Income rules for eligibility can also be waived.

Enacted as part of the [Omnibus Budget Reconciliation Act of 1990](#), MPPPA provides that Medicaid must receive the best discounted price of any institutional purchaser of pharmaceuticals. In doing so, drug companies provide rebates to [Medicaid](#) equal to the difference between the discounted price and the price at which the drug was sold. This bill has resulted in cost shifting throughout the health industry.

Medical Care Evaluation Studies (MCE)

The name given to a generic form of health care review in which problems in the quality of the delivery and organization of health care services are addressed and monitored.

Medical Consumer Price Index

An inflationary statistic that measures the cost of all purchased health care services.

Medical Doctor (MD)

A licensed physician who is a graduate of an accredited medical school and practices allopathic medicine.

Medical Foundations (MF)

An organization through which physicians, hospitals and other providers can integrate the delivery of medical service. Usually an MF is an affiliate of a hospital through a common parent organization or is a subsidiary of a hospital. In most cases MFs are non-profit entities that own and manages facilities, equipment and supplies of a medical practice. They usually contract directly with patients and third party payers and employ non-professional personnel as well as physicians.

Medical Indigence	Inability to pay for needed medical care, whether through insurance, savings, current income, or borrowing against future income.
Medical IRA	A tax-exempt account into which each household would contribute a limited amount of money to cover medical costs or buy insurance.
Medical Laboratory Technician	Works under the direction of a registered medical laboratory technologist and performs many routine clinical laboratory procedures. These procedures include obtaining specimens, mounting tissue specimens and setting up and utilizing laboratory equipment.
Medical Laboratory Technologist (ASCP)	Performs a variety of chemical, microscopic, and bacteriology tests and procedures and related duties, to obtain data for use in the diagnosis and treatment of disease.
Medical Loss Ratio	The cost ratio of health benefits used compared to revenue received. Calculated as total medical expenses/total revenue.
Medical Protocols	Medical protocols are the guidelines that physicians in the future may be required to follow in order to have an acceptable clinical outcome. The protocol would provide the caregiver with specific treatment options or steps when faced with a particular set of clinical symptoms or signs or laboratory data. Medical protocols would be designed through an accumulated database of clinical outcomes.
Medical Savings Account (MSA)	A method of financing health care by giving a tax advantage to individuals who establish and maintain personal accounts for health care purposes; similar to an Individual Retirement Account for retirement purposes. Also referred to as individual health care account .
Medical Services Organization (MSO)	See provider sponsored organization .
Medical Technology	Includes drugs, devices, techniques, and procedures used in delivering medical care and the support systems for that care. There are no accurate estimates of how much new technology contributes to health spending.

Medical Transcriptionist

Transcribes from dictating machine diagnostic work-ups, case histories, physicals, consultations, discharge summaries, and operations, using knowledge of medical terminology. Performs other routine clerical work.

Medical Underwriting

The evaluation process to determine whether the individuals or groups' health risk is acceptable. Individuals or groups may have to have their past experience or medical histories reviewed prior to coverage.

Medically Indigent

A category within the state medical assistance program that defines an individual who is unable to pay for his/her health care.

Medically Necessary

A service or treatment which is appropriate and consistent with diagnosis, and which, in accordance with accepted standards of practice in the medical community of the area in which the health services are rendered, could not have been omitted without adversely affecting the member's condition or the quality of medical care rendered.

Medically Needy

Optional component of the [Medicaid](#) program that allows states to offer [Medicaid](#) to persons who would otherwise be eligible but whose incomes are too high. Such persons become eligible by spending down a portion of their income each month on outstanding medical bills. See [spend down](#), and [categorically needy](#).

Medically Unnecessary Days (MUD)

A term used to describe that part of a stay in a facility deemed to be excessive to diagnose and treat a medical condition because the stay was either too long, or more appropriate care is available in a less costly or more efficient setting.

Medicare (Title XVIII)

Federal program that provides basic health care and limited long term care for retirees and certain disabled individuals without regard to income level. Beneficiaries must pay premiums, deductibles and coinsurance. See [beneficiary](#), [cost sharing](#), [medically necessary](#), and [medigap](#).
Part A - Medicare hospital insurance that helps pay for medically necessary inpatient hospital care, and, after a hospital stay, and limited inpatient care in a

skilled nursing facility, for limited home health care or hospice care.

Part B - [Medicare](#) medical insurance that helps pay for medically necessary physician services, outpatient hospital services and supplies that are not covered by the hospital insurance.

Part C - See [Medicare + Choice](#).

Medicare + Choice

Also referred to as "Medicare Part C," a [Medicare](#) program under which eligible [Medicare](#) enrollees can elect to receive benefits through a managed care program that places providers at risk for those benefits.

Medicare Bonus Payment

An additional 10% payment to the physician above the allowed charge for services delivered to Medicare Beneficiaries in designated Health Professional Shortage Areas.

Medicare Cost HMO or Contract

Prospective payment for acute and primary health care (monthly fee per patient with settlement annually based on actual costs). Primarily used in rural areas where full capitation is not feasible.

Medicare Cost Report (MCR)

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

Medicare Insured Group (MIG)

Employer (or union) groups receiving a capitated rate from [Medicare](#) in exchange for integrating [Medicare](#) covered services into the employers own traditional retiree health plan.

Medicare Payment Advisory Commission (MedPAC)

A non-partisan congressional advisory body charged with providing policy advice and technical assistance concerning the [Medicare](#) program and other aspects of the health system. It conducts independent research, analyzes legislation, and makes recommendations to Congress. The Physician Payment Review Commission (PPRC) has been merged with the Prospective Payment Assessment Commission (ProPAC) to create MedPAC.

Medicare Provider Analysis and Review File (MedPAR)	A HCFA data file that contains charge data and clinical characteristics, such as diagnoses and procedures, for every hospital inpatient bill submitted to Medicare for payment.
Medicare Risk Contract	A contract between Medicare and a health plan under which the plan receives monthly capitated payments to provide Medicare-covered services for enrollees, and thereby assumes insurance risk for those enrollees. A plan is eligible for a risk contract if it is a Federally qualified HMO or a competitive medical plan.
Medicare Secondary Payer	See cost shifting , Medicare .
Medicare Select	A form of Medigap insurance that allows insurers to experiment with the provision of supplemental benefits through a network of providers. Coverage is often limited to those services furnished by the participating network providers and emergency out-of-area care.
Medicare Self Referral Option	A Medicare + Choice point of service option that allows enrollees in a Medicare risk HMO to go out of plan at a higher cost.
Medicare Supplement Policy	See medigap .
Medicare Waiver (222)	Section of the Social Security Amendments of 1972 allowing the Federal Government to waive Medicare payment rules and allow alternative payment methods including capitation.
Medigap	A policy guaranteeing to pay a Medicare beneficiary's co-insurance, deductible and co-payments and will provide additional health plan or non-Medicare coverage for services up to a predefined benefit limit. In essence, the product pays for the portion of the cost of services not covered by Medicare.
MedSupp	See Medigap .
Member	A participant in a health plan who makes up the plan's enrollment.
Member Month	A unit of volume measurement. A member month is equal to one member enrolled in an HMO for one

month, whether or not the member actually receives any services during the period. Two member months are equal to one member enrolled for two months or two members enrolled for one month.

Members Per Year

The number of members effective in the health plan on a yearly basis.

Mid Level Practitioner

Group of health professionals with advanced health care training (including nurse practitioners and physician assistants) that can perform specialized health care tasks usually in support of, and under the supervision of, a physician.

Miller Trusts

Commonly known as income sheltering devices, these trusts enable otherwise income-ineligible [Medicaid](#) applicants to qualify for Medicaid.

Minimum Benefits

See [standard benefits package](#).

Minimum Data Sets (MDS)

Federal data collection system for assessing nursing home patients. The MDS for nursing facility residents is a comprehensive resident assessment instrument (RAI) that measures functional status, mental health status, and behavioral status to identify chronic care patient needs and formalize a care plan in response to 18 Resident Assessment Protocols (RAPs). Under Federal regulation, assessments are conducted at a time of admission into a nursing facility, upon return from a 72-hour hospital admission, whenever there is a significant change in status, quarterly, and annually, Also see [resource utilization groups](#).

Minimum Premium

Financing mechanism for a medical benefit program in which an employer remits only a portion of the conventional premium to the insurer to cover the cost of administering the benefits program and to providing specific and aggregate stop-loss insurance. The employer funds a "bank account" which the insurer draws upon for payment of claims.

Minnesota Care

Minnesota's health care plan passed in April of 1992. This law is intended to provide health care to all of Minnesota's citizens while cutting health care costs. It includes cost-containment provisions for setting overall health care spending targets,

	monitoring providers, reviewing the distribution of new technologies, and evaluating methods for collecting health care data.
Mixed Model HMO	A health plan that includes more than one form of HMO within a single plan.
Modified Community Rating	A separate rating of medical service usage in a given geographic area using age-sex data.
Modified Fee-For-Service	A system in which providers are paid on a fee-for-service basis, with certain fee maximums for each procedure.
Moral Hazard	Tendency of an enrollee to use benefits unnecessarily unless given incentives (such as co-payments and deductibles) not to do so. Also see cost sharing .
Morbidity	Incidents of illness and accidents in a defined group of individuals.
Mortality	Incidents of death in a defined group of individuals.
Most-favored-nation clause	A provision requiring the contracting physician, hospital or group to provide an issuer with the lowest price it charges any other insurer.
Multiple Employer Welfare Arrangement	A group of employers joined together to offer employees health benefits comparable to traditional health insurance packages. Employers take part to reduce health insurance costs and spread the risk over a larger group of people.
Multiple Employer Trust	Legal trust established by a plan sponsor that brings together a number of small, unrelated employers for the purpose of providing group medical coverage on an insured or self-funded basis.
Multiple Option Plan	A health plan design that offers employees the option of electing to enroll under one of several types of coverage, usually from among an HMO , a PPO , and a major medical indemnity plan.
Multipurpose Senior Center	A community or neighborhood facility established for the organization and provision of a broad spectrum of supportive services, including health, social, nutritional, and educational services, and the

	provision of facilities for recreational activities for older individuals.
Multispecialty Group	A group of doctors who represent various medical specialties and who work together in a group practice.
National Board of Medical Examiners	A non-profit organization responsible for preparing and administering qualifying examinations for physicians.
National Cancer Registry	A unit within the National Institutes of Health that provides updates on the latest cancer diseases, research and diagnosis.
National Center for Health Services Research	A division within the U.S. Department of Health and Human Services that supports analyses and evaluations of the health care system and its financing and underwrites the development and testing of new approaches to improve the distribution, use and cost-effectiveness of services.
National Center for Health Statistics	A division within the U.S. Department of Health and Human Services that is responsible for gathering data on illness and disability, producing the vital statistics of the nation and tracking the use and availability of health services and resources.
National Claim History (NCH)	A HCFA data reporting system that combines both Part A and Part B claims in a common file.
National Committee for Quality Assurance (NCQA)	A non-profit organization created to improve patient care quality and health plan performance in partnership with managed care plans, purchasers, consumers, and the public sector.
National Drug Code (NDC)	A national classification system for identification of drugs. Similar to the universal product code (UPC).
National Fire Protection Association (NFPA)	An association that develops standards related to fire protection. Fire departments usually adopt these standards into local regulations.

NFPA Storage Codes

[National Fire Protection Association](#) storage codes. As fire departments inspect businesses, especially radiology departments, several questions arise including storage codes for x-ray films and chemicals. Contact your local fire department for further information for your area.

National Health Board (NHB)

The National Health Board has been described by most managed competition plans as an independent Federal agency charged with implementation and oversight of the national health care plan. It would likely be responsible for developing the uniform benefits package, setting standards and registration requirements for [AHPs](#) and [HPCs](#), and any other tasks as designated by Congress or the Administration. Board members would serve staggered terms and be insulated from the Executive and Legislative branches. Membership would reflect provider, consumer and public policy interests.

National Health Expenditures

All spending in the U.S. for health services, including individual expenditures not reimbursed, the administrative costs of non-profit and government health programs, the net cost to enrollees of private health insurance, government expenditures designed to promote health in general, non-commercial health research, and construction of medical facilities.

National Health Insurance

Proposed Federal program that would use tax funds to finance the provision of comprehensive health benefits for the population. Scope of benefits, provider and beneficiary eligibility, financing, and ownership and control of resources, among other issues, must be defined.

National Institute on Aging (NIA)

Federal agency within [the National Institutes of Health](#) that conducts and supports biomedical and behavioral research to increase knowledge of the aging process and associated factors resulting from old age. NIA conducts laboratory and clinical research at its Gerontology Research Center in Baltimore, MD and its clinics. NIA funds research on aging at universities, hospitals, and other organizations.

National Institutes of Health

A division within the [U.S. Department of Health and Human Services](#) that is responsible for most of

	the agency's medical research programs.
National Practitioner Data Bank	Database containing information on physicians including malpractice claims and disciplinary action operated by the U.S. Department of Health and Human Services .
Negotiated Fee Schedule	Fees set through an organized bargaining process usually used to help determine a global budget. Also called negotiated payment schedule.
Net Loss Ratio	The result of total claims liability and all expenses divided by premiums. This is the carrier's loss ratio after accounting for all expenses.
Network	A set group of providers associated by contractual agreements that provide either specific benefits or a full choice of acute and long term care services.
Network-Model HMO	A network of group practices under the administration of one HMO .
Noncontributory	A situation in which the plan sponsor pays the entire cost or premiums for coverage. Employees do not contribute toward the cost of the coverage.
Nondiscrimination Rules Section 89, Internal Revenue Code	Provisions contained in the Tax Reform Act of 1986 (P.L. 99-514), amending Section 89 of the Internal Revenue Code to help ensure more equity in the provision of employer-financed group term life, accident, health and welfare benefits among the highly compensated and other employees. The provision became effective January 1, 1989. The Internal Revenue Service will establish tests to determine continuous employer compliance with the requirements. Financial penalties for the employer that fails to meet Section 89 requirements will be imposed upon its highly compensated employees.
Nonforfeiture Feature	A provision in some long-term care policies offering a guarantee that certain policy benefits will remain available even if the enrollee stops paying premiums. One type of non-forfeiture is a paid-up policy providing the same benefits for a shorter period of lower benefits for the same period as the original policy. Return of premium benefits are another form of non-forfeiture. Also known as lapsed coverage protection .

Nonparticipating Provider	A health care provider who has not contracted with the carrier or health plan to be a participating provider of health care.
Nuclear Medicine Technologist	Operates radioscopic equipment to produce scanograms and measure concentrations of radioactive isotopes in specific body areas for diagnostic purposes.
Nuclear Regulatory Commission (NRC)	A Federal commission created in 1974 to protect the public health and safety by regulating civilian uses of nuclear materials.
Nurse	A legally qualified person who is licensed by the state to provide nursing services. Also see registered nurse, licensed practical nurse, nurse practitioner, and advanced nurse practitioner.
Nurse Assistant	Performs a variety of routine duties for patients in caring for their personnel needs and comfort. Includes answering signal lights, baths, assists with personal hygiene, alcohol rubs, bed pans, takes and records temperatures, pulse, intake and output, gives enemas, etc.
Nurse Manager	Performs all the duties of an R.N. , plus plans and supervises work of all nursing personnel within an assigned unit of the nursing department.
Nurse Practitioner (NP)	A registered nurse with additional specialized graduate level training. An NP performs physical exams and diagnostic tests, counsels patients, and develops treatment programs. Also see mid level practitioner.
Nurses Aide	Legally qualified person who is certified by the state to perform certain health care services, usually in the area of personal care or home health services. Also called certified nurses aid .
Nursing Facility (NF)	Facilities licensed by and approved by the state in which eligible individuals receive skilled nursing care and appropriate rehabilitative and restorative services.
Nursing Supervisor	Responsible for reviewing specific problems with other nursing personnel; makes rounds to all

nursing units, answers all Dr. Stat calls, assists physicians in these emergencies, develops and directs orientation program for nursing service personnel, assumes administrative duties in absence of assistant director of nursing.

Occupancy Rate

A measure of inpatient health facility use, determined by dividing available bed days by patient days. It measures the average percentage of facilities' beds occupied.

Occupational Safety and Health Administration (OSHA)

A Federal agency within the [U.S. Department of Labor](#) that is responsible for setting standards to promote and enforce employee safety in the workplace.

Occupational Therapist (OT)

Occupational therapists assess functioning in activities of everyday living, including dressing, bathing, grooming, meal preparation, writing, and driving, which are essential for independent living. In making treatment recommendations, the OT addresses (1) fatigue management, (2) upper body strength, movement, and coordination, (3) adaptations to the home and work environment, including both structural changes and specialized equipment for particular activities, and (4) compensatory strategies for impairments in thinking, sensation, or vision.

Off-Open Enrollment Termination

See [attrition rate](#).

Office of Inspector General (OIG) of the U.S. Department of Health and Human Services

The enforcement arm within [the U.S. Department of Health and Human Services](#) that oversees investigations of alleged violations of [Medicare](#) and [Medicaid](#) laws and rules.

Office of Management and Budget (OMB)

A Federal agency responsible for providing fiscal accounting and budgeting services for the Federal government.

Office of Personnel Management (OPM)

Among other things, the Federal agency that administers and directs [all Federal Employee Health Benefits Programs](#).

Office of Professional Standard Review Organizations

The health standards and quality bureau of the Health Care Financing Administration.

Older Americans Act (OAA)

1965 Federal legislation to create a network of state

and area agencies on aging. These agencies help plan and fund programs and services for persons over the age of sixty.

Omnibus Budget Reconciliation Act (OBRA)

An amendment to the Federal budget that outlines new Federally funded programs or revisions to existing programs. In 1985, the amendment was called the [Consolidated Omnibus Budget Reconciliation Act](#), or [COBRA](#).

Open Access

Allows members to see participating providers, usually a specialist, without a referral from the health plan's gatekeeper. These types of arrangements are most often found in IPA-model [HMOs](#).

Open Enrollment

If an employer offers the covered population two or more options in selecting health benefits coverage, there is usually an annual period of time within which the employee can make changes in the coverage previously selected. Changes might include an increase in out-of-pocket expenditures to reduce personal premium participation or a change from indemnity insurance to [HMO](#) or [PPO](#) coverage.

Open Enrollment Termination

See [attrition rate](#).

Open Ended HMO

See [Point of Service Plan](#).

Open Panel HMO

An [HMO](#) in which any licensed physician in an area is eligible to join the [HMO](#). An individual practice association is an example of an open panel plan.

O.R. Tech

Assists the surgical team during operative procedures. Includes acting as scrub nurse and circulating nurse, assists in preparing patient for surgery, transports patient from O.R. to recovery, assists in clean up of operating theatre, counts sponges, needles and instruments used during surgery.

Organ Procurement Organization (OPO)

A non-profit Federally funded organization that has many responsibilities in the organ transplantation process.

Organized Delivery System

A comprehensive, integrated network of providers

who manage and deliver many levels of care in comprehensive set of health services.

ORYX

The integration of performance measurement into the Joint Commission's accreditation process. Each accredited facility must select vendors that have been approved by the [JCAHO](#) for the performance measurement system.

Osteopathic

A school of medicine that uses manipulative measures in treating patients in addition to the diagnostic and therapeutic measures of medicine. The other school is [allopathic](#).

Out-Of-Area Benefits

The coverage allowed to [HMO](#) members for emergency and other situations outside of the prescribed geographic area of the [HMO](#).

Out of Network

Services received from a provider who does not participate with the enrollee's health plan. See [point of services](#), and [freedom of choice](#).

Out of Plan

See [out of network](#).

Out-Of-Pocket Expenses or Costs

The share of health services payments paid by the enrollee.

Out-Of-Pocket Maximum or Cap

An annual limit on how much in deductibles and co-payments the patient is required to pay. Also called "[stop-loss](#)" provision.

Outcome and Effectiveness Research

Medical or health services research that attempts to identify the clinical outcomes of the delivery of health care.

Outcome Audit

A type of patient/medical care evaluation study in which criteria are designed to focus upon desired patient outcome or results of treatment, as distinguished from a process audit in which criteria focus upon the components of appropriate clinical intervention.

Outcome Management

Collecting and analyzing results of medical performance and using that information to optimize healthcare results.

Outcome Measures

Assessments to gauge the results of treatment for a particular disease or condition. Outcome measures

	include the patient's perception of restoration of function, quality of life and functional status, as well as objective measures of mortality, morbidity and health status.
Outcomes and Assessment Information Set (OASIS)	Federal monitoring system for Home Health Agencies.
Outcomes Research	Research on the effects on health, function, or quality of life of the patient resulting from various health services or from ways of organizing and financing health services.
Outlier	A comparative term describing a patient whose stay in the hospital is unusually long or whose costs for hospital care are unusually high compared to other patients with the same diagnosis or condition. The Medicare program uses DRGs as categories to identify outliers. Under Medicare , additional payments are made for outliers meeting certain conditions.
Outpatient	A person who receives health care services without being admitted to a hospital.
Outpatient Services	Medical and other services provided by a qualified facility where an overnight stay is not required, such as therapy and other clinics, labs and diagnostic centers. See inpatient services , and ambulatory care .
Outside Referral	Referral to a consultant provider not on the managed care company's staff or within its network of providers.
Over The Counter Drugs	A drug that does not require a prescription.
Overvalued Procedure	A procedure for which the payment rate has been reduced because it was identified as "overvalued" under the customary, prevailing, and reasonable payment system.
Paid Claims	The amount paid to providers to satisfy the contractual liability of the carrier or plan sponsor. These amounts do not include any member liability for ineligible charges, deductibles, or co-payments.
Paid Claims Loss Ratio	The result of paid claims divided by premiums.

Paid-Up Policy

In long-term care insurance, it is generally the operation of a non-forfeiture feature under which the enrollee's coverage continues for some period based on the amount of premiums paid when the policy lapses. Methods for providing the paid-up policy may include full benefits for a shorter benefit period or partial benefits for the full original benefit period. Some policies also have a provision which pays up the policy under specified conditions upon the death of an insured spouse. Some companies offer limited or single payment premium modes that result in paid up policies when a specified number of annual premiums have been paid.

Palliative Care

Care which is provided to relieve pain rather than provide a cure. Also called "[comfort care](#)."

Partial Capitation

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

Partial Hospitalization Services

A mental health or substance abuse program operated by a hospital that provides clinical services as an alternative or follow-up to [inpatient](#) hospital care.

Partial Risk Contract

A contract between a purchaser and a health plan in which only part of the financial risk is transferred from the purchaser to the plan.

Participant Driven Supports

Program in which an individual decides how limited funds, services, or other resources are used. Most commonly used in reference to attendants employed directly by a consumer who is responsible for, or has influence over, hiring, scheduling and firing. Also known as [consumer directed care](#).

Participating Dentist

See [participating provider](#).

Participating Hospital

See [participating provider](#).

Participating Physician

See [participating provider](#).

Participating Provider

A health care provider who has a contractual arrangement with a health care service contractor, [HMO](#), [PPO](#), [IPA](#) or other [managed care organization](#).

Patient

Person who is receiving medical care. There are two types of patients, please see inpatient or outpatient for definitions.

Patient Advocate

Serves as a liaison between patient and hospital staff. Assists patients in interpreting hospital policies, procedures, and services and to obtaining solutions to problems and concerns. Assists staff in gaining awareness of patients' perceptions of the hospital experience.

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 areas that are useful in locating and planning the development of new services.

Patient Protection Acts

Legislation that requires health benefit plans to take a number of steps to protect patient interests under managed care. The provisions of the acts vary according to state, but some of the most common require plans to disclose coverage provisions, benefits, exclusions, utilization review protocols and policies regarding specialist referral. Many of the acts ban language in provider contracts that may prevent physicians from discussing all treatment options (known as "gag" clauses), and require plans to disclose financial incentive plans for providers that may limit care and referrals and provide appeals processes for denied claims. Provisions may also require that individuals be given a choice between [HMO](#), [PPO](#) and [POS](#) options, and that enrollees be allowed direct access to certain types of physicians, such as OB/GYNs. Plans can also be required to disclose their criteria for selecting and deselecting physicians and to provide due process for providers.

Patient Self-Determination Act

A Federal law that requires health care facilities to determine if new patients have a living will and/or

durable power of attorney for health care and take patients' wishes into consideration in developing their treatment plans.

Payer

Generally regarded as the guarantor of payment. Could be an employer, health and welfare fund, insurer, or a broker for the employer or labor organization acting in a purchasing agent capacity, or an individual.

Payment Withhold

See [risk contract](#).

Peer Review

The evaluation of quality of total health care provided by medical staff with equivalent training.

Peer Review Organization (PRO)

An entity established by the Tax Equity and Fiscal Responsibility Act of 1982 ([TEFRA](#)) to review quality of care and appropriateness of admissions, readmissions and discharges for [Medicare](#) and [Medicaid](#). These organizations are held responsible for maintaining and lowering admission rates, and reducing lengths of stay while insuring against inadequate treatment.

Per Capita Health Care Spending

Annual spending on health care per person. Per capita spending in 1997 was estimated at \$3,925.

Per Case Payment

A set rate of payment for a hospital admission, including all ancillary services excluding separately billed physician services.

Per Diem Rate

A set price for one day of hospital care, including all ancillary services, excluding separately billed physician services.

Per Member Per Month (PMPM)

The amount of money paid or received on a monthly basis for each individual enrolled in a managed care plan, often referred to as capitation.

Percent of Premium

A predetermined percentage of premium is shared between the payer and provider to pay for the costs of medical services provided to the covered population.

Performance Measures

A mechanism to determine if a desired result has been achieved. See [outcomes](#), [key indicators](#), and [quality assurance](#).

Performance Standards	Standards an individual provider is expected to meet, especially with respect to quality of care. The standards may define volume of care delivered per time period.
Person Centered Planning	Process to identify and respond to the expressed needs and desires of an individual. Also known as personal futures planning or essential lifestyle planning .
Personal Attendant Services (PAS) Personal Care	See attendants . Optional Medicaid benefit which allows a state to provide services to assist functionally impaired individuals in performing the activities of daily living (e.g., bathing, dressing, feeding, grooming, etc.). See activities of daily living and attendant service .
Personal Care Advisor	See care coordination benefit .
Personal Care Advocate	See care coordination benefit .
Personal Emergency Response System (PERS or PRS)	A device, carried or worn, that can be activated in an emergency to alert a central location through the phone system. Family, friends, or emergency services are then contacted to check on the nature of the emergency.
Personal Futures Planning	See person centered planning .
Pharmaceutical Care	A strategy that attempts to utilize drug therapy more efficiently to achieve definite outcomes that improve a patient's quality of life. A pharmaceutical care system requires a reorientation of physicians, pharmacists, and nurses toward effective drug therapy outcomes. It is a set of relationships and decisions through which pharmacists, physicians, nurses, and patients work together to design, implement, and monitor a therapeutic plan that will produce specific therapeutic outcomes.
Pharmacist	A health care professional who compounds and dispenses medications and other pharmaceutical supplies, using standard physical and chemical procedures to fill written prescriptions issued by physicians. Maintains records on all unit dose for each nursing unit and also IV additive program.

Pharmacy and Therapeutics (P&T) Committee	<p>Maintains inventory of supplies. Graduation from accredited school of pharmacy and licensed in the State of Delaware.</p> <p>A group of physicians, pharmacists, and other health care providers from different specialties, who advise a managed care plan regarding safe and effective use of medications. The P&T Committee manages the formulary and acts as the organizational line of communication between the medical and pharmacy components of the health plan.</p>
Pharmacy Services Administrative Organization (PSAO)	<p>An organization that is dedicated to provide prescription benefits to enrollees of managed care plans that utilizes existing community pharmacies. The PSAO contracts as a provider group with the managed care organization, so that the individual pharmacies receive negotiating representation in numbers and the prepaid health plan does not have to provide the capital necessary to start, own, and operate their own pharmacy department.</p>
Pharmacy Tech	<p>Fills orders for prepackaged drugs or dispenses drugs from stock containers under the supervision of a pharmacist. In addition, the tech will fill routine orders for non-prescription drugs, replenish supply carts, and keep records on drugs delivered to the department and store incoming merchandise.</p>
Physical Therapist	<p>Assists patients who have experienced disability from illness, trauma, or birth defects, performs individual exercise programs to restore or relocate physical function.</p>
Physical Therapy Assistant	<p>Works under the supervision of a physical therapist. Duties include training patients in everyday activities, assisting patients in walking and exercising, and conducting treatments as prescribed by a physician.</p>
Physician Assistant (PA)	<p>A medically trained professional who can provide many of the health care services traditionally performed by a physician, such as taking medical histories and doing physical examinations, making diagnoses, prescribing and administering therapies. Also see mid level practitioner.</p>
Physician Contingency Reserve (PCR)	<p>See withhold.</p>

Physician's Current Procedural Terminology (PCPT or CPT)

A list of medical services and procedures performed by physicians and other providers. Each service and/or procedure is identified by its own unique 5-digit code. [CPT](#) has become the health care industry's standard for reporting of physician procedures and services, thereby providing an effective method of nationwide communication. See [HCFA common procedural coding system](#).

Physician Dispensing

A physician gives the patient his or her initial doses of a commonly prescribed drug during an office visit. The prescription is usually refilled at the pharmacy and not the physician's office. Doctors who dispense medications usually stock 20 to 30 drugs (antibiotics, anti-inflammatories, etc.). Pharmacists see this as a reduction in their marketshare, whereas physicians see this as both an extra service and convenience to their patients.

Physician-Hospital Organization (PHO)

A legal entity formed and owned by one or more hospitals and physician groups in order to obtain payer contracts and to further mutual interests; one type of integrated delivery system.

Physician Income

Net income after expenses and before taxes.

Physician Organization Arrangement (POA)

See [physician hospital organization](#).

Physician Payment Review Commission (PPRC)

A bipartisan congressional advisory group established in 1986 to advise Congress on setting [Medicare](#) and [Medicaid](#) reimbursement. In 1990, [PPRCs](#) responsibilities were expanded to include other payment policy issues.

Physician Practice Management Company (PPMC)

A company that provides management and administrative support, often with capital for clinical expansion.

Physician Services

One portion of national health care expenditures. Includes physicians' overhead, administrative expenses, and income.

Plan for Achieving Self Support (PASS)

Option to exempt certain income used to improve independence from consideration in determining financial eligibility for disability payments under [SSI](#).

Play or Pay Mandate

Employers are required to provide at least a minimum standard benefits package for their employees or pay a payroll tax. Employees in firms that choose to pay the tax will be "pooled" together for the purchase of health insurance either into a single public program like Medicare or a program in which enrollees choose from competing private health plans. Payroll tax revenues, individual premiums (with subsidies provided for low-income persons) and other general tax revenues would finance the health benefit costs.

Phlebotomist

Semi-skilled technician position involving the collection of blood specimens from patients through venipuncture.

Point of Purchase Plan

A benefit plan that expands enrollee options to choose providers. It usually consists of two or more delivery and financing options including an alternative delivery system, such as an [HMO](#) or [PPO](#), and another plan such as traditional fee-for-service coverage. The participant is not locked-in but may change coverage options each time care is obtained. The scope of benefits and payment provisions are structured to provide incentives for greater use of the alternative delivery system option.

Point-Of-Service (POS) Plan

An insurance plan where members need not choose how to receive services until the time they need them, also known as an open-ended [HMO](#).

Policyholder

Under a group plan, the group is the policyholder; under an individual plan, the individual is the policyholder. The policyholder is the one who has the contract or agreement with the insurer.

Political Action Committee (PAC)

A group of people organized to collect and distribute contributions to political candidates.

Portability

An individual changing jobs would be guaranteed coverage with the new employer, without a waiting period or having to meet additional deductible requirements.

Practice Expense

The cost of non-physician resources incurred by the physician to provide services. Examples include salaries and benefits for employees, the expenses associated with the purchase and use of medical

equipment and supplies.

Practice Guidelines

A statement of what is known about the benefits, risks and costs of particular courses of medical treatment to achieve the best possible patient outcome. Also known as [practice parameters](#).

Practice Parameters

Strategies for patient management developed to assist physicians in clinical decision-making. Parameters improve quality and assure appropriate utilization of health services.

Pre-Admission Certification

Review and approval process completed before hospital admission to ensure the medical necessity for the acute level of care and for the proposed services and procedures, to avoid a weekend admission, and to forecast the expected length of stay. The review process may include an assessment of the physician's proposed treatment protocol and fees. Compliance with changes in the treatment plan recommended by the reviewing entity may be a condition of receiving full coverage under the health benefit. The benefit level may be reduced or services not covered at all if the patient fails to comply with plan requirements. The pre-admission review process may also include an administrative confirmation of the patient's eligibility for benefits, covered services and restrictions, and the determination of applicable deductibles, co-payments, and maximums.

Pre-Admission Notification

Similar to pre-admission certification, a condition of receiving full benefits. Failure to notify the reviewing agency within the time limitations may result in a reduced level or denial of benefits. Differs from certification programs since the counseling offered by the notification agency is not binding upon the patient.

Pre-Admission Review

See [pre-admission certification](#).

Pre-Admission Screening (PAS)

Process to determine the appropriateness of an applicant for nursing home placement.

Pre-Admission Screening and Annual Resident Review (PASARR)

Screening process for mental disabilities which assures that patients get the proper placement and access to services.

Pre-Admission Testing

Patient tests performed on an outpatient basis prior

to admission to the hospital.

Pre-Authorization

Similar to pre-admission certificate, a condition of receiving health benefits. Review and approval process that must be completed before services are provided, when an inpatient or ambulatory site is proposed for care. The review process may include an assessment of the physician's proposed protocol and fees. Compliance with changes in the proposed treatment plan recommended by reviewing entity may be a condition of receiving full coverage under the health benefit.

Pre-Estimate of Cost

See [pre-authorization](#).

Pre-Existing Conditions

When a physical or mental condition of a newly insured individual is present prior to the insurance of the new insurance policy. Normally, these exclusions last from 6 to 12 months, however, more severe conditions may be considered as lifetime exclusions.

Pre-Existing Condition Exclusion

Practices of some health insurers to deny coverage to individuals for a certain period, for health conditions that already exist when coverage is initiated.

Pre-Service Review

Pre-service review programs examine the medical necessity and appropriateness of proposed services to be provided in the ambulatory or inpatient setting that may require frequent treatment, extended courses of treatment, or require the use of expensive technologies. Dental and vision benefits may require predetermination for certain services or charges.

Predetermination

A procedure where a provider submits a treatment plan to the health insurer before treatment begins. The insurer reviews the treatment plan and notifies the provider of one or more of the following: patient's eligibility, covered services, amounts payable, co-payment and deductibles and plan maximums.

Preferred Provider Organization (PPO)

Contractual arrangements among hospitals, physicians, employers, insurance companies, or third-party administrators to provide health care services to subscribers at a negotiated, often discounted, price.

Preferred Providers	Physicians, hospitals, and other health care providers who contract to provide health services to persons covered by a particular health plan.
Premium	Prospectively determined rate for insurance coverage for specific health benefits. Generally, a health insurance plan will have different premium rates for single subscribers, married subscribers and for subscribers with dependants.
Premium, Community-Rated	Premiums based upon the claims experience of all those insured by the carrier and not dependent upon the claims experience of each policyholder. See community rating .
Premium Cost Sharing	The sharing of the cost of the health plan premium between the employer or other group sponsors and the enrollees.
Premium, Experience-Rated	Premium based on the projected utilization and claims experience of a specific group. See experience rating .
Premium Support	Public subsidy to purchase private insurance.
Premium Tax	A state tax levied on commercial insurance premiums.
Prenatal Care	Services to pregnant women designed to insure that both expectant mother and the newborn are in the best health. A lack of prenatal care early in the pregnancy is associated with low birth weight and infant mortality.
Prepaid Health Plan (PHP)	In Medicaid terminology, a PHP is not the same as an HMO even though the terms are often used interchangeably in commercial managed care business. PHPs can contract on a capitated basis for a non-comprehensive set of services (which is often called partial capitation) or on a cost basis. Federally qualified health centers (FQHCs) can also be designated as PHPs if they meet certain conditions. Also see sub- capitation .
Presumptive Eligibility	See eligibility guarantee .
Prevalence	The number of all new and old cases of a disease in

	a defined population at a particular point in time.
Preventive Care	Comprehensive care emphasizing priorities for prevention, early detection and early treatment of conditions, generally including routine physical examination and immunizations.
Primary Care	Entry-level care which may include diagnostic, therapeutic or preventive services.
Primary Care Case Management (PCCM)	Medicaid managed care option allowed under section 1915(b) of the Social Security Act in which each participant is assigned to a single primary care provider who must authorize most other services such as specialty physician care before they can be reimbursed by Medicaid . See gatekeeper .
Primary Care Network	A plan similar to an HMO which provides health services for a fixed price, relying on participating primary care physicians to serve as "gatekeepers" to control patient access to institutional services and specialty care. The primary care physician determines the patient's need for specialty care and any resulting referrals.
Primary Care Physician (PCP)	A physician designated as responsible to provide specific care to a patient, including evaluation and treatment as well as referral to specialists.
Primary Coverage	That coverage which pays first when an individual is covered under two or more insurance plans.
Prior Approval	An authorization for the delivery of services that must be obtained prior to the delivery of those services. Commonly used in the Medicaid program and managed care plans. See Medicaid , managed care , and utilization review . Also called prospective review or re-approval .
Prior Authorization	See prior approval .
Private Duty Nursing	Medicaid term to refer to covered skilled nursing services provided in the home.
Probationary Period	See Waiting Period .
Process Audit	A type of patient/medical care evaluation study in which the criteria are designed to focus on the components of appropriate clinical intervention.

Professional Liability Insurance

The insurance physicians purchase to help protect them from the financial risks associated with medical liability claims. Also known as [malpractice insurance](#).

Professional Review Organization (PRO)

An organization that reviews the activities and records of a health care provider, institution, or group. The reviewer is generally a physician if a physician is the subject of the review; a group of administrators, physicians, and allied health care personnel if a hospital is the subject of the review; etc. The PRO can be state-sponsored or independent.

Profile Analysis

See [profiling](#).

Profiling

An analytic tool that uses epidemiologic methods to compare practice patterns of providers on the dimensions of cost, service use, or quality of care. The provider's pattern of practice is expressed as a rate aggregated over time for defined population of patients.

Program of All-Inclusive Care for the Elderly (PACE)

A combination [Medicare/Medicaid Waiver](#) that provides day health center-based comprehensive community and medical services. PACE capitates primary, acute and long term care services exclusively for frail dual eligibles at risk of institutionalization.

Proportion Rules

The 75/25 Rule and the 50/50 Rule refer to references in Federally statutory requirements for enrollment composition in a full-risk [Medicaid](#) or [Medicare](#) program. The 75/25 Rule states that an [HMO](#) or [HIO](#) that has a [Medicaid](#) comprehensive risk contract cannot have more than 75 percent of its total enrollment be a combination of [Medicaid](#) and [Medicare](#) risk enrollees. [PHPs](#) sponsored by [FQHCs](#) are exempt from the 75/25 Rule. The 50/50 Rule states that an [HMO](#) or [CMP](#) that has a [Medicare](#) risk contract cannot have more than 50 percent of its total enrollment be a combination of [Medicaid Medicare](#) enrollees.

Proprietary Hospital

An investor-owned hospital operated for the purpose of making a profit for its owner.

Prospective Payment Review Commission

An independent body established by Congress to

	advise it on Medicare policies for reimbursing physicians.
Prospective Payment Assessment Commission (ProPAC)	A Federal commission established under the Social Security Act amendments of 1983 to advise and assist Congress and the DHSS in maintaining and updating the Medicare prospective payment system.
Prospective Payment System (PPS)	A method of financing health care that mandates payments in advance for the provision of services and is based on diagnostic related groups.
Prospective Pricing	Method of third party payment by which prices for services are established in advance for a specified period of time. These prices are firm regardless of the actual costs incurred in a specific episode of care.
Prospective Review	See prior authorization .
Protected Resource Amount (PRA)	See spousal impoverishment protection .
Provider	Generically, a professional engaged in the delivery of health services, including physicians, dentists, nurses, podiatrists, optometrists, clinical psychologists, etc. Hospitals and long term care facilities are also providers. The Medicare program uses the term "provider" more narrowly, to mean participating institutions: hospitals, skilled nursing facilities, home health agencies, etc.
Provider Reimbursement Review Board	A Federal board responsible for making decisions regarding provider appeals on Medicare reimbursement issues.
Provider-Services Network	See provider-sponsored organizations .
Provider-Sponsored Organization (PSO)	A provider-owned entity that is certified by HCFA to participate in the Medicare + Choice program and to assume risk for benefits provided to Medicare beneficiaries. Also referred to as Provider Services Organizations .
Pryor Bill	See Medicaid Prudent Pharmaceutical Purchasing Act .
Public Health Service	A Federal agency responsible for public health

services and programs including biomedical research.

Pure Premium

The costs of claims for covered services for eligible individuals under a health insurance contract. This does not include administrative and other insurance costs included in the total costs incurred by an insurer under a contract.

Qualified Medicare Beneficiary (QMB)

A person whose income falls below 100% of Federal poverty guidelines and whose resources do not exceed twice the resource limit of the [SSI](#) program, for whom the state must pay [the Medicare Part B](#) premiums, deductibles and co-payments. Also see [specified low income Medicare beneficiaries](#).

Quality-Adjusted Life-Year

This unit of measure is one way to quantify health outcomes resulting from some type of intervention. The number of quality-adjusted life-years is the number of years at full health that would be valued equivalently to the number of years of life experienced in a less-desirable health state. For example, if a year of life confined to bed is considered on half as desirable as a year spent in full health, then 10 years of survival confined to bed would be counted as five quality-adjusted life-years.

Quality Assessment

An ongoing process to monitor and evaluate aspects of patient/medical care against pre-established criteria and standards to determine the medical necessity, appropriateness, and effectiveness of the services provided.

Quality Assurance

An interactive management process designed to objectively ensure the appropriateness and effectiveness of patient care. It includes identifying deficiencies, implementing corrective action(s) to improve performance, and monitoring the corrective actions to ensure that quality of care has been enhanced. In the broadest sense, this ongoing process should involve the medical and professional staff, the administration, and the governing body of the health care facility.

Quality Assurance Reform Initiative (QARI)

See [quality improvement system for managed care \(QISMC\)](#).

Quality Compass	Quality assessment tool developed by the National Committee for Quality Assurance.
Quality Improvement	A continuous process that identifies problems in health care delivery, examines solutions to those problems, and regularly monitors the solutions for improvement.
Quality Improvement Organization (QIO)	Organization under contract with HCFA to review quality and cost issues for Medicare . Required to oversee Medicare HMOs . Formerly known as a peer review organization. Can also be used in a more general sense to refer to any independent quality review organization. Also see quality assurance .
Quality Improvement System for Managed Care (QISMC)	Guidelines established by the Federal government for quality assurance in Medicaid managed care plans.
Quality of Care	The degree or grade of excellence with respect to medical services received by patients, administered by providers or programs, in terms of technical competence, need, appropriateness, acceptability, humanity and structure.
Quality-Of-Life Measures	An assessment of patient's perceptions of how they deal with their disease or with their everyday life when suffering from a particular condition. It is subjective in the sense that the kinds of information cannot be measured objectively; however, it has been in health care literature for at least 20 years. It has been tapped in the area of pharmaceuticals most recently in the last five or six years. Through statistical means, the indices that have been developed to measure various aspects of quality of life have been validated over time, and we know that these measures are reliable and reproducible.
Race To The Bottom	Process in which health plans in a highly competitive market reduce the scope of their benefit packages in order to offer lower premiums. Competitors must follow suit or risk attracting sicker enrollees. Also see adverse selection .
Rate Cell	Amount paid for an individual's care in a Medicare HMO based on the relevant adjusted average per capita cost. Also see adjusted average per capita

	cost.
Rate-Setting	The determination by a government body of rates a health care provider may charge private pay patients.
Rating	The process of determining rates for insurance policies or health contracts for individuals, groups, or classes of risks.
Rating Bands	Limits on how much an insurer can vary health insurance premiums to different groups for the same insurance plan.
Reasonable and Customary Fee	A reasonable charge is a charge that, in the context of the community is fair. A customary charge is a charge or fee that falls within the customary range of charges or fees prevailing in a specific geographic area for the provision of a similar service, procedure, or supply.
Recidivism	The frequency of the same patient returning to a provider with the same presenting problems. Usually refers to recurring inpatient hospital services.
Recipient	A person who receives a Medicaid service while eligible for the Medicaid program. Individuals may be Medicaid eligible without being Medicaid recipients. Also see Medicaid .
Reciprocity	The right of an enrollee in a health plan who is temporarily away from home to receive necessary medical care under the arrangements of a health plan in the area in which the enrollee receives medical care.
Reconsideration	Review of an adverse coverage determination that may be requested by the patient or representative, the attending physician, or the hospital. Reconsideration is performed by the original reviewing body, not by an independent appeals panel.
Redlining	An insurance practice used to exclude entire occupations, businesses, geographic areas, and age groups from health insurance coverage to limit loss.
Referral	The recommendation by a physician and/or health

plan for a member to receive care from a different physician or facility.

Refined Diagnosis Related Group (RDRG)

An expanded list of diagnosis related groups to take into account a patient's severity of illness.

Registered Nurse (RN)

An individual who provides nursing services after completing a course of study that results in a baccalaureate degree and who has been legally authorized or registered to practice as an RN and use the RN designation after passing examination by a state board of nurse examiners or similar state authority.

Registered Respiratory Therapist

Aids in the treatment of patients with serious respiratory problems and heart and lung disorders. The therapist assists with long term ventilation procedures, administers breathing treatments and maintains respiratory equipment.

Regulation

An authoritative rule having the force of law dealing with details or procedures for implementing governmental programs. Regulations are issued by executive authority of the Federal or state government. Also see [statute](#).

Rehabilitation

To restore health following an accident, injury or illness.

Acute Rehabilitation: Early rehabilitation phase as soon as medically stable. Primary emphasis is to provide intensive physical and cognitive restorative services in the early months following injury. Typical stay 3-4 months (short term). Based in medical facility.

Sub-Acute Rehabilitation: Post-acute phase of rehabilitation. Capacity to treat for 6-24 months. Need not be hospital based. Stay based on demonstrated improvement.

Transitional Rehabilitation: To prepare for community re-entry. Non-medically based. Emphasis on functional skills for maximum independence. May be in group home or part of a continuum of rehabilitation center. Typical stay 4-8 months. Greater focus on compensation vs. restoration.

Long Term Rehabilitation Program: May be called Extended Rehabilitation. Have full range of rehabilitation services available. Frequently after initial year of rehabilitation when progress is slower. Generally not permanent placement. May

be facility or community based.

Rehabilitative (restorative) Care: Skilled care provided by a trained medical person (physical therapist, R.M., speech therapist).

Reinstated Benefits

When a policy has lapsed due to nonpayment of premiums, benefits may be reinstated at the company's option. It is common for the company to determine proof of insurability before it will do so.

Reinsurance

A mechanism to protect against part or all of the financial losses that may be incurred through insuring for risk. Reinsurance may be used for property and casualty losses as well as for life and health claims. It is a common "stop-loss" mechanism used by self-insured and insured entities throughout the economy, including business and industry, labor organizations, hospitals, HMOs, individual professionals, and even insurance companies. It is commercially available from insurance underwriters. It is also referred to as "risk control insurance." The coverage may be uniquely written for an individual claimant or groups of claimants.

Relative Value Scale (RVS)

An approach to physician reimbursement based upon the time, effort, and skill each service or procedure requires from a physician when compared with other medical services or procedures.

Renewable at the Option of the Insurance Company

This refers to policy contract renewability. The insurance company can choose to cancel the policy on an individual basis.

Renewal

Continuance of coverage under a policy beyond its original term by the acceptance of a premium for a new policy term.

Renewability

Guarantee that coverage cannot be discontinued as long as the insurer continues to do business in that particular market. However, the premium that can be charged is not necessarily protected.

Report Cards

Information on health plan performance presented in a consumer friendly manner to facilitate cross-plan comparisons.

Required Request	A system enacted by state lawmakers in 1987 requiring hospitals to request organs from a deceased's family when the deceased is determined to be medically suitable.
Reserves	Monies earmarked to cover anticipated claims and operating expenses for a set period of time. Reserves are an obligated amount and have three principal components: reserves for known liabilities not yet paid; reserves for losses incurred but unreported; and other reserves for various special purposes, including contingency reserves for unforeseen circumstances.
Resident	<p>(1) A physician in training after medical school graduation. In the modern era, specialties require at least three years of residency training. Many specialties require four years or more, and it is not uncommon for physicians to undertake fellowships for further specialty training after a residency. Also see intern.</p> <p>(2) An individual in a nursing home, assisted living or other residential facility.</p>
Resident Assessment Instrument (RAI)	See minimum data set , or resource utilization groups .
Resident Assessment Protocols (RAPs)	Process used to assess nursing home residents who have problems (such as incontinence, or dementia) that have an especially significant impact on their care. Also see minimum data set , or resource utilization groups .
Resource-Based Relative Value Scale (RBRVS)	Medicare fee schedule for physician services that set a uniform payment in each geographic area for most of the approximately 7,000 medical procedures.
Resource Conservation and Recovery Act (RCRA)	RCRA was put into place to protect human health and the environment by regulating the management of hazardous waste and its disposal. Regulates and monitors the generation, storage, treatment and disposal of hazardous waste and is listed in 40 Codes of Federal Regulations (CFR), part 261.
Resource Utilization Groups (RUGS III)	Patient classification system for nursing home patients used by the Federal government and some states to determine reimbursement levels for

Respiratory Therapy Technician (Uncertified)

nursing home care. Also see [minimum data set](#). Administers treatments to patients by performing arteriopunctures, analyzes blood by utilizing blood gas analyzers. Sets up and operates various types of oxygen and other therapeutic gasses.

Respiratory Therapy Technician Certified (CRTT)

Performs duties as described in Respiratory Therapy Technician, but has an associate degree in respiratory therapy and has successfully completed the certification exam.

Respite Care

Short term care which is needed in order to maintain health or safety and provides temporary relief from care-giving duties to a member of the immediate family (or any other unpaid, primary caregiver). Respite care can include such services as [home care](#), [home health care](#), [adult day care](#) and [institutional care](#).

Rest Residential Care

Residential option providing less care than assisted living, usually at the "board and care" level (i.e. no direct health or personal care services) provided in a congregate facility. Also see [family rest residential care](#), [foster care](#), and [board and care](#).

Restoration of Benefits

Provision of some [LTC](#) policies stating that once an individual is benefit-free for a specified length of time, usually six months, those benefits already paid out are restored.

Retention

Insurance carrier's provision in experience rating for taxes, cost for the assumption of risk, benefit plan administration, maintaining reserves, other expenses and contributions to the return on equity of the insurance company.

Retroactive Review

See [retrospective review](#).

Retrospective Review

A manner of judging medical necessity and appropriate billing practices for services that have already been rendered.

Return of Premium Benefit

A type of non-forfeiture benefit included in some long-term care policies that provides a cash value accumulation and return of premiums in the future to enrollees who receive no policy benefits or minimal benefits while the policy is in force. Exact provisions vary from policy to policy, but generally

provide a greater return the longer the policy is in force and usually deduct the amount of any claims paid before returning premiums to the enrollee.

Review, Concurrent

Assessment of a patient's need for inpatient hospital services at admission and at specified intervals throughout the inpatient stay, using objective criteria to determine the medical necessity of acute inpatient care. Includes admission review, continued stay review, and utilization review.

Review, Peer

An examination by practicing physicians or other health professionals of the medical necessity, appropriateness, and quality of the health care services ordered or provided by other physicians or other health professionals. The efficiency and effectiveness of the patient care services are also reviewed. It may be conducted while the patient is in the hospital (concurrent review) or after discharge (retrospective review).

Review, Private

Review of patient care episodes to ensure the medical necessity and appropriateness of services and charges, usually for services financed through institutional purchaser health benefit programs. Private review services are offered by many entities, including insurance companies and their subsidiary companies specializing in managed care services, hospitals, and foundations for medical care. Peer review organizations (**PRO**), Federally authorized agencies, sell review services to private sector purchasers of health care. There are currently no licensure or certification standards for private review programs.

Private review is usually implemented through a contractual relationship between the purchaser and the reviewing entity; it may also be financed on a fee per review, an annual fee based upon the number of covered individuals, or percentage of the annual premium or expenditure, or some combination, and may include a performance incentive bonus relating the costs of conducting the review services, the projected health plan expenditures, and actual savings.

Review, Utilization

See [utilization review](#).

Rider

A legal document that modifies a health care

services contract or insurance policy, either expanding, decreasing or otherwise revising the coverage to be provided. Also referred to as amendments or endorsements.

Risk

The chance or possibility of loss, often employed as a utilization control mechanism within an [HMO](#) setting. Risk is also defined in insurance terms as the possibility of loss associated with a given population.

Risk Adjuster

A measure used to adjust payments made to a health plan on behalf of a group of enrollees in order to compensate for spending that is expected to be lower or higher than average, based on the health status or demographics of the enrollees.

Risk Adjustment

Enhanced [capitated](#) rate based on mitigating factors such as presence of certain conditions in a sub-population.

Risk Agreement

Term used in the disability community to refer to a signed document by both an individual and a services provider that details the tasks that will be the responsibility of each party. In particular it refers to those services that the consumer does not choose to accept even though the service provider believes they are necessary.

Risk Analysis

The process of evaluating the expected medical costs for a prospective group and determining what product, benefit level and price to offer in order to best meet the needs of the group and the carrier.

Risk Assessment

Anticipating the cost of providing health care to groups of enrollees. Actuarial assessments examine utilization history, demographics, health characteristics, environmental attributes, and other sociological, economic and market characteristics.

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 could be an insurer, a health plan, a self-funded employer or a provider sponsored network, for example.

Risk Contract

A legal agreement between a payer and provider to share in either the net revenues after expenses or

financial losses incurred as a result of providing health care services within a defined delivery system, such as an [HMO](#) or [PPO](#). A percentage of provider or professional payments that are withheld by the payer to satisfy the risk provisions at the end of the fiscal period.

Risk Control Insurance

The acceptance by one or more insurers of a portion of the risk underwritten by another insurer who has contracted for the entire coverage. It is also called reinsurance or stop-loss insurance.

Risk Corridor

Form of risk sharing where loss or profit is limited to a small percentage of the break even point to prevent excessive profiteering or catastrophic losses to a risk bearer such as a managed care organization. Often used by public payers such as state governments in [Medicaid](#) managed care plans.

Risk Factors

Conditions that influence a person's health status and are capable of causing illness or injury, including genetic or biological risk factors, life style, or environmental conditions.

Risk Load

A factor that is multiplied into the rate to offset some adverse characteristic of the group.

Risk Pool

A distinct population group, such as employees of a company, insured against costs of their potential use of health care resources. Premium projections are based on variables such as the age of the covered population, health status, sex, occupation, group size, and location. Structure can provide positive incentives to the participants, such as sharing savings when expenses are below projections; sharing losses when actual expenses exceed budgeted expenses, or a combination of these. May also describe a financial arrangement among providers and payers to safeguard against unexpectedly high expenses or utilization.

Risk Pools, Medically Uninsurable

To facilitate access to health care services for individuals with health risks that are considered medically uninsurable, some states are creating risk pools through legislation. These are funded through a variety of mechanisms, including a premium tax on commercial insurance policies, payroll taxes, general revenues, or a combination of these approaches. Premiums for policies are usually

Risk Pools, Residual Risk

150% or more of the generally available insurance premium to avoid disrupting the insurance market. Small groups that include individuals with known health conditions requiring medical services are considered to be high risk and have premiums that are higher than average for groups of comparable size. Creating a larger pool by merging these groups to spread the risk across a larger base or to seek relief through government-sponsored and funded risk pools are two approaches under consideration to contain the premium costs for residual risk groups.

Risk Product

Insurance plan involving partial or full risk.

Risk Segmentation

Disproportionate numbers of persons with higher than average risk of health problems being concentrated in particular risk pools. Also see [adverse selection](#).

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. That is, where one health plan's expected costs differ from another's due to underlying differences in their enrolled populations.

Risk Sharing

Sharing the opportunity for reward or loss.

Risk Withhold

See [withhold](#).

Robert Wood Johnson Foundation (RWJ)

Largest and most important U.S. philanthropic organization concerned with health care issues. Also see [center for health care strategies](#).

Room and Board

See [board and care](#).

Routine Notification

A system being proposed at the state and national levels requiring hospitals to call a regional telephone number when death is imminent to determine if organs are suitable for transplant.

Scope of Benefits or Coverage

Refers to the range of services, providers, and settings covered by a health benefit plan.

Scored Savings

Amount of savings expected to be obtained from enacting new legislation. The Congressional Budget Office makes official estimates by

calculating the difference in spending projected under current law and under the proposed legislation.

Screening

The method by which managed care organizations limit access to health care for unnecessary reasons. In most HMO's, a phone call to the physician or his or her medical office staff is required before an office visit can be arranged. "Gatekeepers" and concurrent review are other methods of screening patients.

Second Opinion Program

Voluntary or mandatory medical or surgical review program established by a health benefit program to ensure the medical necessity of proposed services or procedures. The second opinion is paid for by the plan and provided by a physician other than the professional recommending the treatment. Payment for care is usually assured under the benefit program regardless of the second opinion recommendation if the patient obtains the second opinion in accordance with the health benefit requirements. Coverage limitations may be imposed upon beneficiaries not complying with mandatory programs. Second opinion programs may be required for inpatient and for ambulatory services and procedures. These programs may be considered a cost containment mechanism as well as a means to help ensure the medical necessity of proposed services.

Secondary Care

Services provided by medical specialists, such as cardiologists, urologists and dermatologists, who generally do not have first contact with patients.

Secondary Coverage

The plan that has the responsibility for payment of any eligible charges not covered by the primary coverage.

Selective Contracting

The practice of a managed care organization (MCO) by which the MCO enters into participation agreements only with certain providers (and not with all providers who qualify) to provide health care services to health plan participants as members of the MCO's provider panel.

Self-Administered Plan

Health benefit plan administered by the employer or health and welfare fund rather than through an insurance carrier or third party administrator.

Self-Funding	Often confused with self-insurance, a self-funded health care plan is funded entirely by the employer. A self-funded plan may be self-administered, or the employer may contract with an outside administrator for an administrative services only arrangement. Self-funded plans obtain stop-loss insurance to cover catastrophic illnesses.
Self-Insurance	The practices of an employer or organization assuming complete responsibility for health care losses of its employees. This usually includes setting up a fund against which claim payments are drawn and claims processing is often handled through an administrative service contract with an independent organization.
Self-Insured	Employers who assume direct responsibility or risk for paying for employees' health care without purchasing health insurance. They usually contract with an outside firm to handle claims payment and/or utilization review.
Self Referral	Arrangements for care beyond primary care made by the patient rather than the provider. HMOs generally specify to which in-house departments or services a patient may self refer. Physicians self-referral is when providers refer patients to a facility in which they have a vested interest.
Sentinel Event	An adverse health event that may have been avoided through appropriate care or alternative interventions. Providers are required to alert JCAHO and often state licensing authorities of all sentinel events, including a review of risk factors, preventative measures and case analysis.
Service Area	The geographic area serviced by the health plan as approved by the state regulatory agencies and/or detailed in the certification of authority.
Service Guideline	A type of practice guideline that presents the appropriate and inappropriate indications for the use of particular diagnostic and therapeutic procedures.
Service Substitution	Use of lower cost, but still effective, service in place of a higher cost service.

Severity Modifier	An adjustment that reflects patient factors, such as severity of illness, morbidity, or risk of complications, on the relative work required to deliver a service.
Shared Risk	An arrangement in which financial liabilities are apportioned among two or more entities. For example, an HMO and the medical group may each agree to share the risk of excessive hospital cost over budgeted amounts on a 50/50 basis.
Shared Savings	A provision of most prepaid health care plans where at least part of the providers' income is directly linked to the financial performance of the plan. If costs are lower than projections, a percentage of these savings are referred to the providers.
Single Contract	Coverage for one person as designated on the enrollment or enrollment change card by the enrollee.
Single Payer	A proposed Federally sponsored universal health insurance coverage to all Americans. Employers would not be required to offer health insurance to their employees. Health insurance companies would not exist in the same capacity as they do today. The Government would establish payment rates for physicians, hospitals and other medical services.
Single Payer System	A system in which everyone is covered under a publicly run health insurance program under which the government or some other single entity serves as the sole source of payment for a broad range of health care services.
Site-of-Service Differential	The difference in the monies paid when the same service is performed in different practice setting or by a different provider. One example would be an examination in an emergency room (ER) versus in a family doctor's office.
Skilled Care	That level of care which: requires the training and skills of a Registered Nurse ; and is prescribed by a doctor for the medical care of the patient ; and may not be provided by less skilled or less intensive

Skilled Nursing Facility (SNF)

care, such as [custodial care](#) or [intermediate care](#).

A facility, either freestanding or part of a hospital, that accepts patients in need of rehabilitation and medical care that is of a lesser intensity than that received in the acute care setting of a hospital.

Small Employer Health Insurance Availability Act

In 1994 the General Assembly enacted modifications to the act expanding its scope to firms with 1-50 employees (previously 2-25 employees).

Small Group Market

Measures aimed at alleviating problem areas in the private insurance marketplace, including guaranteed issuance of policies; limitations or prohibitions on benefit plan limitations or exclusions for preexisting health conditions and an end to experience rating.

Small Group Pooling

All segments of small group businesses when combined into a pool or pools. Claims are determined by a pool and not on a group-specific basis.

Small Market Insurance Reform

Changes in the marketing of insurance to small businesses that increase the availability and affordability of coverage.

Social HMO (S/HMO)

Demonstration [HMO](#) under [Medicare](#) that provides capitated acute and primary care as well as limited long term care coverage to a broad cross section of the elderly population on a voluntary basis. Enrollees are mostly private pay and generally benefit from lower cost sharing than in traditional fee for services Medicare, thereby eliminating the need for [Medigap](#) policies. Also see [health maintenance organization](#), [Medicare](#), and [Medigap](#).

Social Security Act

Law that created [Medicare](#), [Medicaid](#) and other Federal programs under the following titles:
[II](#) = Old Age, Survivors and Disability Insurance Benefits (Social Security or OASDI).
[IV -A](#) = Aid to Families with Dependent Children (AFDC).
[IV-B](#) = Child Welfare
[IV-D](#) = Child Support
[IV-E](#) = Foster Care
[IV-F](#) = Job Opportunities and Basic Skills Training

V = Maternal and Child Health Services
XV = Supplemental Security Income (SSI)
XVIII = Medicare
XIX = Medicaid
XX = Social Services Block Grant (SSBG)
XXI = Child Health Insurance Program (CHIP)

Social Security Administration

The administrative branch of the Federal government established in 1935 to provide old age and survivor benefits.

Social Service Block Grant (SSBG)

Flexible Federal grant program established under [Title XX](#) of the Social Security Act to fund non-medical services for low income persons including some long term care services. Financial eligibility is usually more liberal than [Medicaid](#).

Social Worker

Performs duties directly related to the health of the individual and the family in psychiatric and medical social work. Completion of a baccalaureate degree.

Socialized Medicine

See [single payer system](#).

Sole Community Hospital (SCH)

A hospital which (1) is more than 50 miles from any similar hospital, (2) or is the exclusive provider of services to at least 75 percent of its service area populations or (3) has been designated as an SCH under previous rules. The Medicare DRG program makes special optional payment provisions for SCHs, most of which are rural, including providing that their rates are set permanently so that 75 percent of their payment is hospital-specific and only 25 percent is based on regional [DRG](#) rates.

Special Imaging Technician

Proficient in two of the diagnostic procedures, i.e., nuclear medicine, radiology, ultrasound or CT scan. Must fulfill the specific requirements for each of the two selected specialties.

Special Risk Insurance

Coverage for risks or hazards of a special or unusual nature.

Specialist

A physician who has special experience and expertise in a portion of the medical field. In most instances specific credentials, including residency placement and board certification must be acquired in order to qualify as a specialist.

Specialty Differential	The difference in the relative value or amount paid for the same service when performed by physicians in different specialties.
Specialty HMO	An HMO organized around a specific medical specialty, such as cancer or cardiac care.
Specified Disease Insurance	Insurance providing benefits, subject to a maximum amount, for expenses incurred in connection with the treatment of specified diseases, such as cancer.
Specified Low Income Medicare Beneficiaries (SLMB)	Medicare premiums (but not cost sharing) paid by Medicaid on behalf of certain low income eligibles. Also see qualified Medicare beneficiary .
Speech Therapist (ST)	Speech therapist are trained to evaluate and improve speech and community functioning.
Spend Down	Procedure whereby Medicaid applicants use a portion of savings and other resources on medical expenses in order to meet Medicaid resource eligibility requirements. Can also apply to income spend down for states with a medically needy component to Medicaid (currently not available in Delaware). Also see medically needy .
Sponsor	An organization which selects and manages the choice of health insurance products for a group of individuals. Sponsors include employers, government and quasi-public organizations established to manage insurance choice (e.g., HIPCs).
Spousal Discount	A premium reduction, usually from 10% to 25% of the premium, that some insurers provide when both a wife and husband purchase long-term care policies. Insurers offering such discounts sometimes do so for two people who permanently reside together whether or not they are spouses.
Staff Model HMO	An HMO that delivers health services through a group in which physicians are salaried employees who treat HMO members exclusively.
Staff Nurse	Performs a variety of professional nursing care duties including evaluating and recording physical

and emotional conditions, reporting changes observed to charge nurse or physician, gives and receives reports on each patient, administers prescribed medications orally, by intramuscular injection and by intravenous fluids as ordered, starts and monitors blood transfusions, has knowledge of patients at all times.

Standard Benefits Package

Also referred to in some plans as minimum benefits or uniform benefits, this would include the basic package of preventive and acute care benefits to be offered by all health plans. The standard benefits package may be defined in terms of specific services or in terms of services to be included and excluded, allowing health plans to determine which services are rendered on the basis of appropriateness and medical necessity. The generosity of the standard benefit package will be a key political decision and will have wide ranging implications in terms of program costs, public support, and services available to previously uninsured populations.

Standard Class Rate (SCR)

A base revenue requirement on a per member or per employee basis, multiplied by group demographics information to calculate monthly premium rates.

Standing Referral

A referral to a specialist provider that covers routine visits to that provider. It is a common practice to permit the gatekeeper to make referrals for only a limited number of visits (often 3 or fewer). In cases where the circumstances requires regular visits to a specialist, this type of referral eliminates the need to return to the gatekeeper each time the initial referral expires.

Stark II

The commonly used name for Federal laws and regulations that ban physician referral to entities with which the physician has a financial relationship.

State Defined Plan

An [HMO](#) that is not Federally qualified but meets state requirements to contract on a full-risk [capitation](#) basis for [Medicaid](#) enrollees.

State Mandated Benefits Laws

State laws requiring insurance contracts to provide coverage for certain health services (e.g., in vitro

fertilization) or for services provided by certain health care providers (e.g., audiologists). Self-insureds are exempt from these requirements. There are over 800 mandates nationwide.

State/Private Insurer Long-Term Care Partnerships

Arrangements between some states and certain private insurance companies to provide long-term care insurance. Subject to the specific legal requirements for each state, these partnerships help protect the assets of enrollees who typically must become nearly impoverished before qualifying for [Medicaid](#) assistance for long-term care costs. In general, the state approves the long-term care policies offered by insurers who agree to include state-mandated provisions. Enrollees who purchase the approved policies may protect one dollar in assets for every one dollar in benefits paid by the private insurance coverage. The purpose of these plans is to shift some of the burden for long-term care from [Medicaid](#) programs to private insurance while at the same time allowing insurance purchasers to keep assets they would otherwise have to spend in order to qualify for [Medicaid](#) when the private insurance benefits are exhausted.

State Unit on Aging (SUA)

State Units on Aging are agencies of state government designated by the governor and state legislature as focal points for all matters relating to the needs of older persons within the state. The SUA is responsible for planning, coordinating, funding, and evaluating programs for older persons authorized by both state and Federal governments. The SUA aims to improve the quality of life for older Americans by advocating on their behalf, and by promoting the development of community-based systems of social and health services. Also see [area agency on aging](#).

Statute

Rules defined in law. Statutes are issued by legislative authority of the Federal or state government. Also see [regulation](#).

Stop Loss

Agreed upon point beyond which a managed care organization is no longer liable for costs. Also see risk and risk coordinator.

Stop Loss Insurance

Describes two aspects in insurance. The policyholder may be protected by a ceiling on the

	amount that must be paid out-of-pocket for deductibles and co-insurance for covered services and allowable charges in a policy year. A health plan may purchase insurance to protect the plan against costs that exceed specified levels.
Subacute Care	Care given to patients who require less than a 30-day length of stay in a hospital and who have a more stable condition than those receiving acute care.
Sub-Capitation	Capitation for a limited set of medical services. Also see pre-paid health plan.
Subrogation	The recovery of the cost of services and benefits provided to the enrollee of one MCO when other parties are liable.
Subscriber	The person responsible for payment of premiums or whose employment is the basis for eligibility for members in an HMO or other health plan.
Subscriber Contract	A written agreement, which may also be called a subscriber certificate or a member certificate, describing an individual's health care policy.
Summary Plan Description	A description of the entire benefits package available to an employee as required to be given to persons covered by self-funded plans.
Superbill	A modified claim form that lists specific and/or specialty medical services provided by a physician.
Supplemental Medical Benefits	Health care reform plans normally allow the acceptance of supplemental benefits, which are normally not covered by a standard benefit package. These include services not usually medically necessary such as organ transplant, or enhanced psychiatric services. Consumers would have to pay an additional premium for these benefits.
Supplemental Medical Insurance	Private health insurance, also called medigap , designed to supplement Medicare benefits by covering certain health care costs that are not paid for by the Medicare program.
Supplemental Security Income (SSI)	A Federal program of income support for low

income, aged, blind and disabled persons established by [Title XVI](#) of the Social Security Act. Qualification for SSI often is used to establish Medicaid eligibility.

Supplemental Services

Optional services that a health plan may cover or provide in addition to its basic health services.

Supports

Term used in the disability community to refer to a service that promotes independence and does not treat the individual as a passive recipient of care.

Surgicenter

A separate, freestanding medical facility specializing in outpatient or same-day surgical procedures. Surgicenters drastically reduce the costs associated with hospitalizations for routine surgical procedures because extended inpatient care is not required for the specific disorders treated by them.

Survey and Utilization Reviews (SURS)

Medicaid unit that reviews claims and utilization to ensure that Medicaid funds are being used appropriately.

Swing Beds

Acute care hospital beds that can also be used for long-term care.

Table Rates

See [age/sex rates](#).

Targeting

Process that directs the kinds of services, the concentration of programs and the distribution of funds at defined segments of the population. Also see [greatest economic need](#) and [social need](#).

Tax Cap

This would limit the amount of employer-sponsored health insurance to be excluded from taxable income. A tax cap could be for individuals or employers tax liabilities. There are two reasons for a tax cap: (1) to provide revenues to pay for the cost of covering uninsured and (2) to increase consumer awareness of costs.

Tax Credit

Amount that can be deducted from the actual tax owed.

Tax Deduction

Amount that can be deducted from taxable income, if spent on a specific purpose.

Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA)

A Federal law that authorizes health plans to enter into arrangements with [HCFA](#) for cost and risk contracts.

Tax Incentives

Tax deductions, credits, and rebates affecting insurance benefit decisions.

Teaching Hospital

A hospital that has an accredited medical residency training program and is typically affiliated with a medical school.

Technology Assessment

The term used to describe the evaluation process of new or existing diagnostic and therapeutic devices and procedures. Technology assessment evaluates the effect of a medical procedure, diagnostic tool, medical device, or pharmaceutical product. In the past, technology assessment meant primarily evaluating new equipment, focusing on the clinical safety and efficacy of an intervention, in today's health care world, it includes a broader view of clinical outcomes, such as the effect on a patient's quality of life, and the effect on society.

Telemedicine

Health care consultation and education using telecommunication networks to transmit information.

Temporary Assistance to Need Families (TANF)

A state-based Federal cash assistance program for low-income families. TANF replaces the former cash assistance program known as Aid to Families with Dependent Children ([AFDC](#)). Unlike the former [AFDC](#) program, eligibility for TANF does not automatically convey Medicaid eligibility. Low-income families can qualify for Medicaid based on the [AFDC](#) rules in effect in the State on July 16, 1996.

Tertiary Care

Highly specialized care given to patients who are in danger of disability or death often requiring sophisticated technologies (e.g., neurosurgeons or intensive care units).

Therapeutic Alternatives, Equivalents, or Substitution

A drug that is believed to be therapeutically equivalent (i.e., will achieve the same outcome) to the exact drug prescribed by a physician is substituted by the dispensing pharmacist without the need to obtain the physician's permission.

Therapeutic Devices

May include hospital beds, crutches, wheelchairs,

Third-Party Administrator (TPA)

ramps, intravenous pumps and respirators. Also see [durable medical equipment](#) and [assistive technology](#).

Claims administration service conducted by entities specializing in the management of self-insured benefit programs. The TPA may collect premiums, determine employee eligibility, determine covered services, pay claims, prepare management information reports and provide other administrative services. The TPA is often able to provide reinsurance brokering, cost containment programs, and a full range of employee communication programs. Insurers may sell administrative services to self-insured employers, but this is described as "administrative services only."

Third-Party Payor

An organization that pays for or underwrites coverage for health care expenses.

Third Party Payment

Payment by a private insurer or government program to a health care provider for care given to a patient.

Three Tier Rate

A rate structure that sets monthly premiums based on 1) single person coverage, 2) two-person coverage and 3) family coverage.

Title XVII

See [Medicare](#).

Title XIX

See [Medicaid](#).

Title XX

See [Social Service Block Grant](#).

Title XXI

See [Children's Health Insurance Program](#).

Tort

A negligent or intentional civil wrong not arising out of a contract or statute that injures someone in some way and for which the injured person may sue the wrongdoer for damages.

Tort Reform

Efforts to change the procedural or substantive rules for malpractice claims in the judicial system. Examples include reductions in statutes of limitations, mandatory offsets for collateral sources of payment, caps on non-economic damages, periodic payments of large awards, and limits on attorneys' contingency fees.

Total Compensation Package

The total amount of compensation received by a worker for services rendered including wages or salary and fringe benefits.

Trauma Center

An emergency room that is equipped and staffed to care for serious traumatic injuries. Emergency rooms are classified as Level 1, 2 and 3 trauma centers, with Level 1 being the highest care level. Generally, a Level 1 trauma center will be a large emergency room that has most medical specialties (especially trauma, surgery, orthopedics, and neurosurgery) available on-site or on short notice, has good access to CT Scanning and other technology such as MRI, and is able to care for multiple traumatic injuries of both blunt and penetrating nature.

Treatment Facility

A residential or non-residential facility or program licensed, certified or otherwise authorized to provide treatment of substance abuse or mental illness pursuant to the law or jurisdiction in which treatment is received.

Trend Factor

An adjustment factor to represent the predicted change in the level of costs for services from one period to another due to inflation and utilization increases.

Trending

A calculation used to anticipate future utilization of a group based on past utilization by applying trend factor, the rate at which direct and indirect medical costs are changing.

Triage

The process by which patients are sorted or classified according to the type and urgency of their conditions.

Triple Option Plan

An employee health benefit including an [HMO](#), a [PPO](#), and "traditional" fee-for-service insurance, underwritten by a single insurer. This mechanism enables the insurer to spread its risk. Once the employee elects the coverage option, the decision is locked in for the duration of the policy, usually one year.

Tumor Registrar

Identifies, registers and maintains records of all cancer patients by utilizing the tumor registry data system. Analyzes registry data and disseminates

	information in accordance with professional ethics.
Two Tier Rate	A rate structure that sets monthly premiums based on single person coverage and family coverage.
Ultra-Sound Technician	Performs medical diagnosis using high frequency sound waves and imaging techniques to generate images of cross sections of organs. Works under the direction of a radiologist.
Unbundling	Separating a service into its individual components and billing for each component separately. Also refers to a trend in insurance benefits contracting where the purchaser unbundles or contracts separately for specific services.
Uncompensated Care	The charges for services rendered by providers which are not paid for by the recipient and for which there is usually no third-party coverage. Uncompensated care is usually either charity care or bad debt.
Undergraduate Medical Education	The medical training provided to students in medical or osteopathy school.
Underinsured	People with public or private insurance policies that do not cover all necessary medical services, resulting in out-of-pocket expenses that exceed their ability to pay.
Underwriting	The process of selecting, classifying, evaluating, and assuming risks according to their insurability. Its fundamental purpose is to make sure that the group covered has the same probability of loss and probable amount of loss, within reasonable limits, as the universe on which premium rates or subscriber fees were based.
Uniform Benefits	See standard benefits package .
Uniform Billing Code of 1992 (UB-92)	A revised version of the UB-92, a Federal directive requiring a hospital to follow specific billing procedures, itemizing all services included and billed for on each invoice, implemented October 1, 1993.
Uniform Claim Form	All insurers and self-insurers would be required to use a single claims form and standardized format for electronic claims.

Uniform Health Data Act

Amendment of this act ensures that discharge data currently required of hospitals resides with the state and can be publicly released without prior permission of the hospitals. In addition, the act calls upon the Delaware Health Care Commission to study the feasibility of broadening its scope to apply to other health care facilities, such as nursing homes and ambulatory surgical centers.

Uniform Hospital Discharge Data Set

A defined set of data that gives a minimum description of a hospital discharge. It includes data on age, sex, race, residence of patient, length of stay, diagnosis, physicians, procedures, disposition of the patient and sources of payment.

**Uninsured
Uninsured Population**

People who lack health insurance. An estimated 34 million Americans do not have health insurance. 56% are workers. 28% are children. 16.5% are non-working adults. 83% of workers have private health insurance.

Unit Clerk

See [ward clerk](#).

Universal Access

Access to health insurance coverage for everyone.

Universal Coverage

See [standard benefit package](#).

Urgent Care Center

A medical facility where ambulatory patients can be treated without an appointment, and receive immediate, non-emergency care. The urgent care center may be opened 24 hours a day; patients calling an [HMO](#) after hours with urgent, but not emergent, clinical problems, are often referred to these facilities.

**U.S. Department of Health and Human Services
(HHS)**

The Federal department which regulates and administers health and human service programs in the United States. It was created in 1953 and was known as the Department of Health, Education, and Welfare until 1980 when the U.S. Department of Education was created as a separate department. The Secretary of HHS advises the President on the health, welfare, and income security plans, policies, and programs of the Federal government. Also see Health Care Financing Administration [HCFA](#).

U.S. Department of Housing and Urban

Established in 1965, HUD is the principal Federal

Development (HUD)

agency responsible for programs concerned with housing needs, fair housing opportunities, and improving and developing communities.

Usual, Customary and Reasonable Charges (UCR)

Charges for health care services in a geographical area that are consistent with the charges of identical or similar providers in the same geographic area.

Utilization

The patterns of use of a service or type of service within a specified time, usually expressed in a rate per unit of population-at-risk for a given period (e.g., the number of hospital admissions per year per 1,000 persons in a geographic area).

Utilization Management

The process of evaluating the necessity, appropriateness and efficiency of health care services. A review coordinator gathers information about the proposed hospitalization service or procedure from the patient and/or provider then determines whether it meets established guidelines and criteria.

Utilization Review (UR)

Evaluation of the use of hospital services, including the appropriateness of the admission, length of stay and ancillary services. Review may be conducted concurrently, retrospectively, or in combination. The process uses objective clinical criteria to ensure that the services are medically necessary and provided at the appropriate level of care. UR is conducted by the hospital for its own quality assurance and risk management system, using norms, criteria and standards adopted by its medical staff. Reports summarizing the findings and action taken as a result of the process are regularly provided to the hospital board.

Hospitals conduct their own internally accountability system and comply with multiple delegated and non-delegated UR systems simultaneously. This occurs because of the hospital's legal responsibilities as well as each payer requiring its covered population to comply with its unique system as a condition of claims payment.

Utilization Review, Delegated

An entity external to the hospital under contract to the payer to review services provided a specific population contracts to use hospital personnel to conduct the review process. The norms, criteria

Utilization Review, Non-Delegated

and standards may be those adopted by the hospital medical staff or the external agency may require that its protocols be used. The hospital must report its patient-specific findings to the entity; it may also be required to summarize overall findings from its internal UR process.

An entity external to the hospital under contract to the payer to review services provided a specific covered population operates a separate UR system, using its own norms, criteria and standards and relies upon its own personnel to obtain clinical information. It may use information obtained from clinicians, the patient, family, medical records, or claims information submitted for payment after patient discharge. It may be conducted concurrently or retrospectively, in person or the hospital premises, or by telephone, or by review of documentation.

Utilization Review Accreditation Commission (URAC)

A Washington-based, not-for-profit corporation formed in 1990 and dedicated to improving the quality of utilization review in the health care industry by providing a method of evaluation and accreditation of utilization review programs.

Vendor

See [provider](#).

Ventilator

A mechanical device that assists or replaces that natural mechanism for breathing.

Ventilator Dependent

A person who must rely on a ventilator for survival, whether for a short time, or intermittent time but frequently, or constantly.

Vertical Integration

Consolidation or merger of organizations that provide different types of services in a hierarchical continuum such as a hospital acquiring a nursing home and a home health agency. Also see horizontal integration.

Veterans Administration (VA)

A Federal agency responsible for veterans including VA hospitals and Veterans' benefits. Also see [domicillary care](#).

Vocational Rehabilitation (VR)

A program of services designed to enable people with disabilities to become or remain employed. Originally mandated by the Rehabilitation Act of 1973, VR programs are carried out by individually

	<p>created state agencies. In order to be eligible for VR, a person must have a physical or mental disability that results in a substantial handicap to employment.</p>
Volume Performance Standard	<p>A mechanism to adjust Medicare physician fee updates based on how annual increases in actual Part B expenditures compare to previously predicted rates of increase.</p>
Voucher	<p>A certificate, given usually to low or moderate income individuals that can be used to purchase all or part of a specific item such as insurance or a needed service.</p>
Waiting Periods	<p>A period of time an individual must wait to become eligible for benefits for a specific condition(s) after overall coverage has commenced.</p>
Waiver	<p>Term used to refer to a variety of exceptions or variances allowed to circumvent Federal rules. See Medicare waiver or Medicaid waiver.</p>
Waiver of Premium Provision	<p>Any provision included within or as a rider to an insurance policy providing that, when specified conditions exist, the policy will continue in force without further premium payment. When the specified conditions no longer exist, the insured person resumes paying premiums.</p>
Ward Clerk	<p>Performs clerical work in a hospital nursing unit. Records identifying information on medical records, copies TPR's on patients chart from nurse's records; records physician's orders on medication cards for approval by charge nurse, delivers mail, newspapers, etc., to patients.</p>
Well-Baby Care	<p>Services provided in the first year of a newborn's life to identify, treat and prevent health care problems.</p>
Wellness	<p>A type of preventive medicine associated with an individual's lifestyle which, through a combination of exercise and diet, can reduce health care utilization and costs.</p>
Withhold	<p>See withhold fund.</p>

Withhold Fund

The portion of the monthly capitation payment to physicians withheld by the managed care plan until the end of the year or other time period to create an incentive for efficient care. If the physician exceeds utilization norms for other members of his group or geographic region, he or she loses the fund or part of it. The principal of the withhold fund may be applied to hospital services, specialty referrals, laboratory usage, etc.

Work-Up

The total patient evaluation, which may include laboratory assessments, radiologic series, medical history, and diagnostic procedures.

Workers' Compensation

Programs established by state law to provide medical benefits and compensation for injuries and diseases that occur in the course of employment. The workers compensation program is financed by covered employers insured or self-insured under property and casualty lines and is mandatory for employers in almost all states.

X-Ray Technician

Performs in a technical position taking x-rays of patients upon the request of a physician. Prepares and administers barium and other medical preparations to assure x-ray pictures on specific tests. Assists physicians in performing special procedures.

Yield

Ratio of profit to overall gross income for a given service, insurance product or other business venture.

Acronyms

[A](#) [B](#) [C](#) [D](#) [E](#) [F](#) [G](#) [H](#) [I](#) [J](#) [K](#) [L](#) [M](#) [N](#) [O](#) [P](#) [Q](#) [R](#) [S](#) [T](#) [U](#) [V](#) [W](#) [X](#) [Y](#) [Z](#)

COMMON MEDICAL ABBREVIATIONS AND HEALTH CARE ACRONYMS

AA	Alcoholics Anonymous
AAA	Area Agency on Aging
AAAS	American Association for the Advancement of Science.
AABB	American Association of Blood Banks.
AAFP	American Academy of Family Physicians
AAHC	Accreditation Association for Ambulatory Health Care
AAHE	Association for the Advancement of Health Education.
AAHP	American Association of Health Plans (formerly GHAA and AMCRA)
AAHSA	American Association of Homes & Services for the Aging
AAMA	American Association of Medical Assistants
AAMC	Association of American Medical Colleges
AANA	American Association of Nurse Anesthetist
AAP	American Association of Pathologists
AAPI	American Accreditation Program Inc.
AAPCC	Adjusted average per capita cost
AAPPO	American Association of Preferred Provider Organizations
AARP	American Association of Retired Persons
AART	American Association for Respiratory Therapy

ABC	American Blood Commission
ACC	American College of Cardiology
ACG	American College of Gastroenterology
ACHE	American College of Healthcare Executives
ACIL	American Council of Independent Laboratories
ACLA	American Clinical Laboratory Association
ACLPS	Academy of Clinical Laboratory Physicians and Scientists
ACNHA	American College of Nursing Home Administrators
ACNM	American College of Nurse Midwives
ACOG	American College of Obstetricians and Gynecologists
ACP	American College of Physicians
ACPE	American College of Physician Executives
ACR	Adjusted community rating
ACSW	Academy of Certified Social Workers
ADA	American Dental Association, or American Dietetic Association
ADAA	American Dental Assistants Association
ADFS	Alternative Delivery and Financing System
ADHA	American Dental Hygienists Association
ADL	Activity of daily living
ADS	Alternative delivery system
AFC	Adult Foster Care
AFDC	Aid to Families with Dependant Children

AHA	American Hospital Association, or American Heart Association
AHC	Alternative health care.
AHCA	American Health Care Association
AHCCCS	Arizona Health Care Cost Containment System
AHCPR	Agency for Health Care Policy and Research
AHP	Accountable Health Plans
AHPA	American Health Planning Association
AIDS	Acquired Immunodeficiency Syndrome
ALF	Assisted Living Facility
ALT	Alanine aminotransferase
ALTS	Arizona Long Term Care System
AMA	American Medical Association
AMCP	Academy of Managed Care Pharmacy
AMCPA	American Managed Care Pharmacy Association
AMP	Average manufacturer's price
ANA	American Nurses Association
ANCP	Advanced Nurse Care Practitioner
AND	Associate Degree in Nursing
ANDA	Abbreviated new drug approval
ANOVA	Analysis of variance
AOA	American Osteopathic Association
AoA	Administration on Aging
AOCP	American Osteopathic College of Pathologists

APA	American Psychiatric Association, or American Psychological Association
APDRG	All Patient Diagnosis Related Groups
APF	American Pathology Foundation
APGS	Ambulatory Patient Group
AphA	American Pharmaceutical Association
APHA	American Public Health Association
APN	Advanced Practice Nurse
APPMA	American Pharmaceutical Project Managers Associates
APR	Adjusted Payment Rate
APS	Adult Protective Services
APT	Admissions per 1,000
ARC	AIDS-Related Conditions
ARP	Adjusted Payment Rate
ASAHP	American Society of Allied Health Professionals
ASC	Ambulatory Surgical Center
ASCP	American Society of Clinical Pathologists
ASHP	American Society of Hospital Pharmacists
ASIM	American Society of Internal Medicine
ASO	Administrative services only
ASR	Age/Sex Rates
AUR	Ambulatory utilization review
AWP	Average wholesale price
AZT	Zidovudine

BC/BS	Blue Cross/Blue Shield
BP	Blood pressure
BSA	Body surface area
BSN	Bachelor of Science in Nursing
CalPERS	California Public Employees' Retirement System
CAP	College of American Pathologists, or Capitation
CARF	Commission on Accreditation of Rehabilitation Facilities
CCAC	Continuing Care Accreditation Commission
CCHRI	California Cooperative HEDIS Reporting Initiative
CCN	Community Care Network
CCRC	Continuing Care Retirement Community
CCU	Cardiac care unit
CDC	Centers for Disease Control and Prevention
CEA	Cost-effectiveness analysis
CFR	Code of Federal Regulations
CHA	Catholic Health Association
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CHC	Community Health Center
CHCQ	Commission on Health Care Quality
CHIN	Community Health Information Network
CHIP	Children's Health Insurance Plan
CHO	Comprehensive health organization
CHPA	Community Health Purchasing Alliance

CIL	Center for Independent Living
CLIA	Clinical Laboratory Improvement Act/Amendments
Cmax	Maximum concentration
CME	Continuing Medical Education
CMP	Competitive medical plan
CMR	Computerized Medical Record
CNM	Certified Nurse Midwife
CNO	Community Nursing Organization
CNP	Certified Nurse Practitioner
COB	Coordination of benefits
COBRA	Consolidated Omnibus Budget Reconciliation Act
COC	Certificate of coverage
CON	Certificate of Need
CORF	Comprehensive Outpatient Rehabilitation Facility
CPI	Consumer price index
CPR	Cardiopulmonary resuscitation, or Computerized patient record
CPT	Current Procedural Terminology
CQI	Continuous quality improvement
CRNA	Certified Registered Nurse Anesthetist
CRTT	Certified Respiratory Therapy Technician
DAW	Dispense as written
DD	Developmental Disability
DDS	Doctor of Dental Surgery

DEFRA	Deficit Reduction Act of 1984
DHHS	Department of Health and Human Services
DISPRO	Disproportionate Share Hospital
DMD	Doctor of Dental Medicine
DME	Durable medical equipment
DNR	Do not resuscitate
DO	Doctor of Osteopathy
DOB	Date of birth
DOH	Department of Health
DOS	Date of service
DPH	Doctor of Public Health
DPM	Doctor of Podiatric Medicine
DPR	Drug price review
DPT	Diphtheria - pertussis - tetanus vaccine
DRG	Diagnosis-related group
DRR	Drug regimen review
DSc	Doctor of Science
DSH	Disproportionate Share Hospital
DUE	Drug use evaluation
DUR	Drug utilization review
DVM	Doctor of Veterinary Medicine
Dx	Diagnosis
EAP	Employee assistance program
EBRI	Employee Benefit Research Institute

EDI	Electronic Data Interchange
EEOC	Equal Opportunity Commission
ELP	Essential Lifestyle Planning
EMR	Electronic Medical Record
EMS	Emergency Medical Services
EMT	Emergency medical technician
ENT	Ear, nose, and throat
EOMB	Explanation of Medicare Benefits
EPA	Environmental Protection Agency
EPO	Exclusive provider organization, or Erythropoietin
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
EQRO	External Quality Review Organization
ER	Emergency room
ERISA	Employee Retirement Income Security Act of 1974
ESRD	End Stage Renal Disease
FACCT	Foundation for Accountability
FACHE	Fellow of American College of Health Care Executives
FAHS	Federation of American Health Systems
FASB	Financial Accounting Standards Board
FDA	Food and Drug Administration
FEHBP	Federal Employees Health Benefits Program
FFP	Federal Financial Participation

FFS	Fee for service
FHA	Farmers Home Administration
FMAP	Federal Medical Assistance Percentage
FMLA	Family Medical Leave Act
FOC	Freedom of Choice
FP	Family practitioner
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
FSA	Flexible spending account
FSH	Follicle-stimulating hormone
FTE	Full-time equivalent
FY	Fiscal year
GAO	General Accounting Office
GHAA	Group Health Association of America
GHI	Group Health Inc., or Group Health Institute
GI	Gastrointestinal
GIFT	Gamese intrafallopian transfer
GME	Graduate medical education
GNP	Gross national product
GP	General practitioner
GPO	Group Purchasing Organization
HBO	Health benefits organization
HCBS	Home and Community-Based Services
HCFA	Health Care Financing Administration

HCHP	Harvard Community Health Plan
HCPCS	HCFA Common Procedural Coding System
HCPP	Health Care Prepayment Plan
HEDIS	Healthplan Employer Data and Information Set
HFMA	Healthcare Financial Management Association
Hg	Mercury
HHA	Home health agency
HHS	Department of Health and Human Services
HIAA	Health Insurance Association of America
HIMA	Health Industry Manufacturers Association
HIO	Health Insuring Organization
HIPAA	Health Insurance Portability and Accountability Act
HIPC	Health Insurance Purchasing Cooperative
HL7	Health Level Seven
HMO	Health maintenance organization
HMSA	Health Manpower Shortage Area
HSC	Health Services Corporation
HSP	Health service plan
HSO	Health services organization
HUD	Housing and Urban Development
IADL	Instrumental Activities of Daily Living
ICD-9	International Classification of Diseases, 9 th Edition
ICD-9-CM	International Classification of Diseases, 9 th Edition (Clinical Modification)

ICF	Intermediate Care Facility
ICF/MR	Intermediate Care Facility for Mentally Retarded Persons
ICU	Intensive care unit
IDFS	Integrated delivery and financing system
IG	Inspector General
IME	Independent Medical Evaluation
IP	Inpatient
IPA	Independent practice organization, or Individual practice organization
IPN	Integrated Provider Network
ISN	Integrated Services Network
IU	International unit
IV	Intravenous
JCAHO	Joint Commission on Accreditation of Health Care Organizations
JV	Joint venture
LCP	Licensed clinical psychologist
LCSW	Licensed clinical social worker
LOC	Level of Care
LOS	Length of stay
LPC	Licensed professional counselor
LPN	Licensed practical nurse
LSW	Licensed Social Worker
LTC	Long-term care

LTCOP	Long term care options program, or Long term care ombudsman program
MAC	Maximum allowable cost
MAMSI	Mid-Atlantic Medical Services
MCCA	Medicare catastrophic coverage act
MCE	Medical Care Evaluation Studies
MCO	Managed care organization
MCR	Modified community rating
MD	Medical doctor
MDC	Major diagnostic category
MDS	Minimum Data Set
MedPAC	Medicare Payment Advisory Commission
MedPAR	Medicare provider analysis and review file
MET	Multiple employer trust
MEWA	Multiple employer welfare arrangement
MF	Medical foundations
MGMA	Medical Group Management Association
MH/SA	Mental health/substance abuse
MIG	Medicare insured group
MIS	Management information systems
MMIS	Medicaid Management Information System
MMPI	Minnesota multiphasic personality inventory
MMS	Medicaid management information system
MOB	Maintenance of benefits
MPH	Master of public health

MPPPA	Medicaid prudent pharmaceutical purchasing act
MRI	Magnetic resonance imaging
MS	Master of science
MSA	Medical savings account
MSDS	Material safety data sheet
MSO	Management services organization
MSS	Medical social services
MSW	Masters in social work
MUD	Medically unnecessary days
NABP	National Association of Boards of Pharmacy
NAEHCA	National Association of Employers on Health Care Action
NAHDO	National Association of Health Data Organizations
NAIC	National Association of Insurance Commissioners
NAM	National Association of Manufacturers
NAMOR	National Association of HMO Regulators
NAPH	National Association of Public Hospitals
NAPM	National Association of Pharmaceutical Manufacturers
NARD	National Association of Retail Druggists
NASW	National Association of Social Workers
NBME	National Board of Medical Examiners
NCH	National Claims History
NCQA	National Committee on Quality Assurance
NCPDP	National Council of Prescription Drug Programs

NDA	New drug approval
NDC	National Drug Code
NF	Nursing Facility
NFPA	National Fire Protection Agency
NHB	National Health Board
NHI	National health insurance
NHLA	National Health Lawyers Association
NHS	National health service
NIA	National Institute on Aging
NIH	National Institutes of Health
NIMMH	National Institute of Mental Health
NMHCC	National Managed Health Care Congress
NMR	Nuclear magnetic resonance, <i>usu.</i> MRI
NP	Nurse practitioner
NPA	National Prescription Audit
NPC	National Pharmaceutical Council
NRC	Nuclear Regulatory Commission
OA	Osteoarthritis, or Open access
OAA	Older American Act
OASIS	Outcomes and Assessment Information Set
OBRA	Omnibus Budget Reconciliation Act
OC	Oral contraceptive
OIG	Office of the Inspector General

OMB	Office of Management and Budget
OPM	Office of Personnel Management
OPO	Organ Procurement Organization
OR	Operating room
OSHA	Occupational Safety and Health Administration
OT	Occupational Therapist
OTA	Office of Technology Assessment
P&T	Pharmacy and Therapeutics Committee
PA	Physicians assistant, or Professional association
PAC	Political Action Committee
PACE	Program of all-inclusive care for the elderly
PASARR	Pre-admission screening and annual resident review
PASS	Plan for achieving self support
PCCM	Primary care case management
PCN	Primary care network
PCP	Primary Care Physician
PCPM	Per contract per month
PCR	Physician contingency reserve
PCPT	Physician's current procedural terminology
PERS	Personal Emergency Response System
PharmD	Doctor of Pharmacy
PhD	Doctor of Philosophy
PHO	Physician-hospital organization

PHP	Prepaid health plan
PhRMA	Pharmaceutical Research and Manufacturers Association
PHS	Public Health Service
PMA	Pharmaceutical Manufacturers Association
PMG	Primary medical group
PMPM	Per member per month
PMPY	Per member per year
POA	Physician Organization Arrangement
POS	Point of service
PPMC	Physician practice management company
PPO	Preferred provider organization
PPRC	Physician Payment Review Commission
PPS	Prospective payment system
PRO	Peer-review organization, or Professional review organization
ProPAC	Prospective Payment Assessment Commission
PRS	Personal Emergency Response System
PSAO	Pharmacy services administration organization
PSN	Provider sponsored/services network
PSO	Provider Services Organization, or Provider Sponsored Organization
PSRO	Professional Standards Regulatory Organization
PsyD	Doctor of psychology
PT	Physical therapist, or Prothrombin time

QA	Quality assurance, or Quality assessment
QALY	Quality of life-year
QARI	Quality assurance reform initiative
QI	Quality improvement
QIO	Quality improvement organization
QISMC	Quality improvement system for managed care
QM	Quality management
QMB	Qualified Medicare Beneficiary
QOL	Quality of life
R&C	Reasonable and customary
RAI	Resident assessment instrument
RAP	Resident assessment protocols
RBRVS	Resource-based relative value scale
RCRA	Resource Conservation and Recovery Act
RDRG	Refined Diagnosis Related Group
RFP	Request for proposal
RMC	Rating method code
RN	Registered nurse
ROI	Return on investment
RPh	Registered pharmacist
RUGS III	Resource utilization groups
RV	Residual volume
RVS	Residual volume scale
RWJ	Robert Wood Johnson Foundation

SCH	Sole community hospital
SCR	Standard class rate
SD	Standard deviation
SE	Standard error
SEM	Standard error of the mean
S/HMO	Social health maintenance organization
SIC	Standard industry code
SLMB	Specified low income Medicare beneficiaries
SMI	Supplementary medical insurance
SMSA	Standard metropolitan statistical area
SNF	Skilled nursing facility
SSBG	Social Service Block Grant
SSI	Supplemental Security Income
ST	Speech Therapist
SUA	State unit on aging
SURS	Survey and utilization reviews
TA	Technology assessment
TANF	Temporary assistance to needy families
TEFRA	Tax Equity and Fiscal Responsibility Act of 1982
TPA	Third-party administrator
TPN	Total parenteral nutrition
TQM	Total quality management
U	Unit
UB	Uniform billing

UB-92	Uniform Billing Code of 1992
U&C or UC	Usual and customary
UCR	Usual, customary, and reasonable
UM	Utilization management
UR	Utilization review
URAC	Utilization Review Accreditation Commission
URO	Utilization review organization
US	Ultrasound
USAN	United State Adopted Names
USP	United States Pharmacopoeia
USPCC	United States per capita cost
VA	Veterans Administration
VHA	Volunteer Hospital Association
VR	Vocational rehabilitation
WHO	World Health Organization
YTD	Year to date