# Glossary of Terms Commonly Used in Health Care

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# Foreword

"The chief merit of language is clearness, and we know that nothing detracts so much from this as do unfamiliar terms."

– Galen (A.D. 129-199)

This glossary is intended to be used primarily as a reference guide for health care policymakers. It is periodically updated and edited to reflect the changing lexicon of health care terms and concepts. Major sources of original definitions include the publications, articles, and Web sites listed in Appendix B, as well as personal communication with experts in health care policy and service delivery.

The glossary is divided into three sections: (a) health care delivery and financing terms; (b) epidemiological and statistical terms; and (c) accounting and economic terms. It also includes an appendix that lists commonly used acronyms.

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# HEALTH CARE DELIVERY AND FINANCING TERMS

## A

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

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

**active error**
An error that occurs at the level of the front line operator and whose effects are felt almost immediately.

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

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

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

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

**adverse drug reaction (ADR)**
An undesirable response associated with use of a drug that compromises therapeutic efficacy, enhances toxicity, or both.

**adverse event**
In a medical context, an injury resulting from a medical intervention.

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

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

**Agency for Health Care Policy and Research (AHCPR)**
*See Agency for Healthcare Research and Quality*

**Agency for Healthcare Research and Quality (AHRQ)**
AHRQ was created in December 1989 as the Agency for Health Care Policy and Research (AHCPR), a Public Health Service agency within the U.S. Department of Health and Human Services reporting to the Secretary. The agency was reauthorized December 1999, as the Agency for Healthcare Research and Quality. AHRQ's mission is to support research designed to improve the outcomes and quality of health care, reduce its costs, address patient safety and medical errors, and broaden access to effective services. The research sponsored, conducted, and disseminated by AHRQ provides information that helps people

make better decisions about health care.

**Aid to Families with Dependent Children (AFDC)**
A program established by the Social Security Act of 1935 and eliminated by welfare reform legislation in 1996. AFDC provided cash payments to needy children (and their caretakers) who lacked support because at least one parent was unavailable. Families had to meet income and resource criteria specified by the state to be eligible. AFDC has been replaced by a new block grant program, but AFDC standards are retained for use in Medicaid. *See Temporary Assistance to Needy Families*

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

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

**allowable costs**
Items or elements of an institution's costs that are reimbursable under a payment formula. Both Medicare and Medicaid reimburse hospitals on the basis of only certain costs. Allowable costs may exclude, for example, luxury accommodations, costs that are not reasonable expenditures, or that are unnecessary for the efficient delivery of health services to persons covered under the program in question.

**ambulatory care**
All types of health services that are provided on an outpatient basis, in contrast to services provided in the home or to persons who are inpatients. While

many inpatients may be ambulatory, the term ambulatory care usually implies that the patient must travel to a location to receive services that do not require an overnight stay. *See also ambulatory setting and outpatient*

**ambulatory payment classification (APC)**
The basis for payment for care in the Outpatient Prospective Payment System. The APC is used in a fashion similar to the way DRGs (Diagnosis Related Groups) are used for payment for inpatients. Both APCs and DRGs are intended to represent groups of patients that are similar clinically and that also have roughly the same resource consumption. The significant difference between them is that APCs depend on the *procedures* performed whereas DRGs depend on the *diagnoses* treated.

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

**American Association of Health Plans (AAHP)**
The AAHP, located in Washington, D.C., represents more than 1,000 HMOs, PPOs, and other network-based plans. Together they care for close to 140 million Americans nationwide. AAHP was created in 1996 by the merger of the Group Health Association of America (GHAA) and the American Managed Care and Review Association (AMCRA). The merger of the two groups created a new organization that delivers a unified message about the modern style of health care delivery pioneered by HMOs, PPOs, and similar health plans.

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

**anonymous reporting**
An error reporting method used to protect the identity of those individuals who report medical errors so that their reports cannot be easily used in civil lawsuits against them. Under anonymous reporting, data that could identify the reporter are omitted from the report. *See de-identification*

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

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

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

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

**assignment**
A process in which a Medicare beneficiary agrees to have Medicare's share of the cost of a service paid directly ("assigned") to a doctor or other provider, and the provider agrees to accept the Medicare approved charge as payment in full. Medicare pays 80 percent of the cost and the beneficiary 20 percent, for most services. *See participating physician*

**assisted living**
A broad range of residential care services that includes some assistance with activities of daily living and instrumental activities of daily living, but does not include nursing services such as administration of medication. Assisted living facilities and in-home assisted living care stress independence and generally provide less intensive care than that delivered in nursing homes and other long-term care institutions.

**Average Wholesale Price (AWP) of Prescription Drugs**
The average wholesale price of a drug relates to the price that wholesalers charge pharmacies, and is often used by pharmacists to price prescriptions. Drug manufacturers and labelers commonly publish suggested wholesale prices for their products. Price surveys of wholesalers are also available.

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

## B

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

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

**behavioral health**
An umbrella term that includes mental health and substance abuse, and frequently is used to distinguish from "physical" health. Healthcare services provided for depression or alcoholism would be considered behavioral health care, while setting a broken leg would be physical health. *See parity*

**Behavioral Risk Factor Surveillance System (BRFSS)**
The BRFSS, the world's largest telephone survey, tracks risk behaviors related to chronic diseases, injuries, and death in the United States. Administered and supported by the Division of Adult and Community Health, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention, the BRFSS is an ongoing data collection program. By 1994, all states, the District of Columbia, and three territories were participating in the BRFSS.

**benchmark**
A level of care set as a goal to be attained. Internal benchmarks are derived from similar processes or services within an organization. Competitive benchmarks are comparisons with the best external competitors in the field. Generic benchmarks are drawn from the best performance of similar processes in other industries.

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

**biased selection**
The market imperfection that results from the uneven grouping of risks among competing subscribers. Biased selection includes favorable selection (attracting good risks and repelling bad ones) as well as adverse selection (the reverse). Biased selection can occur naturally, according to historical or accidental patterns, or it can occur strategically, according to conscious choices by either subscribers or insurers.

**bioterrorism**
The unlawful use, or threatened use, of microorganisms or toxins derived from living organisms to produce death or disease in humans, animals, or plants. The act is intended to create fear and/or intimidate governments or societies in the pursuit of political, religious, or ideological goals.

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

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

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

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

## C

**cafeteria benefits plan**
An arrangement under which employees may choose their own benefit structure, allowing employees to tailor their benefits package to best meet their specific needs. For example, an employee with no dependents may forgo life insurance but may prefer more comprehensive health insurance package.

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

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

**capitation**
A method of payment for health services in which an individual or institutional provider is paid a fixed amount for each person served, without regard to the actual number or nature of services provided to each person in a set period of time. Capitation is the characteristic payment method in certain health maintenance organizations. It also refers to a method of Federal support of health professional schools. Under these authorizations, each eligible school receives a fixed payment, called a "capitation grant," from the Federal government for each student enrolled.

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

**carve out**
Regarding health insurance, an arrangement whereby an employer eliminates coverage for a specific category of services (e.g., vision care, mental health/psychological services, and prescription drugs) and contracts with a separate set of providers for those services according to a

predetermined fee schedule or capitation arrangement. Carve out may also refer to a method of coordinating dual coverage for an individual.

**case-based**
Refers to a single patient or case.

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

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

**case severity**
A measure of intensity or gravity of a given condition or diagnosis for a patient.

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

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

**categorically needy**
Persons whose Medicaid eligibility is based on their family, age or disability status. Persons not falling into these categories cannot qualify, no matter how low their income. The Medicaid statute defines over 50 distinct population groups as potentially eligible, including those for which coverage is mandatory in all states and those that may be covered at a state's option. The scope of covered services that states provide to the categorically needy is much broader than the minimum scope of services for the other, optional groups receiving Medicaid benefits. *See medically needy*

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

**Centers for Medicare and Medicaid Services (CMS)**
The government agency within the Department of Health and Human Services that directs the Medicare and Medicaid programs (Titles XVIII and XIX of the Social Security Act) and conducts research to support those programs. Formerly the Health Care Financing Administration (HCFA).

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

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

**certified nurse aide (CNA)**
A nurse aide that has completed required State training and competency testing in the skills required to work as a nurse aide.

**CHAMPUS (Civilian Health and Medical**

**Program of the Uniformed Services)**
A former Department of Defense health care program for members of the military, eligible dependents, and military retirees. *See TRICARE*

**charity care**
Generally refers to physician and hospital services provided to persons who are unable to pay for the cost of services, especially those who are low-income, uninsured, and underinsured. A high proportion of the costs of charity care is derived from services for children and pregnant women (e.g., neonatal intensive care).

**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 Care Model**
The Chronic Care Model is a guide to higher-quality chronic illness management within primary care. The model predicts that improvement in six interrelated areas can produce system reform in which informed, activated patients interact with prepared, proactive practice teams. The model was developed by the MacColl Institute for Healthcare Innovation at the Group Health Cooperative of Puget Sound in Seattle, Washington.

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

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

**clinical condition**
A diagnosis (e.g., cerebrovascular hemorrhage) or a patient state that may be associated with more than one diagnosis (such as paraplegia) or that may be as yet undiagnosed (such as low back pain).

**clinical event**
Services provided to patients (items of history taking, physical examination, preventative care, tests, procedures, drugs, advice) or information on clinical condition or on patient state used as a patient outcome.

**clinical performance measures**
Instruments that estimate the extent to which a health care provider: delivers clinical services that are appropriate for each patient's condition; provides them safely, competently, and in an appropriate time frame; and achieves desired outcomes in terms of those aspects of patient health and patient satisfaction that can be affected by clinical services.

**clinical practice guidelines**
Systematically developed statements to assist practitioners and patients' decisions about health care to be provided for specific clinical circumstances.

**coinsurance**
A cost-sharing requirement under a health insurance policy. It provides that the insured party will assume a portion or percentage of the costs of covered services. The health insurance policy provides that the insurer will reimburse a specified percentage of all, or certain specified, covered medical expenses in excess of any deductible amounts payable by the insured. The insured is then liable for the remainder of the costs until their maximum liability is reached.

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

**community health center (CHC)**
An ambulatory health care program (defined under Section 330 of the Public Health Service Act) usually serving a catchment area that has scarce or nonexistent health services or a population with special health needs. Sometimes known as "neighborhood health center." Community health centers attempt to coordinate Federal, State, and local resources in a single organization capable of delivering both health and related social services to a defined population. While such a center may not directly provide all types of health care, it usually takes responsibility to arrange all health care services needed by its patient population.

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

**Community Mental Health Center (CMHC)**
An entity that provides comprehensive mental health services (principally ambulatory), primarily to individuals residing or employed in a defined catchment area.

**community rating**
A method of calculating health plan premiums using the average cost of actual or anticipated health services for all subscribers within a specific geographic area. The premium does not vary for different groups or subgroups of subscribers to reflect their specific claims experience or health status. Under modified community rating (the most common form), rates may vary based on subscribers' specific demographic characteristics (such as age and gender), but rate variation based on individuals' health status, claims experience, or policy duration is prohibited. "Pure" community rating prohibits rate variation based on demographic as well as health factors, and all subscribers in an area pay the same rate.

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

**co-morbidities**
Conditions that exist at the same time as the primary condition in the same patient (e.g., hypertension is a co-morbidity of many conditions such as diabetes, ischemic heart disease, end-stage renal disease, etc.).

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

**Computerized Needs-oriented Quality Measurement Evaluation System (CONQUEST)**
CONQUEST was developed by the Agency for Healthcare Research and Quality (AHRQ) as a tool that permits users to collect and evaluate health care quality measures to find those suited to or adaptable to their needs. CONQUEST has interlocking databases describing "Measures" and clinical "Conditions." The Measure Database contains information on clinical performance measures—tools to assess the quality of the health care delivered by providers. The Condition Database contains information on incidence, prevalence, cost and utilization, co-morbidities, risk factors, treatments, and guidelines. These databases link by codes for clinical services and health outcomes related to specific measures and conditions.

**computerized physician order entry (CPOE)**
Electronic systems in which physicians enter and transmit medication orders as well as orders for radiology, lab work, and other ancillary services. Physician order entry systems help catch and prevent errors by checking physician orders against potential drug to drug interactions, normal dosages, and diagnostic or therapeutic guidelines. Physician order entry systems also prevent medical errors due to misreading of hand-written orders.

**consumer**
A person who purchases or receives goods or services for personal needs or use and not for resale.

**Consumer Assessment of Health Plans® (CAHPS)**
CAHPS is a five-year project funded by the Agency for Healthcare Research and Quality (AHRQ) to help consumers identify the best health care plans and services for their needs. The goals of CAHPS are to (1) develop and test questionnaires that assess health plans and services, (2) produce easily understandable reports for communicating survey information to consumers, and (3) evaluate the usefulness of these reports for consumers in selecting health care plans and services. CAHPS builds on previous focus groups and research about consumer needs for health care decision making as well as public and private survey and report card efforts. The Centers for Medicare and Medicaid Services (CMS) uses CAHPS to assist Medicare beneficiaries in choosing among managed care and fee-for-service plans. CMS works with States to support their implementation of Medicaid CAHPS in sites where it is being used, and promotes its use in State Children's Health Insurance Programs (SCHIP).

**continuing medical education (CME)**
Formal education obtained by a health professional after completing his/her degree and full-time postgraduate training. For physicians, some States require CME (usually 50 hours per year) for continued licensure, as do some specialty boards for certification.

**conversion**
A transaction where all or part of the assets of a health care organization undergo a shift in profit status (non-profit, public, or for-profit) through sale, lease, joint venture, or operating/management agreements.

**continuum of care**
Clinical services provided during a single inpatient hospitalization or for multiple conditions over a lifetime. It provides a basis for evaluating quality, cost, and utilization over the long term.

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

**copayments**
A fixed amount of money paid by a health plan enrollee (beneficiary) at the time of service. For example, the enrollee may pay a $10 "copay" at every physician office visit, and $5 for each drug prescription filled. The health plan pays the remainder of the charge directly to the provider. This is a method of cost-sharing between the enrollee and the plan, and serves as an incentive for the enrollee to use healthcare resources wisely. An enrollee might be offered a lower price benefit package in return for a higher copayment. *See coinsurance and deductible*

**cost-based reimbursement**
Payment made by a health plan or payor to health care providers based on the actual costs incurred in the delivery of care and services to plan beneficiaries. This method of paying providers is still used by some plans; however, cost-based reimbursement is being replaced by prospective payment and other payment mechanisms.

**cost-benefit analysis**
An analytic method in which a program's cost is compared to the program's benefits for a period of time, expressed in dollars, as an aid in determining the best investment of resources. For example, the cost of establishing an immunization service might be compared with the total cost of medical care and lost productivity that will be eliminated as a result of more persons being immunized. Cost-benefit analysis can also be applied to specific medical tests and treatments.

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

**cost consequence analysis (CCA)**
A form of cost effectiveness analysis comparing alternative interventions or programs in which the components of incremental costs (e.g., additional therapies, hospitalization) and consequences (e.g., health outcomes, adverse effects) are computed and listed, without aggregating these results (e.g., into a cost-effectiveness ratio).

**cost-effectiveness analysis (CEA)**
A form of analysis that seeks to determine the costs and effectiveness of a medical intervention compared to similar alternative interventions to determine the relative degree to which they will obtain the desired health outcome(s). Cost-effectiveness analysis can be applied to any of a number of standards such as median life expectancy or quality of life following an intervention.

**cost minimization analysis (CMA)**
An assessment of the least costly intervention/technology among alternatives that produce equivalent outcomes.

**cost of illness analysis (COI)**
An assessment of the economic impact of an illness or condition, including treatment costs.

**cost of living allowance (COLA)**
Increase to an individual's salary or other benefit payment, usually after the first year of payments. May be a flat percentage (e.g., 3 percent) or tied to changes in inflation. For example, in some states, workers' compensation income replacement benefits or long-term disability benefits include annual COLAs.

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

**cost-shifting**
Recouping the cost of providing uncompensated care by increasing revenues from some payers to offset losses and lower net payments from other payers.

**cost utility analysis**
A form of cost effectiveness analysis where outcomes are rated in terms of utility, or quality of life, e.g., quality-adjusted life-years (QALYs).

**coverage**
The guarantee against specific losses provided under the terms of an insurance policy. Coverage is sometimes used interchangeably with benefits or

protection, and is also used to mean insurance or insurance contract.

**coverage decision**
A policy decision about categories of health interventions or benefits that will be provided to a population of patients as part of the contract between a health plan and a beneficiary.

**covered entity**
Refers to three types of entities that must comply with Federal health information privacy regulations (i.e., HIPAA Privacy Rule): health care providers, health plans, and health care clearinghouses. For these purposes, health care providers include hospitals, physicians, and other caregivers, as well as researchers, who provide health care and receive, access, or generate individually identifiable health care information.

**covered services**
Health care services covered by an insurance plan.

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

**critical access hospital (CAH)**
A rural hospital designation established by the Medicare Rural Hospital Flexibility Program (MRHFP) enacted as part of the 1997 Balanced Budget Act. Rural hospitals meeting criteria established by their State may apply for critical access hospital status. Designated hospitals are reimbursed based on cost (rather than prospective payment), must comply with Federal and State regulations for CAHs, and are exempt from certain hospital staffing requirements. *See Medicare Rural Hospital Flexibility Program*

**crowd-out**
A phenomenon whereby new public programs or expansions of existing public programs designed to extend coverage to the uninsured prompt some privately insured persons to drop their private coverage and take advantage of the expanded public subsidy.

**cultural competence**
A practitioner's or institution's understanding of and sensitivity to the cultural background and primary language of patients in any component of service delivery, including patient education materials, questionnaires, office or health care organization setting, direct patient care, and public health campaigns.

**Current Population Survey (CPS)**
A national survey conducted annually by the U.S. Department of Commerce, Bureau of the Census, the CPS gathers information on the noninstitutionalized population of the United States. The CPS is the most commonly reported source for the number of persons without health insurance and other information about this population.

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

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

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

## D

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

**defined benefit**
Funding mechanisms for pension plans that can also be applied to health benefits. Typical pension approaches include: (1) pegging benefits to a percentage of an employee's average compensation over his/her entire service or over a particular

number of years; (2) calculation of a flat monthly payment; (3) setting benefits based upon a definite amount for each year of service, either as a percentage of compensation for each year of service or as a flat dollar amount for each year of service.

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

**de-identification**
A process whereby information that could identify the clinician, the reporter, the health care institution, or another organization involved in a medical error are removed from an error report after it is received. This process is used to maintain records of factors that could cause errors, but assure those who report errors that their reports will not be used in civil lawsuits against them. *See anonymous reporting*

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

**detailing**
Provision of information about drug products by sales representatives of the pharmaceutical industry to physicians to influence the physicians' prescribing behavior. Counter detailing is the educational efforts by health care purchasers or insurers to influence physicians' prescribing behaviors, often to counter the detailing efforts of pharmaceutical manufacturers.

**developmental disability (DD)**
A severe, chronic disability that 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 of lifelong or extended duration and are individually planned and coordinated.

**Diagnosis Related Groups (DRGs)**
Groupings of diagnostic categories drawn from the International Classification of Diseases and modified by the presence of a surgical procedure, patient age, presence or absence of significant comorbidities or complications, and other relevant criteria. DRGs are the case-mix measure used in Medicare's prospective payment system.

**direct patient care**
Any activities by a health professional involving direct interaction, treatment, administration of medications, or other therapy or involvement with a patient.

**direct to consumer (DTC) advertising**
The advertising of prescription drugs (or other products) directly to consumers via various conventional means such as television, radio, or periodicals. DTC advertising can be in lieu of, or in addition to, marketing efforts targeting physicians or other health care professionals.

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

**disaster drill**
An exercise, or demonstration, that tests the readiness and capacity of a hospital, a community, or other system to respond to a public health emergency or other disaster.

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

**disease**
May be defined as a failure of the adaptive mechanisms of an organism to counteract adequately, normally, or appropriately to stimuli and stresses to which it is subjected, resulting in a disturbance in the function or structure of some part of the organism. This definition emphasizes that disease is multi factorial and may be prevented or treated by changing any or a combination of the factors. Disease is a very elusive and difficult concept to define, being largely socially defined. Thus, criminality and drug dependence are presently seen by some as diseases, when they were previously considered to be moral or legal problems.

**disease management**
The process of identifying and delivering within selected patient populations (e.g., patients with asthma or diabetes) the most efficient, effective combination of resources, interventions, or pharmaceuticals for the treatment or prevention of a disease. Disease management could include team-based care where physicians and/or other health professionals participate in the delivery and management of care. It also includes the appropriate use of pharmaceuticals.

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

**drug claims processing**
An automated assessment of drug claims at the point of service, meant to detect potential problems that should be addressed before drugs are dispensed to patients (for example, checking patients' eligibility for drug coverage or checking whether the prescription has been filled at another pharmacy in the last prescription cycle).

**drug risk-sharing arrangements**
Health care provider organizations may be at partial, full, or no risk for drug costs. Provider groups at partial risk share in a proportion of savings and/or cost overruns. The group can share in savings if it prescribes less than the budgeted amount ("upside risk"), and it may also share in any over-expenditures ("downside risk"). Groups at full risk realize all of the savings or absorb all of the losses. Groups at no risk absorb none of the losses and profits (typically, risks are absorbed by the HMO or other managed care organization).

**drug utilization review (DUR)**
A formal program for assessing drug prescription and use patterns. DURs typically examine patterns of drug misuse, monitor current therapies, and intervene when prescribing or utilization patterns fall outside pre-established standards. DUR is usually retrospective, but can also be performed before drugs are dispensed. DURs were established by the Omnibus Budget Reconciliation Act (OBRA) in 1990 and are required for Medicaid programs.

**dual-eligible**
A person who is eligible for two health insurance plans, often referring to a Medicare beneficiary who also qualifies for Medicaid benefits.

**durable medical equipment (DME)**
Medical equipment—such as a ventilator, wheelchair, hospital bed, oxygen system, or home dialysis system—that may be prescribed by a physician for a patient's use for an extended period of time.

## E

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

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

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

**emergency medical services (EMS)**
Services utilized in responding to the perceived individual need for immediate treatment for medical, physiological, or psychological illness or injury.

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

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

**enterprise liability**
A plan relating to tort reform in which medical liability is shifted from physicians to health plans (e.g., HMOs). Under such a system, patients would sue the health plan rather than the physician, thereby providing physicians immunity from medical liability.

**epidemic**
A group of cases of a specific disease or illness

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

**evidence-based decision making**
In a health policy context, evidence-based decision making is the application of the best available scientific evidence to policy decisions about specific medical treatments or changes in the delivery system. The goals of evidence-based decision making are to improve the quality of care, increase the efficiency of care delivery, and improve the allocation of health care resources.

**evidence-based medicine**
Evidence-based medicine is the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. This approach must balance the best external evidence with the desires of the patient and the clinical expertise of health care providers.

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

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

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

## F

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

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

**Federal Employees Health Benefits Program (FEHBP)**
A voluntary health insurance subsidy program administered by the Office of Personnel Management for civilian employees (including retirees and dependents) of the federal government. Enrollees select from a number of approved plans, the costs of which are primarily borne by the government.

**federal poverty level (FPL)**
The amount of income determined by the federal Department of Health and Human Services to provide a bare minimum for food, clothing, transportation, shelter, and other necessities. FPL is reported annually and varies according to family size (e.g., for a family of three in 1999, the FPL was $13,880, or $1,157 per month). Public assistance programs usually define income limits in relation to FPL.

**Federally Qualified Health Center (FQHC)**
A health center in a medically under-served area that is eligible to receive cost-based Medicare and Medicaid reimbursement and provide direct reimbursement to nurse practitioners, physician assistants, and certified nurse midwives. Federal legislation creating the FQHC category was enacted in 1989.

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

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

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

**formulary**
A list of drugs, usually by their generic names, and indications for their use. A formulary is intended to include a sufficient range of medicines to enable physicians, dentists, and, as appropriate, other

practitioners to prescribe all medically appropriate treatment for all reasonably common illnesses. An "open" formulary allows coverage for almost all drugs. A "closed" formulary provides coverage for a limited set of drugs. A "managed" formulary includes a list of preferred drugs that the health plan prefers to use because they cost less, are more effective, or for other reasons. A "tiered formulary" financially rewards patients for using generic and formulary drugs by requiring the patient to pay progressively higher copayments for brand-name and non-formulary drugs. For example, in a three-tiered benefit structure, copayments may be $5 for a generic, $10 for a formulary brand product, and $25 for a nonformulary brand product.

**The Foundation for Accountability (FACCT)**
FACCT is a not-for-profit organization dedicated to helping Americans make better health care decisions. FACCT's board of trustees is made up of consumer organizations and purchasers of health care services and insurance representing 80 million Americans. FACCT creates tools that help people understand and use quality information, develops consumer-focused quality measures, supports public education about health care quality, supports efforts to gather and provide quality information, and encourages health policy to empower and inform consumers.

## G

**gatekeeper**
The primary care practitioner in managed care organizations who determines whether the presenting patient needs to see a specialist or requires other non-routine services. The goal is to guide the patient to appropriate services while avoiding unnecessary and costly referrals to specialists.

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

**generic 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 identical to the 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. There are State and Federal regulations regarding generic substitutions.

**genomics**
The study of genomes, which includes gene mapping, gene sequencing, and gene function.

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

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

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

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

**guaranteed issue**
Requirement that insurance carriers offer coverage to groups and/or individuals during some period each year. HIPAA requires that insurance carriers guarantee issue of all products to small groups (2 - 50). Some State laws exceed HIPAA's minimum standards and require carriers to guarantee issue to additional groups and individuals.

**guaranteed renewal**
Requirement that insurance carriers renew existing coverage to groups and/or individuals. HIPAA requires that insurance issuers guarantee renewal of all products to all groups and individuals.

## H

**handicapped**
As defined by Section 504 of the Rehabilitation Act of 1973, any person who has a physical or mental impairment that substantially limits one or more

major life activity, has a record of such impairment, or is regarded as having such an impairment.

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

**Health Care Financing Administration (HCFA)**
*See Centers for Medicare and Medicaid Services*

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

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

**health insurance**
Financial protection against the health care costs arising from disease or accidental bodily injury. Such insurance usually covers all or part of the costs of treating the disease or injury. Insurance may be obtained on either an individual or a group basis. Although the term is often used by policymakers to refer to comprehensive coverage, insurers and regulators use it also to refer to other forms of coverage such as long term care insurance, supplemental insurance, specified disease policies, and accidental death and dismemberment insurance.

**Health Insurance Flexibility and Accountability (HIFA)**
The primary goal of the HIFA demonstration initiative is to encourage new comprehensive State approaches that will increase the number of individuals with health insurance coverage within current-level Medicaid and State Children's Health Insurance Program (SCHIP) resources. The program utilizes CMS Section 1115 waiver authority and emphasizes broad statewide approaches that maximize private health insurance coverage options and target Medicaid and SCHIP resources to populations with incomes below 200 percent of the Federal poverty level (FPL).

**Health Insurance Portability and Accountability Act of 1996 (HIPAA)**
Sometimes referred to as the Kennedy-Kassebaum bill, this legislation sets a precedent for Federal involvement in insurance regulation. It sets minimum standards for regulation of the small group insurance market and for a set group in the individual insurance market in the area of portability and availability of health insurance.

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

**health maintenance organization (HMO)**
An entity with four essential attributes: (1) an organized system providing health care in a geographic area, which accepts the responsibility to provide or otherwise assure the delivery of (2) an agreed-upon set of basic and supplemental health maintenance and treatment services to (3) a voluntarily enrolled group of persons and (4) for which services the entity is reimbursed through a predetermined fixed, periodic prepayment made by, or on behalf of, each person or family unit enrolled. The payment is fixed without regard to the amounts of actual services provided to an individual enrollee. Individual practice associations involving groups or independent physicians can be included under the definition.

**Health Manpower Shortage Area (HMSA)**
An area or group 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 to prevent members of the group from using local providers, or (3) medium and maximum-security correctional institutions and public or non-profit private residential facilities.

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

**health plan**
An organization that provides a defined set of benefits. This term usually refers to an HMO-like entity, as opposed to an indemnity insurer.

**Health Plan Employer Data and Information Set (HEDIS)**
A set of performance measures for health plans developed for the National Committee for Quality Assurance (NCQA) that provides purchasers with information on effectiveness of care, plan finances and costs, and other measures of plan performance and quality.

**health planning**
Planning concerned with improving health, whether undertaken comprehensively for a whole community or for a particular population, type of health service, institution, or health program. The components of health planning include: data assembly and analysis, goal determination, action recommendation, and implementation strategy.

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

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

**health related quality of life (HRQL)**
In public health and in medicine, the concept of health-related quality of life refers to a person or group's perceived physical and mental health over time. Physicians have often used health-related quality of life indicators to measure the effects of chronic illness in their patients in order to better understand how an illness interferes with a person's day-to-day life. Similarly, public health professionals use health-related quality of life indicators to measure the effects of numerous disorders, short- and long-term disabilities, and diseases in different populations. Tracking health-related quality of life in different populations can identify subgroups with poor physical or mental health and can help guide policies or interventions to improve their health.

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

**health risk factors**
Chemical, psychological, physiological, or genetic factors and conditions that predispose an individual to the development of a disease.

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

**health services research**
Health services research is the multidisciplinary field of scientific investigation that studies how social factors, financing systems, organizational structures and processes, health technologies, and personal behaviors affect access to health care, the quality and cost of health care, and ultimately our health and well-being. Its research domains are individuals, families, organizations, institutions, communities, and populations.

**health status**
The state of health of a specified individual, group, or population. It may be measured by obtaining proxies such as people's subjective assessments of their health; by one or more indicators of mortality and morbidity in the population, such as longevity or maternal and infant mortality; or by using the incidence or prevalence of major diseases (communicable, chronic, or nutritional). Conceptually, health status is the proper outcome measure for the effectiveness of a specific population's medical care system, although attempts to relate effects of available medical care to variations in health status have proved difficult.

**Health Systems Agency (HSA)**
A health planning agency created under the National Health Planning and Resources

Development Act of 1974. HSAs were usually nonprofit private organizations and served defined health service areas as designated by the States.

**health technology assessment (HTA)**
The systematic evaluation of properties, effects, or other impacts of health care technology. HTA is intended to inform decision-makers about health technologies and may measure the direct or indirect consequences of a given technology or treatment.

**Healthcare Cost and Utilization Project Quality Indicators (HCUP QIs)**
HCUP QIs comprise a set of 33 clinical performance measures that inform hospitals' self-assessments of inpatient quality of care as well as State and community assessments of access to primary care. Developed by the Agency for Healthcare Research and Quality (AHRQ) as a quick and easy-to-use screening tool, HCUP QIs are intended as a starting point in identifying clinical areas appropriate for further, more in-depth study and analysis. HCUP QIs span three dimensions of care: (1) potentially avoidable adverse hospital outcomes, (2) potentially inappropriate utilization of hospital procedures, and (3) potentially avoidable hospital admissions.

**health care paraprofessional**
Home health aides, certified nurses aides, and personal care attendants who provide direct care and personal support services in hospitals, nursing homes, other institutions, as well as home-based care to the disabled, aged, and infirm.

**high-risk pool**
A subsidized health insurance pool organized by some States as an alternative for individuals who have been denied health insurance because of a medical condition, or whose premiums are rated significantly higher than the average due to health status or claims experience. Commonly operated through an association composed of all health insurers in a State. HIPAA allows States to use high-risk pools as an "acceptable alternative mechanism" that satisfies the statutory requirements for ensuring access to health insurance coverage for certain individuals.

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

**hindsight bias**
A bias in investigating the cause of a medical error or accident where in retrospect the reviewer simplifies the cause of the error to a single element, overlooking multiple contributing factors. The hindsight bias makes it easy to arrive at a simple solution or to blame an individual, but often makes it difficult to determine the true cause(s) of the error or propose systematic solutions.

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

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

**home- and community-based services (HCBS)**
Any care or services provided in a patient's place of residence or in a non-institutional setting located in the immediate community. Home- and community-based services may include home health care, adult day care or day treatment, medical equipment services, or other interventions provided for the purpose of allowing a patient to receive care at home or in their community.

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

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

**hospice**
A program that provides palliative and supportive care for terminally ill patients and their families, either directly or on a consulting basis with the

patient's physician or another community agency. Originally a medieval name for a way station for crusaders where they could be replenished, refreshed, and cared for, hospice is used here for an organized program of care for people going through life's "last station." The whole family is considered the unit of care, and care extends through their period of mourning.

**hospital**
An institution whose primary function is to provide inpatient diagnostic and therapeutic services for a variety of medical conditions, both surgical and nonsurgical. In addition, most hospitals provide some outpatient services, particularly emergency care. Hospitals may be classified by length of stay (short-term or long-term), as teaching or non-teaching, by major type of service (psychiatric, tuberculosis, general, and other specialties, such as maternity, pediatric, or ear, nose and throat), and by type of ownership or control (Federal, State, or local government; for-profit and nonprofit). The hospital system is dominated by the short-term, general, nonprofit community hospital, often called a voluntary hospital.

**human factors research**
The study of the interrelationships between humans, the tools they use, and the environment in which they live and work.

## I

**iatrogenic**
Caused by medical treatment such as a drug side effect or a post-operative infection.

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

**indemnity**
Health insurance benefits provided in the form of cash payments rather than services. An indemnity insurance contract usually defines the maximum amounts that will be paid for covered services.

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

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

**individually identifiable health information**
Information that is a subset of health information, including demographic information collected from an individual, and (1) is created or received by a health care provider, health plan, employer, or health care clearinghouse; and (2) relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and (a) that identifies the individual; or (b) with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

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

**Institute for Healthcare Improvement (IHI)**
A not-for-profit organization created in 1991 to help lead the improvement of health care systems to increase continuously their quality and value. Measures of improvement include improved health status, better clinical outcomes, lower cost, broadened access, greater ease of use, and higher satisfaction for individuals and their communities.

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

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

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

**intensivist**
A physician who focuses his/her practice on the care of critically ill and injured patients. After initial training in internal medicine, anesthesiology, or surgery, additional training in critical care is required to become board-certified as an intensivist.

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

**International Classification of Diseases (ICD)**
A publication of the World Health Organization (WHO), revised periodically and now in its 10th Revision, dated 1994. The full title is *International Statistical Classification of Diseases and Related Health Problems.* This classification, which originated for use in deaths, is used world-wide for that purpose. In addition, it has been used widely in the United States for hospital diagnosis classification since about 1955 through adaptations and modifications made in the United States of the 7th, 8th, and 9th Revisions.

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

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

## J

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

## K

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

## L

**latent error**
An error in design, organization, training, or maintenance that lead to operator errors and whose effects typically lie dormant in the system for lengthy periods of time.

**The Leapfrog Group**
An organization of large health care purchasers whose goal is to use their purchasing power to influence providers and improve patient safety. Leapfrog members follow a set of purchasing principles designed to recognize and reward providers and practices that reduce medical errors.

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

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

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

# M

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

**major depressive disorder**
To be diagnosed with major depressive disorder, a patient must exhibit a depressed mood or loss of interest in most daily activities, plus at least five of nine major symptoms during a two-week period. Major symptoms include: significant weight gain or loss; insomnia or hypersomnia; psychomotor agitation or retardation; fatigue or loss of energy; feelings of guilt or worthlessness; indecisiveness or impaired ability to concentrate; and recurrent thoughts of death or suicide.

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

**managed behavioral health organization**
An organization that assumes the responsibility for managing the behavioral health benefit for an employer or payer organization under a "carve out" arrangement. The management may range from utilization management services to the actual provision of the services through its own organization or provider network. Reimbursement may be on a fee-for-service, shared risk, or full-risk basis. This is a specialty managed care organization (MCO).

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

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

**mandated health insurance benefits**
Minimum health insurance coverage requirements specified by government statute.

**mandatory reporting**
A system under which physicians or other health professionals are required by law to inform health authorities when a specified event occurs (e.g., a medical error or the diagnosis of a certain disease).

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

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

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

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

**medical error**
An error or omission in the medical care provided to a patient. Medical errors can occur in diagnosis,

treatment, preventative monitoring, or in the failure of a piece of medical equipment or another component of the medical system. Often, but not always, medical errors result in adverse events such as injury or death.

**Medical Expenditure Panel Survey (MEPS)**
MEPS is the third in a series of medical expenditure surveys conducted by the AHRQ. It is a nationally representative survey that collects detailed information on the health status, access to care, health care use and expenses, and health insurance coverage of the civilian noninstitutionalized population of the United States and nursing home residents. MEPS comprises four component surveys: the Household Component, the Medical Provider Component, the Insurance Component, and the Nursing Home Component. The Household Component is the core survey and is conducted each year using an overlapping panel design to collect data for two calendar years from each sampled household.

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

**medical informatics**
The systematic study, or science, of the identification, collection, storage, communication, retrieval, and analysis of data about medical care services that can be used to improve decisions made by physicians and managers of health care organizations.

**medically necessary**
A treatment or service that is appropriate and consistent with a patient's diagnosis and that, in accordance with locally accepted standards of practice, cannot be omitted without adversely affecting the patent's condition or the quality of care.

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

**medical review criteria**
Systematically developed statements that can be used to assess the appropriateness of specific health care decisions, services, and outcomes.

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

**medically needy**
Persons who are categorically eligible for Medicaid and whose income, less accumulated medical bills, is below state income limits for the Medicaid program. *See spend down*

**medically underserved population**
A population group experiencing a shortage of personal health services. A medically underserved population may or may not reside in a particular medically underserved area or be defined by its place of residence. Thus, migrants, American Indians, or the inmates of a prison or mental hospital may constitute such a population. The term is defined and used to give priority for Federal assistance (e.g., the National Health Service Corps).

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

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

**Medicare+Choice**
A new Medicare program created by the 1997 Balanced Budget Act. Medicare+Choice allows the Centers for Medicare and Medicaid Services (CMS) to contract with a variety of different managed care and fee-for-service entities offering greater flexibility to Medicare participants. Persons eligible for Medicare parts A and B are also eligible for Medicare+Choice (Medicare part C).

**Medicare-dependent hospital (MDH)**
A category of hospital that has special claim to higher Medicare Prospective Payment System (PPS) rates. The Medicare-dependent hospital (MDH) program, established in 1987, is intended

to support small rural hospitals for which Medicare patients make up a significant percentage of inpatient days or discharges. This greater dependence on Medicare may make these hospitals more financially vulnerable to prospective payment, and the MDH designation is designed to reduce this risk. To qualify, a hospital must be located in a rural area, have no more than 100 beds, not be classified as a sole community hospital, and have at least 60 percent of inpatient days or discharges covered by Medicare.

**Medicare Payment Advisory Commission (MedPAC)**
MedPAC is an independent federal body that advises the U.S. Congress on issues affecting the Medicare program. It was established by the Balanced Budget Act of 1997 (P.L. 105-33), which merged the Prospective Payment Assessment Commission (ProPAC) and the Physician Payment Review Commission (PPRC).

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

**Medicare Rural Hospital Flexibility Program (MRHFP)**
A limited service hospital program created by the Balanced Budget Act of 1997 and modified by the Balanced Budget Refinement Act in 1999. Under the MRHFP, rural hospitals meeting criteria specified by their State can apply to become critical access hospitals. The Program provides regulatory relief and a cost-based payment option for smaller, low-volume facilities that lack the resources needed to meet hospital staffing and other requirements under Medicare. *See Critical Access Hospital*

**medigap policy**
A private health insurance policy offered to Medicare beneficiaries to cover expenses not paid by Medicare. Medigap policies are strictly regulated by Federal rules. Also known as Medicare supplemental insurance.

**mental health**
The state of being of the individual with respect to emotional, social, and behavioral maturity. Although the term is often used to mean "good mental health," mental health is a relative state, varying from time to time in the individual, with some people more mentally healthy than others.

**Metropolitan Medical Response System (MMRS)**
An operational system, developed by the U.S. Department of Health and Human Services, to respond at the local level to a terrorist incident and other public health emergencies that create mass casualties or casualties requiring unique care capabilities.

**morbidity**
The extent of illness, injury, or disability in a defined population. It is usually expressed in general or specific rates of incidence or prevalence.

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

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

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

## N

**The National Association of State Medicaid Directors (NASMD)**
NASMD is a bipartisan, professional, non-profit organization of representatives of state Medicaid agencies (including the District of Columbia and the territories). Since 1979, NASMD has been affiliated with the American Public Human Services Association. The primary purposes of NASMD are to serve as a focal point of communication between the states and the Federal government and to provide an information

network among the states on issues pertinent to the Medicaid program.

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

**National Guideline Clearinghouse (NGC)™**
The NGC™ (sponsored through a partnership between AHRQ, AAHP, and the AMA) is a publicly available electronic repository for clinical practice guidelines and related materials that provides online access to guidelines at www.guideline.gov.

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

**National Pharmaceutical Stockpile (NPS) Program**
The mission of the Centers for Disease Control and Prevention's (CDC) National Pharmaceutical Stockpile (NPS) Program is to ensure the availability and rapid deployment of life-saving pharmaceuticals, antidotes, other medical supplies, and equipment necessary to counter the effects of nerve agents, biological pathogens, and chemical agents. The NPS Program stands ready for immediate deployment to any U.S. location in the event of a terrorist attack using a biological toxin or chemical agent directed against a civilian population.

**near miss**
A medical error that does not result in harm. Also referred to as a *close call.*

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

**network adequacy**
Standards for provider networks to maintain sufficient numbers and types of providers to ensure accessibility of services without unreasonable delays.

**no-fault compensation**
A proposal that all people injured during medical care be automatically reimbursed, even if the care was not negligent. Patients would forfeit their right to sue and instead be paid out of a pool funded by doctors and hospitals. Theoretically, no-fault compensation would save money currently spent on lawsuits and distribute awards to a wider variety and number of injured people.

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

**nurse practitioner**
A registered nurse qualified and specially trained to provide primary care, including primary health care in homes and in ambulatory care facilities, long-term care facilities, and other health care institutions. Nurse practitioners generally function under the supervision of a physician but not necessarily in his/her or her presence. They are usually salaried rather than reimbursed on a fee-for-service basis, although the supervising physician may receive fee-for-service reimbursement for their services.

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

## O

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

**occupational health services**
Health services concerned with the physical, mental, and social well-being of an individual in relation to his/her working environment and with

the adjustment of individuals to their work. The term applies to more than the safety of the workplace and includes health and job satisfaction. In the United States, the principal Federal statute concerned with occupational health is the Occupational Safety and Health Act administered by the Occupational Safety and Health Administration (OSHA) and the National Institute of Occupational Safety and Health (NIOSH).

**Office of Public Health Preparedness (OPHP)**
The Office of Public Health Preparedness (OPHP) directs the Department of Health and Human Services' (HHS) efforts to prepare for, protect against, respond to, and recover from all acts of bioterrorism and other public health emergencies that affect the civilian population, and serves as the focal point within HHS for these activities. OPHP is headed by a director, who reports directly to the Secretary, and serves as the Secretary's principal advisor on HHS activities relating to protecting the civilian population from acts of bioterrorism and other public health emergencies. The office was created in January 2002.

**Olmstead Decision**
A 1999 Supreme Court decision in the case of Olmstead vs. L.C. whereby the court found that unnecessary institutionalization of individuals with disabilities is discrimination under the Americans with Disabilities Act (ADA). The decision has relevance for State Medicaid programs that provide both institutional and home- and community-based long-term care services. The Court explained that a State may meet its obligation under the ADA by having comprehensive, effectively working plans ensuring that individuals with disabilities receive services in the most integrated setting appropriate to their needs.

**Omnibus Budget Reconciliation Act 1990 (OBRA)**
Among its many provisions, OBRA 1990 created a prescription drug rebate program for State Medicaid agencies, established drug utilization review programs for nursing home residents, and encouraged more active involvement by pharmacists in patient care. OBRA 1990 also required the standardization of Medigap policies to curb marketing abuses and facilitate consumer education, and reduced Medicare payments to hospitals, skilled nursing facilities, and home health agencies.

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

**opportunity cost**
The cost of foregone outcomes that could have been achieved through alternative investments.

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

**outcome**
Refers to the "outcome" (finding) of a given diagnostic procedure. It may also refer to cure of the patient, restoration of function, or extension of life. When used for populations or the health care system, it typically refers to changes in birth or death rates, or some similar global measure.

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

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

**outpatient**
A patient who is receiving ambulatory care at a hospital or other facility without being admitted to the facility. Usually, it does not mean people receiving services from a physician's office or other program that also does not provide inpatient care.

## P

**parity**
Equality or comparability between two things. Parity legislation, usually applicable to mental health conditions such as depression or schizophrenia, requires that health insurers adhere to a principle of equal treatment when making decisions regarding mental health benefits compared to medical benefits. Data parity is a term used by researchers to describe the degree to which different data measures are equivalent.

**participating physician**
A physician who agrees by contractual arrangement to accept the rules, terms, and fee schedule of a given health plan or provider network. In Medicare, a physician who signs an agreement to accept assignment on all Medicare claims for one year. *See assignment*

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

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

**patient safety**
A patient's freedom from accidental injury during treatment. Ensuring patient safety involves the establishment of operational systems and processes that minimize the likelihood of errors and maximizes the likelihood of intercepting them when they occur.

**peer review**
Generally, the evaluation by practicing physicians or other professionals of the effectiveness and efficiency of services ordered or performed by other members of the profession (peers). Frequently, peer review refers to review of research by other researchers. *See Quality Improvement Organization (QIO)*

**performance measures**
Methods or instruments to estimate or monitor the extent to which the actions of a health care practitioner or provider conform to practice guidelines, medical review criteria, or standards of quality.

**Per Member Per Month (PMPM)**
A unit of measure referring to health plan costs, revenues, hospital days, or patient visits.

**pharmaceutical assistance program**
A public program to provide pharmaceutical coverage to those who cannot afford or have difficulty obtaining prescription drugs. Several States operate State-funded pharmaceutical assistance programs, which primarily provide benefits to low-income elderly or persons with disabilities who do not qualify for Medicaid.

**pharmaceutical care system**
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, pharmacist, and nurses toward effective drug therapy outcomes. It is a set of relationships and decisions through which pharmacist, physicians, nurses, and patients work together to design, implement, and monitor a therapeutic plan that will produce specific therapeutic outcomes.

**pharmacoeconomics**
The study of the costs and benefits associated with various pharmaceutical treatments.

**pharmacy benefit manager (PBM)**
Many insurance companies, HMOs, and self-insured employers contract with PBMs to manage drug benefit coverage for employees and health plan members. Common tools employed by PBMs to manage drug benefits include management of pharmacy networks, implementation of generic substitution and mail-order programs, negotiation of rebates with drug manufacturers, formulary management, and clinical programs such as disease management.

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

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

**Physician Payment Review Commission (PPRC)**
Congress created the Physician Payment Review Commission in 1986 to advise it on reforms of the methods used to pay physicians under the Medicare program. The Commission has conducted analyses of physician payment issues and worked closely with the Congress to bring about comprehensive reforms in Medicare physician payment policy. Its recommendations formed the basis of 1989 legislation that created the RBRVS, a resource-based fee schedule limiting the amount physicians may charge patients.

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

**polypharmacy**
Most often, the term refers to the concurrent use of several different medications, which can include more than one medication from the same drug classification. It can also refer to the mixing of multiple drugs into one prescription.

**population-based services**
Health services targeted at populations of patients with specific diseases or disorders (e.g., patients with asthma or diabetes). The concept that the health care can be better administered if patients are examined as populations as well as specific cases is one basis for disease management and managed care.

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

**post-acute care** (also called **subacute care** or **transitional care**)
Type of short-term care provided by many long-term care facilities and hospitals that may include rehabilitation services, specialized care for certain conditions (such as stroke and diabetes), and/or post-surgical care and other services associated with the transition between the hospital and home. Residents on these units often have been hospitalized recently and typically have more complicated medical needs. The goal of subacute care is to discharge residents to their homes or to a lower level of care.

**potentially preventable adverse outcomes**
Complications of a condition that may be modified or prevented with appropriate treatment (e.g., permanent hearing loss as an outcome of otitis media with effusion).

**practice guidelines, parameters**
Standards used to guide providers based on accepted clinical treatment protocols for typical cases.

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

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

**Preferred Drug List (or Drug Formulary)**
A list of prescription drugs which are covered by a health plan (or other payer, e.g., Medicaid). Some drugs may be subject to a prior authorization mechanism, whereby the physician or other prescriber must justify why the patient would need a particular brand-name product. (*See prior authorization.*)

**preferred provider arrangement (PPA)**
Selective contracting with a limited number of health care providers, often at reduced or pre-negotiated rates of payment.

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

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

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

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

country as of the first of the year).

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

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

**primary care provider (PCP)**
A generalist physician (family practice, general internal medicine, general pediatrics, and sometimes obstetrics/gynecology for women patients) who provides primary care services.

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

**primary payer**
The insurer obligated to pay losses before any liability is assumed by other, secondary insurers. Medicare, for instance, is a primary payer with respect to Medicaid.

**prior authorization**
A formal process requiring a provider to obtain approval to provide particular services or procedures before they are done. This is usually required for non-emergency services that are expensive or likely to be abused or overused. A managed care organization will identify those services and procedures that require prior authorization, without which the provider may not be compensated.

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

**Prospective Payment Assessment Commission (ProPAC)**
In 1983, the Congress created the Prospective Payment Assessment Commission to advise the secretary of the Department of Health and Human Services on Medicare's *diagnosis related group*-based prospective payment system. Its members are appointed by the director of the Office of Technology Assessment. The commission's main responsibilities include recommending an appropriate annual percentage change in DRG payments; recommending needed changes in the DRG classification system and individual DRG weights; collecting and evaluating data on medical practices, patterns, and technology; and reporting on its activities.

**Protected Health Information (PHI)** Under the Health Insurance Portability and Accountability Act (HIPAA), PHI is individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. PHI excludes education records covered by the Family Educational Rights and Privacy Act, as amended, 20 U.S.C. 1232g, records described at 20 U.S.C. 1232g(a)(4)(B)(iv), and employment records held by a covered entity in its role as employer.

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

**provider service organization (PSO)**
*See Provider Sponsored Network and Physician-*

**provider sponsored network (PSN)**
Formal affiliations of providers, organized and operated to provide an integrated network of health care providers with which third parties, such as insurance companies, HMOs, or other health plans, may contract for health care services to covered individuals. Some models of integration include physician hospital organizations and management service organizations.

**public health**
The science dealing with the protection and improvement of community health by organized community effort. Public health activities are generally those that are less amenable to being undertaken by individuals or are less effective when undertaken on an individual basis and do not typically include direct personal health services. Public health activities include: immunizations; sanitation; preventive medicine, quarantine and other disease control activities; occupational health and safety programs; assurance of the healthfulness of air, water, and food; health education; epidemiology, and others.

**purchasing organization**
*See health insurance purchasing cooperative (HIPC)*

## Q

**quality-adjusted life years (QALYs)**
Years of life saved by a medical technology or service, adjusted according to the quality of those years (as determined by some evaluative measure). QALYs are the most commonly used unit to express the results in some types of cost-effectiveness analysis.

**Quality Assessment and Performance Improvement Program (QAPI)**
QAPI as part of QISMC, establishes three distinct, but related, strategies for promoting high-quality health care in organizations serving Medicare or Medicaid enrollees. First, each managed care organization must meet certain required levels of performance when providing specific health care and related services to enrollees. Second, managed care organizations must conduct performance improvement projects that are outcome-oriented and that achieve demonstrable and sustained improvement in care and services. The standards expect that an organization will continuously monitor its own performance on a variety of dimensions of care and services for enrollees, identify its own areas for potential improvement, carry out individual projects to undertake system interventions to improve care, and monitor the effectiveness of those interventions. Third, the organization must take timely action to correct significant systemic problems that come to its attention through internal surveillance, complaints, or other mechanisms.

**quality assurance reform initiative (QARI)**
A process developed by the Health Care Financing Administration to develop a health care quality improvement system for Medicaid managed care plans.

**quality improvement**
The sum of all the activities that created a desired change in quality. In the health care setting, quality improvement requires a feedback loop that involves the identification of patterns of the care of patients (or of the performance of other systems involved in care), the analysis of those patterns in order to identify opportunities for improvement (or instances of departure from standards of care), and then action to improve the quality of care for future patients.

**Quality Improvement Organization (QIO)**
The Centers for Medicare and Medicaid Services (CMS) administers the Quality Improvement Organization (QIO) Program which is designed to monitor and improve utilization and quality of care for Medicare beneficiaries. The program consists of a national network of 53 QIOs (formerly known as Peer Review Organizations) responsible for each U.S. state, territory, and the District of Columbia. Each QIO maintains a staff of highly qualified, multi-disciplinary experts in medicine, quality improvement, health information management, statistical analysis, computer programming and operations, communications, public relations, and clerical/administrative support. Their mission is to ensure the quality, effectiveness, efficiency, and economy of health care services provided to Medicare beneficiaries. They operate under a contract known as a "statement of work," governed by extensive portions of Titles 11 and 18 of the Social Security Act, Part B, as amended by the Peer Review Improvement Act of 1982.

**Quality Improvement System for Managed Care (QISMC)**
QISMC, developed by HCFA, is a system for ensuring that managed care (now CMS) organizations contracting with Medicare and Medicaid protect and improve the health and satisfaction of enrolled beneficiaries. It consists of a set of standards and guidelines for their use. For Medicare, the QISMC standards and guidelines are the equivalent of a program manual. As such, they represent CMS' administrative interpretation of the Medicare+Choice requirements relating to an organization's operation and performance in the

areas of quality measurement and improvement and the delivery of health care and enrollee services. Medicare+Choice organizations must comply with the QISMC standards and guidelines in order to meet their quality assurance obligations under the Medicare+Choice regulation and the legislation that it implements, the Balanced Budget Act of 1997 (BBA). For Medicaid, the QISMC standards and guidelines are tools that States may choose to use to ensure that Medicaid managed care organizations meet the comparable quality assurance requirements that the BBA and its implementing regulation establish for them.

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

## R

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

**rate-setting**
A method of paying health care providers in which the Federal or State government established payment rates for all payers for various categories of health services.

**reference-based drug pricing**
Reference-based pricing has been adopted both within Canada (in British Columbia and Nova Scotia) and in other countries (including the United States, Australia, New Zealand, and Germany) as a means of limiting expenditures for drug subsidy and insurance programs. Reference-based pricing limits reimbursement for a group of drugs with similar therapeutic application but different active ingredients to the price of the lowest-cost drug within the group (the reference standard). Patients have the option of purchasing drugs that are partially subsidized, in which case they pay the difference between the retail price and the reference price.

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

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

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

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

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

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

**respite care**
Care given to a hospice patient by another caregiver so that the usual caregiver can rest.

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

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

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

**risk-based capital formula**
A method of establishing the minimum amount of capital appropriate for an insurance company to support its overall business operations in consideration of its size, structure, and risk profile. It is used to assess a managed care organization's financial viability and help prevent insolvency.

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

**risk pool**
*See high-risk pool*

**risk selection**
Occurs when a disproportionate share of high or low users of care join a health plan.

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

**root cause analysis**
A process for identifying the basic or causal factor(s) that underlie variations in performance, including the occurrence or possible occurrence of an error.

**rural health clinic (RHC)**
A public or private hospital, clinic, or physician practice designated by the Federal government as in compliance with the Rural Health Clinics Act (Public Law 95-210). The practice must be located in a medically underserved area or a Health Professions Shortage Area and use a physician assistant and/or nurse practitioners to deliver services. A rural health clinic must be licensed by the state and provide preventive services.

**Rural Health Clinics Act**
Establishes a reimbursement mechanism to support the provision of primary care services in rural areas. Public Law 95-210 was enacted in 1977 and authorizes the expanded use of physician assistants, nurse practitioners, and certified nurse practitioners; extends Medicare and Medicaid reimbursement to designated clinics; and raises Medicaid reimbursement levels to those set by Medicare.

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

**rural referral center (RRC)**
A category of hospital that has special claim to higher Medicare Prospective Payment System (PPS) rates. The RRC program, established in 1983, is intended to support high-volume hospitals that treat a large number of complicated cases and function as regional or national referral centers. RRC designation is intended to support the greater intensity and costs these facilities may have.

**Ryan White CARE Act**
Through the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act, health care and support services are provided for persons living with HIV/AIDS. HRSA administers this Act, which was reauthorized by the Congress in 1996 for five years. The metropolitan areas most affected by the HIV epidemic are awarded Title I grants to improve and expand health care. Title II grants to states and territories support essential health care and support services for persons living with HIV/AIDS, including health insurance and AIDS drug assistance programs. Title III(b) supports early intervention in clinical settings such as community and migrant health centers, health care for the homeless programs, and Native Hawaiian health programs. Title IV supports services for women, children, adolescents, and families affected by the HIV epidemic. Part F of the Act supports Special Projects of National Significance (SPNS) and AIDS Education and Training Centers (AETCs).

## S

**safety net**
The network of providers and institutions that provide low cost or free medical care to medically needy, low income, or uninsured populations. The health care safety net can include (but is not

limited to) individual practitioners, public and private hospitals, academic medical centers, and smaller clinics or ambulatory care facilities.

**safety net providers**
Providers that historically have had large Medicaid and indigent care caseloads relative to other providers and are willing to provide services regardless of the patient's ability to pay.

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

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

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

**secondary payer**
An insurer obligated to pay losses above or beyond losses that are assumed by a primary payer.

**secondary prevention**
Early diagnosis, treatment, and follow-up. Secondary prevention activities start with the assumption that illness is already present and that primary prevention was not successful. The goal is to diminish the impact of disease or illness through early detection, diagnosis, and treatment (for example, blood pressure screening, treatment, and follow up programs).

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

**Section 1915(b) Medicaid Waiver**
Section 1915(b) waivers allow states to require Medicaid recipients to enroll in HMOs or other managed care plans in an effort to control costs. The waivers allow states to: implement a primary care case-management system; require Medicaid recipients to choose from a number of competing health plans; provide additional benefits in exchange for savings resulting from recipients' use of cost-effective providers; and limit the providers from which beneficiaries can receive non-emergency treatment. The waivers are granted for two years, with two-year renewals. Often referred to as a "freedom-of-choice waiver."

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

**Selective Serotonin Reuptake Inhibitor (SSRI)**
A class of antidepressant medications. SSRIs can also be used to treat panic disorder, obsessive-compulsive behavior, alcoholism, obesity, and bulimia. Common SSRIs include Prozac, Paxil, and Zoloft.

**sentinel event**
An unexpected occurrence or variation involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The event is called "sentinel" because it sends a signal or sounds a warning that requires immediate attention.

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

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

**SF-12**
A shorter version of the SF-36 (one-page, two-minute) survey form that has been shown to yield summary physical and mental health outcome scores that are interchangeable with those from the SF-36 in both general and specific populations. This shorter version of the SF-36 was published in early 1995 and is already one of the most widely used surveys of health status.

**SF-36**
A comprehensive short-form health status questionnaire with only 36 questions that yields an eight-scale health profile as well as summary measures of health-related quality of life. As documented in more than 750 publications, the SF-36 has proven useful in monitoring general and specific populations, comparing the burden of different diseases, differentiating the health benefits produced by different treatments, and in screening individual patients. The SF-36 is a standard measure of health care quality used by health services researchers and others who monitor quality of care. The survey is produced by Quality Metric Inc.

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

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

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

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

**sole community hospital (SCH)**
A category of hospital that has special claim to higher Medicare Prospective Payment System (PPS) rates. The intent of the SCH program, started in 1983, is to maintain access to needed health services for Medicare beneficiaries by providing financial assistance to hospitals that are geographically isolated. Specific criteria exists to identify SCHs.

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

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

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

**State Children's Health Insurance Program (SCHIP)**
This program was enacted as part of the Balanced Budget Act of 1997, which established Title XXI of the Social Security Act to provide States with $24 billion in Federal funds for 1998-2002 targeting children in families with incomes up to 200 percent of the Federal poverty level.

**state health expenditure account**
State health expenditure accounts (SHEA) provide measures of personal health care spending for

services and products produced in a given State over a given period of time. SHEA typically include personal health care (PHC) expenditures related to hospital care, physician services, dentist services, other health professional services, home health care, nursing home care, and health care products purchased in retail outlets (such as prescription drugs or over-the counter medicines sold in pharmacies and grocery stores, and eyeglasses sold in optical goods stores). SHEA are typically modeled after the national health expenditure (NHE) accounts prepared annually by the Center for Medicare and Medicaid Services. (The NHE, however, also include spending estimates for public health programs, administration, research, and construction of health facilities.) SHEA provide a framework for measuring health care spending and the sources of revenue used to pay those costs. They can be used to track changes in spending patterns over time, record the impact of policy changes on payers and providers of health care, and serve as a basis for projecting future spending.

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

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

**swing-bed hospital**
A hospital participating in the Medicare swing-bed program. This program allows rural hospitals with fewer than 100 beds to provide skilled post-acute care services in acute care beds.

**systems approach**
A school of thought evolving from earlier systems analysis theory, propounding that virtually all outcomes are the result of systems rather than individuals. In practice, the systems approach is characterized by attempts to improve the quality and/or efficiency of a process through improvements to the system.

**systems error**
An error that is not the result of an individual's actions, but the predictable outcome of a series of actions and factors that comprise a diagnostic or treatment process.

## T

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

**telehealth**
The use of telecommunications technologies and electronic information to support long-distance clinical health care, patient and professional health-related education, or public health and health administration.

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

**Temporary Assistance to Needy Families (TANF)**
Title I of the Welfare Reform Act of 1996 converted Federal funding under the former AFDC program to a State block grant program called TANF. *See Aid to Families with Dependent Children*

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

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

**therapeutic interchange**
Authorized exchange of therapeutic alternates in accordance with previously established and approved written guidelines or protocols within a formulary system.

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

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

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

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

**TOPOFF and TOPOFF II (Top Officials)**
A large-scale simulation of a terrorist event that involved high-level officials as well as law enforcement, emergency management first responders, and other non-governmental officials. The exercises were led by the Department of Justice, the Department of State, and the Federal Emergency Management Agency (FEMA) in May, 2000 and May, 2003, respectively.

**TRICARE**
The health care program for members of the military, eligible dependents, and military retirees. TRICARE was formerly called CHAMPUS (Civilian Health and Medical Program of the Uniformed Services).

## U

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

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

**uninsurables**
High-risk persons who do not have health care coverage through private insurance and who fall outside the parameters of risks of standard health underwriting practices.

**uninsured**
People who lack public or private health insurance.

**underwriting**
In insurance, the process of selecting, classifying, evaluating, and assuming risks according to their insurability. Its purpose is to make sure that the group or individual insured has the same probability of loss and probable amount of loss, within reasonable limits, as the universe on which premium rates were based. Since premium rates are based on an expectation of loss, the underwriting process must classify risks into groups with about the same expectation of loss.

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

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

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

## V

**value-based purchasing**
A concept whereby purchasers should hold providers of health care accountable for both cost and quality of care. Value-based purchasing brings together information on the quality of health care, such as patient outcomes and health status, with data on the dollar outlays going towards health. It focuses on managing the use of the health care system to reduce inappropriate care and to identify and reward the best-performing providers. This strategy can be contrasted with more limited efforts to negotiate price discounts, which reduce costs but do little to ensure that quality of care is improved.

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

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

**voluntary reporting**
A medical error reporting system where the reporter chooses to report an error in order to prevent similar errors from occurring in the future. One theory of voluntary reporting systems is that they allow reporters to focus on a set of errors broader than just those that cause serious harm and that they help to detect system weaknesses before the occurrence of serious harm.

## W

**wellness**
A dynamic state of physical, mental, and social well-being. A way of life that equips the individual to realize the full potential of his/her capabilities and to overcome and compensate for weaknesses. A lifestyle which recognizes the importance of nutrition, physical fitness, stress reduction, and self-responsibility. Wellness has been viewed as the result of four key factors over which an individual has varying degrees of control: human biology, environment, health care organization (system), and lifestyle.

**withhold**
A form of compensation whereby a health plan withholds payment to a provider until the end of a period at which time the plan distributes any surplus based on some measure of provider efficiency or performance.

# EPIDEMIOLOGICAL AND STATISTICAL TERMS

## A

**association**
A term signifying a relationship between two or more events or variables. Events are said to be associated when they occur more frequently together than one would expect by chance. Association does not necessarily imply a causal relationship. Statistical significance testing enables a researcher to determine the likelihood of observing the sample relationship by chance if in fact no association exists in the population that was sampled. The terms "association" and "relationship" are often used interchangeably.

## C

**causality**
Relating causes to the effects they produce. Most of epidemiology concerns causality, and several types of causes can be distinguished. A cause is termed "necessary" when a particular variable must always precede an effect. This effect need not be the sole result of the one variable. A cause is termed "sufficient" when a particular variable inevitably initiates or produces an effect. Any given cause may be necessary, sufficient, neither, or both.

**cognitive testing**
In consumer surveys, studying the process of interpretation of questions and the formation and reporting of responses by respondents to learn how to make the questions more accurately obtain the data the questionnaire is seeking.

**comparative standard**
An interval or range based on a random sample for which there is a given probability that the population mean is contained within that interval.

**confidence interval**
A range within which an estimate is deemed to be close to the actual value being measured. In statistical measurements, estimates cannot be said to be exact matches, but rather are defined in terms of their probability of matching the value of the thing being measured.

## D

**denominator**
For a performance measure, the sample of cases that will be observed (e.g., the number of patients discharged alive with a confirmed diagnosis of acute myocardial infarction, excluding patients with bleeding or other specified conditions). *See numerator*

## E

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

**etiology**
Cause. A term used by epidemiologists.

## I

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

**indicator**
A quantitative or statistical measure or gauge for monitoring clinical care.

## M

**measure set**
A collection of measures with a common purpose and developer. *See clinical performance measures*

**meta-analysis**
A statistical procedure to combine results from different studies on a similar topic. The combination of results from multiple studies may produce a stronger conclusion than can be provided by any singular study. Meta-analysis is generally most appropriate when there are not definitive studies on a topic and non-definitive studies are in some disagreement.

## N

**numerator**
For a performance measure, the cases in the denominator group that experience events specified in a medical review criterion (e.g., the number of patients discharged alive with a confirmed diagnosis of acute myocardial infarction, excluding patients with bleeding or other specified conditions, who were discharged on aspirin). *See denominator*

## P

**pathological**
Indicative of or caused by a disease or condition.

**population**
A set of individual persons, objects, or items from which samples are taken for statistical measurement. For example: All of the patients with a disease or condition that are of interest for a particular study—such as all of the cases of myocardial infarction occurring within a given year.

**precision**
In statistics, the quality of being sharply defined or stated. One measure of precision is the number of distinguishable alternatives from which a measurement was selected, sometimes indicated by the number of significant digits in the measurement. Precision can be contrasted with accuracy, which is the degree of conformity of a measure to a standard or true value. Often, however, this contrast is not relevant, because the true value is not known.

**predictive value**
The statistic generated by dividing the number of true positives by the sum of the true positives and false positives. For example, the number of cases with truly good care divided by the sum of the cases with truly good care plus those cases classified with good care who did not receive it yields the likelihood that a patient classified as the recipient of good care actually received good care.

**probability (P value)**
The likelihood that an event will occur. When looking at differences between data samples, statistical techniques are used to determine if the differences are likely to reflect real differences in the whole group from which the sample is drawn or if they are simply the result of random variation in the samples. For example, a probability (or P value) of 1 percent indicates that the differences observed would have occurred by chance in one out of a hundred samples drawn from the same data.

## R

**rate**
A measure of the intensity of the occurrence of an event. For example, the mortality rate equals the number who die in one year divided by the number at risk of dying. Rates are usually expressed using a standard denominator such as 1,000 or 100,000 persons. Rates may also be expressed as percentages.

**rate band**
The allowable variation in insurance premiums as defined in state regulations. Acceptable variation may be expressed as a ratio from highest to lowest (e.g., 3:1) or as a percent of the index rate (e.g., +/- 20 percent). It is used to limit variation for individual factors (such as age, gender, occupation, or geographic region) or to limit variation for all of these factors together (called a composite rate band).

**regression analysis**
Regression analysis is a tool used by economists and others to estimate the relationships among a dependent variable Y and one (or many) independent variable(s) X. The purpose of regression analysis is the "best fit" data points from a straight line down on an XY graph.

**relative risk**
The rate of disease in one group exposed to a particular factor (e.g., a toxic spill) divided by the rate in another group which is not exposed. A relative risk of one (1) indicates that the two groups have the same rate of disease.

**reliability**
The extent to which a measurement can be replicated with low levels of random error in measurement.

**risk or risk factor**
Risk is a term used by epidemiologists to quantify the likelihood that something will occur. A risk factor is something which either increases or decreases an individual's risk of developing a disease. However, it does not mean that, if exposed, an individual will definitely contract a particular disease.

## S

**sample**
In statistical analysis, a sample is a finite subset of a statistical population whose properties are studied to gain information about the whole population or universe.

**secondary data analysis**
Secondary data analysis utilizes existing data sources either through synthesis or integration; meta-analysis is an example of secondary data analysis.

**sensitivity**
A high rate of detection of "true positives" (i.e., the fraction of patients who actually received good care who are classified as recipients of good care).

**specificity**
A high rate of detection of "true negatives" (i.e., the fraction of patients who actually received bad care who are classified as recipients of bad care).

**standard error**
In statistics, the standard error is defined as the standard deviation of an estimate. That is, multiple measurements of a given value will generally group around the mean (or average) value in a normal distribution. The shape of this distribution is known as the standard error.

**survey**
An investigation in which information is systematically collected. A population survey may be conducted by face-to-face inquiry, by self-completed questionnaires, by telephone, by postal service, or in some other way. Each method has its advantages and disadvantages. The generalizability of results depends upon the extent to which those surveyed are representative of the entire population.

## T

**type I error**
Also known as "false positive" or "alpha error." An incorrect judgment or conclusion that occurs when an association is found between variables where, in fact, no association exists. In an experiment, for example, if the experimental procedure does not really have any effect, chance or random error may cause the researcher to conclude that the experimental procedure did have an effect.

**type II error**
Also known as "false negative" or "beta error." An incorrect judgement or conclusion that occurs when no association is found between variables where in fact, an association does exist. In a medical screening, for example, a negative test result may occur by chance in a subject who possesses the attribute for which the test is conducted.

## U

**Unit (of analysis)**
The unit to which a performance measure is applied (e.g., patients, clinician, group of clinicians, institution).

## V

**validity**
The ability of a performance measure to capture what it purports to measure (e.g., a particular aspect of clinical care).

# ACCOUNTING AND ECONOMIC TERMS

## A

**amortization**
The act or process of retiring a debt, usually by equal payments at regular intervals over a specific period of time.

## C

**capital costs**
Expenditures for land, facilities, and major equipment. They are distinguished from operating costs, which include such items as labor, supplies, and administrative expenses.

**capital depreciation**
The decline in value of capital assets (assets of a permanent or fixed nature, such as goods and plant) with use over time. The rate and amount of depreciation is calculated by a variety of different methods (e.g., straight line, sum of the digits, declining balance), which often give quite different results. Third-party reimbursement for health services usually includes an amount intended to be equivalent to the capital depreciation in any given period experienced by the provider of a service.

**capital expenditure**
An expenditure for the acquisition, replacement, modernization, or expansion of facilities or equipment which, under generally accepted accounting principles, is not properly chargeable as an expense of operation and maintenance.

**competition**
A characteristic of market economics in which buyers choose from among alternative goods and services made available in the market by two or more sellers. In a classic competitive market, there are many buyers and many sellers.

**consumer**
One who may receive or is receiving health services. While all people at times consume health services, a consumer, as the term is used in health legislation and programs, is usually someone who is not associated in any direct or indirect way with the provision of health services.

**contractual allowance**
The difference between what hospitals bill and what they receive in payment from third party payers, most commonly government programs. Also known as contractual adjustment.

**contribution margin**
Revenue from sales less all variable expenses.

**cost**
Expenses incurred in the provision of services or goods. Many different kinds of costs are defined and used (see allowable, direct, indirect, and operating costs). Charges, the price of a service or amount billed an individual or third party, may or may not be equal to service costs.

**cost of goods sold**
Inventoriable costs that are expensed because the units are sold; equals beginning inventory plus cost of goods purchased or manufactured minus ending inventory.

**current cost**
Cost stated in terms of current values (of productive capacity) rather than in terms of acquisition cost.

## D

**debt service**
Required payments for interest on and retirement of a debt. The amount needed, supplied, or accrued for meeting such payments during any given accounting period. A budget or operating statement heading for such items.

**default**
Failure to pay debt service when due.

**demand**
In health economics, the amount of a good or service consumers are willing and able to buy at varying prices, given constant income and other factors. Demand should be distinguished from utilization (the amount of services actually used) and need (which has a normative connotation and relates to the amount of goods or services that should be consumed based on professional value judgments).

**direct cost**
A cost that is identifiable directly with a particular activity, service, or product of the program experiencing the costs. These costs do not include the allocation of costs to a cost center that are not specifically attributable to that cost center.

## F

**financial feasibility**
The projected ability of a provider to pay the capital and operating costs associated with the delivery of a proposed health care service.

## G

**gross domestic product (GDP)**
The market value of all goods and services produced by labor and property *within* the United States during a particular period of time. Income from overseas operations of a domestic corporation would not be included in the GDP, but activities carried on within U.S. borders by a foreign company would be. The GDP measures how the U.S. *economy* is doing.

**gross margin**
Net sales minus goods sold. The difference between sales revenues and manufacturing costs as an intermediate step in the computation of operating profits or net income.

## I

**indirect cost**
A cost that cannot be identified directly with a particular activity, service, or product of the entity incurring the cost. Indirect costs are usually apportioned among an entity's services in proportion to each service's share of direct costs.

**interest**
The cost incurred for borrowing funds. Interest is usually expressed as a percentage of the total loan.

**inventory**
A detailed description of quantities and locations of different kinds of facilities, major equipment, and personnel that are available in a geographic area and the amount, type, and distribution of services these resources can support.

## M

**margin**
Revenue less specified expenses.

## O

**operating cost**
necessary to operate an activity that provides health services. These costs normally include costs of personnel, materials, overhead, depreciation, and interest.

**operating margin**
Revenues from sales minus current cost of goods sold. A measure of operating efficiency that is independent of the cost flow assumption for inventory. Sometimes called "current (gross) margin."

**overhead**
The general costs of operating an entity that are allocated to all the revenue producing operations of the entity but which are not directly attributable to a single activity. For a hospital, these costs normally include maintenance of plant, occupancy costs, housekeeping, administration, and others.

## P

**proprietary**
Profit making. Owned and operated for the purpose of making a profit, whether or not one is actually made.

**public good**
A good or service whose benefits may be provided to a group at no more cost than that required to provide it for one person. The benefits of the good are indivisible and individuals cannot be excluded. For example, a public health measure that eradicates smallpox protects all, not just those paying for the vaccination.

## R

**revenue**
The gross amount of earnings received by an entity for the operation of a specific activity. It does not include any deductions for such items as expenses, bad debts, or contractual allowances.

## S

**supply**
In health economics, the quantity of services provided or personnel in a given area.

## W

**working capital**
The sum of an institution's short-term or current assets including cash, marketable (short-term) securities, accounts receivable, and inventories. Net working capital is defined as the excess of total current assets over total current liabilities.

# Appendix A: ACRONYMS

| | |
|---|---|
| AAHP | American Association of Health Plans |
| AAMC | Association of American Medical Colleges; or Association of American Medical Clinics |
| AAPCC | Adjusted Average Per Capital Cost |
| AAPS | American Association of Physicians and Surgeons |
| ABMT | Autologous Bone Marrow Transplant |
| ADA | American Dietetic Association; American Dental Association; or Americans with Disabilities Act |
| ADL | Activities of Daily Living |
| ADR | Adverse Drug Reaction |
| AFDC | Aid to Families with Dependent Children |
| AGPA | American Group Practice Association |
| AHA | American Hospital Association |
| AHCPR | Agency for Health Care Policy and Research |
| AHEC | Area Health Education Center |
| AHRQ | Agency for Healthcare Research and Quality |
| ANA | American Nurses Association |
| ANHA | American Nursing Homes Association |
| AOA | American Optometric Association; American Osteopathic Association |
| APA | Administrative Procedures Act; or American Pharmaceutical Association |
| APC | Ambulatory Payment Classification |
| APDRG | All Patient Diagnosis Related Groups |
| APHA | American Public Health Association; American Protestant Hospital Association |
| ASTHO | Association of State and Territorial Health Officials |
| AWP | Average Wholesale Price |
| BBA | Balanced Budget Act of 1997 |
| BBRA | Balanced Budget Refinement Act of 1999 |
| BCA | Blue Cross Association |
| BCBSA | Blue Cross Blue Shield Association |
| BPHC | Bureau of Primary Health Care |
| BRFSS | Behavioral Risk Factor Surveillance System |
| CAD | Coronary Artery Disease |
| CAH | Critical Access Hospital |
| CAHPS | Consumer Assessment of Health Plans |
| CAP | Community Action Program; Community Access Program |
| CAT | Computerized Axial Tomography |
| CBO | Congressional Budget Office |
| CCA | Cost Consequence Analysis |
| CCHP | Consumer Choice Health Plan |
| CCU | Coronary Care Unit; or Critical Care Unit |
| CDC | Centers for Disease Control and Prevention |
| CERTs | Centers for Education and Research on Therapeutics |
| CHAMPUS | Civilian Health and Medical Program of the Uniformed Services |
| CHC | Community Health Center |
| CHMC | Community Mental Health Center |
| CHMIS | Community Health Management Information System |
| CMA | Cost Minimization Analysis |
| CME | Continuing Medical Education |
| CMP | Competitive Medical Plan |
| CMS | Centers for Medicare and Medicaid Services |
| CNA | Certified Nursing Assistant |
| COB | Coordination of Benefits |
| COG | Council of Governments |
| COI | Cost of Illness Analysis |
| COLA | Cost of Living Allowance |
| CON | Certificate of Need |
| CONQUEST | Computerized Needs-Oriented Quality Measurement Evaluation System |
| COPC | Community Oriented Primary Care |
| COPD | Chronic Obstructive Pulmonary Disease |
| COTH | Council of Teaching Hospitals |
| CPA | Certified Public Accountant |
| CPHA | Commission on Professional and Hospital Activities |
| CPI | Consumer Price Index |
| CPOE | Computerized Physician Order Entry; Computerized Prescription Order Entry |
| CPR | Customary, Prevailing, and Reasonable; or Cardiopulmonary Resuscitation |
| CPT-4 | Current Procedural Terminology, Fourth Edition |
| CQuIPS | Center for Quality Improvement and Patient Safety |
| CRVS | California Relative Value Studies |
| CT | Computerized Tomographic (scanners) |
| DD | Developmental Disability |
| DDS | Doctor of Dental Surgery |

| | |
|---|---|
| DEA | Drug Enforcement Administration |
| DMD | Doctor of Dental Medicine |
| (D)HHS | Department of Health and Human Services |
| DMO | Disease Management Organization |
| DO | Doctor of Osteopathy |
| DRG | Diagnosis Related Group |
| DSH | Disproportionate Share Hospital |
| DTC | Direct to Consumer |
| DUR | Drug Utilization Review |
| DVM | Doctor of Veterinary Medicine |
| EBM | Evidence-Based Medicine |
| ECF | Extended Care Facility |
| EDI | Electronic Data Interchange |
| EMS | Emergency Medical Services |
| EPA | Exclusive Provider Arrangement |
| EPC | Evidence-Based Practice Center |
| EPSDT | Early and Periodic Screening, Diagnosis, and Treatment Program |
| ER | Emergency Room |
| ERISA | Employee Retirement Income Security Act |
| ESRD | End Stage Renal Disease |
| ET | Expenditure Target |
| FACCT | The Foundation for Accountability |
| FAH | Federation of American Hospitals |
| FDA | Food and Drug Administration |
| FEHBP | Federal Employees Health Benefits Program |
| FICA | Federal Insurance Contributions Act |
| FMG | Foreign Medical Graduate |
| FNP | Family Nurse Practitioner |
| FPL | Federal Poverty Level |
| FTC | Federal Trade Commission |
| FQHC | Federally Qualified Health Center |
| FY | Fiscal Year |
| GDP | Gross Domestic Product |
| GHAA | Group Health Association of America |
| GME | Graduate Medical Education |
| GP | General Practitioner |
| HCBS | Home and Community Based Services |
| HCFA | Health Care Financing Administration |
| HCUP-QIs | Healthcare Cost and Utilization Project Quality Indicators |
| HEDIS | Health Plan Employer Data and Information Set |
| HIAA | Health Insurance Association of America |
| HIFA | Health Insurance Flexibility and Accountability |
| HIPAA | Health Insurance Portability and Accountability Act |
| HIPC | Health Insurance Purchasing Cooperative |
| HMO | Health Maintenance Organization |
| HMSA | Health Manpower Shortage Area |
| HPSAs | Health Professional Shortage Areas |
| HRQL | Health Related Quality of Life |
| HRSA | Health Resources and Services Administration |
| HSA | Health Systems Agency; Health Service Area |
| HTA | Health Technology Assessment |
| IADL | Instrumental Activities of Daily Living |
| IBNR | Incurred But Not Reported |
| ICD | International Classification of Diseases |
| ICDA | International Classification of Diseases, Adapted |
| ICF | Intermediate Care Facility |
| ICU | Intensive Care Unit |
| ICU/MR | Intermediate Care Facility for the Mentally Retarded |
| IHI | Institute for Healthcare Improvement |
| IMG | International Medical Graduate |
| IOM | Institute of Medicine of the National Academy of Sciences |
| IPA | Independent Practice Association |
| ISN | Integrated Services Network |
| JAMA | Journal of the American Medical Association |
| JCAHO | Joint Commission on the Accreditation of Healthcare Organizations |
| LOS | Length of Stay |
| LPN | License Practical Nurse |
| LSC | Life Safety Code |
| LVN | Licensed Vocational Nurse |
| LVRS | Lung Volume Reduction Surgery |
| MAAC | Maximum Allowable Actual Charge |
| MAF | Medical Assistance Facility |
| MAP | Medical Audit Program |
| MCAT | Medical College Admission Test |
| MCH | Maternal and Child Health Program |
| MCO | Managed Care Organization |
| MEDLARS | Medical Literature and Analysis Retrieval System |
| MedPAC | Medicare Payment Advisory |

| | |
|---|---|
| | Commission |
| MEPS | Medical Expenditure Panel Survey |
| MET | Multiple Employer Trust |
| MEWA | Multiple Employer Welfare Arrangement |
| MDH | Medicare-dependent Hospital |
| MMIS | Medical Management Information System |
| MMRA | Metropolitan Medical Response System |
| MR | Mentally Retarded |
| MRHFP | Medicare Rural Hospital Flexibility Program |
| MRI | Magnetic Resonance Imaging |
| MSA | Medical Savings Account; Metropolitan Statistical Area |
| MUA/MUPs | Medically Underserved Areas/Populations |
| NACo | National Association of Counties |
| NACCHO | National Association of County and City Health Officials |
| NCHS | National Center for Health Statistics |
| NASHP | National Academy for State Health Policy |
| NASMD | National Association of State Medical Directors |
| NCQA | National Committee for Quality Assurance |
| NGA | National Governors Association |
| NGC | National Guidelines Clearinghouse |
| NHSC | National Health Services Corps |
| NICU | Neonatal Intensive Care Unit |
| NIH | National Institutes of Health |
| NIMH | National Institute of Mental Health |
| NIOSH | National Institute of Occupational Safety and Health |
| NLM | National Library of Medicine |
| NP | Nurse Practitioner |
| NPRM | Notice of Proposed Rulemaking |
| NPS | National Pharmaceutical Stockpile |
| NRHA | National Rural Health Association |
| OAA | Old Age Assistance |
| OASDHI | Old Age Survivors, Disability, and Health Insurance Program |
| OBRA | Omnibus Budget Reconciliation Act |
| ODS | Organized Delivery System |
| OMB | Office of Management and Budget |
| OPD | Outpatient Department |
| OPHP | Office of Public Health Preparedness |
| OSHA | Occupational Health and Safety Administration |
| PA | Physician Assistant |
| PAHO | Pan American Health Organization |
| PBM | Pharmacy Benefits Manager |
| PCCM | Primary Care Case Management |
| PCP | Primary Care Physician |
| PDI | Professional Development Institute |
| PHO | Physician-Hospital Organization |
| PHS | Public Health Service |
| PIAPHP | Partners in Information Access for Public Health Professionals |
| PMPM | Per Member Per Month |
| PPA | Preferred Provider Arrangement |
| PPO | Preferred Provider Organization |
| ProPAC | Prospective Payment Assessment Commission |
| PSN | Provider Sponsored Network |
| PSO | Provider Sponsored Organization |
| QALY | Quality Adjusted Life Year |
| QAPI | Quality Assessment and Performance Improvement Program |
| QARI | Quality Assurance Reform Initiative |
| QIO | Quality Improvement Organization |
| QISMC | Quality Improvement System for Managed Care |
| QuIC | Quality Interagency Coordination Task Force |
| RAN | Rural Area Computer Network |
| RBRVS | Resource-Based Relative Value Scale |
| RCT | Randomized Clinical Trial; or Randomized Controlled Trial |
| RHC | Rural Health Clinic |
| RRC | Rural Referral Centers |
| RWJF | The Robert Wood Johnson Foundation |
| SAMSHA | Substance Abuse and Mental Health Services Administration |
| SCH | Sole Community Hospitals |
| SCHIP | State Children's Health Insurance Program |
| SDMC | Statistical and Data Management Center |
| SHEA | State Health Expenditure Account |
| SNF | Skilled Nursing Facility |
| SSI | Supplemental Security Income |
| SSRI | Selective Serotonin Reuptake Inhibitor |

| | |
|---|---|
| TANF | Temporary Assistance to Needy Families |
| TPA | Third Party Administrator |
| UNICEF | United Nation's Children's Fund |
| USAID | United States Agency for International Development |
| USP | U.S. Pharmacopeia |
| VIRHN | Vertically Integrated Rural Health Network |
| WHO | World Health Organization |
| WRAIR | Walter Reed Army Institute of Research |

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