

## Glossary of Terms in Managed Health Care

The following are definitions of commonly used terms in the medical provider, hospital and managed care industries.

### A

**Abuse** - When used as a legal term in the business of healthcare, it normally refers to actions that do not involve intentional misrepresentations in billing but which, nevertheless, result in improper conduct. Consequences can result in civil liability and administrative sanctions. An example of abuse is the excessive use of medical supplies. (Also see Fraud, OIG, FBI, and Compliance)

**Access** - The patient's ability to obtain medical care. The ease of access is determined by such components as the availability of medical services and their acceptability to the patient, the location of health care facilities, transportation, hours of operation and cost of care. 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.

**Accountable Health Plan (AHP)** - AHPs can be IDSs, MCOs, Health Networks, partnerships or joint ventures between practitioners, providers or payers that would assume responsibility for delivering medical care and managing the funds required to pay for the services rendered. Physicians and other providers would work for, contract with or own these health plans. When an IDS or hospital group or IPA operates one or more health insurance benefit products, or a managed care organization acquires a large scale medical delivery component, it qualifies as an Accountable Health System or Accountable Health Plan.

**Accountable Health Partnership** - An organization of doctors and hospitals that provides care for people organized into large groups of purchasers.

**Accreditation** - The process by which an organization recognizes a provider, a program of study or an institution as meeting predetermined standards. Two organizations that accredit managed care plans are the National Committee for Quality Assurance (NCQA) and the Joint Commission on Accreditation of Health Care Organizations (JCAHO). JCAHO also accredits hospitals and clinics. CARF accredits rehabilitation providers.

**Accrete** - The addition of new recipients to a health plan; a Medicare term.

**Accrual** - The amount of money that is set aside to cover expenses. The accrual is the plan's best estimate of what those expenses are, and (for medical expenses) is based on a combination of data from the authorization system, the claims system, lag studies, and the plan's prior history.

**Actively-at-Work** - Describes insurer's policy requirement indicating that coverage will not go into effect until the employee's first day of work on or after the effective date of coverage. May also apply to dependents disabled on the effective date.

**Activities of Daily Living (ADL's, ADL)** - An individual's daily habits such as bathing, dressing and eating. ADLs are often used as an assessment tool to determine an individual's ability to function at home, or in a less restricted environment of care.

**Activity-Based Costing (ABC)** - Activity-based costing defines healthcare costs in terms of a healthcare organization's processes or activities. The costs are then associated with significant activities or events. It relies on the following 3 step process: 1) Activity mapping, which involves mapping activities in an illustrated sequence; 2) Activity analysis, which involves defining and assigning a time value to activities; and, 3) bill of activities, which involves generating a cost for each main activity.

**Actuarial** - Refers to the statistical calculations used to determine the managed care company's rates and premiums charged their customers based on projections of utilization and cost for a defined population.

**Actuarial Soundness** - The requirement that the development of capitation rates meet common actuarial principles and rules.

**Actuary** - In insurance, a person trained in statistics, accounting and mathematics who determines policy rates, reserves, and dividends by deciding what assumptions should be made with respect to each of the risk factors involved (such as the frequency of occurrence of the peril, the average benefit that will be payable, the rate of investment earnings, if any, expenses, and persistency rates), and who endeavors to secure as valid statistics as possible on which to base his assumptions. Professionally trained individual, usually with experience or education in insurance, who conducts statistical studies such as determining insurance policy rates, dividend reserves and dividends, as well as conducts various other statistical studies. A capitated health provider would not accept or contract for capitated rates, or agree to a capitated contract without an actuarial determining the reasonableness of the rates.

**Acute Care** - A pattern of health care in which a patient is treated for an acute (immediate and severe) episode of illness, for the subsequent treatment of injuries related to an accident or other trauma, or during recovery from surgery. Specialized personnel using complex and sophisticated technical equipment and materials usually give acute care in a hospital. Unlike chronic care, acute care is often necessary for only a short time.

**Adjudication** - Processing claims according to contract.

**Adjusted Admissions** - Adjusted admissions are equivalent to the sum of inpatient admissions and an estimate of the volume of outpatient services. This is a measure of all patient care activity undertaken in a hospital, both inpatient and outpatient. This estimate is calculated by multiplying outpatient visits by the ratio of outpatient charges per visit to inpatient charges per admission.

**Adjusted Average Per Capita Cost (AAPCC)** - 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. CMS's best estimate of the amount of money care costs for Medicare recipients under fee-for-service Medicare in a given area. The AAPCC is made up of 122 different rate cells; 120 of them are factored for age, sex, Medicaid eligibility, institutional status, and whether a person has both part A and part B of Medicare. Actuarial projections of per capita Medicare spending for enrollees in fee-for-service Medicare. Separate AAPCCs are calculated - usually at the county level - for Part A services and Part B services for the aged, disabled, and people with ESRD. Medicare pays risk plans by applying adjustment factors to 95 percent of the Part A and Part B AAPCCs. The adjustment factors reflect differences in Medicare per capita fee-for-service spending related to age, sex, institutional status, Medicaid status, and employment status. A county-level estimate of the average cost incurred by Medicare for each beneficiary in the fee-for-service system. Adjustments are made so that the AAPCC represents the level of spending that would occur if each county contained the same mix of beneficiaries. Medicare pays health plans 95 percent of the AAPCC, adjusted for the characteristics of the enrollees in each plan.

**Adjusted Community Rate (ACR)** - Health plans and insurance companies estimate their ACRs annually and adjust subsequent year supplemental benefits or premiums to return any excess Medicare revenue above the ACR to enrollees. This are the estimated payment rates that health plans with Medicare risk contracts would have received for their Medicare enrollees if paid their private market premiums, adjusted for differences in benefit packages and service use.

**Adjusted drug benefit list** - A small number of medications often prescribed to long-term patient. Also called a drug maintenance list. A health plan, CMS or 3rd party administrator can modify it from time to time. See also Drug Formulary, Formulary.

**Adjusted per capita cost (APCC)** - Medicare benefits estimation for a person in a given county using sex, age, institutional status, Medicaid disability, and end stage renal disease status as a basis.

**Adjusted Community Rating (ACR)** - ACR is a rating by community influenced by certain group demographics. Estimated payment rates that health plans with Medicare risk contracts would have received for their Medicare enrollees if paid their private market premiums, adjusted for differences in benefit packages and service use. Health plans estimate their ACRs annually and adjust subsequent year supplemental benefits or premiums to return any excess Medicare revenue above the ACR to enrollees. See Adjusted Average Per Capita Cost, Medicare Risk Contract. See also Community Rating.

**Adjusted Payment Rate (APR)** - The Medicare capitated payment to risk-contract HMOs. For a given health plan, the APR is determined by adjusting county-level AAPCCs to reflect the relative risks of the plan's enrollees.

**Administrative Code Sets** - Code sets that characterize a general business situation, rather than a medical condition or service. Under HIPAA, these are sometimes referred to as non-clinical or non-medical code sets. Compare to medical code sets.

**Administrative Costs** - Costs related to utilization review, insurance marketing, medical underwriting, agents' commissions, premium collection, claims processing, insurer profit, quality assurance programs, and risk management. Administrative costs also refer to certain allowable costs on hospital CMS cost reports, usually considered overhead. Rules exist which disallow certain expenses, such as marketing. Costs not linked directly to the provision of medical care. Includes marketing, claims processing, billing, and medical record keeping, among others.

**Administrative Services Organization (ASO)** - A contract between an insurance company and a self-funded plan where the insurance company performs administrative services only and the self-funded entity assumes all risk.

**Administrative Services Only (ASO)** - A relationship between an insurance company or other management entity and a self-funded plan or group of providers in which the insurance company or management entity performs administrative services only, such as billing, practice management, marketing, etc., and does not assume any risk. The client bears the financial risk for the claims. Clients contracting for ASO can include health plans, hospitals, delivery networks, IPAs, etc. A provider system wishing to capitate might contract with a TPA for ASO for certain services for which the provider group does not want to bring in house. This is a form of outsourcing. See also TPA.

**Administrative Simplification** - Title II, Subtitle F, of HIPAA which authorizes HHS to: (1) adopt standards for transactions and code sets that are used to exchange health data; (2) adopt standard identifiers for health plans, health care providers, employers, and individuals for use on standard transactions; and (3) adopt standards to protect the security and privacy of personally identifiable health information.

**Admission Certification** - Methods of assuring that only those patients who need hospital care are admitted. Certification can be granted before admission (preadmission) or shortly after (concurrent). Length-of-stay for the patient's diagnosed problem is usually assigned upon admission under a certification program.

**Admissions Per 1,000** - Number of patients admitted to a hospital or hospitals per 1,000 health plan members. An indicator calculated by taking the total number of inpatient and/or outpatient admissions from a specific group, e.g., employer group, HMO population at risk, for a specific period of time (usually one year), dividing it by the average number of covered members in that group during the same period, and multiplying the result by 1,000. This indicator can be calculated for behavioral health or any disease in the aggregate and by modality of treatment, e.g., inpatient, residential, and partial hospitalization, etc.

**Adverse Event** - An injury to a patient resulting from a medical intervention.

**Adverse Selection** - The problem of attracting members who are sicker than the general population, specifically, members who are sicker than was anticipated when developing the budget for medical costs. A tendency for utilization of health services in a population group to be higher than average or the tendency for a person who is in poor health to be enrolled in a health plan where he or she is below the average risk of the group. 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. Occurs when premium doesn't cover cost. Some populations, perhaps due to age or health status, have a great potential for high utilization. Some population parameter such as age (e.g., a much greater number of 65-year-olds or older to young population) that increases the potential for higher utilization and often increases costs above those covered by a payer's capitation rate. Among applicants for a given group or individual program, the tendency for those with an impaired health status, or who are prone to higher than average utilization of benefits, to be enrolled in disproportionate numbers and lower deductible plans.

**Affiliated Provider** - A health care provider or facility that is part of the HMO's network usually having formal arrangements to provide services to the HMO member.

**Affiliation** - An agreement between two or more otherwise independent entities or individuals that defines how they will relate to one another. Agreements between hospitals may specify procedures for referring or transferring patients. Agreements between providers may include joint managed care contracting.

**Age/Sex Factor** - Underwriting measurement representing the medical risk costs of one population compared to another based on age and sex factors.

**Age/Sex rates (ASR)** - Also called table rates, they are given group products' set of rates where each grouping, by age and sex, has its own rates. Rates are used to calculate premiums for group billing and demographic changes are adjusted automatically in the group.

**Age-at-Issuance Rating** - A method for establishing health insurance premiums whereby an insurer's premium is based on the age of individuals when they first purchased health insurance coverage. This is an older form of actuarial assessment.

**Age-Attained Rating** - Similar to the above, this method for establishing health insurance premiums whereby an insurer's premium is based on the current age of the beneficiary. Age-attained-rated premiums increase in price, as the purchasers grow older.

**Agency for Health Care Policy and Research (AHCPR)** - The agency of the Public Health Service responsible for enhancing the quality, appropriateness and effectiveness of health care services.

**Aggregate Margin** - This is computed by subtracting the sum of expenses for all hospitals in the group from the sum of revenues and dividing by the sum of revenues. The aggregate margin compares revenues to expenses for a group of hospitals, rather than one single hospital.

**Aggregate PPS Operating Margin/Aggregate Total Margin** - This is computed by subtracting the sum of expenses for all hospitals in the group from the sum of revenues and dividing by the sum of revenues. A PPS operating margin or total margin that compare revenue to expenses for a group of hospitals, rather than a single hospital.

**Aggregate Stop Loss** - The form of excess risk coverage that provides protection for the employer against accumulation of claims exceeding a certain level. This is protection against abnormal frequency of claims in total, rather than abnormal severity of a single claim.

**Aid to Families with Dependent Children (AFDC)** - The federal AFDC program provides cash welfare to: (1) needy children who have been deprived of parental support and (2) certain others in the household of such child. States administer the AFDC program with funding from both the federal government and state. The Personal Responsibility & Work Responsibility Act of 1996, enacted in August 1996, replaced AFDC with a new program called Temporary Assistance for Needy Families (TANF).

**All Inclusive Visit Rate** - Aggregate costs for any one patient visit based upon annual operating costs divided by patient visits per year. This rate incorporates costs for all services at the visit.

**Allowable Charge** - The maximum charge for which a third party will reimburse a provider for a given service. An allowable charge is not necessarily the same as either a reasonable, customary, maximum, actual, or prevailing charge.

**Allowed Amount** - Maximum dollar amount assigned for a procedure based on various pricing mechanisms. Also known as a maximum allowable.

**Allowed Charge** - This is the amount Medicare approves for payment to a physician, but may not match the amount the physician gets paid by Medicare (due to co-pay or deductibles) and usually does not match what the physician charges patients. Medicare normally pays 80 percent of the approved charge and the beneficiary pays the remaining 20 percent. The allowed charge for a nonparticipating physician is 95 percent of that for a participating physician. Non-participating physicians may bill beneficiaries for an additional amount above the allowed charge. The CMS intermediary in each state publishes these rates.

**Allowable Costs** - Covered expenses within a given health plan. Items or elements of an institution's costs, which 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 travel or marketing. CMS publishes an extensive list of rules governing these costs and provides software for determining costs. Normally the costs which are not reasonable expenditures, which are unnecessary, which are for the efficient delivery of health services to persons covered under the program in question are not reimbursed. The most common form of cost reimbursement is the "cost report" methodology used for DRG-exempt services, such as many out-patient hospital based programs, long-term care and skilled nursing units, physical rehab, psychiatric and substance abuse inpatient programs. Some specialty hospitals receive all of their CMS reimbursement as cost based reimbursement.

**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.

**Alternate Delivery Systems** - Health services provided in other than an inpatient, acute-care hospital or private practice. A phrase used to describe all forms of health care delivery except traditional fee-for-service, private practice. The term includes HMOs, PPOs, IPAs, and other systems of providing health care. Examples within general health services include skilled and intermediary nursing facilities, hospice programs, and home health care. Alternate delivery systems are designed to provide needed services in a more cost-effective manner. Most of the services provided by community mental health centers fall into this category.

**Ambulatory Care** - Health services provided without the patient being admitted. Also called outpatient care. The services of ambulatory care centers, hospital outpatient departments, physicians' offices and home health care services fall under this heading provided that the patient remains at the facility less than 24 hours. No overnight stay in a hospital is required.

**Ancillary Services (Ancillary Charges)** - Supplemental services, including laboratory, radiology, physical therapy, and inhalation therapy that are provided in conjunction with medical or hospital care.

**Anniversary Date** - The beginning of an employer group's benefit year. The first day of effective coverage as contained in the policy Group Application and subsequent annual anniversaries of that date. An insured has the option to transfer from an indemnity plan (which may have maximum benefit levels) to an HMO.

**Anonymized Data** - Previously identifiable data that have been deidentified and for which a code or other link no longer exists. A provider, third party or investigator would not be able to link anonymized information back to a specific individual.

**Anonymous Data** – Under HIPAA, this refers to data that were collected without identifiers and that were never linked to an individual. Coded data are not anonymous.

**ANSI** - The American National Standards Institute. A national organization founded to develop voluntary business standards in the United States.

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

**Any Willing Provider** - A requirement that a health plan contract for the delivery of health care services with any provider in the area who would like to provide such services to the plan's enrollees.

**Any Willing Provider Laws** - Laws that require managed care plans to contract with all health care providers that meet their terms and conditions.

**Application Integrators** - Software that transparently provides application-to-application functionality, primarily through data conversion and transmission, while eliminating the need for custom programming. Also referred to as application integration gateway, application interface gateway, integration engine, and intelligent gateway. This type of software is key to developing networks of information systems, making client-specific information available in real time to all members of an IHDS.

**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. This term is not to be confused with "usual and customary" or "approved" service. The extent to which a particular procedure, treatment, test, or service is clearly indicated, not excessive, adequate in quantity, and provided in the setting best suited to a patient's or member's needs. See also Medically Necessary.

**Approval** - A term used extensively in managed care and, to many, implies the primary process of "managing" managed care. Approval usually is used to describe treatments or procedures that have been certified by utilization review. Can also refer to the status of certain hospitals or doctors, as members of a plan. Can describe benefits or services, which will be covered under a plan. Generally, approval is either granted by the managed care organization (MCO), third party administrator (TPA) or by the primary care physician (PCP), depending on the circumstances.

**Approved Charge** - Limits of expenses paid by Medicare in a given area of covered service. Charges approved by payment by private health plans. Items that are likely to be reimbursed by the insurance company.

**Approved Health Care Facility, Hospital or Program** - A facility or program authorized to provide health services and allowed by a given health plan to provide services stipulated in contract.

**Assignment of Benefits** - Method used when a claimant directs that payment be made directly to the health care provider by the health plan.

**Assisted Living** - Broad range of residential care services, but does not include nursing services. Normally lower in cost than nursing homes.

**Attestation** - The requirement that the attending physician certify, in writing, the accuracy and completion of the clinical information used for DRG assignment. See also Physician Attestation.

**Audit of Provider Treatment or Charges** - A qualitative or quantitative review of services rendered or proposed by a health provider. The review can be carried out in a number of ways: a comparison of patient records and claim form information, a patient questionnaire, a review of hospital and practitioner records, or a pre- or post-treatment clinical examination of a patient. Some audits may involve fee verification. Something we had better get used to being subjected to since this is usually first type or "first generation" managed care approach.

**Autoassignment or Auto Assignment** - A term used with Medicaid mandatory managed care enrollment plans. Medicaid recipients who do not specify their choice for a contracted plan within a specified time frame are assigned to a plan by the state.

**Authorization** – Any document designating any permission. The HIPAA Privacy Rule requires authorization or waiver of authorization for the use or disclosure of identifiable health information for research (among other activities). The authorization must indicate if the health information used or disclosed is existing information and/or new information that will be created. The authorization form may be combined with the informed consent form, so that a patient need sign only one form. An authorization must include the following specific elements: a description of what information will be used and disclosed and for what purposes; a description of any information that will not be disclosed, if applicable; a list of who will disclose the information and to whom it will be disclosed; an expiration date for the disclosure; a statement that the authorization can be revoked; a statement that disclosed information may be redisclosed and no longer protected; a statement that if the individual does not provide an authorization, s/he may not be able to receive the intended treatment; the subject's signature and date.

**Autoassignment** - A term used with Medicaid mandatory managed care enrollment plans. Medicaid recipients who do not specify their choice for a contracted plan within a specified time frame are assigned to a plan by the state.

**Auto-Enrollment** - The automatic assignment of a person to a health insurance plan, typically done under Medicaid plans.

**Average Length of Stay (ALOS)** - Refers to the average length of stay per inpatient hospital visit. Figure is typically calculated for both commercial and Medicare patient populations.

**Average Wholesale Price (AWP)** - Commonly used in pharmacy contracting, the AWP is generally determined through reference to a common source of information. Average cost of a non-discounted item to a pharmacy provider by wholesale providers. Drug manufacturers commonly publish suggested wholesale prices.

**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**

**Balance Billing** - The practice of billing a patient for the fee amount remaining after insurer payment and co-payment have been made. Under Medicare, the excess amount cannot be more than 15 percent above the approved charge.

**Base Capitation** - Specified amount per person per month to cover healthcare cost, usually excluding pharmacy and administrative costs as well as optional coverages such as mental health/substance abuse services.

**Base Year Costs** - In Medicare, the amount a hospital actually spent to render care in a previous time period. Depending on the hospital's Medicare cost reporting period, the base year was the fiscal year ending on or after September 30, 1982 and before September 30, 1983 for hospitals in operation at that time. Recent legislation has made dramatic changes in cost reporting opportunities for healthcare providers, limiting these reimbursements.

**Bed Days** - Number of inpatient hospital days per 1,000 health plan members for a specified period, usually annual.

**Behavioral Health, Behavioral Healthcare** - An umbrella term that includes mental health, psychiatric, marriage and family counseling, addictions treatment and substance abuse. Services are provided by a myriad of providers, including social workers, counselors, psychiatrist, psychologists, neurologists and even family practice physicians. Many states have "parity" laws that attempt to require that behavioral health insurance coverage be provided "on par" to physical health coverage.

**Behavioral Offset** - This is the change in the number and type of services that is projected to occur in response to a change in fees. A 50 percent behavioral offset suggests that 50 percent of the savings from fee reductions will be offset by increased volume and intensity of services.

**Benchmark** - A goal to be attained. These goals are chosen by comparisons with other providers, by consulting statistical reports available or are drawn from the best practices within the organization or industry. Benchmarks are used in quality improvement programs to encourage improvement of care, efficiencies or services. Benchmarks are also used for length of stay comparisons, costs, utilization review, risk management and financial analysis. The benchmarking process identifies the best performance in the industry (health care or non-health care) for a particular process or outcome, determines how that performance is achieved, and applies the lessons learned to improve performance.

**Beneficiary (Also eligible; enrollee; member)** - Individual who is either using or eligible to use insurance benefits, including health insurance benefits, under an insurance contract. Any person eligible as either a subscriber or a dependent for a managed care service in accordance with a contract. An individual who receives benefits from or is covered by an insurance policy or other health care financing program.

**Beneficiary Liability** - The amount beneficiaries must pay providers for Medicare-covered services. Liabilities include copayments, deductibles, and balance billing amounts. CMS has very strict rules about health providers billing patients for their liabilities. Cost based facilities are not allowed to charge non-payment by beneficiaries to bad debt unless a clear history of collection activity is recorded.

**Benefit Limitations** - Any provision, other than an exclusion, which restricts coverage in the Evidence of Coverage, regardless of medical necessity. Limitations are often expressed in terms of dollar amounts, length of stay, diagnosis or treatment descriptions.

**Benefit Package** - Aggregate services specifically defined by an insurance policy or HMO that can be provided to patients. The services a payer offers to a group or individual. The package will specify include cost, limitation on the amounts of services, and annual or lifetime spending limits.

**Benefit Payment Schedule** - List of amounts an insurance plan will pay for covered health care services.

**Benefits** - Benefits are specific areas of Plan coverage's, i.e., outpatient visits, hospitalization and so forth, that make up the range of medical services that a payer markets to its subscribers. Also, a contractual agreement, specified in an Evidence of Coverage, determining covered services provided by insurers to members.

**Billed Claims** - Fees submitted by a health care provider for services rendered to a covered person. Fees billed and fees paid are rarely synonymous.

**Biometric Identifier** - Identifying information based on a physical characteristic (e.g., a fingerprint). Confidentiality laws and HIPAA privacy rules refer to biometric identifiers.

**Bioterrorism or Biological Warfare** - The unlawful use, wartime use, or threatened use, of microorganisms or toxins to produce death or disease in humans. Often viewed as the preferred choice of warfare of less powerful groups of people in attempt to wage war or protect themselves from more powerful groups or nations. However, biological agents could be used by individuals or by powerful nations as well.

**Block Grant** - Federal funds made to a state for the delivery of a specific group of related services, such as drug abuse related services.

**Board Certified (Boarded, Diplomate)** - Describes a physician who has passed a written and oral examination given by a medical specialty board and who has been certified as a specialist in that area.

**Board Eligible** - Describes a physician who is eligible to take the specialty board examination by virtue of being graduated from an approved medical school, completing a specific type and length of training, and practicing for a specified amount of time. Some HMOs and other health facilities accept board eligibility as equivalent to board certification, significant in that many managed care companies restrict referrals to physicians without certification.

**Bonus Payment** - An additional amount paid by Medicare for services provided by physicians in Health Professional Shortage Areas. Currently, the bonus payment is 10 percent of Medicare's share of allowed charges. This is not to be confused with other payments to hospitals, such as the disproportionate share payment or the settlement made to facilities at the end of a cost report year.

**Bundled Payment** - A single comprehensive payment for a group of related services. Bundled payments have become the norm in recent years and CMS and other payers investigate unbundled services closely. Unbundling service charges has been a common form of fraud as defined by CMS.

**Business Associate** – Under HIPAA rules, this term refers to an outside person/entity that performs a service on behalf of the health care provider (including a researcher) or the health care institution during which individually identifiable health information is created, used, or disclosed. For example, web hosting or data storage companies will be business associates if they receive protected health information. In addition, third parties that handle billing for a research study, or recruitment and screening, will also be business associates. Certain exceptions apply.

**Broker** - One who represents an insured in solicitation, negotiation, or procurement of contracts of insurance, and who may render services incidental to those functions. By law, the broker may also be an agent of the insurer for certain purposes such as delivery of the policy or collection of the premium.

## C

**Cafeteria Plan** - Arrangements under which employees may choose their own benefit structure. Sometimes these are varying benefit plans or add-ons provided through the same insurer or 3rd party administrator, other times this refers to the offering of different plans or HMOs provided by different managed care or insurance companies.

**Capital Costs** - Capital costs usually involve equipment and physical plant costs, not consumable supplies. Included in these costs can be interest, leases, rentals, taxes and insurance on physical assets like plant and equipment. Capital costs are usually reimbursed to cost based facilities through submission of these costs on annual cost reports to the CMS intermediaries. Depreciation schedules apply.

**Capital Expenditure Review** - A review of proposed capital expenditures of hospitals or providers to determine the need for, and appropriateness of, the proposed expenditures. The review is usually done by a designated regulatory agency and has a sanction attached that prevents or discourages unneeded expenditures. Often this is related to CMS or Medicare and the willingness of the federal government to provide allowances for capital costs.

**Capital Cost Report** - Similar to the above review but normally produced retrospectively rather than prospectively.

**Capitation** (Cap, Capped, Capitate) - Specified amount paid periodically to health provider for a group of specified health services, regardless of quantity rendered. Amounts are determined by assessing a payment "per covered life" or per member. The method of payment in which the provider is paid a fixed amount for each person served no matter what the actual number or nature of services delivered. The cost of providing an individual with a specific set of services over a set period of time, usually a month or a year. A payment system whereby managed care plans pay health care providers a fixed amount to care for a patient over a given period. Providers are not reimbursed for services that exceed the allotted amount. The rate may be fixed for all members or it can be adjusted for the age and gender of the member, based on actuarial projections of medical utilization.

**Carrier** - An insurer; an underwriter of risk that finances health care. Also refers to any organization, which underwrites or administers life, health or other insurance programs. When an employer has a "self-insured" plan, the carrier (such as Aetna or Blue Cross) may not serve as carrier in this case, but may serve only as "third party administrator".

**Carve-in** - A generic term that refers to any of a continuum of joint efforts between clinicians and service providers; also used specifically to refer to health care delivery and financing arrangements in which all covered benefits (e.g., behavioral and general health care) are administered and funded by an integrated system.

**Carve Out** - Practice of excluding specific services from a managed care organization's capitated rate. In some instances, the same provider will still provide the service, but they will be reimbursed on a fee-for-service basis. In other instances, carved out services will be provided by an entirely different provider. A payer strategy in which a payer separates ("carves-out") a portion of the benefit and hires an MCO to provide these benefits. A health care delivery and financing arrangement in which certain specific health care services that are covered benefits (e.g., behavioral health care) are administered and funded separately from general health care services. The carve-out is typically done through separate contracting or sub-contracting for services to the special population. Common carve outs include such services as psychiatric, rehab, chemical dependency and ambulatory services. Increasingly, oncology and cardiac services are being carved out. This permits the payer to create a separate health benefits package and assume greater control of their costs. Many HMOs and insurance companies adopt this strategy because they do not have in-house expertise related to the service "carved out." A "carve-out" is typically a service provided within a standard benefit package but delivered exclusively by a designated provider or group. This process may or may not seem transparent to the subscriber, but it often means that separate UR and pre-certification entities are involved as well as different payers and providers. Carve-outs are also called sub-contractors, sub-captivators or junior capitation contracts.

**Case Management** - Method designed to accommodate the specific health services needed by an individual through a coordinated effort to achieve the desired health outcome in a cost effective manner. The monitoring and coordination of treatment rendered to patients with specific diagnosis or requiring high-cost or extensive services. The process by which all health-related matters of a case are managed by a physician or nurse or designated health professional. Physician case managers coordinate designated components of health care, such as appropriate referral to consultants, specialists, hospitals, ancillary providers and services. Case management is intended to ensure continuity of services and accessibility to overcome rigidity, fragmented services, and the misutilization of facilities and resources. It also attempts to match the appropriate intensity of services with the patient's needs over time.

**Case Manager** - A nurse, doctor, or social worker who works with patients, providers and insurers to coordinate all services deemed necessary to provide the patient with a plan of medically necessary and appropriate health care.

**Case Mix** - The mix of patients treated within a particular institutional setting, such as the hospital. Patient classification systems like DRGs can be used to measure hospital case mix. (See also DRGs and Case-Mix Index). Measurement reflecting servicing needs, uses of hospital capabilities, and the general rate of hospital admissions. The types of inpatients a hospital or post acute facility treats. The more complex the patients' needs, the greater the amount spent for patient care. 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-Mix Index (CMI)** - The average DRG weight for all cases paid under PPS. The CMI is a measure of the relative costliness of the patients treated in each hospital or group of hospitals. (See also DRG.) (ProPAC) A measure of the relative costliness of treating in an inpatient setting. An index of 1.05 means that the facility's patients are 5 % more costly than average.

**Case Rate** - Flat fee paid for a client's treatment based on their diagnosis and/or presenting problem. For this fee the provider covers all of the services the client requires for a specific period of time. Also bundled rate, or Flat Fee-Per-Case. Very often used as an intervening step prior to capitation. In this model, the provider is accepting some significant risk, but does have considerable flexibility in how it meets the client's needs. Keys to success in this mode: (1) properly pricing case rate, if provider has control over it, and (2) securing a large volume of eligible clients.

**Case Severity** - A measure of intensity or gravity of a given condition or diagnosis for a patient. May have direct correlation with the amount of service provided and the associated costs or payments allowed.

**Catastrophic Health Insurance** - Policy that provides protection primarily against the higher costs of treating severe or lengthy illnesses or disabilities. Normally these are "add on" benefits that begin coverage once the primary insurance policy reaches its maximum.

**Categorically Needy** - Medicaid eligibility based on defined indicators of financial need by families with children and pregnant women, and to persons who are aged, blind, or disabled. 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 must provide to the categorically needy is much broader than the minimum scope of services for other groups receiving Medicaid benefits.

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

**Centers for Medicare and Medicaid Services (CMS)** - The Centers for Medicare & Medicaid Services (CMS) is a Federal agency within the U.S. Department of Health and Human Services. Programs for which CMS is responsible include Medicare, Medicaid, State Children's Health Insurance Program (SCHIP), HIPAA and CLIA. Formerly was HCFA. Centers for Medicare & Medicaid Services has historically maintained the UB-92 institutional EMC format specifications, the professional EMC NSF specifications, and specifications for various certifications and authorizations used by the Medicare and Medicaid programs. CMS is responsible for oversight of HIPAA administrative simplification transaction and code sets, health identifiers, and security standards. CMS also maintains the HCPCS medical code set and the Medicare Remittance Advice Remark Codes administrative code set.

**Certificate of Authority (COA)** - Issued by state governments, it gives a health maintenance organization or insurance company its license to operate within the state.

**Certificate of Coverage (COC)** - Outlines the terms of coverage and benefits available in a carrier's health plan.

**Certificate of Need (CON)** - In some states, a state agency must review and approve certain proposed capital expenditures, changes in health services provided, and purchases of expensive medical equipment. Before the request goes to the state, a local review panel (the health systems agency or HSA) must evaluate the proposal and make a recommendation. CON is intended to control expansion of facilities and services by preventing excessive or duplicative development of facilities and services. Many states have sunsetted or eliminated their CON processes and requirements.

**Certified Health Plan** - A managed health care plan, certified by the Health Services Commission and the Office of the Insurance Commissioner to provide coverage for the Uniform Benefits Package to state residents. Regulations vary by state since some states require only HMOs to certify but not PPOs, IPAs or MSOs. Increasingly these regs are becoming more consistent state by state.

**Chain of Trust Agreement** - Referred to in HIPAA rules, this is a contract needed to extend the responsibility to protect health care data across a series of sub-contractual relationships.

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

**Charges** - These are the published prices of services provided by a facility. CMS requires hospitals to apply the same schedule of charges to all patients, regardless of the expected sources or amount of payment. Controversy exists today because of the often wide disparity between published prices and contract prices. The majority of payers, including Medicare and Medicaid, are becoming managed by health plans that negotiate rates lower than published prices. Often these negotiated rates average 40% to 60% of the published rates and may be all-inclusive bundled rates.

**Chronic Care** - Long term care of individuals with long standing, persistent diseases or conditions. It includes care specific to the problem as well as other measures to encourage self-care, to promote health, and to prevent loss of function.

**Claim** - A request by an individual (or his or her provider) to that individual's insurance company to pay for services obtained from a health care professional.

**Claims Review** - The method by which an enrollee's health care service claims are reviewed prior to reimbursement. The purpose is to validate the medical necessity of the provided services and to be sure the cost of the service is not excessive.

**Claim Status Codes** - A national administrative code set that identifies the status of health care claims. This code set is used in the X12N 277 Claim Status Inquiry and Response transaction, and is maintained by the Health Care Code Maintenance Committee.

**CLIA** - See Clinical Laboratory Improvement Amendments

**Clinical Data Repository** - That component of a computer-based patient record (CPR) which accepts, files, and stores clinical data over time from a variety of supplemental treatment and intervention systems for such purposes as practice guidelines, outcomes management, and clinical research. May also be called a data warehouse.

**Clinical Decision Support** - The capability of a data system to provide key data to physicians and other clinicians in response to "flags" or triggers which are functions of embedded, provider-created rules. A system that would alert case managers that a client's eligibility for a certain service is about to be exhausted would be one example of this type of capacity. Also a key functional requirement to support clinical or critical pathways.

**Clinical Laboratory Improvement Amendments (CLIA)** - CMS regulates all laboratory testing (except research) performed on humans in the U.S. through the Clinical Laboratory Improvement Amendments (CLIA). In total CLIA covers approximately 175,000 laboratory entities. The Division of Laboratory Services, within the Survey and Certification Group, under the Center for Medicaid and State Operations has the responsibility for implementing the CLIA Program. The objective of the CLIA program is to ensure quality laboratory testing. Although all clinical laboratories must be properly certified to receive Medicare or Medicaid payments, CLIA has no direct Medicare or Medicaid program responsibilities.

**Clinical or Critical Pathways** - A "map" of preferred treatment/intervention activities. Outlines the types of information needed to make decisions, the timelines for applying that information, and what action needs to be taken by whom. Provides a way to monitor care "in real time." These pathways are developed by clinicians for specific diseases or events. Proactive providers are working now to develop these pathways for the majority of their interventions and developing the software capacity to distribute and store this information.

**Clinic Without Walls (CWW)** - Similar to an independent practice association and identical to a practice without walls (PWW). Practitioners form CWWs and PWWs when they want the economies of scale and bargaining power offered by centralizing some administrative functions, but still choosing to practice separately. Many of these were formed to allow practitioners the ability to effectively contract with managed care.

**Closed Access** - Gatekeeper model health plan that requires covered persons to receive care from providers within the plan's coverage. Except for emergencies, the patient may only be referred to and treated by providers within the plan. A managed health care arrangement in which covered persons are required to select providers only from the plan's participating providers.

**Closed Panel** - Medical services are delivered in the HMO-owned health center or satellite clinic by physicians who belong to a specially formed, but legally separate, medical group that only serves the HMO. This term usually refers to a group or staff HMO models.

**CMS (formerly HCFA)** - See Centers for Medicare and Medicaid Services.

**CMS-1450** - The uniform institutional claim form.

**CMS-1500** - The uniform professional claim form.

**COBRA** - See Consolidated Omnibus Budget Reconciliation Act.

**Coded Data** - Data are separated from personal identifiers through use of a code. As long as a link exists, data are considered indirectly identifiable and not anonymous or anonymized. Coded data are not covered by the HIPAA Privacy Rule, but are protected under the Common Rule.

**Code Set** - Under HIPAA, this is any set of codes used to encode data elements, such as tables of terms, medical concepts, medical diagnostic codes, or medical procedure codes. This includes both the codes and their descriptions.

**Coding** - A mechanism for identifying and defining physicians' and hospitals' services. Coding provides universal definition and recognition of diagnoses, procedures and level of care. Coders usually work in medical records departments and coding is a function of billing. Medicare fraud investigators look closely at the medical record documentation, which supports codes and looks for consistency. Lack of consistency of documentation can earmark a record as "upcoded" which is considered fraud. A national certification exists for coding professionals and many compliance programs are raising standards of quality for their coding procedures.

**Co-Insurance (coinsurance)** - A cost-sharing requirement under a health insurance policy that provides that the insured will assume a portion or percentage of the costs of covered services. Health care cost which the covered person is responsible for paying, according to a fixed percentage or amount. A policy provision frequently found in major medical insurance policies under which the insured individual and the insurer share hospital and medical expenses according to a specified ratio. A type of cost sharing where the insured party and insurer share payment of the approved charge for covered services in a specified ratio after payment of the deductible. Under Medicare Part B, the beneficiary pays coinsurance of 20 percent of allowed charges. Many HMOs provide 100% insurance (no coinsurance) for preventive care or routing care provided "in network".

**Common Rule** – Under HIPAA, it outlines the necessity of obtaining informed consent from patients.

**Community Care Network (CCN)** - This vehicle provides coordinated, organized, and comprehensive care to a community's population. Hospitals, primary care physicians, and specialists link preventive and treatment services through contractual and financial arrangements, producing a network that provides coordinated care with continuous monitoring of quality and accountability to the public. While the term, Community Care Network (CCN), often is used interchangeably with Integrated Delivery System (IDS), the CCN tends to be community based and non-profit.

**Community Health Center (CHC)** - An ambulatory health care program (defined under section 330 of the Public Health Service Act) usually serving a catchment area which has scarce or nonexistent health services or a population with special health needs; sometimes known as the neighborhood health center. Community Health Centers attempt to coordinate federal, state and local resources into a single organization capable of delivering both health and related social services to a defined population. While such a center may not directly provide all types of health care, it usually takes responsibility to arrange all medical services needed by its patient population.

**Community Health Information Network (CHIN)** - An integrated collection of computer and telecommunication capabilities that permit multiple providers, payers, employers, and related healthcare entities within a geographic area to share and communicate client, clinical, and payment information. Also known as community health management information system.

**Community Rating** - Setting insurance rates based on the average cost of providing health services to all people in a geographic area, without adjusting for each individual's medical history or likelihood of using medical services. 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. Under the HMO Act, community rating is defined as a system of fixing rates of payment for health services which may be determined on a per person or per family basis and may vary with the number of persons in a family, but must be equivalent for all individuals and for all families of similar composition. With community rating, premiums do not vary for different groups of subscribers or with such variables as the group's claims experience, age, sex or health status. Although there are certain exceptions, in general, federally-qualified HMOs must community rate. The intent of community rating is to spread the cost of illness evenly over all subscribers rather than charging the sick more than the healthy for coverage.

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

**Comorbid Condition** - A medical condition that, along with the principal diagnosis, exists at admission and is expected to increase hospital length of stay by at least one day for most patients.

**Competitive Bidding** - Can be viewed by some as a pricing method that elicits information on costs through a bidding process to establish payment rates that reflect the costs of an efficient health plan or health care provider. Competitive bidding is also the process of offering reduced rates to health plans to obtain exclusive contracts from payers.

**Competitive Medical Plan (CMP)** - A type of MCO created by the 1982 Tax Equity and Fiscal Responsibility Act to facilitate the enrollment of Medicare beneficiaries into managed care plans. Competitive medical plans are organized and financed much like HMOs but are not bound by all the regulatory requirements facing HMOs. A health plan can be eligible for a Medicare risk contract if it meets specified requirements for service provision, capital, risk protection, and financial solvency. This is different from a Federally Qualified HMO.

**Compliance** - Accurately following the government's rules on Medicare billing system requirements and other federal or state regulations. A compliance program is a self-monitoring system of checks and balances to ensure that an organization consistently complies with applicable laws relating to its business activities. (See also Fraud, FBI, OIG, and DOJ)

**Compliance Date** - This is specified date by which health plans and providers are to be in compliance with rules. Under HIPAA, this is the date by which a covered entity must comply with a standard, an implementation specification, or a modification. This is usually 24 months after the effective date of the associated final rule for most entities, but 36 months after the effective date for small health plans. For future changes in the standards, the compliance date would be at least 180 days after the effective date, but can be longer for small health plans and for complex changes.

**Complication** - A medical condition that arises during a course of treatment and is expected to increase the length of stay by at least one day for most patients.

**Competitive Medical Plan (CMP)** - A status, established by TEFRA and granted by the Federal government, to an organization that meets specific requirements enabling that organization to obtain a Medicare risk or cost based contract.

**Composite Rate** - Group rate billed to all subscribers of a given group.

**Comprehensive Major Medical Insurance** - A policy designed to provide the protection offered by both a basic and major medical health insurance policy. It is generally characterized by a low deductible, a co-insurance feature, and high maximum benefits.

**Computer-Based Patient Record (CPR)** - A term for the process of replacing the traditional paper-based chart through automated electronic means; generally includes the collection of patient-specific information from various supplemental treatment systems, i.e., a day program and a personal care provider; its display in graphical format; and its storage for individual and aggregate purposes. Also called "digital medical record" or "electronic medical record".

**Concurrent Review** - Review of a procedure or hospital admission done by a health care professional (usually a nurse) other than the one providing the care, during the same time frame that the care is provided. Usually conducted during a hospital confinement to determine the appropriateness of hospital confinement and the medical necessity for continued stay. See also Utilization Review, Medical Necessity, Appropriate and Continued Stay Review.

**Confidentiality** – The protection of individually identifiable information as required by state or federal law or by policy of the healthcare provider.

**Consent** – See Informed Consent

**Consolidated Omnibus Budget Reconciliation Act (COBRA)** - Federal law that continues health care benefits for employees whose employment has been terminated. Employers are required to notify employees of these benefit continuation options, and, failure to do so can result in penalties and fines for the employer. An act that allows workers and their families to continue their employer-sponsored health insurance for a certain amount of time after terminating employment. COBRA imposes different restrictions on individuals who leave their jobs voluntarily versus involuntarily (Department of Labor, 2002).

**Consumer Health Alliance** - Regional cooperatives between government and the public that will oversee the new payment system. Once all health insurance purchasing cooperatives (HIPPC's), the alliance would make sure health plans within a region conformed to federal coverage and quality standards, and oversee costs within any mandated budget.

**Continued Stay Review** - A review conducted by an internal or external auditor to determine if the current place of service is still the most appropriate to provide the level of care required by the client.

**Continuous Quality Improvement (CQI)** - An approach to health care quality management borrowed from the manufacturing sector. It builds on traditional quality assurance methods by putting in place a management structure that continuously gathers and assesses data that are then used to improve performance and design more efficient systems of care. Also known as quality improvement (QA) and total quality management (TQM).

**Contract** - A legal agreement between a payer and a subscribing group or individual which specifies rates, performance covenants, the relationship among the parties, schedule of benefits and other pertinent conditions. The contract usually is limited to a 12-month period and is subject to renewal thereafter. Contracts are not required by statute or regulation, and less formal agreements may be made.

**Contract Year** - A period of twelve (12) consecutive months, commencing with each Anniversary Date. May or may not coincide with a calendar year.

**Contract Provider** - Any hospital, physician, skilled nursing facility, extended care facility, individual, organization, or agency licensed that has a contractual arrangement with an insurer for the provision of services under an insurance contract.

**Contributory Program** - Program where the employee and the employer or the union shares the cost of group coverage.

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

**Conversion Factor (CF)** - The dollar amount used to multiply the Relative Value Schedule (RVS) of a procedure to arrive at the maximum allowable for that procedure.

**Conversion Factor Update** - Annual percentage change to a conversion factor, either set annually by the government or by the formula reflecting actual expenditure growth from two years falling below or above the original target rate. See Conversion Factor, Sustainable Growth Rate, Sustainable Growth Rate System.

**Conversion Privilege** - The right of an individual insured under a group policy to certain kinds of individual coverage, without a medical examination, upon termination of his association with the group.

**Coordination of Benefits (COB)** - Provision regulating payments to eliminate duplicate coverage when a claimant is covered by multiple group plans. The procedures set forth in a Subscription Agreement to determine which coverage is primary for payment of benefits to Members with duplicate coverage. 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. Also called cross-over.

**Co-Payment, Copayment, Copay** - A cost-sharing arrangement in which the HMO enrollee pays a specified flat amount for a specific service (such as \$10 for an office visit or \$5 for each prescription drug). The amount paid must be nominal to avoid becoming a barrier to care. It does not vary with the cost of the service and is usually a flat sum amount such as \$10 for every prescription or doctor visit, unlike co-insurance that is based on a percentage of the cost.

**Cost-benefit analysis (Evaluation)** - 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 Consequence Analysis (CCA)** - A form of analysis that compares alternative interventions or programs in which the components of incremental costs and consequences are listed without aggregation.

**Cost Containment** - Control of inefficiencies in the consumption, allocation, or production of health care services that contribute to higher than necessary costs. Inefficiencies are thought to exist in consumption when health services are inappropriately utilized; inefficiencies in allocation exist when health services could be delivered in less costly settings without loss of quality; and, inefficiencies in production exist when the costs of producing health services could be reduced by using a different combination of resources. Cost containment is a word used freely in healthcare to describe most cost reduction activities by providers.

**Cost Contract** - An arrangement between a managed health care plan and CMS under Section 1876 or 1833 of the Social Security Act, under which the health plan provides health services and is reimbursed its costs. A TEFRA contract payment methodology option by which CMS pays for the delivery of health services to members based on the HMO's or hospital's reasonable cost. The plan or hospital receives an interim amount derived from an estimated annual budget, which may be periodically adjusted during the course of the contract to reflect actual cost experience. The expenses are audited at the end of the contract to determine the final rate the plan or provider should have been paid.

**Cost Effectiveness (Evaluation)** - The efficacy of a program in achieving given intervention outcomes in relation to the program costs. Follow-up studies, outcome studies and TQM programs attempt to assess treatment efficacy, while cost effectiveness would provide a ratio of this measurement with costs. This analysis may determine the costs and effectiveness of certain interventions compared to similar alternative interventions, determining the relative costs and degree to which they will obtain desired health outcomes.

**Cost Minimization Analysis (CMA)** - An assessment of the least costly interventions among available 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 Outlier** - A case that is more costly to treat compared with other patients in a particular diagnosis related group. Outliers also refer to any unusual occurrence of cost, cases that skew average costs or unusual procedures.

**Cost Sharing** - Payment method where a person is required to pay some health costs in order to receive medical care. The general set of financing arrangements whereby the consumer must pay out-of-pocket to receive care, either at the time of initiating care, or during the provision of health care services, or both. This includes deductibles, coinsurance and copayments, but not the share of the premium paid by the person enrolled.

**Cost Shifting** - Charging one group of patients more in order to make up for underpayment by others. Most commonly, charging some privately insured patients more in order to make up for underpayment by Medicaid or Medicare.

**Cost Utility Analysis** - A form of effectiveness analysis where outcomes are rated in terms of utility, or quality of life.

**Coverage** - The guarantee against specific losses provided under the terms of an insurance policy.

**Covered Services** - Services provided within a given health care plan. Health care services provided or authorized by the payer's Medical Staff or payment for health care services.

**Covered Benefit** - A medically necessary service that is specifically provided for under the provisions of an Evidence of Coverage. A covered benefit must always be medically necessary, but not every medically necessary service is a covered benefit. For example, some elements of custodial or maintenance care, which are excluded from coverage, may be medically necessary, but are not covered.

**Covered Entity** – Under HIPAA, this is a health plan, a health care clearinghouse, or a health care provider who transmits any health information in electronic form in connection with a HIPAA transaction. For purposes of the HIPAA Privacy Rule, 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.

**Credentialing** - Review procedure where a potential or existing provider must meet certain standards in order to begin or continue participation in a given health care plan, on a panel, in a group, or in a hospital medical staff organization. The process of reviewing a practitioners credentials, i.e., training, experience, or demonstrated ability, for the purpose of determining if criteria for clinical privileging are met. 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. In managed care arenas, one hears of a new basis for credentialing, referred to as financial credentialing. This refers to an organization's evaluation of a provider based on that provider's ability to provide value, or high quality care at a reasonable cost.

**Current Dental Terminology (CDT)** - A medical code set of dental procedures, maintained and copyrighted by the American Dental Association (ADA), and adopted by the Secretary of HHS as the standard for reporting dental services on standard transactions.

**Current Procedural Terminology (CPT)** - A standardized mechanism of reporting services using numeric codes as established and updated annually by the AMA. A manual that assigns five digit codes to medical services and procedures to standardize claims processing and data analysis. The coding system for physicians' services developed by the CPT Editorial Panel of the American Medical Association; basis of the Medicare coding system for physicians services. A medical code set of physician and other services, maintained and copyrighted by the American Medical Association (AMA), and adopted by the Secretary of HHS as the standard for reporting physician and other services on standard transactions. See Coding.

**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

**Data Aggregation** – Combining of sets of protected health information by a business associate to permit data analysis.

**Database Management System (DBMS)** - The separation of data from the computer application that allows entry or editing of data.

**Data Condition** - A description of the circumstances in which certain data is required.

**Data Content** - Under HIPAA, this is all the data elements and code sets inherent to a transaction, and not related to the format of the transaction.

**Data Mapping** - The process of matching one set of data elements or individual code values to their closest equivalents in another set of them. This is sometimes called a cross-walk.

**Data Use Agreement (DUA)** - HIPAA Regulation states that a health care entity may use or disclose a "limited data set" if that entity obtains a data use agreement from the potential recipient and can only be used for research, public health or healthcare operations. Relates to privacy rules of HIPAA. A satisfactory assurance between the covered entity and a researcher using a limited data set that the data will only be used for specific uses and disclosures. The data use agreement is required to include the following information: to establish that the data will be used for research, public health or health care operations (further uses or disclosure are not permitted); to establish who is permitted to use or receive the limited data set; and to provide that the limited data set recipient will: (1) not use or further disclose the information other than as permitted by the data use agreement or as required by law; (2) use appropriate safeguards to prevent use or disclosure of the information other than as provided in the agreement; (3) report to the covered entity any identified use or disclosure not provided for in the agreement; (4) ensure that any agents, including a subcontractor, to whom the limited data sets are provided agree to the same restrictions and conditions that apply to the recipient; and (5) not identify the information or contact the individuals.

**Days (Or Visits) Per Thousand** - A standard unit of measurement of utilization. Refers to an annualized use of the hospital or other institutional care. It is the number of hospital days that are used in a year for each thousand covered lives. The formula used to calculate days per thousand is as follows: (# of days/member months) x (1000 members) x (# of months). An indicator calculated by taking the total number of days (for inpatient, residential, or partial hospitalization) or visits (for outpatient) received by a specific group for a specific period of time (usually one year). A measure used to evaluate utilization management performance.

**Day Outlier** - A patient with an atypically long length of stay compared with other patients in a particular diagnosis related group.

**Decedents** - Deceased individuals. Afforded privacy rights under the HIPAA Privacy Rule, even though not considered "human subjects" protected under the Common Rule. As is the current practice, all research protocols involving the review of medical records of deceased subjects or of living and deceased subjects require review and approval by the HRC/IRB and can be conducted without informed consent and authorization only if the protocol satisfies the criteria for a waiver. If the research includes access to the records of decedents, the investigator will be asked to document that the decedents will only be used for research and that the information is necessary for the research. The covered entity may require the investigator to provide proof of death.

**Decision Support Systems** - Computer technologies used in healthcare that allow providers to collect and analyze data in more sophisticated and complex ways. Activities supported include case mix, budgeting, cost accounting, clinical protocols and pathways, outcomes, and actuarial analysis.

**Deductibles** - Amounts required to be paid by the insured under a health insurance contract, before benefits become payable. Usually expressed in terms of an "annual" amount.

**Deductible Carry Over Credit** - Charge incurred during the last three months of a year that may be applied to the deductible and which may be carried over into the next year.

**Defensive Medicine** - Doctors in recent years have admitted to and have been accused of prescribing additional tests or procedures to justify their care, strengthen support for their decisions or simply to corroborate their diagnosis. This defensiveness is a result of lawsuits, malpractice claims and the onslaught of external UR entities questioning care decisions. Defensive medicine is said to be one of the primary causes of the increasing cost of health care. Many physicians and the AMA fight for tort reform to reduce the need for defensive medicine. However, patient groups and patient advocates, not in favor of tort reform, explain that the right to sue for malpractice is a valid method of holding physicians accountable for mistakes made.

**Defined Care** - An umbrella term used for Defined Contribution, Consumer-Driven and Self-Directed health plan arrangements and other consumer-centered initiatives.

**Defined Contribution Coverage** - A payment process for procurement of health benefit plans whereby employers contribute a specific dollar amount toward the costs of insurance coverage for their employees. Sometimes this includes an undefined expectation of guarantee of the specific benefits to be covered.

**Defined Contribution Health Plan** - Health Plans that involve employer funding of a fixed (as opposed to variable) dollar amount for health benefits, which employees may then use to purchase benefits from an employer arranged funding mechanism. The benefits could either be group benefits packaged and arranged by the employer, or purchased individually by the employees. See also Variable Contribution Health Plan.

**Deidentified** - Under the HIPAA Privacy Rule, data are deidentified if either (1) an experienced expert determines that the risk that certain information could be used to identify an individual is "very small" and documents and justifies the determination, or (2) the data do not include any of the following eighteen identifiers (of the individual or his/her relatives, household members, or employers) which could be used alone or in combination with other information to identify the subject: names, geographic subdivisions smaller than a state (including zip code), all elements of dates except year (unless the subject is greater than 89 years old), telephone numbers, FAX numbers, email address, Social Security numbers, medical record numbers, health plan beneficiary numbers, account numbers, certificate/license numbers, vehicle identifiers including license plates, device identifiers and serial numbers, URLs, internet protocol addresses, biometric identifiers, full face photos and comparable images, and any unique identifying number, characteristic or code; note that even if these identifiers are removed, the Privacy Rule states that information will be considered identifiable if the covered entity knows that the identity of the person may still be determined.

**Department of Health and Human Services (HHS)** - The federal agency that oversees Medicare, Medicaid and other federal health care programs. (Also see DOJ, Fraud and FBI)

**Department of Justice (DOJ)** - The federal agency that enforces the law and handles criminal investigations. As the nation's largest law firm, the DOJ protects citizens through effective law enforcement, crime prevention and crime detection. It is the agency that prosecutes those in the health care system guilty of proven "fraudulent" activity. (Also see Fraud and FBI)

**Dependent** - Person covered by someone else's health plan. In a payer's policy of insurance, a person other than the subscriber eligible to receive care because of a subscriber's contract.

**Designated Mental Health Provider** - Person or place authorized by a health plan to provide or suggest appropriate mental health and substance abuse care.

**Designated Record Set** - A health care provider's medical and billing records about individuals and any records used by the provider to make decisions about individuals. Individuals, including research subjects, have the right under the HIPAA Privacy Rule to access and amend protected health information in a Designated Record Set.

**Diagnosis Related Groups (DRGs)** - An inpatient or hospital classification system used to pay a hospital or other provider for their services and to categorize illness by diagnosis and treatment. A classification scheme used by Medicare that clusters patients into 468 categories on the basis of patients' illnesses, diseases and medical problems. 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. System involving classification of medical cases and payment to hospitals on the basis of diagnosis. Used under Medicare's prospective payment system to reimburse inpatient hospitals, regardless of the cost to the hospital to provide services.

**Direct Contracting** - Providing health services to members of a health plan by a group of providers contracting directly with an employer, thereby butting out the middleman or third party insurance carrier. This can be provider heaven, since middleman-MCO-is cut out and provider gets some portion of the money usually made by it. Key is to price services correctly, since provider is usually at full risk in this situation. Takes a strong IDS, MSO or AHP to do this successfully.

**Directly Identifiable Health Information** - Any information that includes personal identifiers. To determine what data may be considered identifiable, please see items that must be removed under the definition of Deidentified.

**Direct Payment Subscriber** - A person enrolled in a prepayment plan who makes individual premium payments directly to the plan rather than through a group. Rates of payment are generally higher, and benefits may not be as extensive as for the subscriber enrolled and paying as a member of the group.

**Disallowance** - When a payer declines to pay for all or part of a claim submitted for payment.

**Discharge Planning** - Required by Medicare and JCAHO for all hospital patients. A procedure where aftercare services are determined for after discharge from the inpatient facility. See also Case Management.

**Disclosure** – Refers to the release of identifiable health information, regarding a patient or patient(s). Disclosure involves the release of information to anyone or any entity outside of the covered entity. See also HIPAA Privacy Rule.

**Discounted Fee-For-Service** - A financial reimbursement system whereby a provider agrees to supply services on an FFS basis, but with the fees discounted by a certain percentage from the physician's usual and customary charges. An agreed upon rate for service between the provider and payer that is usually less than the provider's full fee. This may be a fixed amount per service, or a percentage discount. Providers generally accept such contracts because they represent a means to increase their volume or reduce their chances of losing volume.

**Disease Management** - A type of product or service now being offered by many large pharmaceutical companies to get them into broader healthcare services. Bundles use of prescription drugs with physician and allied professionals, linked to large databases created by the pharmaceutical companies, to treat people with specific diseases. The claim is that this type of service provides higher quality of care at more reasonable price than alternative, presumably more fragmented, care. The development of such products by hugely capitalized companies should be the entire indicator necessary to convince a provider of how the healthcare market is changing. Competition is coming from every direction--other providers of all types, payers, employers who are developing their own in-house service systems, the drug companies.

**Disproportionate Share (DSH) Adjustment** - A payment adjustment under Medicare's PPS for Medicaid utilization at hospitals that serve a relatively large volume of low-income patients, pregnant patients or other patients under the Medicaid program. Disproportionate share has been a continuing topic in Congress. Some wish to eradicate to reduce costs. Rural facilities, teaching hospitals and hospitals in poverty areas claim that the reduction or elimination of disproportionate share payments would cause hospitals to close, move or reduce care to the poor. DSH is a method whereby the government recognizes that hospitals treating high percentages of Medicaid payments would not be able to cover their costs and remain in service without additional government subsidy.

**Dual Choice (Multiple Choice, Dual Option, DC)** - Section 1310 of the HMO Act provides for dual choice. A choice given to employees to select between two or more health plans offered by an employer. The opportunity for an individual within an employed group to choose from two or more types of health care coverage such as an HMO and a traditional insurance plan. Many states also have legislated mandates regarding choices offered within employer packages.

**Dual Eligible** - A Medicare beneficiary who also receives the full range of Medicaid benefits offered in his or her state. Medicare usually pays the charges for inpatient while Medicaid will pay the co-pay for inpatient care in hospitals. Medicare will be considered the primary insurer for inpatient care for the Care/Caid patient.

**Duplicate Coverage Inquiry (DCI)** - Method used by an insurance company or group medical plan to inquire about the existing coverage of another insurance company or group medical plan.

**Duplication of Benefits** - When a person is covered under two or more health plans with the same or similar coverage.

**Durable Medical Equipment (DME)** - Items of medical equipment owned or rented which are placed in the home of an insured to facilitate treatment and/or rehabilitation. DME generally consist of items that can withstand repeated use. DME is primarily and customarily used to serve a medical purpose and is usually not useful to a person in the absence of illness or injury.

**Drug Formulary** - Varying lists of prescription drugs approved by a given health plan for distribution to a covered person through specific pharmacies. Health plans often restrict or limit the type and number of medicines allowed for reimbursement by limiting the drug formulary list. The list of prescription drugs for which a particular employer or State Medicaid program will pay. Formularies are either "closed," including only certain drugs or "open," including all drugs. Both types of formularies typically impose a cost scale requiring consumers to pay more for certain brands or types of drugs. See also Formulary.

**Drug Risk Sharing Arrangements** - Provider organizations may be at partial, full or no risk for drug costs. Providers at partial risk share in the proportion of savings and / or cost overruns. Groups at full risk realize all the savings or absorb all of the losses. Groups at no risk absorb none of the profits or losses. These arrangements are normally made between HMOs and providers (doctors/hospitals) in the HMO's attempt to discourage the overuse of drugs that will cause a loss of profit for the HMO. In a shared risk arrangement, the HMO and provider share the losses and profits, thus aligning their incentives with one another.

**Drug Utilization Review (DUR)** - Review of an insured population's drug utilization with the goal of determining how to reduce the cost of utilization. Reviews often result in recommendations to practitioners, including generic substitutions, use of formularies, use of copayments for prescriptions and education. In some cases, practitioners are now penalized or rewarded depending on their drug prescription related costs and utilization. Some speculate that these incentives can adversely effect doctor decisions.

## E

**Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)** - EPSDT program covers screening and diagnostic services to determine physical or mental defects in recipients under age 21, as well as health care and other measures to correct or ameliorate any defects and chronic conditions discovered.

**Economic Credentialing** - The use of economic criteria unrelated to quality of care or professional competency in determining an individual's qualifications for initial or continuing hospital medical staff membership or privileges. Economic credentialing has become a controversial topic involving much concern about ethics; yet, economic credentialing remains the most powerful form of controlling the behavior of doctors. Other forms of control include utilization review, certification, exclusive provider panels and more.

**EDI Translator** - Used in electronic claims and medical record transmissions, this is a software tool for accepting an EDI transmission and converting the data into another format, or for converting a non-EDI data file into an EDI format for transmission. See also Electronic Data Interchange.

**Effective Date** - The date on which a policy's coverage of a risk goes into effect.

**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. Most claims are electronically submitted.

**Electronic Data Interchange (EDI)** - The automated exchange of data and documents in a standardized format. In health care, some common uses of this technology include claims submission and payment, eligibility, and referral authorization. Refers to the exchange of routine business transactions from one computer to another in a standard format, using standard communications protocols.

**Electronic Media Claims** - A flat file format used to transmit or transport claims, such as the 192-byte UB-92 Institutional EMC format and the 320-byte Professional EMC NSF.

**Electronic Medical Record (EMR)** - A computer-based record containing health care information. This technology, when fully developed, meets provider needs for real-time data access and evaluation in medical care. Together with clinical workstations and clinical data repository technologies, the EMR provides the mechanism for longitudinal data storage and access. A motivation for healthcare entities to implement this technology derives from the need for medical outcome studies, more efficient care, speedier communication among providers and management of health plans. This record may contain some, but not necessarily all, of the information that is in an individual's paper-based medical record. One goal of HIPAA is to protect identifiable health information as the system moves from a paper-based to an electronic medical record system. See also Computerized Medical Record.

**Electronic Remittance Advice** - Any of several electronic formats for explaining the payments of health care claims.

**Eligible Dependent** - Person entitled to receive health benefits from someone else's plan. See also Dependent.

**Eligible Employee** - Employee who qualifies to receive benefits.

**Eligible Expenses** - Charges covered under a health plan. See also Covered Services, Approved Services.

**Eligible Person** - Person who meets the qualifications of a health plan contract.

**Elimination Period** - Most often used to designate the waiting period in a health insurance policy.

**Emergency** - Sudden unexpected onset of illness or injury which requires the immediate care and attention of a qualified physician, and which, if not treated immediately, would jeopardize or impair the health of the Member, as determined by the payer's Medical Staff. Significant in that Emergency may be the only acceptable reason for admission without pre-certification.

**Emergency Center, Emergi-center** - Non-hospital affiliated health facility that provides short-term care for minor medical emergencies or procedures needing immediate treatment; also called urgi-center, urgent center or free standing emergency medical service center.

**Emergency Medical Treatment and Labor Act (EMTALA)** - An act pertaining to emergency medical situations. EMTALA requires hospitals to provide emergency treatment to individuals, regardless of insurance status and ability to pay.

**Employee Assistance Program (EAP)** - A service, plan or set of benefits that are designed for personal or family problems, including mental health, substance abuse, gambling addiction, marital problems, parenting problems, emotional problems or financial pressures. This is usually a service provided by an employer to the employees, designed to assist employees in getting help for these problems so that they may remain on the job. EAP began with a primary drug and alcohol focus with an emphasis on rehabilitating valued employees rather than terminating them for their substance problems. It is sometimes implemented with a disciplinary program that requires that the impaired employee participate in EAP in order to retain employment. With the advent of managed care, EAP has sometimes evolved to include case management, utilization review and gatekeeping functions for the psychiatric and substance abuse health benefits.

**Employee Retirement Income Security Act of 1974 (ERISA)** - Also called the Pension Reform Act, this act regulates the majority of private pension and welfare group benefit plans in the U.S. It sets forth requirements governing, among many areas, participation, crediting of service, vesting, communication and disclosure, funding, and fiduciary conduct. Key legislative battleground now, because ERISA exempts most large self-funded plans from State regulation and, hence, from any reform activities undertaken at state level--which is now the arena for much healthcare reform.

**Employer Mandate** - Under the Federal HMO Act, describes conditions when federally qualified HMOs can mandate or require an employer to offer at least one federally qualified HMO plan of each type (IPA/network or group/staff). Option that federally qualified HMOs have to exercise over employees, requiring them to have available one or more types of HMOs per plan. This requirement was sunsetted in 1995.

**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.

**Encounter Data** - Data relating to treatment or service rendered by a provider to a patient, regardless of whether the provider was reimbursed on a capitated or fee-for-service basis. Used in determining the level of service.

**Enrolled Group** - Persons with the same employer or with membership in an organization in common, who are enrolled collectively in a health plan. Often, there are stipulations regarding the minimum size of the group and the minimum percentage of the group that must enroll before the coverage is available. Same as Contract group.

**Enrollee (Also beneficiary; individual; member)** - Any person eligible as either a subscriber or a dependent for service in accordance with a contract.

**Enrollment** - Initial process whereby new individuals apply and are accepted as members of a prepayment plan. The total number of covered persons in a health plan. Also refers to the process by which a health plan enrolls groups and individuals for membership or the number of enrollees who sign up in any one group.

**Episode of Care** - A term used to describe and measure the various health care services and encounters rendered in connection with identified injury or period of illness.

**Essential Community Providers** - Providers such as community health centers that have traditionally served low-income populations.

**Evidence-based Medicine** - Evidence-based health care is the conscientious use of current best evidence in making decisions about the care of individual patients or the delivery of health services. Term used in quality improvement and peer review programs in hospitals and health plans.

**Evidence or Explanation of Coverage (EOC) or Explanation of Benefits (EOB)** - A booklet provided by the carrier to the insured summarizing benefits under an insurance plan.

**Evidence of Insurability (E of I)** - Proof of a person's physical condition that affects acceptability for insurance or a health care contract.

**Excess Risk** - Either specific or aggregate stop loss coverage.

**Excluded Hospitals and Distinct-Part Units** - Hospitals and hospital units that are specifically excluded from Medicare's prospective pay system. These commonly include children's, cancer, hospital based outpatient care, long-term care, rehabilitation inpatient and psychiatric hospitals or units. Rehabilitation or psychiatric units of acute care hospitals are exempt if they meet certain criteria specified by HHS and are referred to as "DRG exempted". Excluded facilities are paid through submission of cost reports and TEFRA limits.

**Exclusions** - Conditions or situations not considered covered under contract or plan. Clauses in an insurance contract that deny coverage for select individuals, groups, locations, properties or risks. Providers will negotiate for exclusions for outliers and carve-out of certain high cost procedures, while payers will negotiate for exclusions to avoid payment of higher cost care.

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

**Exclusive Provider Organization (EPO)** - A plan that limits coverage of non-emergency care to contracted health care providers. Operates similar to an HMO plan but is usually offered as an insured or self-funded product. Sometimes looks like a managed care organization that is organized similarly to a PPO in that physicians do not receive capitated payments, but the plan only allows patients to choose medical care from network providers. If a patient elects to seek care outside of the network, then he or she will usually not be reimbursed for the cost of the treatment. Uses a small network of providers and has primary care physicians serving as care coordinators (or gatekeepers). Typically, an EPO has financial incentives for physicians to practice cost-effective medicine by using either a prepaid per-capita rate or a discounted fee schedule, plus a bonus if cost targets are met. Most EPOs are forms of POS plans because they pay for some out-of-network care.

**Exclusivity Clause** - A part of a contract which prohibits physicians, providers or other care entities from contracting with more than one managed care organization. Exclusive contracts are common in staff model HMOs and IPAs but becoming less common in other health plan contracting.

**Expansion** - Some HMOs compute Plan expansion as part of the capitation rate in order to provide the necessary capital for growth.

**Experience** - A term used to describe the relationship of premium to claims for a plan, coverage, or benefits for a stated time period. Usually expressed as a ratio or percent. See also Medical Loss Ratio.

**Experience Rating** - The process of setting rates partially or in whole on evaluating previous claims experience for a specific group or pool of groups. The rating system by which the Plan determines the capitation rate or premium rate is determined by the experience of the individual group enrolled, based on actual or anticipated health care use by the specific group of insureds. Each group will have a different rate based on utilization. This system tends to penalize small groups with high utilization. A method of adjusting health plan premiums based on the historical utilization data and distinguishing characteristics of a specific subscriber group, such as determining the premium based on a group's claims experience, age, sex or health status. Experience rating is not allowed for federally qualified HMOs.

**Experience-Rated Premium** - A premium which is based upon the anticipated claims experience of, or utilization of service by, a contract group according to its age, sex, constitution, and any other attributes expected to affect its health service utilization, and which is subject to periodic adjustment in line with actual claims or utilization experience.

**Explanation of Benefits (EOB)** - A statement sent to covered individuals explaining services provided, amount to be billed, and payments made. A summary of benefits provided subscribers by the carrier.

**Extended Care Facility (ECF)** - A nursing or convalescent home offering skilled nursing care and rehabilitation services on a 24-hour basis.

**Extension of Benefits** - Insurance policy provision that allows medical coverage to continue past termination of employments. See also COBRA.

**External Quality Review Organization (EQRO)** - States are required to contract with an entity that is external to and independent of the State and its HMO and HIO contractors to perform an annual review of the quality of services furnished by each HMO or HIO contractor.

## F

**Favorable Selection** - Selection of subscribers or covered lives based on data that shows a tendency for utilization of health services in that population group to be lower than expected or estimated.

**Federal Bureau of Investigation (FBI)** - As an agency under the DOJ, the FBI investigates violations of federal criminal law and provides law enforcement assistance to federal, state, local and international agencies. The FBI has investigated hospitals for fraud and abuse. (See Fraud).

**Federal Medicaid Managed Care Waiver Program** - The process used by States to receive permission to implement managed care programs for their Medicaid or other categorically eligible beneficiaries.

**Federally Qualified Health Center (FQHC)** - A federal payment option that enables qualified providers in medically underserved areas to receive cost-based Medicare and Medicaid reimbursement and allows for the direct reimbursement of nurse practitioners, physician assistants and certified nurse midwives. Many outpatient clinics and specialty outreach services are qualified under this provision that was enacted in 1989.

**Federally Qualified HMO** - A prepaid health plan that has met strict federal standards and has been granted qualification status. A federally qualified HMO is eligible for loans and loan guarantees not available to non-qualified plans. Employers of 25 or more workers were, until recently, required to offer a federally qualified HMO if the plan requested to be included in the company's health benefits program.

**Federal Qualification** - A status designated by CMS after conducting an extensive evaluation of an HMO's organization and operations. An organization must be federally qualified or be designated as a competitive medical plan (CMP) to be eligible to participate in Medicare and cost and risk contracts. Federal designation that allows an organization to participate in certain Medicare cost and risk contracts.

**Fee Disclosure** - Physicians and caregivers discussing their charges with patients prior to treatment.

**Fee-For-Service (FFS)** - Traditional method of payment for health care services where specific payment is made for specific services rendered. Usually people speak of this in contrast to capitation, DRG or per diem discounted rates, none of which are similar to the traditional fee for service method of reimbursement. 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. Payment may be made by an insurance company, the patient or a government program such as Medicare or Medicaid. With respect to the physicians or other supplier of service, this refers to payment in specific amounts for specific services rendered--as opposed to retainer, salary, or other contract arrangements. In relation to the patient, it refers to payment in specific amounts for specific services received, in contrast to the advance payment of an insurance premium or membership fee for coverage, through which the services or payment to the supplier are provided.

**Fee Schedule** - A listing of accepted fees or established allowances for specified medical procedures. As used in medical care plans, it usually represents the maximum amounts the program will pay for the specified procedures.

**Fiduciary** - Relating to, or founded upon, a trust or confidence. A legal term. A fiduciary relationship exists where an individual or organization has an explicit or implicit obligation to act in behalf of another person's or organization's interests in matters which affect the other person or organization. This fiduciary is also obligated to act in the other person's best interest with total disregard for any interests of the fiduciary. Traditionally, it was generally believed that a physician had a fiduciary relationship with patients. This is being questioned in the era of managed care as the public becomes aware of the other influences that are effecting physician decisions. Doctors are provided incentives by managed care companies to provide less care, by pharmaceutical companies to order certain drugs and by hospitals to refer to their hospitals. With the pervasive monetary incentives influencing doctor decisions, consumer advocates are concerned because the patient no longer has an unencumbered fiduciary.

**First Dollar coverage** - Insurance coverage with no front-end deductible where coverage begins with the first dollar of expense incurred by the insured for any covered benefit.

**Fiscal Intermediary** - The agent (e.g., Blue Cross) that has contracted with providers of service to process claims for reimbursement under health care coverage. In addition to handling financial matters, it may perform other functions such as providing consultative services or serving as a center for communication with providers and making audits of providers' needs. This entity may also be referred to as TPA or third party administrator. A private organization, usually an insurance company, that serves as an agent for the Health Care Financing Administration (CMS), which is part of HHS, that determines the amount of payment due to hospitals and other providers and paying them for the Medicare services they have provided. Intermediaries make initial coverage determinations and handle the early stages of beneficiary appeals.

**Fiscal Soundness** - The requirement that managed care organizations have sufficient operating funds, on hand or available in reserve, to cover all expenses associated with services for which they have assumed financial risk.

**Fixed Costs** - Costs that do not change with fluctuations in census or in utilization of services.

**Flat Fee-Per-Case** - Flat fee paid for a client's treatment based on their diagnosis and/or presenting problem. For this fee the provider covers all of the services the client requires for a specific period of time. Often characterizes "second generation" managed care systems. After the MCOs squeeze out costs by discounting fees, they often come to this method. If provider is still standing after discount blitz, this approach can be good for provider and clients, since it permits a lot of flexibility for provider in meeting client needs. DRGs are an example of flat fees paid by diagnosis.

**Flexible Benefit Plan** - Program offered by some employers in which employees may choose among a number of health care benefit options. See also Cafeteria Plan.

**Flexible Spending Account (FSA)** - A plan that provides employees a choice between taxable cash and non-taxable benefits for unreimbursed health care expenses or dependent care expenses. This plan qualifies under Section 125 of the IRS Code. See also Medical Spending Account.

**Formatting and Protocol Standards** - Data exchange standards which are needed between CPR systems, as well as CPT and other provider systems, to ensure uniformity in methods for data collection, data storage and data presentation. Proactive providers are current in their knowledge of these standards and work to ensure their information systems conform to the standards.

**Formulary** - An approved list of prescription drugs; a list of selected pharmaceuticals and their appropriate dosages felt to be the most useful and cost effective for patient care. Organizations often develop a formulary under the aegis of a pharmacy and therapeutics committee. In HMOs, physicians are often required to prescribe from the formulary. See also Drug Formulary.

**Functional Health Status** - Refers to a patient's ability to perform typical daily physical and social/role functions, plus other measures of self-perceived health status such as well-being, vitality and mental health.

**Funding Level** - Amount of revenue required to finance a medical care program.

**Funding Method** - System for employers to pay for a health benefit plan. Most common methods are prospective and / or retrospective premium payment, shared risk arrangement, self-funded, or refunding products. See also Self-insured, Risk and Premium.

**Fraud** - Intentional misrepresentations that can result in criminal prosecution, civil liability and administrative sanctions.

**Freedom of Choice** - A principle of Medicaid that allows a recipient the freedom to choose among participating Medicaid providers. This term is also used by indemnity plans to indicate that subscribers may use the providers of their choice.

## G

**Gag Clause** - A provision of a contract between a managed care organization and a health care provider that restricts the amount of information a provider may share with a beneficiary or that limits the circumstances under which a provider may recommend a specific treatment option.

**Gatekeeper** - A primary care physician, utilization review, case management, local agency or managed care entity responsible for determining when and what services a patient can access and receive reimbursement for. An arrangement in which a primary care provider serves as the patient's agent, arranges for and coordinates appropriate medical care and other necessary and appropriate referrals. A PCP is involved in overseeing and coordinating all aspects of a patient's medical care. In order for a patient to receive a specialty care referral or hospital admission, the PCP must preauthorize the visit, unless there is an emergency. The term gatekeeper is also used in health care business to describe anyone (EAP, employer based case manager, UR entity, etc.) that makes the decision of where a patient will receive services.

**Gatekeeping** - The process by which a primary care physician directly provides primary care and coordinates all diagnostic testing and specialty referrals required for a patient's medical care. Referrals and procedures usually are preauthorized by gatekeepers except in cases of emergency care.

**Genetics** - The study of how particular traits are passed from parents to children. Identifiable genetic information receives the same level of protection as other health care information under the HIPAA Privacy Rule. Of note for genetic researchers, the rule defines "identifiable" information to include information from the individual as well as relatives. Thus researchers considering whether to de-identify data should review the definition of de-identified information closely.

**Global Budgeting** - Limits placed on categories of health spending. 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. Managed care organizations will often seek contracts with hospitals that contain set global fees for certain sets of services. Outliers and carve-outs will be those services not included in the global negotiated rates.

**Guaranteed Issue** - Requirement that health plans offer coverage to all businesses during some period each year.

**Grace Period** - Period past the due date of a premium during which coverage may not be cancelled.

**Grievance Procedures** - The process by which an insured can air complaints and seek remedies.

**Gross Charges Per 1,000** - An indicator calculated by taking the gross charges incurred by a specific group for a specific period of time, dividing it by the average number of covered members or lives in that group during the same period, and multiplying the result by 1,000. This is calculated in the aggregate and by modality of treatment, e.g., inpatient, residential, partial hospitalization, and outpatient. A measure used to evaluate utilization management performance.

**Gross Costs Per 1,000** - An indicator calculated by taking the gross costs incurred for services received by a specific group for a specific period of time, dividing it by the average number of covered members or lives in that group during the same period, and multiplying the result by 1,000. This is calculated in the aggregate and by modality of treatment, e.g. inpatient, residential, partial hospitalization, and outpatient. A measure used to evaluate utilization management performance. This is the key concept for the provider. What matters is our cost and, in managed care, we must control this indicator and make sure it is below our collections per 1,000.

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

**Group Model HMO, Group Network HMO** - An HMO that contracts with one or more independent group practice to provide services to its members in one or more locations. Health care plan involving contracts with physicians organized as a partnership, professional corporation, or other legal association. It can also refer to an HMO model in which the HMO contracts with one or more medical groups to provide services to members. In either case, the payer or health plan pays the medical group, which is, in turn, is responsible for compensating physicians. The medical group may also be responsible for paying or contracting with hospitals and other providers.

**Group Practice** - A group of persons licensed to practice medicine in the State, who, as their principal professional activity, and as a group responsibility, engage or undertake to engage in the coordinated practice of their profession primarily in one or more group practice facilities, and who in their connection share common overhead expenses if and to the extent such expenses are paid by members of the group, medical and other records, and substantial portions of the equipment and the professional, technical, and administrative staffs. Group practices use the acronyms PA, IPA, MSO and others. Group practices are far more common now than a decade ago because physicians seek to lower costs, increase contracting power and share payer contracts.

**Group Practice without Walls (GPWW)** - Similar to an independent practice association, this type of physician group represents a legal and formal entity where certain services are provided to each physician by the entity, and the physician continues to practice in his/her own facility. It can include marketing, billing and collection, staffing, management, and the like. Also called clinic without walls.

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

## H

**Health and Human Services (HHS)** - The Department of Health and Human Services that is responsible for health-related programs and issues. Formerly HEW, the Department of Health, Education, and Welfare. The Office of Health Maintenance Organizations (OHMO) is part of HHS and detailed information on most companies is available here through the Freedom of Information Act.

**HCFA 1500** - The Health Care Finance Administration's standard form for submitting provider service claims to third party companies or insurance carriers. HCFA is now called CMS, see CMS.

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

**Health Benefits Package** - The services and products a health plan offers.

**Health Care, Healthcare** - Care, services, and supplies related to the health of an individual. Health care includes preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, and counseling, among other services. Healthcare also includes the sale and dispensing of prescription drugs or devices.

**Health Care Clearinghouse** - A public or private entity that does either of the following (Entities, including but not limited to, billing services, repricing companies, community health management information systems or community health information systems, and "value-added" networks and switches are health care clearinghouses if they perform these functions): 1) Processes or facilitates the processing of information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction; 2) Receives a standard transaction from another entity and processes or facilitates the processing of information into nonstandard format or nonstandard data content for a receiving entity. This term is used in the HIPAA rules.

**Health Care Financing Administration (HCFA)** - The federal government agency within the Department of Health and Human Services which directs and oversees the Medicare and Medicaid programs (Titles XVIII and XIX of the Social Security Act) and conducts research to support those programs. It is now called CMS and generally it oversees the state's administrations of Medicaid, while directly administering Medicare. See CMS, or Center for Medicare and Medicaid Services.

**Health Care Operations** - Institutional activities that are necessary to maintain and monitor the operations of the institution. Examples include but are not limited to: conducting quality assessment and improvement activities; developing clinical guidelines; case management; reviewing the competence or qualifications of health care professionals; education and training of students, trainees and practitioners; fraud and abuse programs; business planning and management; and customer service. Under the HIPAA Privacy Rule, these are allowable uses and disclosures of identifiable information "without specific authorization." Research is not considered part of health care operations.

**Health Care Provider** - Providers of medical or health care or researchers who provide health care are health care providers. Normally health care providers are clinics, hospitals, doctors, dentists, psychologists and similar professionals.

**Healthcare Provider Taxonomy Codes** - An administrative code set that classifies health care providers by type and area of specialization. The code set will be used in certain adopted transactions. (Note: A given provider may have more than one Healthcare Provider Taxonomy Code.)

**Health Employer Data and Information Set (HEDIS)** - A set of HMO performance measures that are maintained by the National Committee for Quality Assurance. HEDIS data is collected annually and provides an informational resource for the public on issues of health plan quality.

**Health Information** - Information in any form (oral, written or otherwise) that relates to the past, present or future physical or mental health of an individual. That information could be created or received by a health care provider, a health plan, a public health authority, an employer, a life insurer, a school, a university or a health care clearinghouse. All health information is protected by state and federal confidentiality laws and by HIPAA privacy rules.

**Health Insurance** - Financial protection against the health care costs of the insured person. May be obtained in a group or individual policy.

**Health Insurance Portability and Accountability Act of 1996 (HIPAA)** - A Federal law that allows persons to qualify immediately for comparable health insurance coverage when they change their employment relationships. 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. As a result of this law, hospitals, doctors and insurance companies are now required to share patient medical records and personal information on a wider basis. This wide-based sharing of medical records has led to privacy rules, greater computerization of records and consumer concerns about confidentiality. In addition, HIPAA required the creation of a federal law to protect personally identifiable health information; if that did not occur by a specific date (which it did not), HIPAA directed the Department of Health and Human Services (DHHS) to issue federal regulations with the same purpose. DHHS has issued HIPAA privacy regulations (the HIPAA Privacy Rule) as well as other regulations under HIPAA. HIPAA gives HHS the authority to mandate the use of standards for the electronic exchange of health care data; to specify what medical and administrative code sets should be used within those standards; to require the use of national identification systems for health care patients, providers, payers (or plans), and employers (or sponsors); and to specify the types of measures required to protect the security and privacy of personally identifiable health care information. Also known as the Kennedy-Kassebaum Bill, the Kassebaum-Kennedy Bill, K2, or Public Law 104-191.

**Health Insurance Purchasing Cooperatives (HIPC)** - 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 Level Seven (HL7)** - A data interchange protocol for health care computer applications that simplifies the ability of different vendor-supplied IS systems to interconnect. Although not a software program in itself, HL7 requires that each healthcare software vendor program HL7 interfaces for its products.

**Health Maintenance Organization (HMO)** - HMOs offer prepaid, comprehensive health coverage for both hospital and physician services. The HMO is paid monthly premiums or capitated rates by the payers, which include employers, insurance companies, government agencies, and other groups representing covered lives. The HMO must meet the specifications of the federal HMO act as well as meeting many rules and regulations required at the state level. There are 4 basic models: group model, individual practice association, network model and staff model. An HMO contracts with health care providers, e.g., physicians, hospitals, and other health professionals. The members of an HMO are required to use participating or approved providers for all health services and generally all services will need to meet further approval by the HMO through its utilization program. Members are enrolled for a specified period of time. HMOs may turn around and sub-capitate to other groups. For example, it may carve-out certain benefit categories, such as mental health, and subcapitate these to a mental health HMO. Or the HMO may subcapitate to a provider, provider group or provider network. HMOs are the most restrictive form of managed care benefit plans because they restrict the procedures, providers and benefits.

**Health Manpower Shortage Area (HMSA)** - An area or group that the U.S. Department of Health and Human Services designates as having an inadequate supply of health care providers. HMSAs can include: (1) an urban or rural 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 Oversight Agency** – Under HIPAA rules, this refers to a person or entity at any level of the federal, state, local or tribal government that oversees the health care system or requires health information to determine eligibility or compliance or to enforce civil rights laws.

**Health Plan** - An entity that assumes the risk of paying for medical treatments, i.e. uninsured patient, self-insured employer, payer, or HMO.

**Health Plan Employer Data and Information Set (HEDIS)** - A set of performance measures designed to standardize the way health plans report data to employers. HEDIS currently measures five major areas of health plan performance: quality, access and patient satisfaction, membership and utilization, finance, and descriptive information on health plan management. HEDIS was initially developed in 1991 by the National Committee for Quality Assurance.

**Health Professional Shortage Area (HPSA)** - A geographic area, population group, or medical facility that HHS determines to be served by too few health professionals of particular specialties. Physicians who provide services in HPSAs qualify for the Medicare bonus payments. This may also include re-payment of medical school loans or other incentives. These reports are published annually by HHS and can be of assistance to providers or groups wishing to recruit physicians to particular areas.

**Health Insurance Purchasing Cooperative (HIPC)** - Regional consumer groups that are established to shop for highest quality plan at lowest cost on behalf of large number of people, including employees of small businesses. Entity established to purchase bulk health insurance for businesses, groups or individuals. Was a key concept in the Clinton health plan and is not a current concept. Other cooperatives exist now, including business health action groups and health plan purchasing cooperatives. Although it may go by other names, we can expect such cooperatives to exist in the future.

**Health Maintenance Organization (HMO)** - An entity that provides, offers or arranges for coverage of designated health services needed by members for a fixed, prepaid premium. There are three basic models of HMOs: group model, individual practice association (IPA), and staff model.

**Health Plan Employer Data and Information Set (HEDIS)** - A set of performance measures developed to support health plan and Medicaid agency efforts to improve the health status of Medicaid beneficiaries, support the strengthening of health care delivery systems for the Medicaid population, promote standardization of managed care reporting across public and private sectors, and promote the application of performance measurement technology across Medicaid programs.

**Health Resources and Services Administration (HRSA)** - HRSA is a component of the U.S. Department of Health and Human Services. Included in HRSA responsibilities is administration of the Ryan White Care funds with a budget of about \$1 billion/year to support a continuum of care services for persons with HIV infection.

**Health Service Agreement (HSA)** - Detailed explanation of procedures and benefits provided to an employer by a health plan.

**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.

**HEDIS** – See Health Plan Employer Data and Information Set.

**HHS** - See Health and Human Services, above.

**HIPAA** - See Health Insurance Portability and Accountability Act of 1996, above.

**Hold Harmless Clause** - A clause frequently found in managed care contracts whereby the HMO and the physician hold each other not liable for malpractice or corporate malfeasance if either of the parties is found to be liable. Many insurance carriers exclude this type of liability from coverage. It may also refer to language that prohibits the provider from billing patients if their managed care company becomes insolvent. State and federal regulations may require this language.

**Home Health Care** - Full range of medical and other health related services such as physical therapy, nursing, counseling, and social services that are delivered in the home of a patient, by a provider.

**Horizontal integration, Horizontal Consolidation** - Merging of two or more firms at the same level of production in some formal, legal relationship. In hospital networks, this may refer to the grouping of several hospitals, the grouping of outpatient clinics with the hospital or a geographic network of various health care services. Integrated systems seek to integrate both vertically with some organizations and horizontally with others. When local health plans (or local hospitals) merge. This practice was popular in the late 1990s and was used to expand regional business presence. See vertical integration.

**Hospice** - Facility or program providing care for the terminally ill.

**Hospital** - Any institution duly licensed, certified, and operated as a Hospital. In no event shall the term "Hospital" include a convalescent facility, nursing home, or any institution or part thereof which is used principally as a convalescence facility, rest facility, nursing facility, or facility for the aged.

**Hospital Affiliation** - A contractual agreement between a health plan and one or more hospitals whereby the hospital provides the inpatient services offered by the health plan.

**Hospital Alliances** - Groups of hospitals joined together to share services and develop group-purchasing programs to reduce costs. May also refer to a spectrum of contracts, agreements or handshake arrangements for hospitals to work together in developing programs, serving covered lives or contracting with payers or health plans. See also Network, Integrated Delivery System, PHO, or Provider Health Plan.

**Hospital Audit Companies** - Retrospective audit providers that typically achieve a 15-20 percent savings of billed claims

**Hospital Days (per 1,000)** - A measurement of the number of days of hospital care HMO members use in a year. It is calculated as follows: Total Number Of Days Spent In A Hospital By Members divided by Total Members. This information is available through HHS, OHMO and a variety of sources.

**Human Subject** – Under HIPAA rules, this term refers to a living subject participating in research about whom directly or indirectly identifiable health information or data are obtained or created.

## I

**Incentives** - Profit sharing arrangements offered by HMOs and managed care plans that permit hospitals, providers, subcontractors and physicians to share in amounts earned from plan savings through reduced hospital and specialty referral usage. Normally, clinicians involved in profit-sharing will increase personal income or profit by reducing the quantity of care, supplies or services provided to patients. Consumers sometimes view these incentives as suspect, claiming profit sharing between health plans and providers results in reduction of quality of service. Federal fraud and abuse rules may affect the types of incentive plans that health centers and physicians may enter into. Managed care plans view incentives as necessary methods to align the physicians' (and sometimes hospitals') incentives with the incentives of the managed care plans.

**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. Hospitals also track certain risk management or quality problems with a system called incidence reporting.

**Incurred But Not Reported (IBNR)** - Refers to a financial accounting of all services that have been performed but, as a result of a short period of time, have not been invoiced or recorded. Estimates of costs for medical services provided for which a claim has not yet been filed. Refers to claims that reflect services already delivered, but, for whatever reason, have not yet been reimbursed. These are bills "in the pipeline." This is a crucial concept for proactive providers who are beginning to explore arrangements that put them in the role of adjudicating claims--as the result, perhaps, of operating in a sub-capitated system. Failure to account for these potential claims could lead to some very bad decisions. Good administrative operations have fairly sophisticated mathematical models to estimate this amount at any given time.

**Incurred Claims** - All claims with dates of service within a specified period.

**Incurred Claims Loss Ratio** - Incurred claims divided by premiums.

**Indemnify** - To make good a loss through compensation or reimbursement.

**Indemnity** - Health insurance benefits provided in the form of cash payments rather than services. Insurance program in which covered person is reimbursed for covered expenses. An indemnity insurance contract usually defines the maximum amounts that will be paid for covered services. Indemnity insurance plans may have a PPO option, UR and case management features, or include a network or other preferred provider restrictions, but will not have an HMO plan. Indemnity is the traditional form of insurance. Normally when one thinks of indemnity health coverage, one is thinking of the type of plan that does not require "pre-certification" and does not restrict the physicians, drugs or hospitals that will be paid for. Indemnity coverage usually has higher premiums. Indemnity insurance plans are the classic plans - where few restrictions are in place. With these plans, members are normally able to use the providers of their choice and are able to make independent decisions about the type of care they wish to receive. Usually these plans include co-payments, deductibles and maximums but rarely require case management certification or approvals. Managed care, particularly HMO and capitation, has evolved away from the indemnity method. Yet, many people are still covered under indemnity plans.

**Indemnity Carrier** - Usually an insurance company or insurance group that provides marketing, management, claims payment and review, and agrees to assume risk for its subscribers at some pre-determined rate.

**Indemnity Plan (Indemnity health insurance)** - A plan that reimburses physicians for services performed, or beneficiaries for medical expenses incurred. Such plans are contrasted with group health plans, which provide service benefits through group medical practice.

**Independent Practice Association (IPA) or Organization (IPO)** - A delivery model in which the HMO contracts with a physician organization, which in turn contracts with individual physicians. The IPA physicians practice in their own offices and continue to also see their FFS patients. The HMO reimburses the IPA on a capitated basis; however, the IPA may reimburse the physicians on an FFS or capitated basis.

**Indirectly Identifiable Health Information** - Data that do not include personal identifiers, but link the identifying information to the data through use of a code. These data are still considered identifiable by the HIPAA Common Rule. See also HIPAA.

**Individually Identifiable Health Information** – A term used in healthcare to describe a subset of health information that identifies the individual or can reasonably be used to identify the individual. State and Federal confidentiality laws as well as HIPAA have standards and rules regarding the protection of individually identifiable health information of patients. See also HIPAA.

**Individual Plans** - A type of insurance plan for individuals and their dependents who are not eligible for coverage through employer group coverage.

**Individual (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. Sometimes thought of as an HMO model in which the HMO contracts with a physician organization that in turn contracts with individual physicians. The IPA physicians provide care to HMO members from their private offices and continue to see their fee-for-service patients.

**Informed Consent** – Refers to requirements (by HIPAA, Medicare, State and Federal Laws) that healthcare providers and researchers explain the purposes, risks, benefits, confidentiality protections, and other relevant aspects of the provision of medical care, a specific procedure or participation in medical research. Informed consent is also required for the authorization of release or disclosure of individually identifiable health care information, under HIPAA.

**Inpatient Care** - Care given a registered bed patient in a hospital, nursing home or other medical or post acute institution.

**In-Plan Services** - Services that are covered under the state Medicaid plan and included in the patient's managed care contract and/or are furnished by a participating provider.

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

**Institutional Review Board (IRB)** – A group of medical professionals formed together for the purpose of providing peer review to protect the rights of human subjects in medical research and clinical trials. HIPAA privacy regulations require an IRB also to protect the privacy rights of research subjects in specific ways.

**Integrated Delivery System (IDS) or Integrated Services Network (ISN)** - Many different, but similar, definitions exist for IDS. IDS, as an entity, does not have to abide by strict regulations, as does an HMO. When an IDS offers a health plan, however, it must then abide by the requirements of the state and federal government for health plans, insurance companies or HMOs. Without owning a health plan product, an IDS will usually abide by the regulations that govern its separate businesses, that is, regulations governing hospitals, clinics and physicians. An IDS can be a financial or contractual arrangement between health providers (usually hospitals and doctors) to offer a comprehensive range of health care services through a separate legal entity operating, at least for these purposes, as a single health care delivery system. IDS can be 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. IDS can also be a healthcare provider organization which vertically integrates physician, hospital, and, usually, also health plan businesses in some manner in order to establish a full continuum of care, seamless of delivery of services and the ability to manage care under new reimbursement arrangements. Also called delivery system, vertically integrated system, horizontally integrated system, health delivery network, accountable health plan, and other names.

**Intensive Care Management** - Intensive community services for individuals with severe and persistent mental illness that are designed to improve planning for their service needs. Services include outreach, evaluation, and support.

**Interface** - A means of communication between two computer systems, two software applications or two modules. Real time interface is a key element in healthcare information systems due to the need to access patient care information and financial information instantaneously and comprehensively. Such real time communication is the key to managing health care in a cost effective manner because it provides the necessary decision-making information for clinicians, providers and payers.

**Internal Medicine** - Generally, that branch of medicine that is concerned with diseases that do not require surgery, specifically, the study and treatment of internal organs and body systems; it encompasses many subspecialties; internists, the doctors who practice internal medicine, often serve as family physicians to supervise general medical care.

**International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM, ICD-10-CM)** - This is the universal coding method used to document the incidence of disease, injury, mortality and illness. A diagnosis and procedure classification system designed to facilitate collection of uniform and comparable health information. The ICD-9-CM was issued in 1979. This system is used to group patients into DRGs, prepare hospital and physician billings and prepare cost reports. Classification of disease by diagnosis codified into six-digit numbers. See also coding.

**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**

**J-Codes** - A subset of the HCPCS Level II code set with a high-order value of "J" that has been used to identify certain drugs and other items.

**Job-Lock** - Laws have now been enacted by congress which include continuance of benefits (COBRA) and other requirements which eliminate pre-existing clauses for those individuals who change coverage plans but have maintained continuance of coverage overall. The inability of individuals to change jobs because they would lose crucial health benefits.

**Joint Commission on the Accreditation of Healthcare Organizations (JCAHO)** - Formerly called JCAH, or Joint Commission on Accreditation of Hospitals, this is the peer review organization which provides the primary review of hospitals and healthcare providers. Many insurance companies require providers to have this accreditation in order to seek 3rd party payment, although, many small hospitals cannot afford the cost of accreditation. JCAHO usually surveys organizations once every 3 years, sending in a medical and administrative team to review policies, patient records, professional credentialing procedures, governance and quality improvement programs. JCAHO revises its "standards" annually.

## **K**

### **Key Contributor Plan**

This refers to a little known performance-based program with incentives for the purpose of attracting, motivating and retaining key individuals or small groups.

## L

**Large Claim Pooling** - System that isolates claims above a certain level and charges them to a pool funded by charges of all groups who share the pool. Designed to help stabilize significant premium fluctuations.

**Large Urban Area** - An urban statistical region with population of one million or more.

**Legacy Systems** - Computer applications, both hardware and software, which have been inherited through previous acquisition and installation. Most often, these systems run business applications that are not integrated with each other. Newer systems which stress open design and distributed processing capacity are gradually replacing such systems.

**Legend Drug** - Drug that the law says can only be obtained by prescription.

**Length of Stay (LOS)** - The duration of an episode of care for a covered person. The number of days an individual stays in a hospital or inpatient facility. May also be reviewed as Average Length of Stay (ALOS).

**Licensing** - A process most States employ, which involves the review and approval of applications from HMOs prior to beginning operation in certain areas of the State. Areas examined by the licensing authority include: fiscal soundness, network capacity, MIS, and quality assurance. The applicant must demonstrate it can meet all existing statutory and regulatory requirements prior to beginning operations.

**Lifetime Limit** - A cap on the benefits paid under a policy. Many policies have a lifetime limit of \$1 million, which means that the insurer agrees to cover up to \$1 million in covered services over the life of the policy.

**Limited Data Set** – Under HIPAA, this term refers to a set of data that may be used for research, public health or health care operations without an authorization or waiver of authorization. The limited data set is defined as PHI that excludes the following direct identifiers of the individual or of relatives, employers or household members of the individual: names; postal address information, (other than town or city, State and zip code); telephone and FAX numbers; electronic mail addresses; SSN; medical record numbers; health plan beneficiary numbers; account numbers; certificate/license numbers; vehicle identifiers and serial numbers, including license plates; device identifiers and serial numbers; web universal resource locators (URLs); internet protocol (IP) address; biometric identifiers, including finger and voice prints; full face photos, and comparable images. A covered entity must enter into a data use agreement with the recipient of a limited data set. It should be noted that although a limited data set is subject to only select provisions of the HIPAA Privacy Rule, it may be covered by the Common Rule.

**Limiting Charge** - The maximum amount that a non-participating physician is permitted to charge a Medicare beneficiary for a particularly defined procedure or bundled service. These limits are published by the individual state intermediaries for Medicare and CMS and are usually combined in reports with the allowed charges and regional payment schedules. In 1993, the limiting charge was set at 115 percent of the Medicare-allowed charge. However, this does not reflect what the physician will be paid.

**Local Access Transport Area (LATA)** - A defined region in which a telephone and long distance carrier operates. Important concept for those CHINs that depend upon phone lines. When creating communications networks, you try to avoid crossing boundaries of these, if possible, since costs escalate dramatically when there is a need to communicate over more than one LATA.

**Local Codes** - A generic term for code values that are defined for a State or other local division or for a specific payer. Commonly used to describe HCPCS Level III Codes.

**Local Exchange Carrier (LEC)** - The telephone company that provides and supports the local connection to the public switched telephone network. In many areas of the US, the LEC is one of the seven Regional Bell Operating Companies (RBOCs) or "Baby Bells." These LECs become partners for organizations seeking to develop a CHIN or, more conservatively, simply seeking to integrate their information system across many sites within a region.

**Lock-in** - A contractual provision by which members are required to use certain health care providers in order to receive coverage (except in cases of urgent or emergent need).

**Long-term care (LTC)** - 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, which can also be provided on a long-term basis, are seen as alternatives to long-term institutional care.

**Long-term care insurance** - Insurance designed to pay for some or all of the costs of long term care.

**Loss Ratio** - Incurred claims plus expenses, divided by paid premiums. See also Incurred Claims Loss Ratio.

## M

**Major Medical Expense Insurance** - Policies designed to help offset the heavy medical expenses resulting from catastrophic or prolonged illness or injury. They generally provide benefits payments for 75 to 80 percent of most types of medical expenses above a deductible paid by the insured.

**Malpractice Insurance** - Insurance against the risk of suffering financial damage due to professional misconduct or lack of ordinary skill. Malpractice requires that the patient prove some injury and that the injury was the result of negligence on the part of the professional. A practitioner is liable for damages or injuries caused by malpractice.

**Managed Behavioral Health Program** - A program of managed care specific to psychiatric or behavioral health care. This usually is a result of a "carve-out" by an insurance company or managed care organization (MCO). Reimbursement may be in the form of sub-capitation, fee for service or capitation. See also Carve-Out.

**Managed Care** - Systems and techniques used to control the use of health care services. Includes a review of medical necessity, incentives to use certain providers, and case management. 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) but this is not always the case. Managed care is a broad term and encompasses many different types of organizations, payment mechanisms, review mechanisms and collaborations. Managed care is sometimes used as a general term for the activity of organizing doctors, hospitals, and other providers into groups in order to enhance the quality and cost-effectiveness of health care. Managed Care Organizations (MCO) include HMO, PPO, POS, EPO, PHO, IDS, AHP, IPA, etc. Usually when one speaks of a managed care organization, one is speaking of the entity that manages risk, contracts with providers, is paid by employers or patient groups, or handles claims processing. Managed care has effectively formed a "go-between", brokerage or 3rd party arrangement by existing as the gatekeeper between payers and providers and patients. The term managed care is often misunderstood, as it refers to numerous aspects of healthcare management, payment and organization. It is best to ask the speaker to clarify what he or she means when using the term "managed care". In the purest sense, all people working in healthcare and medical insurance can be thought of as "managing care." Any system of health payment or delivery arrangements where the plan attempts to control or coordinate use of health services by its enrolled members in order to contain health expenditures, improve quality, or both. Arrangements often involve a defined delivery system of providers with some form of contractual arrangement with the plan. See Health Maintenance Organization, Independent Practice Association, Preferred Provider Organization.

**Managed Care Organization (MCO)** - A health plan that seeks to manage care. Generally, this involves contracting with health care providers to deliver health care services on a capitated (per-member per-month) basis. For specific types of managed care organizations, see also health maintenance organization and independent practice association.

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

**Managed Competition** - A health insurance system that bands together employers, labor groups and others to create insurance purchasing groups; employers and other collective purchasers would make a specified contribution toward insurance purchase for the individuals in their group; the employer's set contribution acts as an incentive for insurers and providers to compete. This term first surfaced as a result of Bill Clinton's health reform package in the early 1990s.

**Managed Health Care Plan** - An arrangement that integrates financing and management with the delivery of health care services to an enrolled population. It employs or contracts with an organized system of providers that delivers services and frequently shares financial risk.

**Management Information System (MIS)** - The common term for the computer hardware and software that provides the support of managing the plan.

**Management Services Organization (MSO)** - Usually an entity owned by a hospital, physician group, PHO or IDS that provides management services and administrative systems to one or more medical practices. The management services organization provides administrative and practice management services to physicians. A hospital, hospitals, or investors may typically own an MSO. Large group practices may also establish MSOs to sell management services to other physician groups. See also Medical Services Organization.

**Mandated Benefits** - Benefits that health plans are required by law to provide.

**Mandated Providers** - Providers whose services must be included in coverage offered by a health plan. State or federal law can require these mandates.

**Manual Rates** - Rates based on a health plan's average claims data and adjusted for certain factors, such as group demographics or industry.

**Market Area** - The targeted geographic area or areas of greatest market potential. The market area does not have to be the same as the post acute facility's catchment area.

**Market Basket Index** - A common term in the field of economics. In healthcare business, this refers to a ratio or index of the annual change in the prices of goods and services providers used to produce health services. Different market baskets exist for PPS based hospital inputs and capital inputs, DRG exempt facility operating inputs (such as SNF, home health agency and renal dialysis facility). Also called input price index.

**Market Share** - A certain percentage of the market area or targeted market population. Usually used to describe a forecasted goal or a past penetration of the market.

**Master Patient / Member Index** - An index or file with a unique identifier for each patient or member that serves as a key to a patient's or member's health record.

**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.

**Maximum Defined Data Set** - Under HIPAA, this is all of the required data elements for a particular standard based on a specific implementation specification. An entity creating a transaction is free to include whatever data any receiver might want or need. The recipient is free to ignore any portion of the data that is not needed to conduct their part of the associated business transaction, unless the inessential data is needed for coordination of benefits.

**Maximum Out-of-Pocket Expenses** - Limit on total number of co-payments or limit on total cost of deductibles and co-insurance under a benefit plan.

**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)** - Government entitlement program for the poor, blind, aged, disabled or members of families with dependent children (AFDC). Each state has its own standards for qualification. 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. All states but Arizona have Medicaid programs.

**Medical Allied Manpower** - This category includes some sixty occupations or specialties that can be divided into two large categories based on time required for occupational training. The first category includes those occupations that require at least a baccalaureate degree, for example, clinical laboratory scientists and technologists, dietitians and nutritionists, health educators, medical record librarians, and occupational speech and rehabilitation therapists. The second group includes those occupations that require less than a baccalaureate degree, such as aides for each of the above categories as well as physician assistants and radiological technicians.

**Medical Care Evaluation Studies (MCE)** - The name given to a generic form of health care review in which problems in the quality of the delivery and organization of health care services are addressed and monitored. A program based on MCEs is recommended as a way of meeting the federal government's requirements for an internal quality assurance program for federally qualified HMOs.

**Medical Code Sets** - Codes that characterize a medical condition or treatment. These code sets are usually maintained by professional societies and public health organizations. Compare to administrative code sets.

**Medical Group Practice** - The American Group Practice Association, the American Medical Association, and the Medical Group Management Association define medical group practice as: provision of health care services by a group of at least three licensed physicians engaged in a formally organized and legally recognized entity sharing equipment, facilities, common records and personnel involved in both patient care and business management.

**Medical Informatics** - Medical informatics is the systematic study, or science, of the identification, collection, storage, communication, retrieval, and analysis of data about medical care services to improve decisions made by physicians and managers of health care organizations. Medical informatics will be as important to physicians and medical managers as the rules of financial accounting are to auditors.

**Medical Loss Ratio (MLR)** - Cost ratio of total benefits used compared to revenues received. Usually referred to by a ratio, such as 0.96--which means that 96% of premiums were spent on purchasing medical services. The goal is to keep this ratio below 1.00--preferably in the 0.80 ranges, since the MCO's or insurance company's profit comes from premiums. Currently, successful HMOs do have MLRs in the 0.70-0.80 range. The ratio between the cost to deliver medical care and the amount of money that was taken in by a plan. Insurance companies often have a medical loss ratio of 96 percent or more: tightly managed HMOs may have medical loss ratios of 75 percent to 85 percent, although the overhead (or administrative cost ratio) is concomitantly higher. See also Loss Ratio and Incurred Claims Loss Ratio.

**Medically Necessary, Medical Necessity, Medical Necessary Services** - Services or supplies which meet the following tests: They are appropriate and necessary for the symptoms, diagnosis, or treatment of the medical condition; They are provided for the diagnosis or direct care and treatment of the medical condition; They meet the standards of good medical practice within the medical community in the service area; They are not primarily for the convenience of the plan member or a plan provider; and They are the most appropriate level or supply of service which can safely be provided.

**Medically Needy** - Persons who are categorically eligible for Medicaid and whose income, less accumulated medical bills, are below state income limits for the Medicaid program. Often seen as a problem among the "working poor" or among the senior population. See spend down.

**Medical Management Information System (MMIS)** - A data system that allows payers and purchasers to track health care expenditure and utilization patterns. May also be referred to as Health Information System (HIS), Health Information Management (HIM) or Information System (IS). See also Electronic Medical Record (EMR).

**Medical Review, Medical Review Criteria** – Screening of healthcare utilization and the criteria used for this screening. Medical reviews are usually conducted by insurance companies, third-party payers, review organizations and case managers. This is the underlying basis for reviewing the quality and appropriateness of care provided to selected cases. Insurance companies rely heavily on medical review and their own criteria as cost control. Through medical review, payers are able to limit or reduce the utilization of health care services. Medical review may sometimes put patients at odds with their insurance companies or hospitals and doctors in conflict with payers.

**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 is 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. President George W. Bush promoted MSAs heavily in his 2004 presidential campaign as a method to provide coverage for the uninsured. However, MSAs are unlikely to meet that need due to the disparity between income levels and health care costs.

**Medical Services Organization (MSO)** - An organized group of physicians, usually from one hospital, into an entity able to contract with others for the provision of services. See also Management Services Organization and MSO.

**Medical Underwriting** - The federal health benefit program for the elderly and disabled that covers over 35,000,000 beneficiaries or over 14% of the US with an annual cost of over \$120 billion. Medicare pays for 25% of all hospital care and 23% of all physician services. This high cost is the source of constant debate in Congress. This refers to the Medicare program, the largest single payer in US.

**Medicare (Title XVIII)** - A federal program for the elderly and disabled, regardless of financial status. It is not necessary, as with Medicaid, for Medicare recipients to be poor. 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 covers more than 34 million Americans (16% of population) at an annual estimated cost of more than \$133 billion.

**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 Contractor** - A Medicare Part A Fiscal Intermediary (institutional), a Medicare Part B Carrier (professional), or a Medicare Durable Medical Equipment Regional Carrier (DMERC)

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

**Medicare Economic Index (MEI)** - An index that tracks changes over time in physician practice costs. From 1975 through 1991, increases in prevailing charge screens were limited to increases in the MEI.

**Medicare Provider Analysis and Review (MedPAR) File** - A CMS data file that contains charge data and clinical characteristics, such as diagnoses and procedures, for every hospital inpatient bill submitted to Medicare for payment.

**Medicare Remittance Advice Remark Codes** - A national administrative code set for providing either claim-level or service-level Medicare-related messages that cannot be expressed with a Claim Adjustment Reason Code. This code set is used in the X12 835 Claim Payment & Remittance Advice transaction.

**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 Supplemental Policy** - A policy that pays for the cost of services not covered by Medicare, such as coinsurance and deductibles.

**Medigap** - Private health insurance plans that supplement Medicare benefits by covering some costs not paid for by Medicare. MediGap plans are supplements to Medicare insurance. MediGap plans vary from State to State; standardized MediGap plans also may be known as Medicare Select plans.

**Member** - Used synonymously with the terms enrollee and insured. A member is any individual or dependent who is enrolled in and covered by a managed health care plan.

**Mental Health Parity** - Mental health parity refers to providing the same insurance coverage for mental health treatment as that offered for medical and surgical treatments. The Mental Health Parity Act was passed in 1996 and established parity in lifetime benefit limits and annual limits.

**Mental Health Provider** - Psychiatrist, social worker, hospital or other facility licensed to provide mental health services.

**Midlevel Practitioner** - Nurse practitioners, certified nurse-midwives and physicians' assistants who have been trained to provide medical services that otherwise might be performed by a physician. Midlevel practitioners practice under the supervision of a doctor of medicine or osteopathy who takes responsibility for the care they provide. Physician extender is another term for these personnel. It is important to note that, in many states now, nurse practitioners are not required to practice under the supervision of an MD or DO.

**Minimum Necessary** - A HIPAA Privacy Rule standard requiring that when protected health information is used or disclosed, only the information that is needed for the immediate use or disclosure should be made available by the health care provider or other covered entity. This standard does not apply to uses and disclosures for treatment purposes (so as not to interfere with treatment) or to uses and disclosures that an individual has authorized, among other limited exceptions. Justification regarding what constitutes the minimum necessary will be required in some situations (e.g., disclosures with a waiver of authorization and non-routine disclosures).

**Miscellaneous Expenses** - Hospital charges, other than room and board, such as those for x-rays, drugs, laboratory fees, and other ancillary services.

**Modified Community Rating** - Rating of medical service usage in a given area, adjusted for data such as age, sex, etc. See also Community Rating.

**Modified Fee-for-Service** - System that pays providers fees for services provided, with certain maximum fees for each service. See also Fee for Service, Benefits, and Preferred Providers.

**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).

**MSO** - One of the following: Medical Staff Organization An organized group of physicians, usually from one hospital, into an entity able to contract with others for the provision of services, or Management (or Medical) Services Organization An entity formed by, for example, a hospital, a group of physicians or an independent entity, to provide business-related services such as marketing and data collection to a grouping of providers like an IPA, PHO or CWW. This second definition is becoming the almost exclusive usage. See Management Services Organization or Medical Services Organization.

**Multiple Employer Trust (MET)** - A legal trust established by a plan sponsor that brings together a number of small, unrelated employers for the purpose of providing group medical coverage on an insured or self-funded basis. Not quite a Health Plan Purchasing Cooperative, but along the same lines. More market-oriented and usually smaller in scale. Redefined as a MEWA by the Multiple Employer Welfare Arrangement Act of 1982. See below.

**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.

**Multiple Option Plan** - Health care plan that lets employees or members choose their own plan from a group of options, such as HMO, PPO or major medical plan. See also Cafeteria Plan or Flexible Benefits Plan.

**Multi-Specialty Group** - A group of doctors who represent various medical specialties and who work together in a group practice.

## N

**National Claims History System (NCH)** - A CMS data reporting system that combines both Part A and Part B claims in a common file. The NCH system became fully operational in 1991.

**National Committee for Quality Assurance (NCQA)** - A non-profit organization created to improve patient care quality and health plan performance in partnership with managed care plans, purchasers, consumers, and the public sector. NCQA was formed in 1979 by the managed care industry and became independent in 1990. NCQA review is voluntary for health plans, but most plans seek its accreditation. The object of NCQA review and accreditation is to provide information to purchasers and patients and to encourage plans to compete based on quality and value rather than solely on price and provider network.

**National Council for Prescription Drug Programs** - An ANSI-accredited group that maintains a number of standard formats for use by the retail pharmacy industry, some of which have been adopted as HIPAA standards.

**National Drug Code (NDC)** - A medical code set maintained by the Food and Drug Administration that contains codes for drugs that are FDA-approved. The Secretary of HHS adopted this code set as the standard for reporting drugs and biologics on standard transactions. Classification system for drug identification, similar to UPC code.

**National Health Insurance** - Proposal by politicians to make government the single payer for all health care, similar to Great Britain or Canada. Providers like some aspects of this idea because it provides for "universal coverage" for all citizens. However, businesses and providers (as businesses themselves) dislike the idea of the government administering a program that they will either have to fund or be funded by. Proposals for national health insurance are surely to be debated by politicians for many years to come. See also Universal Coverage.

**National Practitioner Data Bank** - A computerized data bank maintained by the federal government that contains information on physicians against whom malpractice claims have been paid or certain disciplinary actions have been taken. Hospitals and other agencies pay a fee to access these records. Many regulatory agencies now require hospitals to utilize the NPDB prior to credentialing physicians at their facilities.

**National Provider Identifier** - A system for uniquely identifying all providers of health care services, supplies, and equipment. A term proposed by the Secretary of HHS as the standard identifier for health care providers.

**Network** - An affiliation of providers through formal and informal contracts and agreements. Networks may contract externally to obtain administrative and financial services. A list of physicians, hospitals and other providers who provide health care services to the beneficiaries of a specific managed care organization. See also IDS, PPO, PHO or Hospital Alliances.

**Network Model HMO** - This type of HMO contracts with more than one physician group and may contract with single or multi-specialty groups as well as hospitals and other health care providers. A health plan that contracts with multiple physician groups to deliver health care to members. Generally limited to large single or multi-specialty groups. Distinguished from group model plans that contract with a single medical group, IPA's that contract through an intermediary, and direct contract model plans that contract with individual physicians in the community.

**Neonatal Intensive Care Unit (Neo ICU)** - A hospital unit with special equipment for the care of premature and seriously ill newborn infants.

**Non-Participating Physician (or Provider)** - A provider, doctor or hospital that does not sign a contract to participate in a health plan, usually which requires reduced rates from the provider. In the Medicare Program, this refers to providers who are therefore not obligated to accept assignment on all Medicare claims. In commercial plans, non-participating providers are also called out of network providers or out of plan providers. If a beneficiary receives service from an out of network provider, the health plan (other than Medicare) will pay for the service at a reduced rate or will not pay at all.

**Non-Plan Provider** - A health care provider without a contract with an insurer. Same as nonparticipating provider.

**Nosocomial Infections** - Infections that are acquired while a patient is in a hospital are referred to as nosocomial infections; a term derived from 'nosos' the Greek word for 'disease'. Often nosocomial infections become apparent while the patient is still in the hospital but in some cases symptoms may not show up until after the affected patient is discharged. About one patient in ten acquires an infection as a direct result of being hospitalized. Infection control can be very cost-effective. Approximately one third of nosocomial infections are preventable.

**NPLANID** - A term used by CMS for a proposed standard identifier for health plans. CMS had previously used the terms PayerID and PlanID for the health plan identifier.

**Nurse Practitioner (NP)** - 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. Normally, NPs are licensed and possess masters degrees. Nurse practitioners generally function under the supervision of a physician but not necessarily in his/her or her presence. In some states, NPs are able to provide basic medical services without requiring MD or DO supervision. They are either salaried or reimbursed on a fee-for-service basis. Are sometimes considered "midlevel practitioners".

## 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** - OSHA, county health departments and regulatory bodies oversee occupational health hazards in workplaces, including hospitals. Occupational health programs include the employer activities undertaken to protect and promote the health and safety of employees in the workplace, including minimizing exposure to hazardous substances, evaluating work practices and environments to reduce injury, and reducing or eliminating other health threats. Many health providers offer occupational health consultations as well as occupational health screenings, treatments and case-management. Employers and health providers often enter agreements whereby health providers will provide these services as well as managed the related workers compensation case management and rehabilitation programs. Employers seek to remain in compliance with regulations and reduce costs associated with employee injury and benefit utilization. Often, EAPs and drug prevention or drug testing programs are also combined under this category.

**Office for Civil Rights** - This office is part of HHS. Its HIPPA responsibilities include oversight of the privacy requirements.

**Office of Inspector General (OIG)** - The office responsible for auditing, evaluating and criminal and civil investigating for HHS, as well as imposing sanctions, when necessary, against health care providers. See also Fraud, FBI, and Dept. of Justice.

**Ombudsperson or Ombudsman** - A person within a managed care organization or a person outside of the health care system (such as an appointee of the state) who is designated to receive and investigate complaints from beneficiaries about quality of care, inability to access care, discrimination, and other problems that beneficiaries may experience with their managed care organization. This individual often functions as the beneficiary's advocate in pursuing grievances or complaints about denials of care or inappropriate care. Organizations are mostly able to designate a member of their own staff as ombudsman.

**Open Access** - A term describing a member's ability to self-refer for specialty care. Open access arrangements allow a member to see a participating provider without a referral from another doctor. Health plan members' abilities, rights or invitation to self refer for specialty care. Also called Open Panel.

**Open Enrollment Period** - A period during which subscribers in a health benefit program have an opportunity to select among health plans being offered to them, usually without evidence of insurability or waiting periods. A period of time which eligible subscribers may elect to enroll in, or transfer between, available programs providing health care coverage. Under an open enrollment requirement, a plan must accept all who apply during a specific period each year.

**Open Panel** - A term describing a member's ability to self-refer for specialty care. Open access arrangements allow a member to see a participating provider without a referral from another doctor. Health plan members' abilities, rights or invitation to self refer for specialty care. Also called Open Access.

**Organized Care System** - Often used to discuss a more evolved form of IDSs and CCNs, this relatively new term describes the result of mergers and alliances between and among physicians, health systems, and managed care organizations. These systems often have the same performance imperatives as IDSs and CCNs: improve health status, integrate delivery, demonstrate value, improve efficiency of care delivery and prevention, and meet patient and community needs.

**Outcome** - A clinical outcome is the result of medical or surgical intervention or nonintervention, or the results of a specific health care service or benefit package. The valued results of care as experienced primarily by the patient but also by physicians and all other participants in the processes contributing to the outcomes.

**Outcomes Management** - Providers and payers alike wish to find a method of managing care in a way that would produce the best outcomes. Managed care organizations are increasingly interested in learning to manage the outcome of care rather than just managing the cost of care. It is thought that through a database of outcomes experience, caregivers will know better which treatment modalities result in consistently better outcomes for patients. Outcomes management may lead to the development of clinical protocols. A clinical outcome is the result of medical or surgical intervention or nonintervention. Managed services organizations are now attempting to better manage clinical outcomes for their enrollees to increase the satisfaction of patients and payers while holding down costs.

**Outcomes Measurement** - System used to systematically track clinical treatment and responses to that treatment. The methods for measuring outcomes are quite varied among providers. Much disagreement exists regarding the best practice or tools to utilize to measure outcomes. In fact, much disagreement exists in the medical field about the definition of outcome itself. A tool to assess the impact of health services in terms of improved quality and/or longevity of life and functioning.

**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. With the elimination of the physician's fiduciary responsibility to the patient, outcomes data is gaining increasing importance for patient advocacy and consumer protection. Outcomes research will also be used in the future by payers to identify potential partners on the basis of good outcomes.

**Outlier** - A patient whose length of stay or treatment cost differs substantially from the stays or costs of most other patients in a diagnosis related group. Under DRG reimbursement, outliers are given exceptional treatment subject to peer review and organization review.

**Outlier thresholds** - The day and cost cutoff points that separate inlier patients from outlier patients.

**Out of Area Benefits** - Benefits supplied to a patient by a payer or managed care organization when the patient needs services while outside the geographic area of the network. MCOs often attempt to negotiate a case-by-case discount with providers when patients utilize their services while "out of area".

**Out of Network Benefits** - With most HMOs, a patient cannot have any services reimbursed if provided by a hospital or doctor who is not in the network. With PPOs and other managed care organizations, there may exist a provision for reimbursement of "out of network" providers. Usually this will involve higher copay or a lower reimbursement. See also point of service plans.

**Out-of-Network Provider** - A health care provider with whom a managed care organization does not have a contract to provide health care services. Because the beneficiary must pay either all of the costs of care from an out-of-network provider or their cost-sharing requirements are greatly increased, depending on the particular plan a beneficiary is in, out-of-network providers are generally not financially accessible to Medicaid beneficiaries.

**Out of Pocket Expenses, Out of Pocket Costs** - Costs borne by the member that are not covered by health care plan. Portion of health services or health costs that must be paid for by the plan member, including deductibles, co-payments and co-insurance. In the age of managed care, out of pocket expenses can also refer to the payment of services not covered by or approved for reimbursement by the health plan.

**Out of Pocket Limit** - A cap placed on out of pocket costs, after which benefits increase to provide full coverage for the rest of the year. It is a stated dollar amount set by the insurance company, in addition to regular premiums.

**Outpatient Care** - Care given a person who is not bedridden. Also called ambulatory care. Many surgeries and treatments are now provided on an outpatient basis, while previously they had been considered reason for inpatient hospitalization. Some say this is the fastest growing segment of healthcare.

## P

**Paid Claims Loss Ratio** - Paid claims divided by premiums. See also Loss Ratio.

**Participating physician or Participating Provider** - Simply refers to a provider under a contract with a health plan. A physician or hospital that has agreed to provide services for a set payment provided by a payer, or who agrees to other arrangements, or who agrees to provide services to a set of covered lives or defined patients. Also refers to a provider or physician who signs an agreement to accept assignment on all Medicare claims for one year. See also Assignment, Preferred Provider or Network.

**Patient Liability** - The dollar amount that an insured is legally obligated to pay for services rendered by a provider. These may include co-payments, deductibles and payments for uncovered services.

**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.

**Participating Physician** - A primary care physician in practice in the payer's managed care service area who has entered into a contract.

**Part A Medicare** - Refers to the inpatient portion of benefits under the Medicare Program, covering beneficiaries for inpatient hospital, home health, hospice, and limited skilled nursing facility services. Beneficiaries are responsible for deductibles and copayments. Part A services are financed by the Medicare HI Trust Fund, which consists of Medicare tax payments. Part B, on the other hand, refers to outpatient coverage.

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

**Partial Capitation** - A contract between a payer and a sub-capitor, provider or other payer whereby payments made are a combination of capitated premiums and fee for service payments. The proportion of the ratios determines the amount of risk. Sometimes certain outliers are paid as fee for service (difficult childbirth, cardiac care, cancer) while routine care (preventative, family, simple surgeries and common diagnoses) are capitated.

**Partial Hospitalization Program (PHP)** - Acute level of psychiatric treatment normally provided for 4 or more hours per day. Normally includes group therapies and activities with homogeneous patient populations. Is used as a referral step-down from inpatient care or as an alternative to inpatient care. Unlike intensive outpatient or simple outpatient services, PHP provides an attending psychiatrist, onsite nursing and social work. Reimbursed by payers at a rate that is roughly one half of inpatient psychiatric hospitalization day rate. Patients do not spend the night at the partial hospital.

**Partial Risk Contract** - A contract between a purchaser and a health plan, in which only part of the financial risk is transferred from the purchaser to the plan. Forms of this are often seen in "self-funded" plans, competitive bidding arrangements and new health plans.

**Participating Provider** - Any provider licensed in the state of provision and contracted with an insurer. Usually this refers to providers who are a part of a network. That network would be a panel of participating providers. Payers assemble their own provider panels.

**Payer (usually Third Party Payer)** - The public or private organization that is responsible for payment for health care expenses. Payers may be insurance companies or self-insured employers.

**PCP** - Primary care physician who often acts as the primary gatekeeper in health plans. That is, often the PCP must approval referrals to specialists. Particularly in HMOs and some PPOs, all members must choose or are assigned a PCP.

**PCP Capitation** - A reimbursement system for healthcare providers of primary care services who receive a pre-payment every month. The payment amount is based on age, sex and plan of every member assigned to that physician for that month.

**Peer Review** - The mechanism used by the medical staff to evaluate the quality of total health care provided by the Managed Care Organization. The evaluation covers how well all health personnel perform services and how appropriate the services are to meet the patients' needs. Evaluation of health care services by medical personnel with similar training. 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 the activities of the Professional Review Organizations, and also to review of research by other researchers. This is the most common method utilized in managed care for monitoring the utilization by physicians. In other words, other physicians will review the decisions made by a physician. Much controversy has surfaced in this area in recent years. Some physicians are reluctant to be reviewed by physicians over the phone or by having their written records read. Some consumers suspect that peer review is not true peer review since both the providers and the reviewers often have personal financial incentives to reduce or increase medical care. See fiduciary. Nonetheless, peer review is utilized in all managed care settings.

**Peer Review Organization (PRO)** - An organization established by the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 to review quality of care and appropriateness of admissions, readmissions, and discharges for Medicare and Medicaid. These organizations are held responsible for maintaining and lowering admission rates, reducing lengths of stay, while insuring against inadequate treatment. PROs can conduct review of medical records and claims to evaluate the appropriateness of care provided. PROs also exist within private carriers and providers. Peer Review itself is a process whose confidentiality in private organizations is protected by law. This allows hospitals and groups to conduct internal investigation and monitoring of care decisions and outcomes without the production of related documents in court proceedings. Providers have fought for these protections.

**Performance Gap** - The occurrence, trend, or incident that shows that a clinician's performance falls short of expected performance levels, particularly when the clinician ignores accumulated scientific evidence supporting other clinical interventions or when the clinician does not reach benchmarked targets.

**Performance Measurement** – Measures and results that describe the health care being provided and the outcomes. Performance may be stated in terms of health outcome, quality of care, timeliness, correctness, percentage of goals attained or percentage of mistakes made. Performance measures may also indicate whether a health plan or provider has appropriately provided certain services expected to lead to desirable outcomes. Closely related to Continuous Quality of Improvement (CQI) and Utilization Review (UR).

**Per Diem Rates** - A form of payment for services in which the provider is paid a daily fee for specific services or outcomes, regardless of the cost of provision. Per diem rates are paid without regard to actual charges and may vary by level of care, such as medical, surgical, intensive care, skilled care, psychiatric, etc. Per diem rates are usually flat all-inclusive rates.

**Performance Standards** - Standards set by the MCO or payer that the provider will need to meet in order to maintain its credentialing, renew its contract or avoid penalty. These will vary from payer to payer, and contract to contract. Standards an individual provider is expected to meet, especially with respect to quality of care. The standards may define volume of care delivered per time period. Thus, performance standards for obstetrician/gynecologist may specify some or all of the following office hours and office visits per week or month, on-call days, deliveries per year, gynecological operations per year, etc.

**Per Member Per Month (PMPM)** - Applies to a revenue or cost for each enrolled member each month. The number of units of something divided by member months. Often used to describe premiums or capitated payments to providers, but can also refer to the revenue or cost for each enrolled member each month. Many calculations, other than cost or premium, use PMPM as a descriptor.

**Personal Representative** - A person authorized under state or other law to act on behalf of the individual in making health-related decisions. Examples include a court-appointed guardian with medical authority, a health care agent under a health care proxy, and a parent acting on behalf of an un-emancipated minor (with exceptions where state law gives minors the right to make health decisions). For a decedent, the personal representative may be an executor, administrator, or other authorized person.

**Per Thousand Members Per Year (PTMPY)** - A common way of reporting utilization. The most common example of hospital utilization, expressed as days PTMPY.

**Pharmacy Benefit Manager (PBM)** - PBMs are third party administrators of prescription drug benefits.

**Physician Attestation** - The requirement that the attending physician certify, in writing, the accuracy and completion of the clinical information used for DRG assignment.

**Physician Contingency Reserve (PCR)** - Portion of a claim deducted and held by a health plan before payment is made to a capitated physician. Revenue that is withheld from a provider's payment to serve as an incentive for providing less expensive service. A typical withhold is approximately 20 percent of the claim. This amount can be paid back to the provider following analysis of his/her practice and service utilization patterns. See also Withhold.

**Physician Current Procedural Terminology (CPT)** - List of services and procedures performed by providers, with each service/procedure having a unique 5-digit identifying code. CPT is the health care industry's standard for reporting of physician services and procedures. Used in billing and records.

**Physician-Hospital Organization (PHO)** - An organization representing hospitals and physicians as an agent. 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. A contracted arrangement among physicians and hospital(s) wherein a single entity, the PHO, agrees to provide services to insurers' subscribers. The PHO serves as a collective negotiating and contracting unit. A PHO may be structured to share the risk of contracting between hospital(s) and doctors. PHOs may also own, operate or subcontract MSOs, health plans or providers. A PHO can manage risk. It is typically owned and governed jointly by a hospital and shareholder physicians.

**Physician Organization** - This term describes physician linkages and alliances that allow physicians to manage risk and capitation. Information systems, physician relationships, and financial integration allow these organizations to be more integrated than the traditional solo practice or IPA relationship between healthcare providers and/or managed care organizations that are working to develop a "seamless" continuum of healthcare services. Sometimes physician organizations are simply group practices or professional organizations without intention of acting as a contracting entity.

**Physician Payment Review Commission** - Established by Congress in 1986 to advise it on reforms of Medicare policies for paying physicians. Submits a report to Congress annually.

**Physician Practice Management Company (PPMC)** - A company that provides management and administrative support, often with capital for clinical expansion. The usual management fee is 15-30% of net revenue minus the non-provider related clinic expenses.

**Plan Administration** - A term often used to describe the management unit with responsibility to run and control a managed care plan - includes accounting, billing, personnel, marketing, legal, purchasing, possibly underwriting, management information, facility maintenance, servicing of accounts. This group normally contracts for medical services and hospital care. If an insurance company is the underwriter, it may serve as its own administrator or may contract to a 3<sup>rd</sup> party administrator. Self-insured plans do the same.

**Plan Document** - The document that contains all of the provisions, conditions, and terms of operation of a pension or health or welfare plan. This document may be written in technical terms as distinguished from a summary plan description (SPD) that, under ERISA, must be written in a manner calculated to be understood by the average plan participant.

**Plan Sponsor** - An entity that sponsors a health plan. This can be an employer, a union, or some other entity.

**Play or Pay** - Proposal to make employers provide health care coverage for employees or pay a special government tax.

**Point-of-Service Plan (POS)** - A health services delivery organization that offers the option to its members to choose to receive a service from participating or a nonparticipating provider. Generally the level of coverage is reduced for services associated with the use of non-participating providers. Managed care plan that specifies that those patients who go outside of the plan for services may pay more out of pocket expenses. 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 and at the time of accessing the 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 the "in network" or approved providers are less than when care is rendered by non-contracting providers. Or the costs are less if provided by approved providers in either the HMO or PPO rather than "out of network" or "out of plan" providers. This is a method of influencing patients to use certain providers without restricting their freedom of choice too severely.

**Pooling** - Combining risks for groups into one risk pool. Also see Risk.

**Portability** - Requirement that health plans guarantee continuous coverage without waiting periods for persons moving between plans. The ability for an individual to transfer from one health insurer to another health insurer with regard to pre-existing conditions or other risk factors. This is a new protection for beneficiaries involving the issuance of a certificate of coverage from previous health plan to be given to new health plan. Under this requirement, a beneficiary who changes jobs is guaranteed coverage with the new plan, without a waiting period or having to meet additional deductible requirements. Primarily, this refers to the requirement that insurers waive any pre-existing condition exclusion for beneficiaries previously covered through other insurance. See also HIPAA.

**PPS Inpatient Margin** - A measure that compares DRG based operating and capital payments with Medicare-allowable inpatient operating and capital costs. It is calculated by subtracting total Medicare-allowable inpatient operating and capital costs from total PPS operating and capital payments and dividing by total PPS operating and capital payments.

**PPS Operating Margin** - A measure that compares PPS operating payments with Medicare-allowable inpatient operating costs. This measure excludes Medicare costs and payments for capital, direct medical education, organ acquisition, and other categories not included among Medicare-allowable inpatient operating costs. It is calculated by subtracting total Medicare-allowable inpatient operating costs from total PPS operating payments and dividing by total PPS operating payments.

**PPS Year** - A designation referring to hospital cost reporting periods that begin during a given Federal fiscal year, reflecting the number of years since the initial implementation of PPS. For example, PPS1 refers to hospital fiscal years beginning during Federal fiscal year 1984, which was the first year of PPS. For a hospital with a fiscal year beginning July 1, PPS 1 covers the period from July 1, 1984, through June 30, 1985. (See also Fiscal Year)

**Practical Nurses** - Practical nurses, also known as vocational nurses, provide nursing care and treatment of patients under the supervision of a licensed physician or registered nurse. Licensure as a licensed practical nurse (L.P.N.) or in California and Texas as a licensed vocational nurse (L.V.N.) is required.

**Practice Parameters, Practice Guidelines** - Systematically developed statements to standardize care and to assist in practitioner and patient decisions about the appropriate health care for specific circumstances. Practice guidelines are usually developed through a process that combines scientific evidence of effectiveness with expert opinion. Practice guidelines are also referred to as clinical criteria, protocols, algorithms, review criteria, and guidelines. The American Medical Association defines practice parameters as strategies for patient management, developed to assist physicians in clinical decision-making. Practice parameters may also be referred to as practice options, practice guidelines, practice policies, or practice standards.

**Preadmission Review, Pre-Admission Certification, Pre-Certification, or Pre-authorization** - Review of "need" for inpatient care or other care before admission. This refers to a decision made by the payer, MCO or insurance company prior to admission. The payer determines whether or not the payer will pay for the service. Most managed care plans require pre-cert. This is a method of controlling and monitoring utilization by evaluating the need for service prior to the service being rendered. The practice of reviewing claims for inpatient admission prior to the patient entering the hospital in order to assure that the admission is medically necessary. A method of monitoring and controlling utilization by evaluating the need for medical service prior to it being performed. The process of notification and approval of elective inpatient admission and identified outpatient services before the service is rendered. An administrative procedure whereby a health provider submits a treatment plan to a third party before treatment is initiated. The third party usually reviews the treatment plan, monitoring one or more of the following: patient's eligibility, covered service, amounts payable, application of appropriate deductibles, co-payment factors and maximums. Under some programs, for instance, predetermination by the third party is required when covered charges are expected to exceed a certain amount. Similar processes: preauthorization, precertification, pre-estimate of cost, pretreatment estimate, and prior authorization.

**Pre-Authorization** - A cost containment feature of many group medical policies whereby the insured must contact the insurer prior to a hospitalization or surgery and receive authorization for the service.

**Pre-existing Condition, Preexisting Condition** - A medical condition developed prior to issuance of a health insurance policy that may result in the limitation in the contract on coverage or benefits. Some policies exclude coverage of such conditions is often excluded for a period of time or indefinitely. Federally qualified HMOs cannot limit coverage for pre-existing conditions. New statutes in 1997 and 1998 altered the freedom other health plans have enjoyed in setting preexisting time limits. Certification of prior coverage may mean new insurers would need to waive preexisting clauses for some subscribers. See Portability.

**Preferred Provider Organization (PPO)** - Some combination of hospitals and physicians that agrees to render particular services to a group of people, perhaps under contract with a private insurer. A health care delivery system that contracts with providers of medical care to provide services at discounted fees to members. Members may seek care from non-participating providers but generally are financially penalized for doing so by the loss of the discount and subjection to co-payments and deductibles. The services may be furnished at discounted rates and the insured population may incur out-of-pocket expenses for covered services received outside the PPO if the outside charge exceeds the PPO payment rate. A PPO can also be a legal entity or it may be a function of an already formed health plan, HMO or PHO. The entity may have a health benefit plan that is also referred to as a PPO. PPOs are a common method of managing care while still paying for services through an indemnity plan. Most PPO plans are point of service plans, in that they will pay a higher percentage for care provided by providers in the network. Many insurers will offer PPOs as well as HMOs. Generally PPOs will offer more choice for the patient and will provide higher reimbursement to the providers. See also point of service.

**Premium** - Amount paid to a carrier for providing coverage under a contract. Money paid out in advance for insurance coverage.

**Prepaid Capitation** - A prospectively paid, fixed, annual, quarterly, or monthly premium per person or per family that covers specified benefits. A cost containment alternative to fee-for-service usually employed by HMOs.

**Prepaid Group Practice** - Prepaid Group Practice Plans involve multi-specialty associations of physicians and other health professionals, who contract to provide a wide range of preventive, diagnostic and treatment services on a continuing basis for enrolled participants.

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

**Prepayment** - A method of paying for the cost of health care services in advance of their use. A method providing in advance for the cost of predetermined benefits for a population group, through regular periodic payments in the form of premiums, dues, or contributions, including those contributions that are made to a Health and Welfare Fund by employers on behalf of their employees.

**Prevailing Charge, Prevailing Fee** - One of the factors determining a physician's payment for a service under Medicare, or other plan, 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 Care** - Health care that emphasizes prevention, early detection and early treatment, thereby reducing the costs of healthcare in the long run. Health care that seeks to prevent or foster early detection of disease and morbidity and focuses on keeping patients well in addition to health them while they are sick.

**Pricer, or Repricer** - A person, an organization, or a software package that reviews procedures, diagnoses, fee schedules, and other data and determines the eligible amount for a given health care service or supply. Additional criteria can then be applied to determine the actual allowance, or payment, amount.

**Primary Care** - Basic or general health care usually rendered by general practitioners, family practitioners, internists, obstetricians and pediatricians -- who are often referred to as primary care practitioners or PCPs. Professional and related services administered by an internist, family practitioner, obstetrician-gynecologist or pediatrician in an ambulatory setting, with referral to secondary care specialists, as necessary.

**Primary Care Case Management (PCCM)** – This is a Freedom of Choice Waiver program, under the authority of section 1915(b) of the Social Security Act. States contract directly with primary care providers who agree to be responsible for the provision and/or coordination of medical services to Medicaid recipients under their care. Currently, most PCCM programs pay the primary care physician a monthly case management fee in addition to receiving fee-for-services payment.

**Primary Care Network (PCN)** - A group of primary care physicians who share the risk of providing care to members of a given health plan.

**Primary Care Physician, (PCP)** - A "generalist" such as a family practitioner, pediatrician, internist, or obstetrician. In a managed care organization, a primary care physician is accountable for the total health services of enrollees including referrals, procedures and hospitalization. Also see Primary Care Provider.

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

**Primary Coverage** - Plan that pays its expenses without consideration of other plans, under coordination of benefits rules.

**Primary Physician Capitation** - The amount paid to each physician monthly for services based on the age, sex and number of the Members selecting that physician.

**Principal Diagnosis** - The medical condition that is ultimately determined to have caused a patient's admission to the hospital. The principal diagnosis is used to assign every patient to a diagnosis related group. This diagnosis may differ from the admitting and major diagnoses.

**Prior Authorization** - A formal process requiring a provider obtain approval to provide particular services or procedures before they are done. This is usually required for nonemergency 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.

**Privacy** - For purposes of the HIPAA Privacy Rule, privacy means an individual's interest in limiting who has access to personal health care information. See also HIPAA Privacy Rule.

**Privacy Board** - A board of members authorized by the HIPAA Privacy Rule to approve a waiver of authorization for use and/or disclosure of identifiable health information. For research purposes, the Institutional Review Board may also function as the Privacy Board. See also HIPAA Privacy Rule.

**Privacy Notice** – Institution-wide notice describing the practices of the covered entity regarding protected health information. Health care providers and other covered entities must give the notice to patients and research subjects and should obtain signed acknowledgements of receipt. Internal and external uses of protected health information are explained. It is the responsibility of the researcher to provide a copy of the Privacy Notice to any subject who has not already received one. If the researcher does provide the notice, the researcher should also obtain the subject's written acknowledgement of receipt. These have become more common and visible in hospitals and physician offices due to HIPAA requirements.

**Professional Review Organization** - An organization that reviews the services provided to patients in terms of medical necessity professional standards; and appropriateness of setting.

**Professional Standards Review (PSRO)** - A physician-sponsored organization charged with reviewing the services provided patients who are covered by Medicare, Medicaid and maternal and child health programs. The purpose of the review is to determine if the services rendered are medically necessary; provided in accordance with professional criteria, norms and standards; and provided in the appropriate setting.

**Profile** - Aggregated data in formats that display patterns of health care services over a defined period of time.

**Profile Analysis or Profiling** - Review and analysis of profiles to identify and assess patterns of health care services. Expressing a pattern of practice as a rate - some measure of utilization (of costs or services) or outcome (as functional status, morbidity, or mortality) aggregated over time for a defined population of patients. This is used to compare with other practice patterns. May be used for physician practices, health plans, or geographic areas.

**Prospective Payment System (PPS)** - A payment method that establishes rates, prices or budgets before services are rendered and costs are incurred. Providers retain or absorb at least a portion of the difference between established revenues and actual costs. (1) The Medicare system used to pay hospitals for inpatient hospital services; based on the DRG classification system. (2) Medicare's acute care hospital payment method for inpatient care. Prospective per-case payment rates are set at a level intended to cover operating costs in an efficient hospital for treating a typical inpatient in a given diagnosis-related group. Payments for each hospital are adjusted for differences in area wages, teaching activity, care to the poor, and other factors. Hospitals may also receive additional payments to cover extra costs associated with atypical patients (outliers) in each DRG. Capital costs, originally excluded from PPS, are being phased into the system. By 2001, capital payments will be made on a fully prospective, per-case basis.

**Protected Health Information** – Under HIPAA, this refers to individually identifiable health information transmitted or maintained in any form.

**Provider** - Usually refers to a hospital or doctor who "provides" care. A health plan, managed care company or insurance carrier is not a healthcare provider. Those entities are called payers. The lines are blurred sometimes, however, when providers create or manage health plans. At that point, a provider is also a payer. A payer can be provider if the payer owns or manages providers, as with some staff model HMOs.

**Provider Excess** - Specific or aggregate stop loss coverage extended to a provider instead of a payer or employer.

**Provider Services Organization (PSO)** - Defined by CMS as a public or private entity that is established or organized by a health care provider or group of affiliated providers; that provides a substantial proportion of the services under its Medicare contract directly through the provider or group of affiliated providers; and in which the provider or affiliated providers directly or indirectly share substantial financial risk and have at least a majority financial interest. Similar to the concept of MSO, see Medical Services Organization, or Management Services Organization.

**Psychotherapy Notes** - These include notes recorded by the health care provider who is a mental health professional during a counseling session, either in a private session or in a group. These notes are separate from documentation placed in the medical chart and do not include prescriptions. Specific patient authorization is required for use and disclosure of psychotherapy notes.

**Public Health Authority** - A federal, state, local or tribal person or organization that is required to conduct public health activities.

**Purchaser** - This entity not only pays the premium, but also controls the premium dollar before paying it to the provider. Included in the category of purchasers or payers are patients, businesses and managed care organizations. While patients and businesses function as ultimate purchasers, managed care organizations and insurance companies serve a processing or payer function.

## Q

**Quality** - Quality is, according to the Institute of Medicine (IOM), the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge. Quality can be defined as a measure of the degree to which delivered health services meet established professional standards and judgments of value to consumers. Quality may also be seen as the degree to which actions taken or not taken maximize the probability of beneficial health outcomes and minimize risk and other untoward outcomes, given the existing state of medical science and art. Quality is frequently described as having three dimensions: quality of input resources; quality of the process of services delivery (the use of appropriate procedures for a given condition); and quality of outcome of service use (actual improvement in condition or reduction of harmful effects). Quality programs are commonly called QA, TQM, QI, CQI - all referring to the process of monitoring quality in systematic ways.

**Quality Assurance (QA)** - Activities and programs intended to assure the quality of care in a defined medical setting. Such programs include peer or utilization review components to identify and remedy deficiencies in quality. The program must have a mechanism for assessing its effectiveness and may measure care against pre-established standards. Also called quality improvement. A formal methodology and set of activities designed to assess the quality of services provided. Quality assurance includes formal review of care, problem identification, corrective actions to remedy any deficiencies and evaluation of actions taken. See also Continuous Quality Improvement.

**Quality Assurance Reform Initiative (QARI)** - A process developed by the Health Care Financing Administration (now called CMS) to develop a health care quality improvement system for Medicaid managed care plans. The Quality Assurance Reform Initiative was unveiled in 1993 to assist States in the development of continuous quality improvement systems, external quality assurance programs, internal quality assurance programs, and focused clinical studies.

**Quality Improvement (QI)** - Also called performance improvement (PI), QI is a management technique to assess and improve internal operations. QI focuses on organizational systems rather than individual performance and seeks to continuously improve quality rather than reacting when certain baseline statistical thresholds are crossed. The process involves setting goals, implementing systematic changes, measuring outcomes, and making subsequent appropriate improvements. QI implies that concurrent systems are used to continuously improve quality, rather than reacting when certain baseline statistical thresholds are crossed. Quality improvement programs usually use tools such as cross-functional teams, task forces, statistical studies, flow charts, process charts, Pareto charts, etc. This is the more commonly used term in healthcare, replacing QA. See also Continuous Quality Improvement.

**Quality Management (QM)** - Used interchangeably with Quality Assurance (QA), Quality Management usually involves an internal review process that audits the quality of care delivered and implements corrective actions to remedy any deficiencies identified in the quality of direct patient care, administrative services or support services. The process can employ peer review, outcomes assessment, and utilization management techniques to assess and improve the quality of care. The level of care may be measured against preestablished standards.

## R

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

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

**Real Value** - Measurement of an economic amount corrected for change in price over time (inflation), thus expressing a value in terms of constant prices. A common term in economics.

**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.

**Referral Center, also called Triage, Call Center, 24 Hour Certification or 1-800** - This is a mechanism established by health plans to direct patients to approved hospitals and doctors. Often the Referral Center serves a UR function and certified or pre-certifies the care. These centers are also used by hospitals to refer patients to certain doctors, reduce use of the emergency room or to provide follow-up patient contact. Managed care organizations utilize these centers as their central hub of communications with patients and providers at the time of service. See also pre-certification, utilization review or case management.

**Referral Pool** - An amount set aside to pay for non-capitated services provided by a PCP, services provided by a referral specialist and/or emergency services.

**Referral Services** - Medical Services arranged for by the physician and provided outside the physician's office other than Hospital Services.

**Refinement** - The correction of relative values in Medicare's relative value scale that was initially set incorrectly.

**Registered Nurses (R.N.'s)** - Registered nurses are responsible for carrying out the physician's instructions. They supervise practical nurses and other auxiliary personnel who perform routine care and treatment of patients. Registered nurses provide nursing care to patients or perform specialized duties in a variety of settings from hospital and clinics to schools and public health departments. A license to practice nursing is required in all states. For licensure as a registered nurse (R.N.), an applicant must have graduated from a school of nursing approved by the state board for nursing and have passed a state board examination.

**Reinsurance** - An insurance arrangement whereby the MCO or provider is reimbursed by a third party for costs exceeding a pre-set limit, usually an annual maximum. A method of limiting the risk that a provider or managed care organization assumes by purchasing insurance that becomes effective after set amount of health care services have been provided. This insurance is intended to protect a provider from the extraordinary health care costs that just a few beneficiaries with extremely extensive health care needs may incur. Insurance purchased by an insurance company or health plan from another insurance company to protect itself against losses. A contract by which an insurer procures a third party to insure it against loss or liability by reason of such original insurance. The practice of an HMO or insurance company of purchasing insurance from another company to protect itself against part or all the losses incurred in the process of honoring the claims of policyholders. See also stop loss. Also called "risk control" insurance. See risk.

**Relative Value Scale (RVS)** - An index assigning various weights to various medical services. Each weight represents a relative amount to be paid for each service. The RVS used in the development of the Medicare Fee Schedule for physicians consists of three cost components: physician work, practice expense, and malpractice expense.

**Relative Value Unit (RVU)** - The unit of measure for a relative value scale. RVUs must be multiplied by a dollar conversion factor to become payment amounts. This is a common term in economics. RVUs are often used in physician practice management to compare performance of doctors within a group.

**Renewal** - Continuance of coverage for a new policy term.

**Report Card** - An accounting of the quality of services, compared among providers over time. The report card measures and compares providers on predetermined, measurable quality and other outcome indicators. Hospitals and insurance companies may publish their report card results if favorable. Generally, consumers use report cards to choose a health plan or provider, while policy makers may use report card results to determine overall program effectiveness, efficiency, and financial stability.

**Research** – When used by HIPAA, this term refers to a systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge.

**Reserves** - Monies earmarked by health plans to cover anticipated claims and operating expenses. A fiscal method of withholding a certain percentage of premium to provide a fund for committed but undelivered health care and such uncertainties as: longer hospital utilization levels than expected, over-utilization of referrals, accidental catastrophes and the like. The fiscal method of providing a fund for committed but undelivered health services or other financial liabilities. A percentage of the premiums support this fund. Businesses other than health plans also manage reserves. For example, hospitals document reserves as that portion of the accounts receivables that they hope to collect but have some doubt about its collectability. Rather than book these amounts as income, hospitals will "reserve" these amounts until paid.

**Resource-Based Relative Value Scale (RBRVS)** - A schedule of values assigned to health care services that give weight to procedures based upon resources needed by the provider to effectively deliver the service or perform that procedure. Unlike other relative value scales, RBRVS ignores historical charges and includes factors such as time, effort, technical skill, practice cost, and training cost. 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. This payment methodology has three components: a relative value for each procedure, a geographic adjustment factor, and a dollar conversion factor. A Medicare weighting system to assign units of value to each CPT code (procedure) performed by physicians and other providers.

**Retrospective Rating (Retro)** - Insurance coverage that provides for premium determination at the end of the coverage period, subject to a minimum and maximum based upon actual experience.

**Retrospective Review Process** - System for analyzing medical necessity and appropriateness of services rendered. A review that is conducted after services are provided to a patient. The review focuses on determining the appropriateness, necessity, quality, and reasonableness of health care services provided. Becoming seen as least desirable method; supplanted by concurrent reviews.

**Revenue Share** - The proportion of a practice's total revenue devoted to a particular type of expense. For example, the practice expense revenue share is that proportion of revenue used to pay for practice expense.

**Risk** - The chance or possibility of loss. For example, physicians may be held at risk if hospitalization rates exceed agreed upon thresholds. Potential financial liability, particularly with respect to who or what is legally responsible for that liability. With insurance, the patient and insurance company share risk but the company's risk is limited by the policy's dollar limitations. In HMO's, the patient is at risk only for copayments and the cost of non-covered services. The HMO, however, with its income fixed, is at risk for whatever volume of care is entailed, however costly it turns out to be. Providers may also bear risk if they are paid a fixed amount (capitation) by the HMO. The sharing of risk is often employed as a utilization control mechanism within the HMO setting. Risk is also defined in insurance terms as the possibility of loss associated with a given population.

**Risk-Adjusted Capitation** - An actuarial term, this refers to methodology of payment to providers which reflects fixed payment amounts per member per month and then is adjusted further to take into account the lower or higher costs of providing care to individuals or groups of individuals, based on health status or characteristics.

**Risk Adjuster** - A measure used to adjust payments made to carriers or payers on behalf of a group of enrollees in order to compensate for spending, that is expected to be lower or higher than average, based on the health status or demographic characteristics of the enrollees. An actuarial result of analysis.

**Risk Adjustment** - A system of adjusting rates paid to managed care providers to account for the differences in beneficiary demographics, such as age, gender, race, ethnicity. Medical condition, geographic location, at-risk population (i.e. homeless), etc. 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. A statistical method of paying managed care organizations different capitated payments based on the composition and relative healthiness of their beneficiaries. This procedure would generally compensate providers of HIV services with a higher capitated payment than providers of other (often less costly) health care services. In a competitive and voluntary health insurance market, like that in the US, health plans have a strong financial incentive to attract the healthiest enrollees, while excluding sicker, higher risk enrollees. This incentive encourages health plans to compete on the basis of risk selection rather than on the basis of cost efficiency and quality of health care. In the private insurance market, risk adjustment is a corrective tool designed to re-orient the incentives for health plans and enrollees, reducing the negative consequences of enrolling high-risk users by compensating plans according to the health risk of plans' enrollees.

**Risk Assessment** - Anticipating the cost of providing health care to groups of enrollees. Actuarial assessments examine utilization history, demographics, health characteristics, environmental attributes, and other sociological, economic and market characteristics. Risk assessment can also include, less commonly, the identification of etiology of health problems.

**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. Health plans (except under employer self-insured programs) usually are risk bearing. Providers and provider organizations, if capitated, can also be risk bearing. There are 2 types of risk: insurance risk and business risk, each calculated and considered separately.

**Risk Contract** - A risk contract is broadly any contract that results in any party assuming insurance or business risk. Normally this means, in health care, that if the employer, health plan or provider assumes risk, it is agreeing to cover the expense of increased utilization beyond the projected costs or payment provided. Normally risk is assumed by the health plan or insurance carrier but can be carried by the provider in capitated arrangements or by the employer in self-insured arrangements. A contract payment methodology between HCFA and an HMO or CMP that requires the delivery of (at least) all covered services to members as medically necessary in return for a fixed monthly payment rate from the government and (often) a premium paid by the enrollee. The HMO is then liable for those contractually offered services without regard to cost. (Note: Medicaid beneficiaries enrolled in risk contracts are not required to pay premiums.)

**Risk Corridor** - A financial arrangement between a payer of health care services, such as a state Medicaid agency, and a provider, such as a managed care organization that spreads the risk for providing health care services. Risk corridors protect the provider from excessive care costs for individual beneficiaries by instituting stop-loss protections and they protect the payer by limiting the profits that the provider may earn.

**Risk Factor** - Any characteristic, behavior, or condition which, based on history, utilization, or theory, is thought to directly influence susceptibility to a specific health problem, increase costs or result in increased utilization.

**Risk Load** - In underwriting, a factor that is multiplied into the rate to offset some adverse parameter of the group.

**Risk Measure** - The expected per capita costs of health care services to a defined group in a specific future period.

**Risk Pool** - A pool of money that is at risk for being used for defined expenses. Commonly, if the pool money that is put at risk is not expended by the end of the year, some or all of it is returned to those managing the risk. Two different definitions are in use: 1) A pool of funds set aside as reserves to be used for defined expenses. Under capitation, if all of the risk pool is not used by the end of the contract year, it is usually disseminated to participating providers, and, 2) Legislatively created programs that group individuals who cannot secure coverage in the private market. Funding comes from government or assessment on insurers.

**Risk Selection** - Occurrence when a disproportionate share of high or low users of care join a health plan. See Adverse Selection.

**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. A method by which medical insurance premiums are shared by plan sponsors and participants. In contrast to traditional indemnity plans in which insurance premiums belonged solely to insurance company that assumed all risk of using these premiums. Key to this approach is that the premiums are only payment providers receive; provides powerful incentive to be parsimonious with care.

**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. These providers are usually qualified for special compensations, reimbursements and exemptions.

**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.

## S

**Sanction** - Reprimand that gives binding force to a law or rule, or secures obedience to it, as the penalty for breaking it, or a reward for carrying it out. The government and its agencies can sanction hospitals, providers and health plans. Health plans sometimes seek to sanction hospitals and physicians. Medical staffs sometimes seek sanctions against its members.

**SCHIP** - See State Children's Health Insurance Program, below.

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

**Secondary Coverage** - Health plan that pays costs not covered by primary coverage under coordination of benefits rules. Any insurance that supplements Medicare coverage. The three main sources for secondary insurance are employers, privately purchased Medigap plans, and Medicaid.

**Section 1115 Medicaid Waiver** - The Social Security Act grants the secretary of HHS broad authority to waive certain laws relating to Medicaid for the purpose of conducting pilot, experimental or demonstration projects which 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. Health plans and capitated providers can seek waivers through their state intermediaries.

**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** - Employer or organization assumes complete responsibility for health care losses of its covered employees. This usually includes setting up a fund against which claim payments are drawn and claims processing is often handled through an administrative services contract with an independent organization. In this case, the employer does not pay premiums to an insurance carrier, but, rather pays administrative costs to the insurance company or health plan, and, in essence, treats them as a third party administrator (TPA) only. However, the employee may not be able to detect any difference because the plan description and membership card may carry the name of the insurance company not the employer. Same as self-insured, see below.

**Self-Insurance or Self-Insured** - An individual or organization that assumes the financial risk of paying for health care. This term is usually used to describe the type of insurance that an employer provides. When an employer is self-insured, this means that the payer or managed care company manages the employer's funds whether than requiring the employer to pay premiums. Many employers choose to self-insure because they are then exempted from certain insurance laws and also think that they will spend less money in the short run. Employers assume the risks involved and also have full rights to all insurance claim information. Typically, the self-insured employer is a large employer. The employees or patients will not be able to discern if their employer is self-insured easily since all paperwork or benefits cards usually contain the name of the insurance company.

**Sentinel Event** - Adverse health events that may have been avoided through appropriate care or alternate interventions. Providers are required to alert JCAHO and often state licensing authorities of all sentinel events, including a review of risk factors, preventative measures and case analysis.

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

**Shared Risk Pool for Referral Services** - In capitation, the pool established for the purpose of sharing the risk of costs for referral services among all participating providers. Commonly, this involves a group or specialty category of physicians and is based on utilization. Sometimes, risk pools are established in partnered or limited partner or foundation capitation systems, whereby both providers share risk in a limited way and health plans.

**Shared Savings** - A provision of most prepaid health care plans where at least part of the providers' income is directly linked to the financial performance of the plan. If costs are lower than projections, a percentage of these savings are referred to the providers.

**Single-Stream Funding** - The consolidation of multiple sources of funding into a single stream. This is a key approach used in progressive mental health systems to ensure that "funds follow consumers."

**Site-of-Service Differential** - The difference in the monies paid when the same service is performed in different practice setting or by a different provider. One example would be an examination in an ER versus in a family doctor's office.

**Skilled Nursing Facility (SNF)** - A licensed institution, as defined by Medicare, which is primarily engaged in the provision of skilled nursing care. SNFs are usually DRG or PPS exempt and are located within hospitals, but sometimes are located in rehab facilities or nursing homes.

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

**Sole Community Hospital (SCH)** - A hospital which (1) is more than 50 miles from any similar hospital, (2) is 25 to 50 miles from a similar hospital and isolated from it at least one month a year as by snow, or is the exclusive provider of services to at least 75 percent of its service area populations, (3) is 15 to 25 miles from any similar hospital and is isolated from it at least one month a year, or (4) has been designated as an SCH under previous rules. The Medicare DRG program makes special optional payment provisions for SCHs, most of which are rural, including providing that their rates are set permanently so that 75 percent of their payment is hospital-specific and only 25 percent is based on regional DRG rates.

**Solo Practice, Solo Practitioner** - A physician who practices alone or with others but does not pool income or expenses. This form of practice is becoming increasingly less common as physicians band together for contracting, overhead costs and risk sharing.

**Specific Stop Loss** - The form of excess risk coverage that provides protection for the employer against high claim on any one individual. This is protection against abnormal severity of a single claim rather than abnormal frequency of claims in total. Also see Reinsurance and Stop Loss.

**Spend Down** - A term used in Medicaid for persons whose income and assets are above the threshold for the state's designated medically needy criteria, but are below this threshold when medical expenses are factored in. 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.

**Spider Graphs/Charts** - A technique or tool developed by Ernst & Young, to combine analyses of a market's level of managed care evolution with an internal readiness review.

**State Children's Health Insurance Program (SCHIP)** - Although Medicaid has made great strides in enrolling low-income children, significant numbers of children remain uninsured. From 1988 to 1998, the proportion of children insured through Medicaid increased from 15.6% to 19.8%. At the same time, however, the percentage of children without health insurance increased from 13.1% to 15.4%. The increase in uninsured children is mostly the result of fewer children being covered by employer-sponsored health insurance. The Balanced Budget Act of 1997 created a new children's health insurance program called the State Children's Health Insurance Program. This program gave each state permission to offer health insurance for children, up to age 19, who are not already insured. SCHIP is a state administered program and each state sets its own guidelines regarding eligibility and services.

**Sub-Capitation** - An arrangement that exists when an organization being paid under a capitated system contracts with other providers on a capitated basis, sharing a portion of the original capitated premium. Can be done under Carve Out, with the providers being paid on a PMPM basis.

**Subrogation** - Procedure where insurance company recovers from a third party when the action resulting in medical expense (e.g. auto accident) was the fault of another person. The recovery of the cost of services and benefits provided to the insured of one health plan when other parties are liable.

**Subscriber** - Person responsible for payment of premiums, or person whose employment is the basis for membership in a health plan.

**Subscriber Contract** - A written agreement that describes the individual's health care policy. Also called subscribe certificate or member certificate.

**Summary Plan Description (SPD)** - In self-funded plans, a written explanation of the eligibility for and benefits available to employees required by ERISA.

**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.

**Supplemental Services** - Optional services a health plan covers or provides.

**Supplemental Insurance** - Any private health insurance plan held by a Medicare beneficiary or commercial beneficiary, including Medigap policies and post-retirement health benefits. Supplemental usually pays the deductible or co-pay and sometimes will pay the entire bill when the primary carrier's benefits are exhausted.

**Supplemental Medical Insurance (SMI)** - Part B of the Medicare program. Part B normally covers the outpatient services, as opposed to Part A that covers inpatient. This voluntary program requires payment of a monthly premium, which covers 25 percent of pro-ram costs. Beneficiaries are responsible for a deductible and coinsurance payments for most covered services. See also Part B.

**Surplus Lines Tax** - A tax imposed by state law when coverage is placed with an insurer not licensed or admitted to transact business in the state where the risk is located. Unlike premium tax for admitted insurers, the surplus lines tax is not included in the premium and must be collected from the policyholder and remitted to the state.

**Staff Model HMO** - A model in which the HMO hires its own physicians. All premiums and other revenues accrue to the HMO, which, in turn, compensates physicians. Very much like the group model, except the doctors are employees of the HMO. Generally, all ambulatory health services are provided under one roof in the staff model.

**Standard Class Rate (SCR)** - Base revenue requirement per member multiplied by demographic information to determine monthly premium rates.

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

**State Children's Health Insurance Plan (SCHIP)** - Under Title XXI of the Balanced Budget Act of 1997, the availability of health insurance for children with no insurance or for children from low-income families was expanded by the creation of SCHIP. SCHIPs operate as part of a State's Medicaid program.

**Stop Loss Insurance** - Insurance purchased by an insurance company or health plan from another insurance company to protect itself against losses. Reinsurance purchased to protect against the single overly large claim or the excessively high aggregated claim during a set period. Stop Loss may also be used by providers when purchasing Malpractice, Workers Comp and Liability coverages. Also see Reinsurance and Specific Stop Loss.

**Subcapitation** - An arrangement whereby a capitated health plan pays its contracted providers on a capitated basis.

**Subscriber** - Employment group or individual that contracts with an insurer for medical services. Usually synonymous with enrollee, covered individual or member.

## T

**Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA)** - The Federal law that created the current risk and cost contract provisions under which health plans contract with HCFA. Legislation that created the target rate of increase cost based limits on reimbursements for inpatient operating costs. These limits are considered per Medicare discharges total amounts. A facility's target amount is derived from costs in its base year (1st full fiscal year of operation with application to CMS as same) updated to the current fiscal year by the annual allowable rate of increase. Medicare payments for operating costs generally may not exceed the facility's target amount and still be paid by CMS. These provisions apply to hospitals and units excluded from PPS and DRG. When cost reports fall short of the TEFRA limit, certain paybacks are provided. If costs exceed TEFRA, facilities can submit an exception report and may or may not be provided additional payment. Many facilities that established TEFRA limits in the early 1980s are finding they consistently exceed their TEFRA limits. Units normally under the TEFRA rules are psychiatric units, rehab units, free standing specialty hospitals, oncology outpatient clinics and others.

**Telehealth, Telemedicine, Telehealth, E-Health** - The use of telecommunications (i.e., wire, internet, radio, optical or electromagnetic channels transmitting text, x-ray, images, records, voice, data or video) to facilitate medical diagnosis, patient care, patient education and/or medical learning. Many rural areas are finding uses for telehealth and telemedicine in providing oncology, home health, ER, radiology and psychiatry among others. Telehealth services have been used between providers, to provide supervision of one another and to provide evaluation of patients. Medicaid and Medicare provide some limited reimbursement for certain services provided to patients via telecommunication. Telehealth is likely to serve greater purposes and populations in the future.

**Termination Date** - Date that a group contract expires or an individual is no longer eligible for benefits.

**Tertiary Care** - Services provided by highly specialized providers such as neurosurgeons, thoracic surgeons and intensive care units. These services often require highly sophisticated technology and facilities.

**Therapeutic Alternatives** - Drug products that provide the same pharmacological or chemical effect in equivalent doses. Also see Drug Formulary.

**Third Party Administrator (TPA)** - An independent organization that provides administrative services including claims processing and underwriting for other entities, such as insurance companies or employers. Often insurance companies will contract as TPAs with other insurance companies or health plans. TPAs are not always insurance companies. TPAs are organizations with expertise and capability to administer all or a portion of the claims process. Self-insured employers will often contract with TPAs to handle their insurance functions. Insurance companies will sometimes outsource the claims, UR or membership functions to a TPA. Sometimes TPAs will only manage provider networks, only claims or only UR. Hospitals or provider organizations desiring to set up their own health plans will often outsource certain responsibilities to TPAs. TPAs are prominent players in the managed care industry.

**Third-Party Payment** - Payment by a financial agent such as an HMO, insurance company or government rather than direct payment by the patient for medical care services. The payment for health care when the beneficiary is not making payment, in whole or in part, in his own behalf.

**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).

**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.

**Tort Reform** - Legislative limits or changes or judicial reform of the rules governing medical malpractice lawsuits and other lawsuits. Tort simply refers to lawsuit. Reform implies that limits can be placed on individual rights to sue or on the amounts or situations for which they can seek relief. Tort is considered to be by some as the primary cause of the rising costs of health care. Reform, then, would lower health care costs. On the other hand, patient advocates are against tort reform, claiming that the health care industry and managed care industries require monitoring and that lawsuits keep health care providers and payers in check. Congress debates tort reform each session, but, to date, few restrictions have been placed on tort cases.

**Total Budget** - Otherwise known as a "global" budget, a cap on overall health spending.

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

**Total Quality Management** - Related to quality management, TQM identifies required system elements to measure, design, and select processes that consistently deliver superior outcomes. These fundamentals make up the basis for TQM. See also Quality Improvement.

**Tracking of Disclosures** - The HIPAA Privacy Rule gives individuals the right to request an accounting of disclosures of protected health information over the previous six years. If an individual authorizes uses or disclosures for research, the disclosures do not need to be tracked, but disclosures must be tracked if the researcher receives an IRB-approved waiver of authorization. The accounting of disclosures generally must include: the date of the disclosure, the name of the entity or person (and address if known) who received the protected health information, a brief description of the information disclosed, and a brief statement of the purpose of the disclosure. The Rule allows for an alternative tracking option is available for research involving 50 or more people.

**Transaction** – Usually refers to the exchange of information for administrative or financial purposes such as health insurance claims or payment. Under HIPAA, this is the exchange of information between two parties to carry out financial or administrative activities related to health care.

**Transfer** - Movement of a patient between hospitals or between units in a given hospital. In Medicare, a full DRG rate is paid only for transferred patients that are defined as discharged. In managed care, transfers are often suggested by UR entities to move patients to lower cost care facilities.

**Treatment** - The provision of health care by one or more health care providers. Treatment includes any consultation, referral or other exchanges of information to manage a patient's care. The HIPAA Privacy Notice explains that the HIPAA Privacy Rule allows Partners and its affiliates to use and disclose protected health information for treatment purposes without specific authorization.

**Treatment Episode** - The period of treatment between admission and discharge from a modality, e.g., inpatient, residential, partial hospitalization, and outpatient, or the period of time between the first procedure and last procedure on an outpatient basis for a given diagnosis. Many healthcare statistics and profiles use this unit as a base for comparisons.

**Trending** - Methods of estimating future costs of health services by reviewing past trends in cost and utilization of these services. Also see Actuarial.

**Triage** - Triage is the act of categorizing patients according to acuity and by determining that need services first. Most commonly occurs in emergency rooms, but, can occur in any healthcare setting. Classification of ill or injured persons by severity of condition. Designed to maximize and create the most efficient use of scarce resources of medical personnel and facilities. Managed care organizations, health plans and provider systems are setting up programs or clinics called "triage centers". These centers serve as an extension of the utilization review process, as diversions from emergency room care or as case management resources. These triage centers also serve to steer patients away from more costly care (for example, a child with a cold is steered away from an emergency room). Triage can also be handled on the telephone and be called a pre-authorization center, crisis center, call center or information line.

**Triage Providers** - Medical personnel who classify ill or injured persons by severity of condition. When providers or insurance companies manage triage on the telephone, this service may be referred to as pre-authorization center, crisis center, call center or information line. Providers may also manage triage in emergency rooms, walk-in centers, disaster scenes or outreach centers.

**Triple Option Plan** - A plan (usually offered by a single carrier or a joint venture between two or more carriers) that gives subscribers or employees a choice among HMO, PPO and traditional indemnity plans. Also see Cafeteria Plan.

## U

**UB-92 - Uniform Billing Code of 1992** - Bill form used to submit hospital insurance claims for payment by third parties. Similar to HCFA 1500, but reserved for the inpatient component of health services. An electronic format of the CMS-1450 paper claim form that has been in general use since 1993.

**Unbundling** - The practice of providers billing for a package of health care procedures on an individual basis when a single procedure could be used to describe the combined service.

**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. See cost shifting.

**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. See cost shifting.

**Underwriting** - Process of selecting, classifying, analyzing and assuming risk according to insurability. The insurance function bearing the risk of adverse price fluctuations during a particular period. Analysis of a group that is done to determine rates or to determine whether the group should be offered coverage at all.

**Uninsured** - People who lack public or private health insurance.

**Universal Access** - The right and ability to receive a comprehensive, uniform, and affordable set of confidential, appropriate, and effective health services. Universal service is a reality in countries with national medicine programs or socialized healthcare, such as the UK, Canada, France and most countries in the world. Few countries have the private insurance programs as the primary form of healthcare, as in the US. See Universal Coverage.

**Universal Coverage** - A type of government sponsored health plan that would provide healthcare coverage to all citizens. This is an aspect of Clinton's original health plan in the mid 1990s and is an attribute of national health insurance plans similar to those offered in other countries such as the UK or Canada. While government sponsored health care is not likely to be universal, politicians in Washington continuously discuss the concept of providing healthcare to all Americans. Expect to see more and more discussion of modified universal coverage ideas in the years to come. See also National Health Insurance.

**Update Factor** - The year-to-year increase in base payment amounts for PPS and excluded hospitals and dialysis facilities. The update factors generally are legislated by the Congress after considering annual recommendations provided by ProPAC and HHS.

**Urgent Services** - Benefits covered in an Evidence of Coverage that are required in order to prevent serious deterioration of an insured's health that results from an unforeseen illness or injury.

**Use** – Under HIPAA, this term refers to the sharing of individually identifiable health information within a covered entity. For Partners' purposes, a use is the sharing of such information within the Partners affiliated covered entity.

**U.S. Per Capita Cost (USPCC)** - The national average cost per Medicare beneficiary, calculated annually by CMS's Office of the Actuary. See also Capitation.

**Usual, Customary and Reasonable (UCR) Charges** - The amount a health plan will recognize for payment for a particular medical procedure. It is typically based on what is considered "reasonable" for that procedure in your service area. Commonly charged fees for health services in a certain area. The use of fee screens to determine the lowest value of provider reimbursement based on: (1) the provider's usual charge for a given procedure, (2) the amount customarily charged for the service by other providers 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. Most health plans provide reimbursement for usual and customary charges, although no universal formula has been established for these rates.

**Utilization** - Use of services and supplies. Utilization is commonly examined in terms of patterns or rates of use of a single service or type of service such as hospital care, physician visits, and prescription drugs. Measurement of utilization of all medical services in combination is usually done in terms of dollar expenditures. Use is expressed in rates per unit of population at risk for a given period such as the number of admissions to the hospital per 1,000 persons over age 65 per year, or the number of visits to a physician per person per year for an annual physical. See also UR, UM.

**Utilization Management (UM)** - The process of evaluating the necessity, appropriateness and efficiency of health care services against established guidelines and criteria. Evaluation of the necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities. UM usually includes new actions or decisions based on the overall analysis of the utilization.

**Utilization Review (UR), Case Management** - A formal review of utilization for appropriateness of health care services delivered to a member on a prospective, concurrent or retrospective basis. 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. A peer review group, or a public agency can do utilization review. UR is a method of tracking, reviewing and rendering opinions regarding care provided to patients. Usually UR involves the use of protocols, benchmarks or data with which to compare specific cases to an aggregate set of cases. Those cases falling outside the protocols or range of data are reviewed individually. Managed care organizations will sometimes refuse to reimburse or pay for services that do not meet their own sets of UR standards. UR involves the review of patient records and patient bills primarily but may also include telephone conversations with providers. The practices of pre-certification, re-certification, retrospective review and concurrent review all describe UR methods. UR is one of the primary tools utilized by IDS, MCO and health plans to control over-utilization, reduce costs and manage care.

**Utilization Risk** - The risk that actual service utilization might differ from utilization projections.

## V

**Variable Contribution Health Plan** – In contrast to a fixed contribution plan, a variable contribution involves employers committing to a specified level of benefits funding for its employees, regardless of the actual benefit price. Employers are thus locked into variable contribution arrangements because they are committed to funding a certain benefit structure without knowing what the future costs may be if premiums are raised. See also Fixed Contribution Health Plan.

**Vertical Disintegration** - A practice of selling off health plan subsidiaries or provider activities. Vertical disintegration was a trend in the late 1990s.

**Vertical Integration** - Organization of production whereby one business entity controls or owns all stages of the production and distribution of goods or services. In health care, vertical integration can take many forms, but, generally implies that physicians, hospitals and health plans have combined their organizations or processes in some manner to increase efficiencies, increase competitive strength or to improve quality of care. Integrated delivery systems or healthcare networks are generally vertically integrated. Also see IDS, AHP, horizontal integration.

**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. Vital statistics can be obtained from CDC, state health departments, county health departments and other agencies. An individual patient's vital statistics in a health care setting may also refer simply to blood pressure, temperature, height and weight, etc.

**Volume and Intensity of Services** - The quantity of health care services per enrollee, taking into account both the number and the complexity of the services provided.

**Volume Performance Standard (VPS) System** - The VPS provides a mechanism to adjust fee updates for the Medicare Fee Schedule based on how annual increases in actual expenditures compare with previously determined performance standard rates of increase.

**Volume Performance Standards (VPS)** - A mechanism to adjust updates to fee-for-service payment rates based on actual aggregate.

## W

**Waiting Periods** - The length of time an individual must wait to become eligible for benefits for a specific condition after overall coverage has begun.

**Waiver** - Approval that the Centers for Medicare and Medicaid Services (CMS, formerly called HCFA), the federal agency that administers the Medicaid program, may grant to state Medicaid programs to exempt them from specific aspects of Title XIX, the federal Medicaid law. Most federal waivers involve loss of freedom of choice regarding which providers beneficiaries may use, exemption from requirements that all Medicaid programs be operated throughout an entire state, or exemption from requirements that any benefit must be available to all classes of beneficiaries (which enables states to experiment with programs only available to special populations).

**Waiver of Authorization** – Under HIPAA, under limited circumstances, a waiver of the requirement for authorization for use or disclosure of private health information may be obtained from the IRB by the researcher. A waiver of authorization can be approved only if specific criteria have been met. See Authorization also.

**Wellness** - A dynamic state of physical, mental, and social well-being; a way of life which equips the individual to realize the full potential of his/her capabilities and to overcome and compensate for weaknesses; a lifestyle 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 and lifestyle. Preventive medicine associated with lifestyle and preventive care that can reduce health-care utilization and costs. "Wellness" programs became popular with the advent of managed care in the 1980s, with the philosophy and business idea that health plans needed to emphasize keeping their beneficiaries well. However, there has been a drop off in these programs in the 1990s as health plans recognize the difficulty in assessing efficacy and they found that subscribers tend to change plans regularly, thus reducing benefit of keeping one population "well".

**Withhold** - Portion of a claim deducted and held by a health plan before payment is made to a capitated physician. 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. That portion of the monthly capitated payment to providers withheld by the MCO to create an incentive for efficient or reduced utilization of care or services. A provider that exceeds their withhold amount does not receive a dispersion at the end of the contract period. See also PCR or physician contingency reserve.

**Withhold Pool** - The aggregate amount withheld from all providers' capitation payments as an amount to cover excess expenditures of his or a groups referral or other pool. See also risk pool, capitation or sub-capitation. See also Risk Pool, Capitation, and Shared Risk.

**Workers' Compensation** - A state-mandated program providing insurance coverage for work-related injuries and disabilities. Several states have either enacted or are considering changes to the Workers Compensation Laws to allow employers to cover occupational injuries and illnesses within their own existing group medical plans. Some employers pay premiums to the state or to insurance companies for this coverage. Others are self-funded and use third party case management or administrative services to manage the processes. See also Occupational Health.

**X & Y – No Terms**

**Z**

**Zero-Sum Budgeting** - A "deficit neutral" budget process in which new expenditures are paid through cuts in existing programs or increases in revenue. The end result is the same bottom line and no increase in the deficit (if governmental) or debt (if referring to private or public corporation or company).