ACRONYMS & GLOSSARY

Medicare & Medicaid Briefings: Common Health Care Terms

JANUARY 15, 2009

[ A ]

AAA Area Agency on Aging
AAPCC Adjusted Average Per Capita Cost
ADA Americans with Disabilities Act
ADL Activities of Daily Living
AFDC Aid to Families with Dependent Children
AHEC Area Health Education Center
AHRQ Agency for Healthcare Research and Quality
AMP Average Manufacturer Price
APC Ambulatory Payment Classification
ASPE HHS Office of the Assistant Secretary for Planning and Evaluation
ASC Ambulatory Surgical Center
ASP Average Sales Price
AWP Average Wholesale Price

[ B ]

BBA Balanced Budget Act of 1997
BBRA Balanced Budget Refinement Act of 1999
BHO Behavioral Health Organization
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>BIPA</td>
<td>Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000</td>
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<tr>
<td>BLS</td>
<td>Bureau of Labor Statistics</td>
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<td>BPHC</td>
<td>Bureau of Primary Health Care</td>
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<tr>
<td>CAH</td>
<td>Critical Access Hospital</td>
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<tr>
<td>CAHPS®</td>
<td>Consumer Assessment of Healthcare Providers and Systems®</td>
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<tr>
<td>CAP</td>
<td>Community Access Program</td>
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<tr>
<td>CBO</td>
<td>Congressional Budget Office; Community-Based Organization</td>
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<tr>
<td>CCU</td>
<td>Coronary Care Unit; Critical Care Unit</td>
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<tr>
<td>CDC</td>
<td>Centers for Disease Control and Prevention</td>
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<tr>
<td>CFR</td>
<td>Code of Federal Regulations</td>
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<tr>
<td>CHC</td>
<td>Community Health Center</td>
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<tr>
<td>CHF</td>
<td>Congestive Heart Failure</td>
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<td>CMHC</td>
<td>Community Mental Health Center</td>
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<tr>
<td>CME</td>
<td>Continuing Medical Education</td>
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<tr>
<td>CMM</td>
<td>Center for Medicare Management (within CMS)</td>
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<tr>
<td>CMS</td>
<td>Centers for Medicare &amp; Medicaid Services (formerly known as HCFA)</td>
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<tr>
<td>CMSO</td>
<td>Center for Medicaid and State Operations (within CMS)</td>
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<tr>
<td>CNA</td>
<td>Certified Nursing Assistant</td>
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<tr>
<td>COB</td>
<td>Coordination of Benefits</td>
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<tr>
<td>COLA</td>
<td>Cost of Living Allowance</td>
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<tr>
<td>Acronym</td>
<td>Definition</td>
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<tr>
<td>CON</td>
<td>Certificate of Need</td>
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<tr>
<td>COP</td>
<td>Conditions of Participation</td>
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<tr>
<td>COPD</td>
<td>Chronic Obstructive Pulmonary Disease</td>
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<td>CPC</td>
<td>Center for Health Plan Choices (within CMS)</td>
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<tr>
<td>CPI</td>
<td>Consumer Price Index</td>
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<tr>
<td>CPOE</td>
<td>Computerized Physician Order Entry; Computerized Prescription Order Entry</td>
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<tr>
<td>CPR</td>
<td>Customary, Prevailing, and Reasonable; Cardiopulmonary Resuscitation</td>
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<td>CPS</td>
<td>Current Population Survey</td>
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<tr>
<td>CRS</td>
<td>Congressional Research Service</td>
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<thead>
<tr>
<th>Acronym</th>
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<tbody>
<tr>
<td>DD</td>
<td>Developmental Disability</td>
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<tr>
<td>DGME</td>
<td>Direct Graduate Medical Education</td>
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<td>DME</td>
<td>Durable Medical Equipment; Direct Medical Education</td>
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<td>DMERCs</td>
<td>Durable Medical Equipment Regional Carriers</td>
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<tr>
<td>DMO</td>
<td>Disease Management Organization</td>
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<tr>
<td>DRA</td>
<td>Deficit Reduction Act of 2005</td>
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<td>DRG</td>
<td>Diagnosis-Related Group</td>
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<td>DSH</td>
<td>Disproportionate Share Hospital</td>
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<td>DTC</td>
<td>Direct-to-Consumer Advertising</td>
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<td>DUR</td>
<td>Drug Utilization Review</td>
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### [E ]

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>E &amp; M</td>
<td>Evaluation and Management</td>
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<tr>
<td>EBM</td>
<td>Evidence-Based Medicine</td>
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<tr>
<td>ED</td>
<td>Emergency Department</td>
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<tr>
<td>EMR</td>
<td>Electronic Medical Record</td>
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<tr>
<td>EHR</td>
<td>Electronic Health Record</td>
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<tr>
<td>EMS</td>
<td>Emergency Medical Services</td>
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<tr>
<td>EMTALA</td>
<td>Emergency Medical Treatment and Active Labor Act of 1986</td>
</tr>
<tr>
<td>EPSDT</td>
<td>Early and Periodic Screening, Diagnosis, and Treatment Program</td>
</tr>
<tr>
<td>ER</td>
<td>Emergency Room</td>
</tr>
<tr>
<td>ERISA</td>
<td>Employee Retirement Income Security Act of 1974</td>
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<tr>
<td>ESI</td>
<td>Employer-Sponsored Insurance</td>
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<tr>
<td>ESRD</td>
<td>End Stage Renal Disease</td>
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### [F ]

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<tr>
<th>Abbreviation</th>
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<tbody>
<tr>
<td>FDA</td>
<td>Food and Drug Administration</td>
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<tr>
<td>FEHBP</td>
<td>Federal Employees Health Benefits Program</td>
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<td>FFP</td>
<td>Federal Financial Participation</td>
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<td>FFS</td>
<td>Fee-For-Service</td>
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<td>FFY</td>
<td>Federal Fiscal Year</td>
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<td>FI</td>
<td>Fiscal Intermediary</td>
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<td>FICA</td>
<td>Federal Insurance Contributions Act</td>
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<td>FMAP</td>
<td>Federal Medical Assistance Percentage</td>
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<td>FMG</td>
<td>Foreign Medical Graduate</td>
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<td>Acronym</td>
<td>Description</td>
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<tr>
<td>FPL</td>
<td>Federal Poverty Level</td>
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<td>FQHC</td>
<td>Federally Qualified Health Center</td>
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<td>FTC</td>
<td>Federal Trade Commission</td>
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<tr>
<td>FUL</td>
<td>Federal Upper Limit</td>
</tr>
<tr>
<td>FY</td>
<td>Fiscal Year</td>
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</tbody>
</table>
| GAO     | Government Accountability Office
(formerly the General Accounting Office) |
| GDP     | Gross Domestic Product |
| GME     | Graduate Medical Education |
| GP      | General Practitioner |
| GR      | General Revenue |
| HCBS    | Home and Community-Based Services |
| HCFA    | Health Care Financing Administration
(now known as CMS) |
<p>| HCPCS   | Healthcare Common Procedure Coding System |
| HCPPs   | Health Care Prepayment Plans |
| HEDIS®  | Health Plan Employer Data and Information Set® |
| HHA     | Home Health Agency |
| HHRG    | Home Health Resource Group |
| HHS     | U.S. Department of Health and Human Services |
| HI      | Hospital Insurance (Medicare Part A) |
| HIFA    | Health Insurance Flexibility and Accountability |</p>
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<tr>
<th>Acronym</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>HIPAA</td>
<td>Health Insurance Portability and Accountability Act of 1996</td>
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<td>HIPC</td>
<td>Health Insurance Purchasing Cooperative</td>
</tr>
<tr>
<td>HIT</td>
<td>Health Information Technology</td>
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<tr>
<td>HMO</td>
<td>Health Maintenance Organization</td>
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<tr>
<td>HPSA</td>
<td>Health Professional Shortage Area</td>
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<tr>
<td>HRSA</td>
<td>Health Resources and Services Administration</td>
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<tr>
<td>HSA</td>
<td>Health Savings Account</td>
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<th>Acronym</th>
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<tr>
<td>IADL</td>
<td>Instrumental Activities of Daily Living</td>
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<tr>
<td>ICD</td>
<td>International Classification of Diseases</td>
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<tr>
<td>ICU</td>
<td>Intensive Care Unit</td>
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<tr>
<td>ICF/MR</td>
<td>Intermediate Care Facility for the Mentally Retarded</td>
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<tr>
<td>IGT</td>
<td>Intergovernmental Transfer</td>
</tr>
<tr>
<td>IMD</td>
<td>Institution for Mental Disease</td>
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<tr>
<td>IME</td>
<td>Indirect Medical Education</td>
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<tr>
<td>IMG</td>
<td>International Medical Graduate</td>
</tr>
<tr>
<td>IOM</td>
<td>Institute of Medicine (of the National Academy of Sciences)</td>
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<tr>
<td>IPA</td>
<td>Independent Practice Association</td>
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<tr>
<td>JAMA</td>
<td><em>Journal of the American Medical Association</em></td>
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<tr>
<td>JCAHO</td>
<td>Joint Commission on the Accreditation of Health Care Organizations; now known as the Joint Commission</td>
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[ L ]

LOS  Length of Stay
LPN  Licensed Practical Nurse
LTC  Long-Term Care

[ M ]

MA  Medicare Advantage
    (formerly known as Medicare+Choice)
M+C  Medicare+Choice
MAAC  Maximum Allowable Actual Charge
MCBS  Medicare Current Beneficiary Survey
MCH  Maternal and Child Health Program
MCO  Managed Care Organization
MDS  Minimum Data Set
MedPAC  Medicare Payment Advisory Commission
MEPS  Medical Expenditure Panel Survey
MIPPA  Medicare Improvement for Patients and Providers
        Act of 2008
MMA  Medicare Prescription Drug, Improvement, and
        Modernization Act of 2003
MMIS  Medical Management Information System
MOU  Memorandum of Understanding
MR  Mentally Retarded
MRI  Magnetic Resonance Imaging
MSA  Medical Savings Account;
    Metropolitan Statistical Area
MSP  Medicare Savings Program; Medicare Secondary Payor
MUA  Medically Underserved Area

[ N ]
NCHS  National Center for Health Statistics
NCQA  National Committee on Quality Assurance
NHPF  National Health Policy Forum
NHSC  National Health Services Corps
NICU  Neonatal Intensive Care Unit
NIH  National Institutes of Health
NP  Nurse Practitioner
NPRM  Notice of Proposed Rulemaking

[ O ]
OAA  Older Americans Act of 1965
OACT  Office of the Actuary (within CMS)
OASDI  Old Age Survivors, Disability, and Health Insurance Program
OASIS  Outcome and Assessment Information Set
OBRA  Omnibus Budget Reconciliation Act
OCR  Office of Civil Rights
OIG  Office of Inspector General
OMB  Office of Management and Budget
OPD  Outpatient Department
OPL  Operational Policy Letter
ACRONYMS

OSCAR  Online Survey, Certification and Reporting System
OSHA  Occupational Safety and Health Administration

[ P ]
PA  Physician Assistant
PACE  Program of All-inclusive Care for the Elderly
PBM  Pharmacy Benefit Manager
PCA  Personal Care Attendant
PCCM  Primary Care Case Management
PCP  Primary Care Provider
PDL  Preferred Drug List
PDP  Prescription Drug Plan
PHO  Physician-Hospital Organization
PHP  Prepaid Health Plan
PHS  Public Health Service
PMPM  Per Member Per Month
POS  Point of Service
PPO  Preferred Provider Organization
PPRC  Physician Payment Review Commission
        (now known as MedPAC)
PPS  Prospective Payment System
PRO  Peer Review Organization (now known as QIO)
ProPAC  Prospective Payment Assessment Commission
        (now known as MedPAC)
PSO  Provider Sponsored Organization
[ Q ]

QI  Qualified Individual
QIO  Quality Improvement Organization
     (formerly known as PRO)
QMB  Qualified Medicare Beneficiary
QWDI  Qualified Working Disabled Individual

[ R ]

RBRVS  Resource-Based Relative Value Scale
RHC  Rural Health Clinic
RHHI  Regional Home Health Intermediary
RUG-III  Resource Utilization Group, Version III
RWJF  The Robert Wood Johnson Foundation

[ S ]

SAMHSA  Substance Abuse and Mental Health Services Administration
SCHIP  State Children’s Health Insurance Program
SFY  State Fiscal Year
SGR  Sustainable Growth Rate
SHMO  Social Health Maintenance Organization
SLMB  Specified Low-Income Medicare Beneficiary
SMD  State Medicaid Director
SMI  Supplementary Medical Insurance (Medicare Part B)
SNF  Skilled Nursing Facility
<table>
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<tr>
<th>Acronym</th>
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<tr>
<td>SNP</td>
<td>Special Needs Plan (Medicare Advantage)</td>
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<td>SPAP</td>
<td>State Pharmacy Assistance Program</td>
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<tr>
<td>SSA</td>
<td>Social Security Administration</td>
</tr>
<tr>
<td>SSI</td>
<td>Supplemental Security Income</td>
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<tr>
<td>SSDI</td>
<td>Social Security Disability Insurance</td>
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<tr>
<td>TANF</td>
<td>Temporary Assistance to Needy Families</td>
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<tr>
<td>TPA</td>
<td>Third-Party Administrator</td>
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<tr>
<td>TPL</td>
<td>Third-Party Liability</td>
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<tr>
<td>TWIIA</td>
<td>Ticket to Work Investment and Improvement Act</td>
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<tr>
<td>UCR</td>
<td>Usual, Customary, and Reasonable</td>
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<tr>
<td>UPL</td>
<td>Upper Payment Limit</td>
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<tr>
<td>UR</td>
<td>Utilization Review</td>
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G L O S S A R Y

This glossary draws extensively from one developed by AcademyHealth (www.academyhealth.org), a nonprofit organization located in Washington, DC. Support for the development of this glossary has been provided in part by the U.S. Agency for Healthcare Research and Quality, User Liaison Program (Contract Numbers 290-91-0082 and 290-98-0003).

Definitions for some terms were developed with the use of Centers for Medicare & Medicaid Services, 2006 Annual Report of the Boards of Trustees of the Federal Hospital Insurance Trust and Federal Supplementary Medical Insurance Trust Funds, May 1, 2006; available at www.cms.hhs.gov/publications/trusteesreport/tr2006.pdf.

[A]

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

activities of daily living — Index or scale that measures a patient’s degree of independence in bathing, dressing, using the toilet, eating, and moving from one place to another.

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

adjusted average per capita cost (AAPCC) — The basis for HMO (health maintenance organization) reimbursement under Medicare risk contracts prior to the Balanced Budget Act of 1997.

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

adverse selection — A tendency for utilization of health services in a population group to be higher than average. From an insurance perspective, adverse selection occurs when persons with poorer-than-average health status apply for or continue insurance coverage to a greater extent than do persons with average or better health status.
**Agency for Healthcare Research and Quality (AHRQ)** — AHRQ is a Public Health Service agency within the U.S. Department of Health and Human Services (HHS) reporting to the HHS Secretary. AHRQ’s mission is to support research designed to improve the outcomes and quality of health care, reduce its costs, address patient safety and medical errors, and broaden access to effective services.

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

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

**ambulatory payment classification (APC)** — The basis for payment for care in the outpatient prospective payment system. The APC is used in a fashion similar to the way DRGs (diagnosis-related groups) are used for payment for inpatients. Both APCs and DRGs are intended to represent groups of patients that are similar clinically and that also have roughly the same resource consumption. The significant difference between them is that APCs depend on the procedures performed, whereas DRGs depend on the diagnoses treated.

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

**amount, duration, scope** — The phrase used to describe the Medicaid program policy under which states are allowed to limit the items and services they cover within a statutory benefit category (for example, physician, inpatient hospital, prescription drug). Each benefit category that a state covers must be sufficient in amount, duration, and scope to reasonably achieve its purpose.
ancillary services — Supplemental services, including laboratory, radiology, physical therapy, and inhalation therapy, that are provided in conjunction with medical or hospital care.

annual out-of-pocket threshold — The amount of out-of-pocket expenses that must be paid before significantly reduced beneficiary cost sharing is effective under Part D. Amounts paid by a third-party insurer are not included in testing this threshold, but amounts paid by state or federal assistance programs are included.

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

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

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

assignment — In Medicare, if a beneficiary agrees to have Medicare’s share of the cost of a service paid directly (“assigned”) to a doctor or other provider, and the provider agrees to accept the Medicare approved charge as payment in full. Medicare pays 80 percent of the cost and the beneficiary 20 percent, for most services. In Medicaid, providers that elect to participate must accept as payment in full the program’s payment for an item or service delivered to a Medicaid beneficiary and may not “balance bill” or charge the beneficiary any additional amount with the exception of allowable cost-sharing amounts.

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

**average manufacturer price (AMP)** — The average price paid to a manufacturer by wholesalers for drugs distributed to retail pharmacies. Federal supply schedule (FSS) prices and prices associated with direct sales to health maintenance organizations and hospitals are excluded. AMP was a price created by the Omnibus Budget Reconciliation Act of 1990 to use in determining Medicaid rebates.

**average sales price (ASP)** — The weighted average of a manufacturer’s sales to all purchasers in a given quarter, after certain pricing adjustments such as discounts and rebates, and excluding certain government and other purchasers. In the Medicare Modernization Act, Congress adopted the ASP to replace the average wholesale price (AWP) for reimbursing outpatient drugs under Medicare Part B beginning in 2005.

**average wholesale price (AWP)** — The average list price that a manufacturer suggests wholesalers charge pharmacies. AWP is typically less than the retail price, which will include the pharmacy’s own price markup. AWP is referred to as a sticker price because it is not the actual price that large purchasers normally pay.

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

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

**behavioral health** — An umbrella term that includes mental health and substance abuse, and is frequently used to differentiate from “physical” health. Health care services provided for depression or
alcoholism would be considered behavioral health care, while setting a broken leg would be physical health care.

**benchmark** — A level of care set as a goal to be attained. For example, competitive benchmarks are comparisons with the best external competitors in the field. The State Children’s Health Insurance Program benefit package includes a benchmark package that is used to compare other benefit packages’ value and comprehensiveness.

**beneficiary** — A person enrolled in Medicare; an individual who is eligible for and enrolled in the Medicaid program in the state in which he or she resides. Millions of individuals are eligible for Medicaid but not enrolled and are therefore not program beneficiaries.

**best price** — The lowest price on a prescription drug available from a manufacturer to any wholesaler, retail pharmacy, provider, or managed care organization, subject to certain exceptions. Used in calculating the amount of the rebate participating manufacturers are required to pay on covered outpatient drugs (other than generic drugs) purchased by state Medicaid programs.

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

**Boren Amendment** — Part of the Medicaid law, known by the name of its principal congressional sponsor. It provides that state payment for hospitals and nursing facilities must be reasonable and adequate to meet the costs incurred by efficiently and economically operated facilities to provide care and services meeting state and federal standards. The Boren Amendment was repealed in the Balanced Budget Act of 1997 and replaced by a requirement that states follow a public process when setting payment rates.

[C]

capital — Fixed or durable nonlabor inputs or factors used in the production of goods and services, the value of such factors, or the money
specifically allocated for their acquisition or development. Capital costs include, for example, the buildings, beds, and equipment used in the provision of hospital services.

**capitation** — A method of payment for health services in which an individual or institutional provider is paid a fixed amount for each person served, without regard to the actual number or nature of services provided to each person in a set period of time. Capitation is the characteristic payment method in certain health maintenance organizations.

**carrier** — A health insurance company that is selected (by competition or designation) by CMS to make payment to physicians, other practitioners and suppliers for covered Medicare services.

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

**case management** — The monitoring and coordination of treatment rendered to patients with specific diagnoses or requiring high-cost or extensive services. Sometimes considered a subset of disease management and often used interchangeably with care coordination.

**case mix** — A measure of the mix of cases being treated by a particular health care provider that is intended to reflect the patients’ different needs for resources. Case mix may be measured by factors such as diagnosis, severity of illness, utilization of services, and provider characteristics.

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

**catastrophic health insurance** — Health insurance that provides protection against the high cost of treating severe or lengthy illnesses or disability. Generally such policies cover all or a specified percentage of medical expenses above an amount that is the responsibility of another insurance policy, or the beneficiary, up to a maximum limit of liability.
**categorically eligible** — Persons whose Medicaid eligibility is based on their family size, age, or disability status. Persons not falling into these categories cannot qualify, no matter how low their income. The Medicaid statute defines 25 categorically eligible groups. The scope of covered services that states provide to the categorically needy is much broader than the minimum scope of services for the other, optional groups receiving Medicaid benefits.

**Centers for Medicare & Medicaid Services (CMS)** — The government agency within the U.S. Department of Health and Human Services that directs the Medicare, Medicaid, and State Children’s Health Insurance Programs (Titles XVIII, XIX, XXI of the Social Security Act). Formerly the Health Care Financing Administration (HCFA).

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

**chronic care** — Care and treatment rendered to individuals whose health problems are of a long-term and continuing nature.

**chronic care model (CCM)** — The CCM integrates community and health plan resources to facilitate productive interactions between an informed, activated patient and a prepared, proactive practice team. Important elements include support for patient self-management, reliance on evidence-based guidelines or decision-support tools, delivery system re-design, and investment in clinical information systems.

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

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

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

**community health center (CHC)** — An ambulatory health care program (defined under Section 330 of the Public Health Service Act) usually serving an area that has scarce health services. Sometimes known as a “neighborhood health center.”

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

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

**Consumer Assessment of Healthcare Providers and Systems® (CAHPS®)** — CAHPS® is an instrument that measures consumer satisfaction with health plans. The Centers for Medicare & Medicaid Services (CMS) uses CAHPS® to assist Medicare beneficiaries in choosing among managed care and fee-for-service plans. CMS works with states to support their implementation of CAHPS® in Medicaid and SCHIP as well.

**consumer price index (CPI)** — A measure of the average change in prices over time in a fixed group of goods and services.
continuing medical education (CME) — Formal education obtained by a health professional after completing his/her degree and full-time postgraduate training. For physicians, some states require CME (usually 50 hours per year) for continued licensure, as do some specialty boards for certification.

continuous eligibility — An option available to states under federal Medicaid and SCHIP law whereby children may remain eligible for a continuous period of 12 months, regardless of intervening changes in family income or status.

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

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

coop-payment — A fixed amount of money paid by a health plan enrollee (beneficiary) at the time of service. For example, the enrollee may pay a $20 “co-pay” at every physician office visit, and $10 for each drug prescription filled. The health plan pays the remainder directly to the provider.

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

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

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

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

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

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

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

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

**creditable prescription drug coverage** — Prescription drug coverage that meets or exceeds the actuarial value of Part D coverage provided through a group health plan or otherwise.

**critical access hospital (CAH)** — A rural hospital designation established by the Medicare Rural Hospital Flexibility Program (MRHFP) enacted as part of the Balanced Budget Act of 1997. Rural hospitals meeting criteria established by their state may apply for critical access hospital status. Designated hospitals are reimbursed based on cost (rather than prospective payment), must comply with federal and state regulations for CAHs, and are exempt from certain hospital staffing requirements.
crowd-out — A phenomenon also knowns as “substitution,” whereby new public programs or expansions of existing public programs designed to extend coverage to the uninsured prompt some privately insured persons to drop their private coverage and take advantage of the expanded public subsidy.

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

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

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

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

[D]

deductible — The amount of loss or expense that must be incurred by an insured or otherwise covered individual before an insurer will assume any liability for all or part of the remaining cost of covered services. Deductibles may be either fixed dollar amounts or the value of specified services (such as two days of hospital care or one physician visit). Deductibles are usually tied to some reference period over which they must be incurred, for example, $250 per calendar year, benefit period, or spell of illness.

defined benefit — Funding mechanisms for pension plans that can also be applied to health benefits. Defined benefit plans generally guarantee a specific package of benefits and services.
defined contribution — Funding mechanism for pension plans that can also be applied to health benefits based on a specific dollar contribution, without defining the services to be provided.

destititutionalization — A policy that calls for the provision of supportive care and treatment for medically and socially dependent individuals in the community rather than in an institutional setting. The term is commonly used in relation to the disabled who live in the community, given the appropriate supportive services.

direct subsidy — The amount paid to the prescription drug plans representing the difference between the plan’s risk-adjusted bid and the beneficiary premium for basic coverage.

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

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

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

disability — Any limitation of physical, mental, or social activity of an individual as compared with other individuals of similar age, sex, and occupation. Frequently refers to limitation of a person’s usual or major activities, most commonly vocational. There are varying types
(functional, vocational, learning), degrees (partial, total), and durations (temporary, permanent) of disability. Medicare and Medicaid offer full benefits for individuals with disabilities who are eligible for Supplemental Security Income/Social Security Disability Income.

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

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

**disproportionate share hospital (DSH) payment** — A payment adjustment under Medicare’s prospective payment system or under Medicaid for hospitals that serve a relatively large volume of low-income patients. Also refers to supplemental payments to states to assist them in financing hospitals that provide a disproportionate amount of uncompensated care.

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

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

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

**durable medical equipment regional carrier (DMERC)** — A health insurance company that is selected (by competition or designation) by CMS to make payment to durable medical equipment suppliers.
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program — A required benefit of the Medicaid program. The law requires that all states have in effect a program for eligible children under age 21 to routinely screen them and to provide such health care treatments as deemed necessary to correct or ameliorate conditions discovered.

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

employer subsidy — The amount paid to the sponsors of qualifying employment-based retiree Medicare prescription drug plans (also known as a retiree drug subsidy). This amount subsidizes a portion of actual drug expenditures between specified coverage limits and is determined without regard to actual employer plan payments.

encounter — A term used within managed care to reflect any 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.

entitlement — A program that imposes legal obligations on the federal government to any person, business, or unit of government that meets the criteria set in law. Federal spending for an entitlement program is controlled through the program’s eligibility criteria and benefit and payment rules, not by the appropriation of a specific level of funding in advance. Entitlement programs such as Medicare and Medicaid are also referred to as “direct” or “mandatory” spending. Medicaid is both an individual entitlement and an entitlement to the states that elect to participate.

evidence-based medicine — Evidence-based medicine is the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. This approach must balance the best external evidence with the desires of the patient and the clinical expertise of health care providers.
experience rating — A method of adjusting health plan premiums based on the historical utilization data and distinguishing characteristics of a specific subscriber group.

[F]

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

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

federal medical assistance percentage (FMAP) — The federal matching rate paid to states for the operation of Medicaid programs. FMAP is determined annually using a formula that compares the state’s average per capita income level with the national average income level. FMAPs range from 50 percent in the wealthier states (for example, Maryland, California, and New York) to 77 percent in the poorest state (Mississippi).

federal financial participation (FFP) — The term used to describe reimbursement for states for Medicaid expenditures for certain populations or services.

federal poverty level (FPL) — Guidelines issued by the U.S. Department of Health and Human Services that reflect the amount of income required to provide a bare minimum for food, clothing, transportation, shelter, and other necessities. The FPL is updated annually and varies according to family size (for example, for a family of four in 2004, the FPL was $18,850 per year). Public assistance programs usually define income limits expressed as a percentage of FPL (for example, 133 percent of FPL).

federally qualified health center (FQHC) — A health center in a medically underserved area that provides primary care services to all in their service area regardless of ability to pay, and that receives cost-based Medicaid and Medicare reimbursement. Many FQHCs receive
federal grant dollars as well. Federal legislation creating the FQHC category was enacted in 1989.

**federal upper limit (FUL)** — The maximum amount that federally funded programs may pay for certain drugs. The FUL for a drug is set at 150 percent of the published price for the least costly therapeutically equivalent product plus a reasonable dispensing fee. The Centers for Medicare & Medicaid Services establishes FULs in order to limit the amount that Medicaid can reimburse for multiple-source drugs.

**fee-for-service** — Method of billing for health services under which a physician or other practitioner charges separately for each patient encounter or service rendered. 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.

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

**fiscal intermediary** — An agency or organization that is nominated by a group or association of providers of health care services to make payments for covered Medicare services.

**fiscal year** — The accounting year of the U.S. government. Since 1976, each fiscal year has begun October 1 of the prior calendar year and ended the following September 30. For example, fiscal year 2007 began October 1, 2006 and will end September 30, 2007.

**formulary** — A list of drugs, usually sorted by their generic names, and indications for their use. Used by states, Medicare prescription drug plans, health plans, or hospitals, a formulary is a tool used in the management of prescription drug benefits. A formulary is intended to include a sufficient range of medicines to enable physicians, dentists, and, as appropriate, other practitioners to prescribe all medically appropriate treatment for all reasonably common illnesses. An “open” formulary allows coverage for almost all drugs. A “closed” formulary provides coverage for a limited set of drugs. A “managed” formulary includes a list of preferred drugs that the health plan prefers to use because they cost less, are more effective, or for other reasons. A “tiered formulary” financially rewards patients for using generic and formulary drugs by requiring the patient to pay progressively higher
copayments for brand-name and nonformulary drugs. For example, in a three-tiered benefit structure, copayments may be $5 for a generic, $20 for a formulary brand product, and $40 for a nonformulary brand product.

freedom of choice — Refers to both the right of providers to choose whether or not to participate in the Medicare or Medicaid programs and the right of beneficiaries to choose providers from among those participating in the programs. This right with respect to beneficiaries is commonly waived in states implementing Medicaid managed care.

[ G ]

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

generic substitution — Involves the dispensing of a generic drug when a brand-name drug was originally prescribed. Generic drugs contain the same active ingredients as their brand-name counterparts and are typically available after the branded drug’s patent has expired.

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

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

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

graduate medical education (GME) — Medical education after receipt of the doctor of medicine (MD) or equivalent degree, including the education received as an intern, resident (which involves training in a specialty), or fellow, as well as continuing medical education.
The Centers for Medicare & Medicaid Services partly finances GME through direct and indirect payments.

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

**guaranteed issue** — Requirement that insurance carriers offer coverage to groups and/or individuals, regardless of their health status or prior claims experience, during some period each year. HIPAA (the Health Insurance Portability and Accountability Act of 1996) requires that insurance carriers guarantee issue of all products to small groups (2 to 50). Some state laws exceed HIPAA’s minimum standards and require carriers to guarantee issue to additional groups and individuals.

**guaranteed renewal** — Requirement that insurance carriers renew existing coverage to groups and/or individuals at the group or individual’s option. The Health Insurance Portability and Accountability Act of 1996 requires that insurance issuers guarantee renewal of all products to all groups and individuals (provided all premiums are paid and the insurer continues to do business in the market).

[ H ]

**Health Care Financing Administration (HCFA)** — See Centers for Medicare & Medicaid Services.

**HIFA initiative** — The Health Insurance Flexibility and Accountability (HIFA) initiative was designed by the Centers for Medicare & Medicaid Services to provide increased flexibility for states in proposing Medicaid section 1115 demonstrations. Under HIFA, states have received approval to reduce benefits, increase cost sharing, and cap enrollment beyond the parameters of traditional Medicaid.

**Health Insurance Portability and Accountability Act of 1996 (HIPAA)** — HIPAA contains two sections. The first deals with protecting health insurance coverage for people who change or lose their job. It prohibits discrimination against employees and their families based
on health status, and it guarantees availability and renewability of coverage in the group and individual markets. The second section of HIPAA deals with the standardization of health care–related information systems.

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

**health maintenance organization (HMO)** — An entity with four essential attributes: (i) an organized system providing health care in a geographic area, which accepts the responsibility to provide or otherwise assure the delivery of (ii) an agreed upon set of basic and supplemental health maintenance and treatment services to (iii) a voluntarily enrolled group of persons (iv) for which services the entity is reimbursed through a predetermined fixed, periodic prepayment made by, or on behalf of, each person or family unit enrolled. The payment is fixed without regard to the amounts of actual services provided to an individual enrollee.

**health professional shortage area (HPSA)** — An area which the U.S. Department of Health and Human Services designates as having an inadequate supply of health care providers. HPSAs are based on population to provider ratios and are designated for primary care, mental health, and dental providers.

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

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

**health savings account (HSA)** — A tax-exempt trust or custodial account created by an individual and/or an employer to pay for the qualified medical expenses of the account holder and his/her spouse or dependents.

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

**health status** — The state of health of a specified individual, group, or population. It may be measured by obtaining proxies, such as individuals’ 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 proven difficult.

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

**high-risk pool** — A subsidized health insurance pool organized by some states as an alternative for individuals who have been denied health insurance because of a medical condition or whose premiums are rated significantly higher than the average due to health status or claims experience. Commonly operated through an association composed of all health insurers in a state. HIPAA allows states to use high-risk pools as an “acceptable alternative mechanism” that satisfies the statutory requirements for ensuring access to health insurance coverage for certain individuals.
**Hill-Burton Act** — Coined from the names of the principal sponsors of the Hospital Survey and Construction Act of 1946. This program provided federal support for the construction and modernization of hospitals and other health facilities. Hospitals that have received Hill-Burton funds incur an obligation to provide a certain amount of charity care.

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

**home- and community-based services (HCBS)** — Any care or services provided in a patient's place of residence or in a non-institutional setting located in the immediate community. Home- and community-based services may include home health care, adult day care or day treatment, medical equipment services, or other interventions provided for the purpose of allowing a patient to receive care at home or in his or her community. Medicaid provides federal funds for states to operate Section 1915(c) waivers. See Section 1915(c) Medicaid waiver.

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

**hospice** — A program that provides palliative and supportive care for terminally ill patients and their families, either directly or on a consulting basis with the patient's physician or another community agency.

[ 1 ]

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

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

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

**initial coverage limit** — The amount up to which the coinsurance applies under the standard prescription drug benefit.

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

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

**intergovernmental transfer (IGT)** — The transfer of nonfederal public funds from a local government (locally owned hospital or nursing facility) to the state Medicaid agency, or from another state agency (or state-owned hospital) to the State Medicaid agency, usually for the purpose of providing the state share of a Medicaid expenditure in order to draw down federal matching funds. Often used in connection with payments to DSH hospitals and UPL transactions.

**intermediate care facility (ICF)** — An institution that is licensed under state law to provide, on a regular basis, health related care and services to individuals who do not require the degree of care or treatment that a hospital or skilled nursing facility is designed to provide. Public institutions for care of the mentally retarded (ICFs/MR) or people with related conditions are also included in the definition.

**International Classification of Diseases (ICD)** — A publication of the World Health Organization (WHO), revised periodically and now in its 10th Revision. The full title is International Statistical Classification of Diseases and Related Health Problems. This classification, which originated for use in deaths, is used worldwide for that purpose. In addition, it has been used widely in the United States for hospital diagnosis classification since about 1955 through adaptations and modifications made in the United States of the 7th, 8th, and 9th Revisions.
international medical graduate (IMG) — A physician who graduated from a medical school outside of the United States. U.S. citizens who go to medical school abroad are classified as international medical graduates, as are foreign-born persons who are not trained in a medical school in this country.

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

[ J ]

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

[ K ]

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

[ L ]

late enrollment penalty — Additional beneficiary premium amounts for those who either do not enroll in Part D at the first opportunity or fail to maintain other creditable coverage for more than 63 days.

lifetime reserve days — Under HI, each beneficiary has 60 lifetime reserve days that he or she may opt to use when regular inpatient hospital benefits are exhausted. The beneficiary pays one-half of the inpatient hospital deductible for each lifetime reserve day used.
long-term care — A set of health care, personal care, and social services required by persons who have lost or never acquired some degree of functional capacity (for example, the chronically ill, aged, disabled, or mentally 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, ICFs/MR, and mental hospitals. Ambulatory services such as home health care and assisted living, which can also be provided on a long-term basis, are seen as alternatives to long-term institutional care.

low-income beneficiaries — Individuals meeting income and assets tests who are eligible for prescription drug coverage subsidies to help finance premiums and out-of-pocket payments.

low-income subsidy — A provision in the Medicare prescription drug benefit to offer beneficiaries who have limited income and resources an opportunity to receive “extra help” to pay for prescription drug costs.

[ M ]

malpractice — The failure of a professional to follow the accepted standards of practice in his or her profession. A practitioner may be held liable for damages or injuries caused by malpractice. For some professions, including medicine, malpractice insurance can cover the costs of defending suits instituted against the professional and/or any damages assessed by the court, usually up to a maximum limit.

managed care — A 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 (for example, health maintenance organizations). Medicare and Medicaid have experimented with managed care as a form of health care delivery as well as a cost-savings technique.

margin — Revenue less specified expenses.

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 charge, MAACs limit actual charge increases so they may not exceed 115 percent.

**Medicaid (Title XIX)** — A state-operated and administered program that is jointly funded by the federal and state governments. Medicaid provides medical benefits for certain indigent or low income persons in need of health and medical care. The program is authorized by Title XIX of the Social Security Act. Within broad federal guidelines, states determine the benefits covered, program eligibility, rates of payment for providers, and methods of administering the program.

**medical assistance** — The term used in the federal Medicaid statute (Title XIX of the Social Security Act) to refer to payment for items and services covered under a state’s Medicaid program on behalf of individuals eligible for benefits.

**Medical Expenditure Panel Survey (MEPS)** — MEPS is a survey conducted by the Agency for Healthcare Research and Quality. It is a nationally representative survey that collects detailed information on the health status, access to care, health care use and expenses, and health insurance coverage of the civilian noninstitutionalized population of the United States and nursing home residents.

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

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

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

**medically needy** — An optional eligibility category within the Medicaid program under which the state allows an individual to qualify by deducting the cost of the person’s medical care from his or her annual income when determining eligibility.
**medical savings account (MSA)** — An account in which individuals can accumulate contributions to pay for medical care or insurance. Some states give tax-preferred status to MSA contributions, but such contributions are still subject to federal income taxation. MSAs differ from medical reimbursement accounts, sometimes called flexible benefits or Section 115 accounts, in that they need not be associated with an employer.

**medically underserved area or population (MUA/MUP)** — An area which the U.S. Department of Health and Human Services designates as experiencing a shortage of personal health services. A designated population that may include persons who face language, cultural, or economic barriers to health care. The term is defined and used to give priority for federal assistance (for example, the community health center program).

**Medicare (Title XVIII)** — A U.S. health insurance program for people aged 65 and over, for persons eligible for Social Security disability payments for two years or longer, and for certain workers and their dependents who need kidney transplantation or dialysis. Monies from payroll taxes and premiums from beneficiaries are deposited in special trust funds for use in meeting the expenses incurred by the insured. Traditional Medicare consists of two separate but coordinated programs: hospital insurance (Part A) and supplementary medical insurance (Part B). Part C, which combines both Parts A and B, has typically been delivered through contracts with managed care plans. Part C (Medicare+Choice) was renamed the Medicare Advantage (MA) program under the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003. The MMA also added a new outpatient prescription drug benefit to Medicare known as Part D, which went into effect on January 1, 2006.

**Medicare Advantage (MA)** — Established under the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003, the program replaces and expands the Medicare+Choice program. Persons eligible for Medicare Parts A and B are also eligible for Medicare Advantage.

**Medicare Advantage prescription drug plan (MA-PD)** — Medicare Advantage plans that offer prescription drug coverage under Medicare Part D.
**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.

**Medicare+Choice** — Medicare+Choice was created by the Balanced Budget Act of 1997 to allow the Centers for Medicare & Medicaid Services (CMS) to contract with a variety of different managed care and fee-for-service entities to provide Medicare services to beneficiaries. The program was renamed Medicare Advantage (MA) in the MMA of 2003. See Medicare Advantage.

**Medicare economic index (MEI)** — An index often used in the calculation of the increases in the prevailing charge levels that help determine allowed charges for Medicare-covered physician services. In 1992 and later, this index is considered in connection with the update factor for the physician fee schedule.

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

**Medicare prescription drug account** — The separate account within the SMI trust fund to manage revenues and expenditures of the Part D drug benefit.

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

**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 (for example, 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 (for example, number of deaths from cancer in white males in relation to the white male population during a given year).
[ N ]

**national average monthly bid** — The weighted average of all drug bids, including all of the bids from PDPs and the drug portion of bids from MA-PDPs.

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

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

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

[ O ]

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

**Olmstead decision** — A 1999 Supreme Court decision in the case of *Olmstead v. L.C.* whereby the court found that unnecessary institutionalization of individuals with disabilities is discrimination under the Americans with Disabilities Act (ADA). The decision has relevance for state Medicaid programs that provide both institutional and home- and community-based long-term care services. The Court explained that a state may meet its obligation under the ADA by having comprehensive, effectively working plans ensuring that individuals with disabilities receive services in the most integrated setting appropriate to their needs.
open enrollment — A method for ensuring that insurance plans, especially prepaid plans, do not exclusively select good risks. Under an open enrollment requirement, a plan must accept all who apply during a specific period each year.

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

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

outlier — A data point that is “off the chart.” In Medicare, a hospital patient requiring either substantially more expense or a much longer length of stay than average. Under diagnosis-related group (DRG) reimbursement, hospitals receive additional payments to compensate them for the expenses associated with these extremely costly patients (subject to peer review and organization review).

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

parity — Equality or comparability between two things. Parity legislation, usually applicable to mental health conditions such as depression or schizophrenia, requires that health insurers adhere to a principle of equal treatment when making decisions regarding mental health benefits compared to medical benefits.

participating physician — A physician who agrees by contractual arrangement to accept the rules, terms, and fee schedule of a given health plan or provider network. In Medicare, a physician who signs an agreement to accept assignment on all Medicare claims for one year.
pay-as-you-go financing — A financing scheme, also known as “pay-go” in which taxes are scheduled to produce just as much income as required to pay current benefits, with trust fund assets built up only to the extent needed to prevent exhaustion of the fund by random fluctuations.

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

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

per member per month (PMPM) — A unit of measure referring to health plan costs, revenues, hospital days, or patient visits.

PDP regions — Regional areas that are fully serviced by prescription drug plans.

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

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

point of service (POS) — A health insurance benefits program in which subscribers can select between different delivery systems [that is, health maintenance organization (HMO), preferred provider organization (PPO), and fee-for-service] when in need of health care services, rather than making the selection between delivery systems at time of open enrollment at place of employment. Typically, the costs associated with receiving care from HMO providers are less than those of care rendered by PPO or noncontracting providers.
polypharmacy — Most often, the term refers to the concurrent use of several different medications, which can include more than one medication from the same drug classification. It can also refer to the mixing of multiple drugs into one prescription.

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

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

preferred drug list (PDL) — A list of prescription drugs that are covered by a health plan (or other payer, for example, Medicaid). Some drugs may be subject to a prior authorization mechanism, whereby the physician or other prescriber must justify why the patient would need a particular brand-name product. See formulary.

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

prepayment — Usually refers to any payment to a provider for anticipated services (such as that made by an expectant mother paying in advance for maternity care). Prepayment can refer to payments made to organizations (such as health maintenance organizations, prepaid group practices, and medical foundations) that, unlike insurance companies, take responsibility for arranging for and providing needed services as well as paying for them.

prescription drug plans (PDPs) — Stand-alone prescription drug plans offered to beneficiaries in traditional fee-for-service Medicare and to beneficiaries in Medicare Advantage plans that do not offer a prescription drug benefit.

presumptive eligibility — The option available to states to extend limited Medicaid coverage (with federal matching payments) to certain groups of individuals from the point a qualified provider
determines that the individual’s income does not exceed the eligibility threshold until a formal determination of eligibility is made by the state Medicaid agency. The groups to whom states may offer Medicaid coverage during a presumptive eligibility period are pregnant women, children, and women diagnosed with breast or cervical cancer.

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

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

**primary care case management (PCCM)** — The use of a primary care physician to manage the use of medical or surgical care, generally in return for a per member per month fee. PCCM programs usually pay for all care on a fee-for-service basis.

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

**prior authorization** — A formal process requiring a provider to obtain approval to provide particular services or procedures before they are done. This is usually required for 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.

**Program of All-inclusive Care for the Elderly (PACE)** — PACE is a managed care program under Medicare and a state option under Medicaid. The program provides a comprehensive array of Medicare and Medicaid institutional and community-based benefits for a subset of the dual eligible population who meet the following requirements:
(i) are a minimum of 55 years of age, (ii) live within a defined geographical area, and (iii) are certified eligible by the state for nursing home level care. It is reimbursed on a capitated basis, assuming financial risk for the full range of primary, acute, and long-term care services.

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

**provider** — Any organization, institution, or individual who provides health care services to Medicare beneficiaries. Hospitals (inpatient services), skilled nursing facilities, home health agencies, and hospices are the providers of services covered under Medicare Part A. Physicians, ambulatory surgical centers, and outpatient clinics are some of the providers of services covered under Medicare Part B.

**provider tax** — A tax, fee, assessment, or other mandatory payment required of health care providers by a state. States may use revenues from provider taxes to pay the state share of Medicaid spending only under limited circumstances specified in federal Medicaid law.

**[ Q ]**

**qualified Medicare beneficiary (QMB)** — The QMB program pays for Medicare’s premiums, deductibles, and coinsurance for beneficiaries whose incomes are below 100 percent of the federal poverty level and who have limited assets.

**quality improvement organization (QIO)** — Medicare QIOs are the successors to the Peer Review Organization (PRO) program created in 1982 by Congress to monitor beneficiaries’ quality of care and safeguard the integrity of Medicare. In the early years, PROs primarily
conducted utilization review work to make sure Medicare was paying for medically necessary care. Early quality efforts were limited largely to reviewing individual patients’ care, a process known as case review. In the mid-1990s, Medicare shifted the main focus of the program to proactive community-based quality improvement and beneficiary education. Under contract with the Centers for Medicare & Medicaid Services, QIOs now work in partnership throughout the health care system with physicians, hospitals, nursing homes, and beneficiaries to help ensure the routine delivery of high-quality medical care.

[R]

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

**rate-setting** — A method of paying health care providers in which the federal or state government establishes payment rates for all payers for various categories of health services.

**reference-based drug pricing** — Reference-based pricing limits reimbursement for a group of drugs with similar therapeutic application but different active ingredients to the price of the lowest-cost drug within the group (the reference standard). Patients have the option of purchasing drugs that are partially subsidized, in which case they pay the difference between the retail price and the reference price.

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

**regional home health intermediary (RHHI)** — A fiscal intermediary designated by the Centers for Medicare & Medicaid Services to make payment for covered Medicare services to home health agencies and hospices.

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

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

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

**reinsurance subsidy** — Payments to the prescription drug plans in the amount of 80 percent of drug expenses that exceed the annual out-of-pocket threshold.

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

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

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

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

**risk corridor** — Triggers that are set to protect prescription drug plans from unexpected losses and that allow the government to share in unexpected gains.

**risk selection** — Occurs when a disproportionate share of high or low users of care join a health plan.
**risk sharing** — The distribution of financial risk among parties furnishing a service. For example, if a hospital and a group of physicians form a corporation to provide health care at a fixed price, a risk-sharing arrangement would mean both the hospital and the group would have to assume a share of the loss if expenses exceed revenues.

**risk corridor** — Triggers that are set to protect prescription drug plans from unexpected losses and that allow the government to share in unexpected gains.

**rural health clinic (RHC)** — A for profit or nonprofit, public or private clinic located in a rural medically underserved area or health professional shortage area that uses physician assistants and/or nurse practitioners to provide a majority of care. A rural health clinic must be licensed by the state and provide primary care services. RHCs receive cost-based Medicaid and Medicare reimbursement within federally established payment caps.

**Rural Health Clinics Act** — Established a reimbursement mechanism to support the provision of primary care services in rural areas. It authorizes the expanded use of physician assistants and nurse practitioners and provides for cost-based Medicare and Medicaid reimbursement within federally established payment caps.

**Ryan White CARE Act** — Through the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act, health care and support services are provided for persons living with HIV/AIDS.

**safety net** — The network of providers and institutions that provide low-cost or free medical care to medically needy, low-income, or uninsured populations. The health care safety net can include individual practitioners, public and private hospitals, academic medical centers, and smaller clinics or ambulatory care facilities.

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

**secondary payer** — An insurer obligated to pay losses above or beyond losses that are assumed by a primary payer.
Section 1115 Medicaid waiver — Section 1115 of the Social Security Act authorizes demonstration waivers that 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. See HIFA.

Section 1915(b) Medicaid waiver — Section 1915(b) waivers allow states to require Medicaid recipients to enroll in health maintenance organizations 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.”

Section 1915(c) Medicaid waiver — This waiver authority enables states to provide home and community-based services (other than room and board) not usually covered by the Medicaid program, as long as these services are required to keep a person from being institutionalized. Services covered under waiver programs may include: case management, homemaker, home health aide, personal care, adult day health, habilitation, respite care, and “day treatment or other partial hospitalization services, psychosocial rehabilitation services, and clinic services (whether or not furnished in a facility) for individuals with chronic mental illness.”

selective serotonin reuptake inhibitor (SSRI) — A class of antidepressant medications. SSRIs can also be used to treat panic disorder, obsessive-compulsive behavior, alcoholism, obesity, and bulimia. Common SSRIs include Prozac, Paxil, and Zoloft.

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

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

**specialist** — A physician, dentist, or other health professional who is specially trained in a certain branch of medicine or dentistry related to specific services or procedures (for example, surgery, radiology, pathology), certain age categories of patients (for example, geriatrics), certain body systems (for example, dermatology, orthopedics, cardiology), or certain types of diseases (for example, allergy, periodontics).

**specified low-income Medicare beneficiary (SLMB)** — The SLMB program pays for the Medicare Part B premium for beneficiaries with incomes between 100 and 120 percent of the federal poverty level.

**spend down** — The concept of “spending down” to Medicaid eligibility often refers to elderly individuals who are in nursing facilities, assisted living, or other community-based settings who have high medical or prescription drug expenses. It is the process of depleting one’s income and assets to reach a level low enough to qualify for Medicaid. See medically needy.

**Social Security Act** — Public Law 74-271, enacted on August 14, 1935, with subsequent amendments. The Social Security Act consists of 20 titles, four of which have been repealed. The HI and SMI trust funds are authorized by Title XVIII of the Social Security Act.

**Social Security Insurance (SSI) disability** — For individuals age 18 and older, the law defines disability as the inability to engage in any substantial gainful activity as a result of any medically determinable physical or mental impairment(s) which can be expected to result in death or has already lasted or can be expected to last for a continuous period of not less than 12 months.

**standard prescription drug coverage** — Prescription drug coverage that includes a deductible, coinsurance up to an initial coverage limit, and protection against high out-of-pocket expenditures by having reduced coinsurance provisions for individuals exceeding the out-of-pocket threshold.

**State Children’s Health Insurance Program (SCHIP)** — This program was enacted as part of the Balanced Budget Act of 1997, which established Title XXI of the Social Security Act to provide states with $39 billion in federal “enhanced matching” funds over ten years targeting uninsured children in families with incomes up to 200 percent of the...
federal poverty level. States can expand the existing Medicaid program, create a separate State Children's Health Insurance Program, or use a combination of the two approaches.

**State Medicaid plan** — Until Title XIX of the Social Security Act, no federal Medicaid funds are available to a state unless it has submitted to the Secretary of HHS, and the Secretary has approved, its state Medicaid plan (and all amendments to the state plan.) The state Medicaid plan must meet 64 federal statutory requirements.

**State Plan Amendment (SPA)** — A state that wishes to change its Medicaid eligibility criteria or its covered benefits or its provider reimbursement rates must amend its state Medicaid plan to reflect the proposed change. Similarly, states must conform their state plans to changes in federal Medicaid law. In either case, the state must submit an SPA to CMS for approval.

**Statewideness** — The requirement that states electing to participate in Medicaid must operate their programs throughout the state and may not exclude individuals residing in, or providers operating in, particular counties or municipalities. This requirement may be waived under section 1115, 1915(b), and 1915 (c) waivers.

**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. All individuals eligible for SSI are eligible for Medicaid.

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

**Technology assessment** — In health policy, the term has come to mean any form of policy analysis concerned with medical technology, especially the evaluation of efficacy and safety.

**Temporary Assistance for Needy Families (TANF)** — Title I of the Personal Responsibility and Work Opportunity Act of 1996 converted
federal funding under the former Aid to Families with Dependent Children program to a state block grant program called TANF.

**tertiary care** — Services provided by highly specialized providers (for example, neurologists, neurosurgeons, thoracic surgeons, intensive care units). Such services frequently require highly sophisticated equipment and support facilities.

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

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

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

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

**Title XXI (SCHIP)** — The title of the Social Security Act which contains the principal legislative authority for the State Children’s Health Insurance Program.

**transitional medical assistance** — Refers to Medicaid coverage for families and children leaving welfare to become self-supporting through work. States are required to continue Medicaid benefits to families who lose their cash assistance due to an increase in earnings. The transitional coverage extends for up to 12 months as long as the family continues to report earnings.
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 bills.

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

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

uninsured — Individuals who lack any form of private or public health insurance coverage.

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

upper payment limit (UPL) — To ensure reasonable payments to Medicaid providers, the Centers for Medicare & Medicaid Services established a set of upper limits on what it would agree to pay for a variety of services. The UPLs are based on what Medicare would pay for comparable services. Because state Medicaid payment rates are generally less than Medicare rates, states often have gaps between their actual Medicaid payments and what they would be paid under Medicare.

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

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

**utilization review** — Evaluation of the necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities. In a hospital, this includes review of the appropriateness of admissions, services ordered and provided, length of a stay, and discharge practices, both on a concurrent and retrospective basis.

[ V ]

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