AHLA's Health Care Law and Policy Acronyms and Terms

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AMERICAN
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ASSOCIATION

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Editors' Note

I wish I could say that the concept for this publication was entirely original. However, more than 25 years ago I sat in a lecture hall at an orientation to begin my Master of Public Health program and was given a photocopied packet of health care acronyms and terms. As the packets were being handed out, the speaker said something to the effect of, "If you leave this program without a fundamental understanding of what's in that packet, this school has done something wrong." I lost the packet years ago, but the value of what was in it has never been lost on me.

Our health care industry or system, however you want to label it, is one of the most regulated in the country. It is also grounded in science. As a result, it is steeped in its own specific jargon or language. There are thousands of acronyms and terms that have come and gone in health care. This publication is an effort to bring them together in a comprehensive resource that I hope remakes, enhances, and brings forward to the present that packet I was given so many years ago. Most importantly, I hope this publication serves as a comprehensive resource for everyone who engages with health law and policy.

I also have to acknowledge that I had some incredible resources to bring this publication together. First, I had a team of amazing Content Editors—Anthony Baker, Giselle Lai and Kat Underwood—who helped get a good deal of information onto these pages. Second, I worked with the AHLA publications staff, Rob Anderson, Kara Kinney Cartwright, and Steffan Welch, and AHLA externs, Kristen Dagher, Lis Del Valle, Kayli Chovanec, and Wei Wei, who saved an incredible amount of time by pulling information from AHLA resources so that we were not starting entirely from scratch. They also worked on editing and cleaning up the publication so that we could get it from draft to final form.

Prior to closing, I also have to acknowledge the amazing support and resources I received from Venable LLP. Without its support, I would not have been able to get this done. Most importantly, this is the 7th major publication I have authored or edited during my career and it's probably the one I am most proud of. In addition to the time I've spent as a practicing health lawyer and teaching, I've given a lot of time to writing on health law and policy topics. My family—Lara, Ian and Bennett—have persevered through the extra time I've put into writing, and I can't thank them enough for enduring it all.

Ari J. Markenson
Editor in Chief

About the Editor in Chief

Ari J. Markenson, J.D., M.P.H. is currently a partner in the health care and corporate groups at Venable LLP in its New York office. His legal and academic career sits at the intersection of health care, law, and business.

Ari advises health care industry clients, including investors, lenders, providers, and suppliers, on a broad range of regulatory and corporate matters, and has significant experience conducting due diligence in complex health care industry acquisitions and financial transactions. He regularly represents private equity firms and lenders in such transactions and evaluates and advises on compliance and regulatory issues with regard to sellers and potential borrowers from banks and financing sources. He also advises various health care entities on regulatory matters, including conditions for participation; fraud and abuse; and survey, certification, licensure, and enforcement issues.

Ari is a current member of the Board of the American Health Law Association (AHLA), has written articles and publications for AHLA, spoken at many AHLA programs, and held various leadership roles in his 20-plus year membership with AHLA. He is a former Chair of the New York State Bar Association–Health Law Section.

Ari frequently writes for industry publications and speaks at industry and professional events. He also teaches health care law, public health law, health care lawyering skills and other health care management and policy topics at the Columbia University Mailman School of Public Health, the Pace University College of Health Professions Department of Health Sciences, and the Elisabeth Haub School of Law at Pace University. He has also taught at The School of Health Sciences and Practice at New York Medical College, the Graduate School at the University of Maryland Global Campus, and Brooklyn Law School.

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About the American Health Law Association

Excellence in health care starts with excellence in health law. The American Health Law Association (AHLA) is the nation's largest, nonpartisan, 501(c)(3) educational organization devoted to legal issues in the health care field. AHLA maintains excellence in health law by educating and connecting the health law community.

With a diverse membership of over 12,000 health law professionals, representing the entire spectrum of the health care industry, AHLA is able to leverage the deep expertise of practitioners to produce high-quality, just-in-time educational resources that help members of the health law community provide analysis, assess risk, ensure compliance, and make informed recommendations to their organizations and clients. AHLA's trusted resources benefit anyone who advises physicians, hospitals, health systems, specialty providers, payers, life sciences companies, vendors, investors, and many other health care stakeholders.

If you have an interest in health law, you have a home in AHLA. For more information about our educational, professional development, and networking opportunities, please visit us at americanhealthlaw.org

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TABLE OF ACRONYMS

A	
AHC	Academic Health Center
AMC	Academic Medical Center
APP	Academic-Practice Partnership
ACE	Accelerated-compensation event
ACO	Accountable Care Organization
ACGME	Accreditation Council for Graduate Medical Education
ADL	Activities of Daily Living
AAPCC	Adjusted Average Per Capita Cost
ALJ	Administrative Law Judge
ASO	Administrative Services Organization
ADT	Admission, Discharge, and Transfer
ACF	Adult Care Facility
ADHC	Adult Day Health Care
APS	Adult Protective Services
ABN	Advance Beneficiary Notice
APM	Advanced Alternative Payment Model
ACLS	Advanced Cardiac Life Support
ALS	Advanced Life Support
APC	Advanced Primary Care
ADE	Adverse Drug Event
ACIP	Advisory Committee on Immunization Practices
ACA	Affordable Care Act of 2010
AMA	Against Medical Advice
AHRQ	Agency for Healthcare Research and Quality
AFDC	Aid to Families with Dependent Children
ADAP	AIDS Drug Assistance Program
APR-DRGs	All Patient Refined Diagnosis Related Groups
AHP	Allied Health Professional
ALC	Alternate Level of Care
ARMS	Alternative Rate Methodology System
ADG	Ambulatory Diagnostic Group
APG	Ambulatory Patient Group
APC	Ambulatory Payment Classification
ASC	Ambulatory Surgery Center
ASU	Ambulatory Surgery Unit
AVG	Ambulatory Visit Group
AHIP	America's Health Insurance Plans
AAHPM	American Academy of Hospice and Palliative Medicine
AAP	American Academy of Pediatrics
AAPL	American Association for Physician Leadership
AAHSA	American Association of Homes and Services for the Aging
ACHE	American College of Healthcare Executives
ACOG	American College of Obstetricians and Gynecologists
AHCA	American Health Care Association
AHIMA	American Health Information Management Association
AHLA	American Health Law Association
AHA	American Hospital Association

AMA	American Medical Association
ARRA	American Recovery and Reinvestment Act of 2009
ASCO	American Society of Clinical Oncology
AKS	Anti-Kickback Statute
AR	Appropriateness Review
AHEC	Area Health Education Center
AI	Artificial Intelligence
ACT	Assertive Community Treatment
ARD	Assessment Reference Date
ASPR	Assistant Secretary for Preparedness and Response
ALF	Assisted Living Facility
ALP	Assisted Living Program
ALR	Assisted Living Residence
AAMC	Association of American Medical Colleges
AWHONN	Association of Women's Health, Obstetric, and Neonatal Nurses
AICD	Automatic Implantable Cardioverter Defibrillator
ALOS	Average Length of Stay
AMP	Average Manufacturer Price
ASP	Average Sale Price
AWP	Average Wholesale Price
APA	The Administrative Procedures Act
ADA	The Americans with Disabilities Act of 1990
340B	340B Drug Discount Program
B	
BSN	Bachelor of Science in Nursing
BD	Bad debt
BBA	Balanced Budget Act of 1997
BBRA	Balanced Budget Refinement Act of 1999
BIP	Balancing Incentive Payments Program
BHP	Basic Health Program
BLS	Basic Life Support
BOE	Basis of Eligibility
BHO	Behavioral Health Organization
BRFSS	Behavioral Risk Factor Surveillance System
BENDEX	Beneficiary & Earnings Data Exchange
BEER	Beneficiary Earnings Exchange Record
BERT	Beneficiary Enrollment Retrieval System
BP	Benefit Period
BSF	Benefit Stabilization Fund
BIPA	Benefits Improvement and Protection Act of 2000
BP	Best Price
BHIE	Bi-directional Health Information Exchange
B&C	Billings and Collections
BRDPI	Biomedical Research & Development Price Index
BIPA	Biometric Information Privacy Act of 2008
BSV	Biosurveillance
BCBSA	BlueCross BlueShield Association
BCBS	BlueCross/BlueShield
BLUES	

B&C	Board and Care
BPCI	Bundled Payments for Care Improvement Initiative
BIA	Bureau of Indian Affairs
BLS	Bureau of Labor Statistics
BESS	Part B Extract & Summary System
C	
CMI	Case Mix Index
CMG	Case-Mix Group
CHA	Catholic Health Association
CDRH	Center for Devices and Radiological Health
CMMI	Center for Medicare and Medicaid Innovation
CDC	Centers for Disease Control and Prevention
CMS	Centers for Medicare and Medicaid Services
COA	Certificate of Authority
CON	Certificate of Need
CASPER	Certification and Survey Provider Enhanced Reporting (or Reports)
CCHIT	Certification Commission for Health Information Technology
CDCES	Certified Diabetes Care and Education Specialist
CDE	Certified Diabetes Educator
CNA	Certified Nurse Aide
CPHQ	Certified Professional in Health Care Quality
CRPA	Certified Recovery Peer Advocate
CRNA	Certified Registered Nurse Anesthetist
CDM	Charge Description Master
CIO	Chief Information Officer
CMIO	Chief Medical Information Officer
CMO	Chief Medical Officer
CNIO	Chief Nursing Information Officer
CNO	Chief Nursing Officer
CHIP	Children's Health Insurance Program
CMPL	Civil Monetary Penalties Law of 1981
CMP	Civil Monetary Penalty
CHAMPVA	Civilian Health and Medical Program of the Veteran's Administration
CDAC	Clinical Data Abstraction Center
CLIA	Clinical Laboratory Improvement Amendments of 1988
CQM	Clinical Quality Measure
CCN	CMS Certification Number
CFR	Code of Federal Regulations
CPT	Coding
CHIME	College of Healthcare Information Management Executives
CARF	Commission on Accreditation of Rehabilitation Facilities
CHAP	Community Health Accreditation Program
CHNA	Community Health Needs Assessment
CER	Comparative Clinical Effectiveness Research
CMP	Competitive Medical Plan
CAMH	Comprehensive Accreditation Manual for Hospitals
CJR	Comprehensive Care for Joint Replacement
CERT	Comprehensive Error Rate Testing
CPOE	Computerized Provider Order Entry

CMHA	Conference of Metropolitan & Regional Hospital Associations
CBO	Congressional Budget Office
COBRA	Consolidated Omnibus Budget Reconciliation Act of 1985
CCRC	Continuing Care Retirement Community
CME	Continuing Medical Education
CQI	Continuous Quality Improvement
CHSO	Cooperative Hospital Service Organizations
COB	Coordination of Benefits
CARES Act	Coronavirus Aid, Relief, and Economic Security Act
CIA	Corporate Integrity Agreement
CCI	Correct Coding Initiative
CRY	Cost Reporting Year
CCR	Cost-to-Charge Ratio
COGME	Council on Graduate Medical Education
CASAC	Credentialed Alcoholism and Substance Abuse Counselor
CVO	Credentialing verification organization
CVS	Credentials Verification Service
CAH	Critical Access Hospital
CPT	Current Procedural Terminology
CGFNS	The Commission on Graduates of Foreign Nursing Schools
D	
DEIP	Data exchange incentive program
DPT	Days per thousand
DVT	Deep Vein Thrombosis
DRA	Deficit Reduction Act of 2005
DSRIP	Delivery System Reform Incentive Payment
DMO	Dental Health maintenance organization
DAB	Department of Appeals Board
DFS	Department of Financial Services
DOH	Department of Health
DHHS	Department of Health and Human Services
DOJ	Department of Justice
DOL	Department of Labor
DOT	Department of Treasury
DHS	Designated Health Services
DSME	Diabetes Self-Management Education
DRGs	Diagnosis Related Groups
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders, fourth edition
DICOM	Digital Imaging and Communication in Medicine
DME	Direct Medical Education
DBL	Disability Benefits Law
DAMA	Discharge Against Medical Advice
DAW	Dispense as Written
DSH	Disproportionate Share Hospital
DOB	Division of the Budget
DNR	Do-Not-Resuscitate Order
DO	Doctor of Osteopathic Medicine
DANY	Doctors across New York
DUR	Drug Utilization Review

DCI	duplicate coverage inquiry
DME	durable medical equipment
E	
EIP	early intervention program
EOC	effectiveness of care
ECQM	Electronic Clinical Quality Measures
EDI	electronic data interchange
EHR	electronic health record
EMR	electronic medical record
ED	emergency department
EMS	emergency medical services
EMT	emergency medical technician
EMTALA	emergency medical treatment and labor act of 1986
ER	emergency room
EAP	employee assistance program
EHS	employee health services
ERISA	employee retirement income security act of 1974
EAPG	enhanced ambulatory patient group
EPC	enhanced primary care
EPM	episode payment model
E/M	Evaluation and Management
EPO	exclusive provider organization
EOB	explanation of benefits
ECF	extended care facility
EPSDT	the early and periodic screening, diagnostic and treatment
F	
FPP	faculty practice plan
FMV	fair market value
FCA	false claims act
FCHCO	federal coordinated health care office
FEMA	Federal Emergency Management Agency
FEHBARS	Federal Employee Health Benefit Acquisition Regulations
FEHB	Federal Employee Health Benefits Program
FFP	Federal Financial Participation
FHA	Federal Housing Administration
FICA	Federal Insurance Contributions Act
FMAP	federal medical assistance percentage
FPL	federal poverty level
FQHC	federally qualified health center
FAH	Federation of American hospitals
FSMB	Federation of State Medical Boards
FFS	Fee-For-Service
FACHE	Fellow of the American College of Healthcare Executives
FHFMA	Fellow of the Healthcare Financial Management Association
FI	Fiscal Intermediary
FY	fiscal year
FDA	food and drug administration
FMG	foreign medical graduate
FASC	freestanding ambulatory surgery center

FSED	Freestanding Emergency Department
FERA	The Fraud Enforcement and Recovery Act of 2009
G	
GSA	general services administration
GAF	Geographic Adjustment Factor
GPCI	Geographic Practice Cost Index
GMLOS	Geometric Mean Length of Stay
GME	Graduate Medical Education
GPWW	Group Practice Without Walls
GPO	Group Purchasing Organization
GAO	U.S. Government Accountability Office
H	
HCEARA	Health Care and Education Affordability Reconciliation Act of 2010
HCFA	Health Care Financing Administration
HCFAC	Health Care Fraud and Abuse Control Program
HCQIP	Health Care Quality Improvement Program
HIE	Health Information Exchange
HIM	Health Information Management
HIMSS	Health Information Management System Society
HISP	Health Information Service Provider
HIT	Health Information Technology
HITECH	Health Information Technology for Economic and Clinical Health Act
HIAA	Health Insurance Association of America
HIPAA	Health Insurance Portability and Accountability Act of 1996
HMO	Health Maintenance Organization
HEDIS	health plan employer data and information set
HPSA	Health Professional Shortage Area
HRA	Health Reimbursement Arrangement
HRSA	Health Resources and Services Administration
HSA	Health Savings Account
HCPCS	Healthcare Common Procedure Coding System
HFAP	Healthcare Facilities Accreditation Program
HFMA	Healthcare Financial Management Association
HFPP	Healthcare Fraud Prevention Partnership
HIPDB	Healthcare Integrity and Protection Data Bank
HAC	Healthcare-Acquired Condition
HAI	Healthcare-Acquired Infection
HDHP	High Deductible Health Plan
HHA	home health agency
HHVBP	Home Health Value-Based Purchasing Model
HPNA	Hospice and Palliative Nurses Association
HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems
HIQRP	Hospital Inpatient Quality Reporting Program
HOPD	Hospital Outpatient Department
HOP QDRP	Hospital Outpatient Quality Data Reporting Program
HQA	Hospital Quality Alliance
HQI	Hospital Quality Initiative
HRET	Hospital Research and Educational Trust
HSRV	Hospital-Specific Relative Value

HPPD	Hours Per Patient Day
HUD	U.S. Department for Housing and Urban Development
HHS	U.S. Department of Health and Human Services
I	
IBNR	Incurred But Not Reported
ICD	Internation Classification of Disease
ICF	Intermediate Care Facility
ICM	Intensive Case Management
ICR	Institutional Cost Report
ICU	Intensive Care Unit
IDN	Integrated Delivery Network
IDS	Integrated Delivery System
IGT	Intergovernmental Transfer
IHI	Institute for Healthcare Improvement
IHO	Integrated Health Care Organization
IME	Indirect Medical Education
IMG	International Medical Graduate
IMPACT Act	Improving Medicare Post-Acute Care Transformation Act of 2014
IMS	Indicator Measurement System
INS	Infusion Nurses Society
IOM	Institute of Medicine
IPAB	Independent Payment Advisory Board
IPA	Individual Practice Association
IPF	Inpatient Psychiatric Facility
IPPS	Inpatient Prospective Payment System
IPS	Interim Payment System
IQR	Inpatient Quality Reporting
IRB	Institutional Review Board
IRF-PAI	Inpatient Rehabilitation Facility-Patient Assessment Instrument
IRF	Inpatient Rehabilitation Facility
IRO	Independent Review Organization
ISMP	Institute for Safe Medication Practices
J	
JCR	Joint Commission Resources
JOA	Joint-Operating Agreement/ Arrangement
JOC	Joint Operating Company
JCAHO	The Joint Commission on the Accreditation of Healthcare Organizations
L	
LA	leading age
LOS	length of stay
LPN	licensed practical nurse
LVN	licensed vocational nurse
LCAH	life care at home
LCD	local coverage determination
LTCH	long term care hospital
LTC	long-term care
LTD	long-term disability
LWDII	Lost Work Day Injury and Illness
LUPA	low utilization payment adjustment

LVA	low volume adjustment
LVH	low volume hospital
M	
MA	Medicare Advantage Plan
MAC	Medicare Administration Contractor
MACRA	Medicare Access and CHIP Reauthorization Act of 2015
MA	Medical Assistance
MAR	Medication Administration Record
MAT	Medication-assisted Treatment
MCC	Major Complication or Comorbidity
MCE	Medical Care Evaluation
MCO	Managed Care Organization
MD-VIPER	Medical Device Vulnerability Intelligence Program for Evaluation and Response
MD	Doctor of Medicine
MDH	Medicare Dependent Hospital
MDISS	Medical Device Innovation, Safety & Security Consortium
MDS	Minimum Data Set
MEC	Minimum Essential Coverage
MedPAC	Medicare Payment Advisory Commission
MedPAR	Medicare Provider Analysis and Review
MET	Multiple Employer Trust
MEWA	Multiple Employer Welfare Association
MFCU	Medicaid Fraud Control Unit
MGCRB	Medicare Geographic Classification Review Board
MHPAEA	Mental Health Parity and Addiction Equity Act
MIC	Medicaid Integrity Contractor
MIP	Managed Indemnity Plan
MIPPA	Medicare Improvements for Patients and Providers Act of 2008
MIPS	Merit-based Incentive Payment System
MIS	Management Information System (or Service)
MLR	Medical Loss Ratio
MMA	Medicare Modernization Act of 2003
MMIS	Medicaid Management Information System
MMPPPA	Medicare and Medicaid Patient and Program Protection Act
MMSEA	Medicare, Medicaid, and SCHIP Extension Act of 2007
MMT	Methadone Maintenance Treatment
MMWR	Morbidity and Mortality Weekly Report
MOLST	Medical Orders for Life-Sustaining Treatment
MOU	Memorandum of Understanding
MPFS	Medicare Physician Fee Schedule
MQSA	Mammogram Quality Standards Act of 1992
MS-DRG	Medicare Severity Diagnosis Related Group
MSA	Management Services Agreement
MSA	Medical Savings Account
MSA	Metropolitan Statistical Area
MSO	Management Services Organization
MSSP	Medicare Shared Savings Program
MUA	Medically Under-Served Area

N	
NICHD	Eunice Kennedy Shriver National Institute of Child Health and Human Development
NAM	National Academy of Medicine
NAHC	National Association for Home Care and Hospice
NACHRI	National Association of Children's Hospitals and Related Institutions
NAIC	National Association of Insurance Commissioners
NAB	National Association of Long-Term Care Administrator Boards
NBCCEDP	National Breast and Cervical Cancer Early Detection Program
NCI	National Cancer Institute
NCATS	National Center for Advancing Translational Sciences
NCAL	National Center for Assisted Living
NCCIH	National Center for Complementary and Integrative Health
NCHS	National Center for Health Statistics
NCCS	National Coalition for Cancer Survivorship
NCQA	National Committee for Quality Assurance
NCCN	National Comprehensive Cancer Network
NCERS	National Continuing Education Review Service
NCLEX-RN	National Council Licensure Examination-Registered Nurse
NCLEX-PN	National Council Licensure Examination-Practical Nurse
NCI	National Council of ISACs
NCSBN	National Council of State Boards of Nursing, Inc
NCD	National Coverage Determinations
NDNQI	National Database of Nursing Quality Indicators
NDC	National Drug Code
NGS	National Government Services
NH-ISAC	National Health Information Sharing and Analysis Center
NHSN	National Healthcare Safety Network
NHLB	National Heart, Lung, and Blood Institute
NHGRI	National Human Genome Research Institute
NIOSH	National Institute for Occupational Safety and Health
NIAID	National Institute of Allergy and Infectious Diseases
NIAMS	National Institute of Arthritis and Musculoskeletal and Skin Diseases
NIBIB	National Institute of Biomedical Imaging and Bioengineering
NIDCR	National Institute of Dental and Craniofacial Research
NIDDK	National Institute of Diabetes and Digestive and Kidney Diseases
NIEHS	National Institute of Environmental Health Sciences
NIGMS	National Institute of General Medical Sciences
NIMH	National Institute of Mental Health
NINDS	National Institute of Neurological Disorders and Stroke
NINR	National Institute of Nursing Research
NIA	National Institute on Aging
NIAAA	National Institute on Alcohol Abuse and Alcoholism
NIDCD	National Institute on Deafness and Other Communication Disorders
NIDA	National Institute on Drug Abuse
NIMH	National Institute on Minority Health and Health Disparities
NIH	National Institutes of Health
NLRA	National Labor Relations Act
NLRB	National Labor Relations Board

NLM	National Library of Medicine
NPDB	National Practitioner Data Bank
NPI	National Provider Identifier
NQF	National Quality Forum
NSC	National Safety Council
NIH-CC	NIH Clinical Center
Nonpar	Non-Participating
NP	Nurse Practitioner
NHQI	Nursing Home Quality Initiative
NEI	The National Eye Institute
O	
OSHA	Occupational Safety and Health Administration
OAT	Office for Advancement of Telehealth
OCR	Office for Civil Rights
OAS	Office of Audit Services
OEI	Office of Evaluations and Inspections
OIG	Office of Inspector General
OI	Office of Investigations
OMB	Office of Management and Budget
OPM	Office of Personnel Management
ORHP	Office of Rural Health Policy
ONC	Office of the National Coordinator for Health Information Technology
SDP	OIG Provider Self-Disclosure Protocol
OBRA	Omnibus Budget Reconciliation Act
OR	Operating Room
OTP	Opioid Treatment Program
OUD	Opioid Use Disorder
OPO	Organ Procurement Organization
OON	out-of-network
OASIS	Outcome and Assessment Information Set
OBQI	Outcome-Based Quality Improvement
OPD	outpatient department
OPPS	Outpatient Prospective Payment System
OQR	Outpatient Quality Reporting Program
P	
P4P	Pay for Performance
PAC-PRD	Post-Acute Care Payment Reform Demonstration
PACE	Program of All-Inclusive Care for the Elderly
PA	Physician's Assistant
PASARR	Pre-Admission Screening and Annual Resident Review
PBD	Provider-Based Department
PBM	Pharmacy Benefit Manager
PCA	Personal Care Assistant
PCCM	Primary Care Case Manager
PCF	Primary Care First
PCMH	Patient-Centered Medical Home
PC	Personal Care
PCP	Primary Care Physician
PCS	Personal Care Services

PDMP	Prescription Drug Monitoring Program
PDSA	Plan-Do-Study-Act
PEL	Permissible Exposure Limits
PERS	Personal Emergency Response System
PhRMA	Pharmaceutical Research and Manufacturers of America
PHI	Protected Health Information
PHO	Physician Hospital Organization
PHP	Partial Hospitalization Program
PHSP	Prepaid Health Service Plan
PHS	Public Health Service
PIA	Personal and Incidental Allowance
PIP	Periodic Interim Payment
PMG	Primary Medical Group
PMPM	Per Member Per Month
PMPY	Per Member Per Year
POLST	Physicians Orders for Life-Sustaining Treatment
POS	Point-of-Service
PPE	Personal Protective Equipment
PPM	Physician Practice Management Company
PPO	Preferred Provider Organization
PPPCH	Paycheck Protection Program and Health Care Enhancement Act
PPR	Potentially Preventable Readmission
PPS	Prospective Payment System
PRF	Provider Relief Fund
PRI	Patient Review Instrument
PRM	Provider Reimbursement Manual
PRO	Peer Review Organization
PRRB	Provider Reimbursement Review Board
PSA	Professional Services Agreement
PS&R	Provider Statistical and Reimbursement Report
PSI	Patient Safety Indicator
PSN	Provider Sponsored Network
PSO	Provider-Sponsored Organization
PSRO	Professional Standards Review Organization
PTMPY	Per Thousand Members Per Year
Q	
QAPI	Quality Assurance and Performance Improvement
QA	Quality Assurance
QIES	Quality Improvement and Evaluation System
QIO	Quality Improvement Organization
QM	Quality Management
R	
R&C	Reasonable and Customary Charges
RAC	Recovery Audit Contractor
RAI	Resident Assessment Instrument
RAP	Resident Assessment Protocol
RBRVS	Resource-Based Relative Value Scale
RCC	Reasonable and Customary Charge
RCF	Residential Care Facility

RHC	Rural Health Clinic
RHIO	Regional Health Information Organization
RVS	Relative Value Study
RRP	Readmissions Reduction Program
S	
SAE	Serious Adverse Event
SCHIP	The State Children's Health Insurance Program
SCP	Specialty Care Physician
SHSMD	Society for Healthcare Strategy and Market Development
SIW	Service Intensity Weight
SMG	Specialty Medical Group
SNF	Skilled Nursing Facility
SNP	Special Needs Plan
SPD	Summary Plan Description
SSA	Social Security Administration
SSI	Supplemental Security Income
SUD	Substance Use Disorder
T	
TANF	Temporary Assistance for Needy Families Tax Credit
TCPI	Transforming Clinical Practices Initiative
TCU	Transitional Care Unit
TDD	Telecommunications Device for the Deaf
TEFRA	Tax Equity Fiscal Responsibility Act of 1982
TJC	The Joint Commission
TPA	Third-Party Administrator
TPE	Targeted Probe and Educate
TPL	Third-Party Liability
TQI	Total Quality Improvement
TrOOP	True Out of Pocket
U	
UCC	Uncompensated Care
UCDS	Uniform Clinical Data Set
UCR	Usual, Customary, and Reasonable Fees
UDS	Universal Data System
UHDDS	Uniform Hospital Discharge Data Set
UM	Utilization Management
UM/UR	Utilization Management/Utilization Review
UPPL	Uniform Policy Provisions Law
UR	Utilization Review
URO	Utilization Review Organization
V	
VBP	Value-Based Payment
VBP	Value-Based Purchasing
VHA	VHA, Inc. F/k/a Voluntary Hospitals of America
VNA	Visiting Nurses Association
W	
WCB	Workers' Compensation Board
WIC	Supplemental Nutrition Program for Women, Infants, and Children

Z	
ZPIC	Zone Program Integrity Contractor

Health Care Law and Policy Terms

A

Abuse Abuse (distinguished from patient abuse) is a practice or practices that may directly or indirectly result in unnecessary costs to federal health care programs. It includes any practice that does not provide patients with medically necessary services or meet professionally recognized standards of care. Abuse can also be identified as fraud.

Academic Health Center *or* **AHC** *See* **Academic Medical Center** *or* **AMC**

Academic Medical Center *or* **AMC** Academic Medical Center is a designation often used by government agencies to refer to an institution that includes a school of medicine, a teaching hospital, and at least one additional health education school (e.g., nursing), and that is owned or affiliated with clinical agencies providing for the delivery of patient services. *Also known as* an **Academic Health Center** *or* **AHC**.

Academic-Practice Partnership *or* **APP** Formal and strategic relationship between an educational program and a clinical practice setting established to advance their mutual interests related to practice, education, and research. APPs often create systems for clinicians to achieve educational and career advancement, prepare clinicians for the future to practice and lead, provide mechanisms for lifelong learning, and provide a structure for residency programs.

Accelerated Benefits Option A type of life insurance provision under which terminally ill policyholders with life expectancies of less than a year or who are confined to a nursing home can choose to have a portion of life insurance proceeds paid out before death to use as they deem appropriate.

Accelerated-Compensation Event *or* **ACE** These are medically induced injuries that should not occur. ACEs do not cover all injuries, just certain classes of adverse outcomes that are usually, although not invariably, avoidable through good medical care.

Access The ability to obtain needed health care. Barriers to access can be financial, geographic, organizational and sociological. Efforts to improve access often focus on providing/improving health coverage.

Accessibility In the context of the ADA, it is the requirement of the removal of barriers that would hinder a person with a disability from entering, functioning, and working within a particular building or facility. Additionally, in the context of access to health care, it is the ability to obtain health care services such as prevention, diagnosis, treatment, and management of diseases, illness, disorders, and other health-impacting conditions. *Also referred to as* **Accessibility of Services, Accessibility of Healthcare** *or* **Accessibility of Healthcare Servic**es.

Accountable Care Organization *or* **ACO** A network or organization of health care providers that offer a complete coordinated continuum of health care services for patients. The ACO receives payment for all care provided to a patient and is held accountable for the quality and cost of care provided. The ACA provides financial incentives for these organizations to improve quality and reduce costs by allowing them to share in any savings realized as a result of these efforts. The goal of an ACO is to ensure that patients receive the proper care at the right time, while avoiding unnecessary duplication of services and preventing medical errors.

Accreditation Granting of approval or credentials to an agency or facility, based on that agency or facility demonstrating that the standards prescribed by the accrediting body have been met. This is typically demonstrated by passing a specific survey or inspection.

Accreditation Commission for Healthcare, Inc. *or* **ACHC** A private non-profit organization that sets accreditation standards for many types of health care providers and has Medicare deeming authority in certain provider areas. It inspects and accredits the providers it has established standards for.

Accreditation Council for Graduate Medical Education *or* **ACGME** A private non-profit organization that sets standards for United States (U.S.) graduate medical education (residency and fellowship) programs and the institutions that sponsor them as well as renders accreditation decisions based on the promulgated standards.

Accrete A term used by CMS for the process of adding new Medicare enrollees to a plan.

Accrual The amount of money that is set aside to cover expenses. The accrual is a health plan's best estimate of what

those expenses are and (for medical expenses) is based on a combination of data from the plan's authorization system, claims system, lag studies and the plan's claims history.

Activities of Daily Living *or* **ADL** ADLs are activities related to personal care such as bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet, and eating.

Actuarial Assumptions The assumptions that an actuary uses in calculating the expected costs and revenues of a health plan. Examples include utilization rates, age and sex mix of enrollees and cost of medical services.

Actuarial Value A measure of the average value of benefits in a health plan. It is a calculated percentage of benefit costs a health plan expects to pay for a standard population, using standard assumptions and taking into account cost-sharing provisions. It represents an average for a population and does not necessarily represent the actual cost-sharing of an individual.

Acute Care A type of health care service in which a patient is treated for an immediate and severe episode of illness and generally on a short-term basis. This can include treatment of injuries related to an accident or other trauma, or during recovery from surgery. Acute care is usually given in a hospital by specialized personnel using complex and sophisticated technical equipment and materials.

Adjusted Average Per Capita Cost *or* **AAPCC** The best estimate of the quantity of money it will cost for Medicare recipients under fee-for-service Medicare, as determined by CMS. In computing the AAPCC, CMS uses the U.S. per capita incurred cost and adjusts it by the specified factors to establish an AAPCC for each class of Medicare enrollees.

Administration for Strategic Preparedness and Response *or* **ASPR** An agency within HHS that leads the medical and public health preparedness for, response to, and recovery from disasters and public health emergencies on the federal level. ASPR is responsible for being in front of whatever emergency may come next, whether natural or manmade. The agency is headed by the Assistant Secretary for Preparedness and Response, also referred to as ASPR.

Administrative Law Judge *or* **ALJ** An employee of HHS who presides over administrative hearings involving HHS enforcement matters, including survey and certification matters, terminations and suspensions and civil fraud and abuse administrative hearings. An ALJ's decision is final and binding unless the decision is appealed to the DAB or the DAB grants an extension of time to file an appeal.

The Administrative Procedures Act *or* **APA** Enacted in 1946, the Administrative Procedure Act governs the process by which federal agencies develop and issue regulations. It includes requirements for publishing notices of proposed and final rulemaking in the Federal Register and provides opportunities for the public to comment on notices of proposed rulemaking.

Administrative Services Organization *or* **ASO** An outsourced company that provides several business functions to health care businesses, such as human resources, financial, information technology, billing services and other types of services depending on the customer. *Also referred to as* a **Management Services Organization** or **MSO** *and, in some cases* a **Third-Party Administrator** or **TPA**.

Admission, Discharge, and Transfer *or* **ADT** These are the core administrative functions in health care in-patient settings and in some out-patient surgery settings. The acronym is also used as a reference to a system of patient notifications that are sent when a patient is admitted to a facility, transferred to another facility, or discharged from a facility.

Adult Care Facility *or* **ACF** A widely used term that can be defined differently by specific state law. They are often a type of facility that provides long-term, non-medical residential services to adults who are unable to live independently.

Adult Day Healthcare *or* **ADHC** A program of medically-supervised health care services or social services for adults or children with physical and/or mental impairment. A medical program can include the following: nursing, transportation, leisure activities, physical therapy, speech pathology, nutrition assessment, occupational therapy, medical social services, psychosocial assessment, rehabilitation and socialization, nursing evaluation and treatment, coordination of referrals for outpatient health, and dental services. A social program can be limited to activities, meals and socialization services.

Adult Protective Services *or* **APS** State and/or county agencies tasked with protecting vulnerable adults living in the community from abuse, neglect and/or exploitation. APS agencies investigate complaints and often work with community partners to help vulnerable adults with short-term assistance such as: a place to live, or stay, or home repairs, food, transportation or help with utilities, managing money or legal help, medical care, home health care or mental health services.

AdvaMed Code of Ethics A code of ethics adopted by AdvaMed for its members that primarily relates to its members' relationships with health care professionals. The code is intended to help AdvaMed members make reasonable and appropriate decisions regarding the perception of their interactions with and their actual interactions with health care professionals. *See also* **Advanced Medical Technology Association** *or* **AdvaMed**

Advance Beneficiary Notice *or* **ABN** A Medicare notice, commonly known as the Advance Beneficiary Notice of Noncoverage. It is issued by providers in the Medicare program in situations where Medicare payment is expected to be denied. *Also known as* **Form CMS-R-131**

Advance Directives Written instructions executed by mentally capable adults that pertain to the future medical treatment preferences or values of the party executing the document. These directives take effect only if the patient is mentally incapacitated at the time that specific decisions need to be made.

Advance Premium Tax Credit *or* **APTC** A tax credit you can take in advance to lower your monthly health insurance premium. When an individual applies for coverage in an ACA health insurance exchange they estimate their expected income for the year. If the individual qualifies for a premium tax credit based on the estimate, they can use any amount of the credit in advance to lower their premium.

Advanced Alternative Payment Model *or* **APM** A type of track under CMS' QPP that offers incentives for meeting participation thresholds based on levels of payments or patients. *See* **Quality Payment Program** *or* **QPP**.

Advanced Cardiac Life Support *or* **ACLS** *See* **Advanced Life Support** *or* **ALS.**

Advanced Life Support *or* **ALS** ALS is a set of life-saving protocols and skills that extend beyond BLS in pre-hospital care services and in in-patient facilities. It is used to provide urgent treatment to cardiac emergencies such as cardiac arrest, stroke, myocardial infarction, and other conditions. Services are performed by certain emergency medical technicians with advanced training, paramedics, and other qualified health care professionals.

Advanced Medical Technology Association *or* **AdvaMed** A trade association of medical technology developers, manufacturers and associated business entities focused on medical technology, such as medical devices, diagnostic products and digital health technologies, designed to achieve healthier lives and healthier economies around the world. It has over 400 members in countries including Europe, India, China, Brazil, and Japan.

Advanced Primary Care *or* **APC** APC is a more integrative approach to primary care that builds on the patient-provider relationship with longer appointments and empathetic listening. It's a comprehensive care delivery model that combines primary provider with a patient-support team that can include mental health counselors and wellness coaches.

Adverse Drug Event *or* **ADE** An unexpected or inappropriate occurrence at the time a medicine is used, whether or not it is associated with the administration of the medicine.

Adverse Selection A situation faced by health care insurance providers in which individuals who are sicker are more attracted, than the general population is, to participate in certain coverage plans because of the benefits the plans offer, resulting in unanticipated costs to the insurance provider.

Advisory Committee on Immunization Practices *or* **ACIP** A committee of medical and public health experts who develop recommendations on the use of vaccines in the civilian population of the U.S. The recommendations stand as public health guidance for the safe use of vaccines and related biological products. Recommendations of the committee are made to the Director of the CDC, and if adopted, are published as official CDC/HHS recommendations in MMWR.

Advisory Opinion OIG has the authority to issue advisory opinions in response to written inquiries by parties seeking advice on the application of the Anti-Kickback Statute in response to specific factual situations. A party may seek an advisory opinion to determine whether an actual or proposed arrangement meets a particular safe harbor of the AKS; however, the failure of a party to seek an advisory opinion may not be introduced into evidence to prove that the party intended to violate the provisions of the AKS. Advisory opinions are only binding on the requesting party and HHS because they are based on a specific set of facts and circumstances. OIG sets forth the limitations of the advisory opinion at the outset of the document.

CMS also has the authority to issue advisory opinions in response to written inquiries by parties seeking guidance on how the Stark Law applies to a particular business arrangement. The purpose of the CMS advisory opinion process is to provide meaningful advice on how the Stark Law applies to specific factual situations. Like OIG advisory opinions, CMS advisory opinions are binding only on the requestor(s) and only the particular requestor(s) may rely on an advisory opinion. Because each opinion applies to specific individuals or entities in specific situations, no third parties are bound by, nor may legally rely on, an advisory opinion.

Affordability Exemption An exemption that's needed when applying in an ACA exchange for catastrophic coverage for people 30 years or older whose coverage is unaffordable. Affordability exemptions are one type of exemption that someone can claim to qualify for catastrophic coverage, along with hardship exemptions.

Affordable Care Act of 2010 *or* **ACA** Enacted in 2010, the Act was a comprehensive health care reform law with several goals: (1) to make affordable health insurance available to more people; (2) to expand the Medicaid program; and (3) to support innovative medical care delivery methods designed to lower the costs of health care generally. *Also known as* **The Patient Protection and Affordable Care Act** *or* **PPACA** *or* Obamacare.

Against Medical Advice *or* **AMA** A term used in health care institutions when a patient leaves a hospital or in-patient health care facility against the advice of their physician. *Also known as* **Discharge Against Medical Advice** *or* **DAMA**.

Agency for Healthcare Research and Quality *or* **AHRQ** An agency within HHS responsible for improving the safety and quality of health care for all Americans. It develops the knowledge, tools, and data needed to improve the health care system and help consumers, health care professionals, and policymakers make informed health-related decisions.

Aid to Families with Dependent Children *or* **AFDC** A program created by the Social Security Act to provide grant payments to children deprived of parental support.

AIDS Drug Assistance Program *or* **ADAP** Programs designed to ensure people living with HIV/AIDS who are uninsured or under-insured have access to medication.

All Patient Refined Diagnosis Related Groups *or* **APR-DRGs** A classification system used by payors and providers in their payment systems that arranges patients according to their reason of admission, severity of illness, and risk of mortality.

Allied Health Professional *or* **AHP** Health care professionals involved with the delivery of health or related services that comprise many different disciplines. Physicians, dentists, and nurses are excluded from this category. Instead, such professionals are often technologists, therapists, technicians, or assistants. Examples include dental hygienists, diagnostic medical sonographers, dietitians, medical technologists, and radiographers.

Allowed Charge *or* **Allowed Amount** Discounted fees that insurers will recognize and pay for covered services. Insurers negotiate these discounts with providers in their health plan network, and network providers agree to accept the allowed charge as payment in full. Each insurer has its own schedule of allowed charges. *Also referred to as* **Eligible Expense**, **Permitted Rate**, **Permitted Charge**, **Payment Allowance** *or* **Negotiated Rate**.

Alternate Level of Care *or* **ALC** This is a designation that is used in acute care settings to refer to patients who occupy an acute care hospital bed, who can be cared for elsewhere, but for some reason they are still in an acute care hospital.

Alternative Benefits Plan An option for states to tailor benefits to meet the needs of specific populations by using an Alternative Benefits Plan rather than following traditional Medicaid funding plans.

Alternative Rate Methodology System *or* **ARMS** A general term often used to refer to an alternative payment system that uses a different methodology than a fee-for-service or cost-based system.

Ambulatory Patient Group *or* **APG** A reimbursement methodology developed by 3M Health Information Systems for CMS. APGs are to outpatient procedures what DRGs are to inpatient days. APGs provide for a fixed reimbursement to a provider for outpatient procedures or visits and incorporate data regarding the reason for the visit and patient data. APGs prevent unbundling of ancillary services.

Ambulatory Payment Classification *or* **APC** Used by hospitals to bill the Medicare program for outpatient services under the OPPS. They are analogous to DRGs used under the in-patient hospital PPS.

Ambulatory Surgery Center *or* **ASC** An entity that operates exclusively to furnish outpatient surgical services to patients who do not require hospitalization, and in which the expected duration of services does not exceed 24 hours following admission.

America's Health Insurance Plans *or* **AHIP** A national trade group association of health care insurers and organizations that provide health care coverage, services, and solutions to beneficiaries.

American Academy of Hospice and Palliative Medicine *or* **AAHPM** A professional organization for physicians, nurses and other health care providers specializing in hospice and palliative medicine.

American Academy of Pediatrics *or* **AAP** A professional organization for physicians specializing in the care of infants, children, adolescents, and young adults.

American Association for Physician Leadership *or* **AAPL** A professional organization focused on providing leadership education, management training and career development for physicians.

American Association of Homes and Services for the Aging *or* **AAHSA** Former name for Leading Age (LA). *See* **Leading Age** *or* **LA.**

American College of Healthcare Executives *or* **ACHE** A professional organization of health care executives. Associated with The Foundation of The American College of Health care Executives which supports ongoing research and education relating to health care leadership and includes the Health Administration Press (HAP), a publisher of books and journals on health services management.

American College of Obstetricians and Gynecologists *or* **ACOG** A professional membership organization for obstetrician–gynecologists. It produces practice guidelines for health care professionals and educational materials for patients, provides practice management and career support, facilitates programs and initiatives to improve women's health, and advocates for members and patients.

American Health Care Association *or* **AHCA** A national trade group organization that represents long-term and post-acute care providers. Its membership includes non-profit and proprietary skilled nursing centers, assisted living communities, sub-acute centers, and homes for individuals with intellectual and development disabilities. S*ee also* **National Center for Assisted Living** *or* **NCAL.**

American Health Information Management Association *or* **AHIMA** A nonprofit association of health information professionals.

American Health Law Association *or* **AHLA** A national professional organization of health law professionals and the largest, nonpartisan, nonprofit educational organization devoted to legal issues in the health care field. It provides education and professional opportunities for its members. *Formerly known as* **American Health Lawyers Association** and is the successor organization to the **National Health Lawyers Association** and the **American Academy of Healthcare Attorneys**.

American Health Lawyers Association *See* **American Health Law Association** *or* **AHLA**

American Hospital Association *or* **AHA** A national trade group organization that represents and serves hospitals, health care networks, and their respective patients and communities. It provides educational programming, publications, and related services, and engages in advocacy activities. It represents its members in national health policy development, legislative and regulatory debates, and judicial matters.

American Medical Association *or* **AMA** A national professional organization of physicians, state and specialty medical societies and related stakeholders. Founded in 1847, its mission is to promote the art and science of medicine and the betterment of public health.

American Nurses Association *or* **ANA** A national professional organization founded in 1896 to advance and protect the profession of nursing. It began as the Nurses Associated Alumnae and was renamed the American Nurses Association in 1911.

American Recovery and Reinvestment Act of 2009 *or* **ARRA** A comprehensive piece of federal legislation that was designed as a stimulus package in response to the Great Recession of 2008. The legislation was designed to save jobs and create new ones. It provided temporary relief programs for those most affected by the recession and investment in infrastructure, education, health, and renewable energy. It included approximately $155 Billion dollars in health care spending. The bulk of that spending went towards expanding state Medicaid programs. The law also included the Health Information Technology for Economic and Clinical Health Act (HITECH). *See* **Health Information Technology for Economic and Clinical Health Act** *or* **HITECH**.

American Society of Clinical Oncology *or* **ASCO** A national professional organization for physicians and oncology professionals treating people with cancer. The organization provides education and professional resources, conducts advocacy, and assists with clinical research.

The Americans with Disabilities Act of 1990 *or* **ADA** Enacted in 1990, the Americans with Disabilities Act is a civil rights law (42 U.S.C. § 12101) that prohibits discrimination against people with disabilities in everyday activities. It guarantees that people with disabilities have the same access and opportunities as those who do not have disabilities. This law covers numerous areas such as employment, education, and public services and accommodations.

Annual Benefit Limit Prohibited in 2014 under the Affordable Care Act, this described the practice of insurers placing a limit on the amount of claims that they would pay for an individual in a given year. After an individual reached this

ceiling during the year, the individual would be required to pay the full cost for all subsequent claims.

Annual Deductible Combined *or* **Family Deductible** Usually in health plans, this is the total combined amount that family members on a plan must pay out-of-pocket for health care or prescription drugs before the health plan begins to pay.

Anti-Kickback Statute *or* **AKS** The federal Anti-Kickback Statute (42 U.S.C. § 1320a-7b(b)) is a criminal law that prohibits the knowing and willful payment of "remuneration" to induce or reward patient referrals or the generation of business involving any item or service payable by the federal health care programs (e.g., drugs, supplies, or health care services for Medicare or Medicaid patients). There are similar state-specific anti-kickback prohibitions. However, the acronym AKS is most often associated with the federal statute.

Anti-Supplementation Provision A provision of the SSA that makes it a criminal offense to charge a higher amount than the Medicaid rate for a covered service provided to a Medicaid beneficiary. Violation of this provision can subject an individual to a fine and imprisonment.

Appropriateness Review *or* **AR** This term can have several different meanings. It can refer to a patient's medication review to ensure that the patient is receiving the proper medication(s). It can refer to a review of the appropriateness of a resident's ongoing care in a residential facility. It can also refer to the need methodology used in a certificate of need regulatory review. *See* **Certificate of Need** *or* **CON**.

Area Health Education Center *or* **AHEC** A local program or center designed to develop and enhance education and training networks within communities, academic institutions, or community-based organizations. The networks' support increased diversity among health professionals, broaden the distribution of the health workforce, enhance health care quality, and improve health care delivery to rural and underserved areas and populations. The programs are funded by HRSA.

Artificial Intelligence *or* **AI** The simulation of human intelligence processes by machines, especially computer systems. AI has rising applications in health care technology, including but not limited to unstructured medical data analysis, medical imaging interpretation, drug and device development, disease forecasting, predictive analytics, and the development and discovery of new medications.

Assertive Community Treatment *or* **ACT** An evidence-based practice that offers treatment, rehabilitation, and support services, using a person-centered, recovery-based approach, to individuals who have been diagnosed with serious mental illness.

Assessment Reference Date *or* **ARD** Used in post-acute and long-term care payment systems, it refers to the date that signifies the end of an observation period for a patient or resident care assessment, and it provides a common reference point for all care team members participating in the assessment.

Assignment of Benefits The payment of medical benefits directly to a provider of care rather than to a beneficiary. This generally requires either a contract between the health plan and the provider or a written release from the subscriber to the provider allowing the provider to bill the health plan.

Assisted Living Facility *or* **ALF** An assisted living facility, residence or program refers to housing facilities for individuals with disabilities or for adults who cannot or who choose not to live independently. Facilities provide a group living environment and typically have an older adult population. Licensed facilities can provide differing levels of services and support depending on the requirements of the license, however, facilities do not regularly provide significant, if any, medical or clinical care.

Assisted Living Program *or* **ALP** *See* **Assisted Living Facility** *or* **ALF**.

Assisted Living Residence *or* **ALR** *See* **Assisted Living Facility** *or* **ALF**.

Association of American Medical Colleges *or* **AAMC** A non-profit industry association that serves the academic medicine community through medical education, health care, medical research, and community collaborations. Its members include medical schools, hospitals, and academic medical centers as well as other constituencies.

Association of Women's Health, Obstetric, and Neonatal Nurses *or* **AWHONN** A professional nonprofit organization that provides educational resources, professional development opportunities, and advocacy activities to support nurses who specialize in the care of women and newborns.

Auditing The action of systematic or ongoing inspection of records, policies, and procedures, to assess compliance with laws, regulations policies or procedures to identify potential non-compliance or discrepancies that should be corrected. Audits may be performed by health care entities themselves, outside contractors, or government agencies. Auditing is

also one of the seven elements of an effective compliance program outlined in the Federal Sentencing Guidelines and the OIG's compliance guidance.

Average Length of Stay *or* **ALOS** An operational or financial term used in in-patient health care facility settings that refers to the average number of days those patients or residents spend in the facility. It is generally measured by dividing the total number of days stayed by all inpatients during a year by the number of admissions or discharges.

Average Manufacturer Price *or* **AMP** With respect to an outpatient drug of a manufacturer, the average price paid to the manufacturer for the drug in the U.S. by wholesalers for drugs distributed to retail community pharmacies and retail community pharmacies that purchase drugs directly from the manufacturer.

Average Sale Price *or* **ASP** The measure of the average price at which a manufacturer's drug product is sold to all purchasers. The metric is also used in determining reimbursement for pharmaceuticals.

Average Wholesale Price *or* **AWP** The measure of the average price at which a pharmacy purchases pharmaceuticals from the wholesaler.

B

Bachelor of Science in Nursing *or* **BSN** A four-year undergraduate academic degree program often needed as a prerequisite to obtaining licensure to practice as a nurse in the U.S.

Bad Debt *or* **BD** A term used in the context of a health care provider's uncompensated care. It is one element of uncompensated care alongside charity care. Bad Debt generically refers to an unpaid obligation by an individual who could pay for the health care service they received. Uncompensated care can be addressed for certain types of hospitals through DSH payments. DSH funding is provided by federal and state health care to ensure the financial stability of safety-net providers and other hospitals that serve large Medicaid and or uninsured populations.

Balance Billing The practice of a provider billing a patient for all charges, or a portion of charges, not paid for by a health plan, even if those charges were above what the plan would pay or are considered medically unnecessary.

Balanced Budget Act of 1997 *or* **BBA** Enacted in 1997, the BBA of '97 was an omnibus legislative package designed to balance the federal budget by 2002. Enacted during Bill Clinton's second term as president, the Act was designed to result in spending reductions between 1998 and 2002. The BBA increased spending on welfare and children's health care, while implementing Medicare cuts by reducing payments to health service providers. Some of the payment changes were reversed by subsequent legislation in 1999 and 2000.

Balanced Budget Refinement Act of 1999 *or* **BBRA** Enacted on November 29, 1999, BBRA restored billions of dollars in Medicare provider payment reductions that had been made by the BBA. *Also known as* the **Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999**.

Balancing Incentive Payments Program *or* **BIP** A CMS program that provided financial incentives to Medicaid programs to increase access to non-institutional long-term services and supports. The program authorized grants to serve more people in home and community-based settings, from October 1, 2011 to September 30, 2015. Certain states continue to participate in the program.

Basic Health Plan Beginning in 2014, the Affordable Care Act gave states the option of creating a basic health plan (also known as the Basic Health Program) to provide coverage to individuals who have incomes between 133 and 200 percent of the FPL instead of having these individuals enroll in the health insurance exchange and include the essential health benefits as defined by the law.

Basic Health Program *or* **BHP** *See* **Basic Health Plan**

Basic Life Support *or* **BLS** A level of pre-hospital medical care used for victims of life-threatening illnesses or injuries until they can be given more advanced medical care by either other pre-hospital providers, such as Paramedics, or by providers at a hospital. BLS can be provided by trained medical personnel, such as EMTs and by qualified bystanders.

Basis of Eligibility *or* **BOE** Often used in the context of public benefits, including health care benefits like Medicaid, it refers to a scenario in which an individual meets the eligibility requirements for a particular benefit.

Bed Capacity The number of beds a hospital or other in-patient facility has been designed and constructed to contain. It may also refer to the number of beds set up and staffed for use. It can also refer to the number of beds that are approved for use via a license or CON. Bed capacity can also be referred to as bed size or licensed bed capacity or size.

Behavioral Health Organization *or* **BHO** Often used in the context of State Medicaid programs, BHOs are managed care contractors responsible for delivering mental health and substance abuse services to patients / beneficiaries.

Behavioral Health Urgent Care Similar to medical urgent care, behavioral health urgent care providers have non-traditional hours and can quickly provide medication adjustments, referrals to ongoing care in the community, or assess and care for urgent patient needs. *Also see* **Urgent Care** *or* **Urgent Care Center**

Behavioral Healthcare A broad reference to a range of mental health services, including services for a wide range of mental health disorders such as, psychiatric and psychological treatment, addiction treatment, and eating disorder and alcohol and substance abuse treatment.

Behavioral Risk Factor Surveillance System *or* **BRFSS** A health survey system run by the CDC. BRFSS is a system

of health-related telephone surveys that collect state data about U.S. residents regarding their health-related risk behaviors, chronic health conditions, and use of preventive services.

Benchmarking A method of comparing the procedures and results of a process, system, or operation under study with a similar process, system, or operation under study that is generally recognized as outstanding. Most often used in health care quality analysis and programs, performance improvement and auditing.

Beneficiary A person who has health care insurance coverage through some type of health plan, such as an employer sponsored plan, or a federal health care program like Medicare or Medicaid. *Also known as* an **Enrollee, Member, Participant** *or* **Customer**.

Beneficiary & Earnings Data Exchange *or* **BENDEX** A record in the SSA data exchange application that provides Title 2 (disability benefits) and earnings data to state agencies.

Beneficiary Earnings Exchange Record *or* **BEER** A record in the SSA data exchange application that provides earnings data to states.

Beneficiary Enrollment Retrieval System *or* **BERT** One part of the three-part Medicare Beneficiary Enrollment System maintained by CMS.

Benefit Description A written description of what is included and, in some instances, excluded from a beneficiary's benefit package. *See* **Benefit Package**.

Benefit Package The set of health care items and services that are covered by a health plan. Items and services can include physician visits, hospitalizations, and prescription drugs. The benefit package specifies cost-sharing requirements for services, limits on particular services, and annual or lifetime spending limits. *Also known as* a **Benefit Plan**.

Benefit Period *or* **BP** The way that a health care payer measures a time-limited covered item or service. For example, Medicare applies a defined benefit period to its coverage of skilled nursing services. The benefit period begins the day skilled nursing facility services begin, i.e. the resident is admitted, and ends the day the resident is discharged. A payer may allow multiple benefit periods but limit the period itself to a defined number of days.

Benefit Plan *See* **Benefit Package**.

Benefit Stabilization Fund *or* **BSF** A segregated monetary fund that CMS can set up, at the request of a participating MA plan, to be used to withhold a portion of the MA plan's monthly per capita payments. The fund would be used in subsequent contract periods to prevent excessive fluctuation in the provision of additional benefits an MA plan may have offered to its beneficiaries.

Benefits Improvement and Protection Act of 2000 *or* **BIPA** Enacted on December 21, 2000, it restored an estimated $11.5 billion in payments over five years to hospitals under Medicare, Medicaid, and other federal and state health care programs. *Also known as* the **Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000**.

Best Price *or* **BP** Refers to a federal regulatory policy that requires a drug manufacturer to offer state Medicaid programs the best price given to any other purchaser (with a few exceptions).

Bi-directional Health Information Exchange *or* **BHIE** A HIE that is designed to allow the parties on both ends of a health care exchange to stay updated as to the patient's current treatment and record information.

Billings and Collections *or* **B&C** A term referring to the claims (i.e. billings), and collections on those claims, that health care providers have submitted to health care insurers, both private and government payors.

Biologicals A broad term used to generically describe certain medicines or therapeutics such as vaccines, growth factors, immune modulators, monoclonal antibodies, as well as products derived from human blood and plasma. Biologicals are products that are derived from living culture systems or from blood, whereas other medicines or therapeutics are generally made synthetically or purified from other living organisms like plants.

Biomedical Research & Development Price Index *or* **BRDPI** An annual index that is computed with the cooperation of the U.S. Department of Commerce's Bureau of Economic Analysis (BEA) and the U.S. National Institutes of Health's (NIH) Division of Statistical Analysis and Reporting (DSAR). The index measures changes in the weighted average of prices of all the inputs (e.g., personnel services, various supplies, and equipment) purchased with the NIH funds to support research. The annual change in the index indicates how much NIH funding must change to maintain purchasing power.

Biometric Identifier An identifier based on some distinctive, measurable physical or behavioral characteristic of an individual, such as fingerprints, palm veins, face recognition, palm prints, hand geometry, iris recognition, retina,

odor/scent, typing rhythm, gait, signature, behavioral profiling, and credentials. The term can also be used to describe a device used to identify and measure one of these characteristics, such as a fingerprint, iris or facial recognition scanner.

Biometric Information Privacy Act of 2008 *or* **BIPA** An Illinois law enacted on October 3, 2008, designed to regulate the collection, use, and handling of biometric identifiers and information by private entities.

Biosurveillance *or* **BSV** Biosurveillance is the process of active data-gathering and analysis, interpretation of biosphere data that might relate to disease activity and threats to human or animal health designed to achieve early warning of health threats, early detection of health events, and overall situational awareness of disease activity.

Birthing Center A stand-alone facility that often presents a more home-like environment, separate from a maternity ward or physician's office, that provides a setting for labor, delivery, immediate post-partum care and immediate care of newborn infants. The facility is often staffed by nurse midwives, midwives and/or obstetricians. Staff may also include doulas and birthing coaches.

Block Grants A generic term for certain types of federal grants to aid States. Grants are usually provided on an annual basis. As an example, States can receive block grants related to Social Services, Community Services, Maternal and Child Health, Preventive Health and Health Services, Substance Abuse, and Mental Health. States often submit proposals to federal agencies that receive and use the grants.

BlueCross BlueShield Association *or* **BCBSA** One of the oldest health insurance plan associations in the U.S., it is a national industry association of affiliated Blue Cross Blue Shield health plans. The association owns the Blue Cross and Blue Shield trademarks and grants licenses to use the trademarks and names in exclusive geographic areas.

BlueCross/BlueShield *or* **BCBS** *See* **BlueCross BlueShield Association** *or* **BCBSA**. Also, the generic trade name often used by a local health plan that is part of the BCBSA affiliation and has licensed the trademark.

BLUES *or* **The Blues** *See* **BlueCross BlueShield Association** *or* **BCBSA**

Board and Care *or* **B&C** Board and care refers generically to a type of care home, often for adults, which can be found in residential neighborhoods. They are equipped, adapted, and staffed to care for a small number of residents and are smaller than large adult care facilities, including assisted living. These facilities are often licensed by state regulatory authorities.

Board Certified Board certified often refers to a physician's certification by a medical specialty board that the physician has met established criteria in a specific medical specialty. Board certification is based on an independent evaluation and verification of a physician's skills and expertise.

Board Eligible A term that refers to a physician who has completed the requirements for a medical specialty certification but has not yet completed the board exam required to obtain board certification.

Broker An individual authorized to sell, solicit, or negotiate insurance for compensation. Brokers often must be licensed by a state insurance regulatory agency.

Bundled Payment A comprehensive payment structure that includes the costs of all applicable services furnished to an individual during an episode of care.

Bundled Payments for Care Improvement Initiative *or* **BPCI** A CMS payment initiative comprised of four broadly defined models of care, linking payments for multiple services beneficiaries received during an episode of care. Under the initiative, organizations entered into payment arrangements that included financial and performance accountability for episodes of care. The purpose of the models was to increase quality and care coordination while achieving lower cost.

Bureau of Indian Affairs *or* **BIA** The Bureau of Indian Affairs is an agency within the Department of the Interior and its mission is to enhance the quality of life, promote economic opportunity, and carry out the responsibility to protect and improve the trust assets of American Indians, Indian tribes and Alaska Natives. It often works collaboratively with the IHS an agency of HHS.

Bureau of Labor Statistics *or* **BLS** A unit of the DOL, it is the primary U.S. agency responsible for measuring labor market activity, working conditions, price changes, and productivity in the U.S. economy to support public and private decision-making.

Business Associate Defined by the administrative simplification provisions of HIPAA, a business associate is generally a person or entity who performs functions or activities on behalf of a Covered Entity that involve "the use or disclosure

of individually identifiable health information." Examples include "claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, billing, benefit management, practice management, and repricing," as well as providing legal, accreditation, or financial services. *See* **Health Insurance Portability and Accountability Act of 1996** *or* **HIPAA** and **Covered Entity**

Business Associate Agreement HIPAA requires a Covered Entity to obtain written commitments from Business Associates before disclosing individually-identifiable health information or PHI to them. Consequently, the parties typically enter into Business Associate Agreements.

C

Capitation A method of reimbursement where the provider, hospital, or health plan is paid a fixed per patient amount on a periodic basis and is expected to provide all necessary covered services at no additional charge.

Carrier Fraud Control Unit A fraud control unit housed within a Medicare carrier that receives referrals of potential fraud and abuse cases and conducts case reviews and audits.

Carve-Out Refers to a set of medical services that are carved out of the basic coverage arrangement for a health plan. In terms of plan benefits, it may refer to a set of benefits that are carved out and contracted for separately; for example, mental health/substance abuse services may be separated from basic medical-surgical services. The term may also refer to carving out a set of services from a basic capitation rate with a provider (e.g., a capitation rate for cardiac care but carving out cardiac surgery and paying case rates for that).

Case Management An approach to managing the provision of health care to individuals who may have chronic conditions, may be health plan beneficiaries with high-cost medical conditions, or have multiple conditions. The goal is to coordinate the care to improve both continuity and quality of care and to lower costs.

Case Mix A term that refers to the mix of illness and severity of cases for a provider as well as the payors associated with each case.

Case Mix Index *or* **CMI** For participating hospitals in the Medicare program, Case Mix Index is the average relative DRG weight of a hospital's inpatient discharges, calculated by summing the MS-DRG weight for each discharge and dividing the total by the number of discharges.

Case-Mix Group *or* **CMG** An identifier used in-patient classification system to group together patients with similar characteristics.

Catastrophic Coverage An insurance coverage option that offers limited benefits and a high deductible and is intended to only protect against catastrophic medical expenses that could lead to significant negative financial outcomes, such as bankruptcy, due to unforeseen illness or injury.

Catholic Health Association *or* **CHA** An industry association affiliated with the Catholic Church and comprised of more than 600 hospitals and 1,600 long-term care and other health facilities in all 50 states.

Center for Devices and Radiological Health *or* **CDRH** A unit within the FDA responsible for protecting and promoting public health by assuring patients and providers have access to safe, effective, and high-quality medical devices and safe radiation-emitting products. It oversees such products by providing understandable and accessible science-based information, facilitating medical device innovation, providing industry with predictable, consistent, transparent, and efficient regulatory pathways, and assuring consumer confidence in devices marketed in the U.S.

Center for Information Technology *or* **CIT** CIT is a unit within the NIH that incorporates the power of modern computers into the biomedical programs and administrative procedures of the NIH by focusing on three primary activities: conducting computational biosciences research, developing computer systems, and providing computer facilities.

Center for Medicare and Medicaid Innovation *or* **CMMI** A center within CMS that supports the development and testing of innovative health care payment and service delivery models.

Center for Scientific Review *or* **CSR** CSR is a unit within NIH that oversees and implements peer review for grant applications to NIH, as well as for some other components of HHS. The mission of CSR is to see that NIH grant applications receive fair, independent, expert, and timely scientific reviews free from inappropriate influences so NIH can fund the most promising research.

Centers for Disease Control and Prevention *or* **CDC** The U.S. Centers for Disease Control and Prevention is the primary federal agency responsible for the protection and security of the U.S. from health, safety and security threats, both foreign and in the U.S. CDC conducts critical science and provides health information that protects against expensive and dangerous health threats and responds when these arise.

Centers for Medicare and Medicaid Services *or* **CMS** An agency within HHS that is the primary government agency

responsible for the administration of the Medicare, Medicaid, and the State Children's Health Insurance Programs. *Formerly known as* the **Healthcare Financing Administration** *or* **HCFA**.

Certificate of Authority *or* **COA** Issued by state agencies that regulate insurance or managed care organizations. A COA is essentially the license an agency provides a health maintenance organization or insurance company to operate within the state.

Certificate of Coverage Refers to the document that a health plan must provide to a beneficiary to show evidence that the beneficiary has coverage and to give basic information about that coverage.

Certificate of Need *or* **CON** A permit or license issued by a state agency under a state legal/regulatory scheme for approving major capital expenditures and projects for certain health care facilities or services. A state with CON requirements has a planning agency or board that reviews and approves projects. The programs are designed to control health care costs by restricting duplicative services and determining whether new capital expenditures meet a community need. *Also see* **Appropriateness Review** *or* **AR**

Certification and Survey Provider Enhanced Reporting (or Reports) *or* **CASPER** A CMS data application and report generation system that allows skilled nursing facility providers to access CMS quality measure program public reporting data.

Certification Commission for Health Information Technology *or* **CCHIT** A non-profit established in 2004 by three health care information organizations, the American Health Information Management Association, the Healthcare Information and Management Systems Society and The National Alliance for Health Information Technology. The organization is no longer in existence, it was originally tasked with being an independent group that could test and certify EHR systems.

Certified Diabetes Care and Education Specialist *or* **CDCES** Is a credential awarded by the Certification Board for Diabetes Care and Education program. The certification program is a practice-based certification for experienced health professionals who provide diabetes care and education in the U.S. or its territories. *Formerly known as* **Certified Diabetes Educator** *or* **CDE.**

Certified Diabetes Educator *or* **CDE** *See* **Certified Diabetes Care and Education Specialist** *or* **CDCES.**

Certified Nurse Aide *or* **CNA** A front line or entry-level nursing position in an in-patient setting. CNAs help patients with direct health care and social needs, often referred to as activities of daily living, under the supervision of a licensed nurse. *Also referred to as* **Certified Nursing Assistant**, **Nursing Assistant**, **Nurse's Aide**, *or* **Patient Care Assistant**.

Certified Professional in Healthcare Quality *or* **CPHQ** A professional credential that is overseen by the NAHQ.

Certified Recovery Peer Advocate *or* **CRPA** Substance use counselors who draw from personal experience with substance use, and professional training to provide non-clinical support services as identified in the patient's treatment or recovery plan.

Certified Registered Nurse Anesthetist *or* **CRNA** A registered nurse who has specialized training in anesthesia.

Charge Description Master *or* **CDM** A list of services, procedures and products representing all the items and services used by patients in a hospital setting.

Charge Master *See* **Charge Description Master** *or* **CDM**.

Chief Information Officer *or* **CIO** A c-suite level executive responsible for managing and implementing the information and technology systems of an organization.

Chief Medical Information Officer *or* **CMIO** A c-suite level executive responsible for serving as the liaison between medical and IT departments at a health care organization.

Chief Medical Officer *or* **CMO** A c-suite level executive responsible for managing a health care organization's physicians from an administrative, clinical and quality perspective.

Chief Nursing Information Officer *or* **CNIO** A c-suite level executive responsible for serving as the liaison between nursing and IT departments at a health care organization.

Chief Nursing Officer *or* **CNO** A c-suite level executive responsible for managing a health care organization's nursing staff from an administrative, clinical and quality perspective.

Children's Health Insurance Program *or* **CHIP** A federal-state program that provides health care coverage for uninsured low-income children who are not eligible for Medicaid. States have the option of administering the CHIP through their Medicaid programs, through a separate program, or a combination of both. The federal government matches state spending for CHIP but federal CHIP funds are capped.

Children's Hospital Association *or* **CHA** A national trade association of more than 220 children's hospitals with a mission of advancing child health through innovation in the quality, cost and delivery of care in children's hospitals and health systems.

Civil Monetary Penalties Law of 1981 *or* **CMPL** A federal law that authorizes the Secretary of HHS to impose civil money penalties, an assessment, and program exclusion for various forms of fraud and abuse involving the Medicare and Medicaid programs. Often CMPL enforcement is undertaken by the OIG.

Civil Monetary Penalty *or* **CMP** A monetary penalty that can be imposed for regulatory compliance violations by different health care regulatory agencies.

Civilian Health and Medical Program of the Veteran's Administration *or* **CHAMPVA** A comprehensive health care benefits program in which the VA shares the cost of covered health care services and supplies with eligible beneficiaries. Eligible beneficiaries are generally spouses and children of veterans subject to specific criteria.

Claim Fraud Use of various means (material misrepresentation, exaggeration of an injury, alteration of medical bills and so on) to obtain benefits to which an individual, insured, provider or supplier is not entitled.

The Clayton Antitrust Act of 1914 An element of federal antitrust law that prohibits price discrimination between different purchasers if such a discrimination substantially lessens competition or tends to create a monopoly in any line of commerce; exclusive sales dealings; purchase "tying" when the act substantially lessens competition; mergers and acquisitions where the effect may substantially lessen competition; and any person from being a director of two or more competing corporations, in certain circumstances.

Clinical Data Abstraction Center *or* **CDAC** A CMS department that assesses the accuracy of chart-abstracted data submitted to the OQR Program. CMS verifies on a quarterly basis that hospital-abstracted data submitted to CMS' Clinical Warehouse via the HIQRP system can be reproduced by a trained abstractor using a standardized process.

Clinical Integration A process that facilitates the coordination of patient care across conditions, providers, settings, and time.

Clinical Laboratory Improvement Amendments of 1988 *or* **CLIA** Enacted in 1988, CLIA regulates laboratory testing and require clinical laboratories to be certified by CMS before they can accept human samples for diagnostic testing. Laboratories can obtain multiple types of CLIA certificates, based on the kinds of diagnostic tests they conduct. CMS, FDA and the CDC all cooperate in carrying out the statutory requirements of CLIA.

Clinical Pathway Evidenced-based care plans that are used for patients with a specific disease or condition.

Clinical Quality Measure *or* **CQM** A mechanism for assessing observations, treatment, processes, experience, and/or outcomes of patient care.

CMS Certification Number *or* **CCN** The CMS identification number issued to providers and used to verify Medicare/Medicaid certification on all survey and certification, and resident/patient assessment transactions. The Medicare/Medicaid Provider Number was renamed the CCN in 2007. *Also known as* the **OSCAR Provider Number**, **Medicare Identification Number** *or* **Provider Number.**

CMS Self-Referral Disclosure Protocol *See* **Self-Referral Disclosure Protocol** *or* **SRDP**

CMS-1500 A standardized claim form used by professionals to bill for services to health plans and other payers for health care services. Required by Medicare and generally used by private insurance companies and managed care plans. *Formerly known as* the **HCFA-1500**. *See* **UB-04/UB-92**

CMS-R-131 *See* **Advance Beneficiary Notice** or **ABN**

Coalition to Protect America's Healthcare An advocacy organization that represents the interests of community, children, teaching, public, religious, rehabilitation, behavioral health, and long-term care hospitals, and their patients.

Code of Conduct A set of rules or guidelines outlining an organization's social norms, rules, responsibilities, proper practices, and/or expectations of its employees. Having a Code of Conduct is also one of the seven elements of an effective compliance program outlined in the Federal Sentencing Guidelines and the OIG's compliance guidance.

Code of Federal Regulations *or* **CFR** The U.S. Code of Federal Regulations is the codification of the general and permanent rules established by the departments and agencies of the U.S. Federal Government. It is divided into 50 titles that represent broad areas subject to federal regulation.

Coinsurance A provision in a health plan beneficiary's coverage that limits the amount of coverage by the plan to a certain percentage, commonly 80%. The additional costs, in this case 20%, paid by the beneficiary out of pocket are referred to as co-insurance.

Cold Claim A claim for medical services received by a health plan for which no authorization has been received.

College of Healthcare Information Management Executives *or* **CHIME** A professional organization dedicated to serving CIOs, CMIOs, CNIOs and other senior health care IT leaders.

Commission on Accreditation of Rehabilitation Facilities *or* **CARF** CARF is a non-profit organization that established accreditation standards and accredits organizations providing certain types of clinical and social services, including: aging services, behavioral health, psychosocial rehabilitation, child and youth services, durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS), employment and community services, medical rehabilitation, and opioid treatment programs.

The Commission on Graduates of Foreign Nursing Schools *or* **CGFNS** A nonprofit organization that provides foreign students and health care professionals with a comprehensive assessment of their academic records to facilitate their successful admission to schools, or licensure, in the US and other countries.

Commissioner of Insurance Chief state official responsible for matters related to insurance regulation.

Community Health Accreditation Program *or* **CHAP** An independent, nonprofit accrediting body for home and community-based health care organizations with deeming authority granted by the CMS.

Community Health Needs Assessment *or* **CHNA** An IRS requirement for non-profit hospitals qualified as tax-exempt under IRC 501(c)(3), and enacted as part of the ACA. Hospitals must periodically conduct a CHNA which includes defining the community it serves, assessing the health needs of that community, and soliciting and taking into account input received from persons who represent the broad interests of that community, including those with special knowledge of or expertise in public health. The CHNA must be documented and available to the public.

Community Rating The rating methodology required of federally qualified HMOs, HMOs under the laws of many states, and occasionally indemnity plans under certain circumstances. The HMO must obtain the same amount of money per beneficiary for all beneficiaries in the plan. Community rating does allow for variability by allowing the HMO to factor in differences for age, sex, mix (average contract size) and industry factors; not all factors are necessarily allowed under state laws, however. Such techniques are referred to as community rating by class and adjusted community rating. *See also* **Experience Rating**.

Comparative Billing Report *or* **CBR:** A CBR provides comparative billing data to an individual Medicare health care provider. CBR's contain actual data-driven tables and graphs with an explanation of findings that compare provider's billing and payment patterns to those of their peers on both a national and state level. Graphic presentations contained in these reports help to communicate a provider's billing pattern more clearly.

Comparative Clinical Effectiveness Research *or* **CER** Analysis and research which compares two or more medical treatments, services, or health practices to help patients and other stakeholders make better-informed decisions about their health and health care choices.

Competitive Bidding Open bidding for federal contracts between independent groups that compete for the contract by providing the best bid. Section 302 of the MMA of 2003 established requirements for a competitive bidding program for certain DMEPOS.

Competitive Medical Plan *or* **CMP** A type of managed care organization defined by federal regulation and designed to contract with CMS to cover Medicare beneficiaries.

Compliance The adherence to the requirements of applicable laws and regulations, such as the laws and regulations governing the Medicare and Medicaid programs, as well as the adherence to an organization's internal policies and procedures.

Compliance Hotline A telephone line that an employee or other individual may call to report compliance violations or concerns or to submit compliance questions. A confidential reporting mechanism, often taking the format of a compliance hotline, is one of the seven elements of an effective compliance program outlined in the Federal Sentencing Guidelines and the OIG's compliance guidance.

Compliance Plan *See* **Compliance Program**.

Compliance Program An organizational management program designed to prevent, detect, respond to, and report violations of laws and ethical rules. Programs are often designed around the seven elements of an effective compliance program found in Section §8B2.1 – Effective Compliance and Ethics Program of the U.S. Sentencing Commission Guidelines Manual and voluntary compliance guidance published by the OIG.

Comprehensive Accreditation Manual for Hospitals *or* **CAMH** The CAMH is the accreditation manual for hospitals seeking accreditation from the Joint Commission.

Comprehensive Care for Joint Replacement *or* **CJR** The CJR Model is a CMS demonstration designed to improve care for Medicare patients undergoing hip and knee replacements performed in inpatient or outpatient settings and for total ankle replacements performed in inpatient settings.

Comprehensive Error Rate Testing *or* **CERT** A CMS program that monitors and reports on the accuracy of Medicare FFS payments. The CERT program measures the error rate for claims submitted to Medicare contractors.

Computerized Provider Order Entry *or* **CPOE** Refers to the process of health care providers entering and sending treatment instructions, including medication, laboratory, and radiology orders, via a computer application rather than paper, fax, or telephone.

Concurrent Review Refers to utilization management that takes place during the provision of services. Almost exclusively applied to inpatient hospital stays.

Conditions of Participation Conditions of Participation are requirements that Medicare Part A providers must follow to participate in the Medicare program. They are designed to protect patient health and safety and ensure quality of care. Generally, if the Conditions of Participation are not met, a provider's enrollment in the Medicare program may be impacted and/or various sanctions may be imposed upon the provider, including a corrective action plan, monetary sanctions, and increased reporting requirements. Some Medicaid programs also impose Conditions of Participation.

Conditions of Payment Conditions of payment are requirements that must be satisfied before the government will pay a claim. Failure to comply with a condition of payment can result in: (i) the denial of the claim for payment; (ii) if the payment has already been made, an overpayment that must be refunded; or (iii) the imposition of civil monetary penalties.

Conference of Metropolitan & Regional Hospital Associations *or* **CMHA** An industry association of local and regional hospital provider associations.

Congressional Budget Office *or* **CBO** A federal agency located within the legislative branch of the U.S. Government that provides budget and economic information to Congress.

Consolidated Omnibus Budget Reconciliation Act of 1985 *or* **COBRA** A federal statute requiring employers with more than 20 employees to make group health care coverage available for 18 months after employment termination, at employee expense, to employees who leave the employer for any reason other than gross misconduct.

Consumer-Directed Health Plan Health plans that seek to increase consumer awareness about health care costs and provide incentives for consumers to consider costs when making decisions about health care. These plans usually have high deductibles along with a consumer-controlled savings account for health care services.

Continuing Care Retirement Community *or* **CCRC** A self-sufficient life-care community in which residents, for a substantial entry fee plus a monthly maintenance fee, enter into a contractual relationship with the community that can last a lifetime. Most communities have independent living apartments, assisted living and skilled nursing units as part of the campus.

Continuing Medical Education *or* **CME** Educational programs or activities designed to maintain, develop, or increase the knowledge, skills, and professional performance of a licensed physician.

Continuous Quality Improvement *or* **CQI** A business process focused on continuous and ongoing efforts to achieve measurable improvements in the efficiency, effectiveness, performance, accountability, outcomes, and other indicators of quality for the provision of health care.

Contributory Plan A group health plan in which the employees must contribute a certain amount toward the premium cost, with the employer paying the rest.

Conversion The conversion of a beneficiary covered under a group master contract for coverage under an individual contract. This is offered to beneficiaries who lose their group coverage (for example, through job loss, death of a

working spouse and so forth) and who are ineligible for coverage under another group contract. *See also* **Consolidated Omnibus Budget Reconciliation Act of 1985** *or* **COBRA**.

Cooperative Hospital Service Organizations *or* **CHSO** Organizations that are available for hospitals considering certain types of joint ventures with other hospitals. If the terms for their use strictly meet the regulatory requirements, CHSOs can provide both tax exemption and Antikickback Statute Safe Harbor protection for such joint ventures.

Coordinated Care *See* **Integrated Care**.

Coordination of Benefits *or* **COB** Method of integrating benefits payable under more than one health plan so that the insured's benefits from all sources do not exceed 100% of allowable medical expenses.

Copayment The portion of a claim or medical expense not covered by insurance that a patient must pay out of pocket.

Coronavirus Aid, Relief, and Economic Security Act *or* **CARES Act** Enacted on March 27, 2020, The CARES Act was a massive $2.2 trillion economic stimulus bill that included many measures designed to respond to the economic effect of the COVID-19 pandemic. It included spending programs such as cash payments to individuals, increased unemployment benefits, the Paycheck Protection Program, and the Provider Relief Fund. The CARES Act was considered "Phase 3" of certain Congressional legislation designed to address the effect of the pandemic.

Corporate Compliance Program *See* **Compliance Program**.

Corporate Integrity Agreement *or* **CIA** An agreement that a health care company has entered into with the government as part of a global settlement of a government investigation.

Corporate Practice of Medicine Prohibitions State laws that prohibit a physician from working for a general business corporation or entity; in other words, a physician can only work for himself, herself, another physician or through a professional entity. Put another way, a general business corporation or entity cannot practice medicine.

Correct Coding Initiative *or* **CCI** *See* **National Correct Coding Initiative** *or* **NCCI**.

Cost Reporting Year *or* **CRY** For health care providers reimbursed on a cost-basis, it represents the year in which their cost reporting period is.

Cost Sharing Any form of coverage in which the beneficiary pays some portion of the cost of providing services. Usual forms of cost sharing include deductibles, coinsurance, and payments. *See* **Coinsurance** *and* **Copayment**.

Cost Shifting When a provider cannot cover the cost of providing services under the reimbursement received, the provider raises the prices to other payers to cover that portion of the cost. Some of the costs are shifted to and absorbed by private health insurance.

Cost-to-Charge Ratio *or* **CCR** The total amount of money required to operate a hospital, divided by the sum of the revenues received from patient care and all other operating revenues.

Council on Graduate Medical Education *or* **COGME** It provides an ongoing assessment of physician workforce trends, training issues and financing policies, and recommends appropriate federal and private sector efforts on these issues. The Council advises and makes recommendations to the Secretary of HHS, the Senate Committee on Health, Education, Labor and Pensions, and the House of Representatives Committee on Energy and Commerce.

Coverage Exclusion Specific items and services that are expressly not covered by a health plan or insurance contract, and therefore are the beneficiary's financial responsibility.

Covered Entity Used almost exclusively in the context of HIPAA, a Covered Entity is an entity that is primarily responsible for compliance with the law and includes: (1) a health plan; (2) a health care clearinghouse; or (3) a health care provider who transmits any health information in electronic form in connection with a transaction covered by HIPAA.

Covered Service The services, drugs, supply and equipment for which benefits are available to a beneficiary under their health care plan.

CPT® *or* CPT® Coding *See* **Current Procedural Terminology**

Credentialed Alcoholism and Substance Abuse Counselor *or* **CASAC** A credential provided to an individual substance use professional who has completed a course of study and successfully passed a credentialing exam to obtain the credential.

Credentialing The process for obtaining and reviewing the licensure and professional qualification documentation of professional health care providers.

Credentialing Verification Organization *or* **CVO** An independent organization that performs primary verification of a professional provider's credentials.

Credentials Verification Service *or* **CVS** *See* **Credentialing Verification Organization** *or* **CVO**

Critical Access Hospital *or* **CAH** A critical access hospital is a CMS designation given to certain rural hospitals with 25 or fewer acute care inpatient beds, located more than 35 miles from another hospital, who maintain an annual average length of stay of 96 hours or less for acute care patients and provide 24/7 emergency care services. Hospitals with this designation receive cost-based reimbursement and a different type of reimbursement flexibility than standard acute care hospitals.

Critical Care Unit *or* **CCU** *See* **Intensive Care Unit** *or* **ICU**.

Current Procedural Terminology *or* **CPT®** *or* **CPT® Coding** A medical code set produced by the AMA that is used to report medical, surgical, and diagnostic procedures and services to entities such as physicians, health insurance companies, and accreditation organizations. The codes are five-digit codes corresponding to medical, surgical, and diagnostic procedures and services that are frequently used for billing purposes. CPT® codes are also used for administrative management purposes such as claims processing and developing guidelines for medical care review.

Custodial Care Care provided to an individual that is primarily related to assisting with the activities of living. *See* **Activities of Daily Living** *or* ADLs.

D

Date of Service Refers to the date that medical services were rendered and often set forth on a claim for services submitted to a health plan. Usually different from the date a claim is actually submitted.

Days Per Thousand A standard unit of measurement of utilization. Refers to an annualized use of the hospital or other institutional care. It is the number of hospital days that are used in a year for each thousand covered lives.

Death Spiral An insurance term that refers to a spiral of high premium rates and adverse selection, generally in a free-choice environment (typically, an insurance company or health plan in an account with multiple other plans or a plan offering coverage to potential beneficiaries who have alternative choices, such as through an association). One plan, often the indemnity plan competing with managed care plans, ends up having continually higher premium rates such that the only beneficiaries who stay with the plan are those whose medical costs are so high (and who cannot change because of provider loyalty or benefits restrictions, such as preexisting conditions) that they far exceed any possible premium revenue. Called the death spiral because the losses from underwriting mount faster than the premiums can ever recover, and the account eventually terminates coverage, leaving the carrier in a permanent loss position.

Deductible The portion of a beneficiary's health care expenses that must be paid out of pocket before any insurance coverage applies. Common in insurance plans and PPOs, but uncommon in HMOs. May apply only to the out-of-network portion of a point-of-service plan. May also apply only to one portion of the plan coverage (for example, there may be a deductible for pharmacy services but not for anything else). Under the ACA, deductibles for new plans sold in the small group insurance market are limited to $2,000 for individual policies and $4,000 for family policies. Generally, health plans with higher deductibles are less expensive.

Defensive Medicine Physician use of extensive laboratory tests, increased hospital admissions and extended hospital stays for the principal purposes of reducing the likelihood of malpractice suits by patients or providing a good legal defense in the event of such lawsuits.

Deficit Reduction Act of 2005 *or* **DRA** Legislation affecting, among other things, Medicare and Medicaid. The DRA provides states with flexibility to reform their Medicaid programs. Also, the DRA encourages states to enact their own version of the False Claims Act and it increased efforts and funding to develop programs that combat health care waste, fraud, and abuse. The DRA made certain compliance activities mandatory. For example, Section 6032 of the DRA, entitled "Employee Education about False Claims Act Recovery," requires an organization to provide specific education programs as a prerequisite to receiving Medicaid reimbursement. The DRA also provided funding for the creation of a Medicaid Integrity Program.

Dental Health Maintenance Organization *or* **DMO** An HMO organized strictly to provide dental benefits.

Department of Appeals Board *or* **DAB** In an administrative action brought by an agency within HHS, a party may appeal an ALJ's decision to the DAB. The DAB's decision is final and binding 60 days after the parties are notified of the decision. Any petition for review of the DAB's decision must be filed with the appropriate U.S. Court of Appeals before the 60-day period has expired.

Department of Health and Human Services *or* **HHS** *or* **DHHS** A cabinet level U.S. department with a mission to enhance the health and well-being of all Americans, by providing for effective health and human services and by fostering sound, sustained advances in the sciences underlying medicine, public health, and social services. HHS has many significant operating divisions that are responsible for among other things the administration of the Medicare and Medicaid programs, the regulation of drugs, devices and food products, Indian health care, public health, health care research, infectious disease study and protection, and health information protection and technology. These divisions include the Administration for Strategic Preparedness and Response (ASPR), Agency for Healthcare Research and Quality (AHRQ), Agency for Toxic Substances and Disease Registry (ATSDR), Centers for Disease Control and Prevention (CDC), the Centers for Medicare & Medicaid Services (CMS), the Departmental Appeals Board (DAB), the Food and Drug Administration (FDA), the Health Resources and Services Administration (HRSA), the Indian Health Service (IHS), the National Institutes of Health (NIH), the Office for Civil Rights (OCR), the Office of Inspector General (OIG), the Office of the National Coordinator for Health Information Technology (ONC) and the Substance Abuse and Mental Health Services Administration (SAMHSA).

Department of Justice *or* **DOJ** DOJ has both civil and criminal divisions and its function is to enforce federal law and investigate and prosecute actions against individuals and entities that defraud or threaten the U.S. Government. For example, in the health care industry the DOJ investigates and prosecutes alleged violations of the AKS, FCA, and non-health care specific laws such as mail fraud.

Department of Labor *or* **DOL** The agency works to foster, promote, and develop the welfare of the wage earners, job seekers, and retirees of the U.S.; improve working conditions; advance opportunities for profitable employment; and assure work-related benefits and rights.

Department of Treasury *or* **DOT** The agency responsible for maintaining a strong economy and creating economic and job opportunities by promoting the conditions that enable economic growth and stability at home and abroad, strengthening national security by combating threats and protecting the integrity of the financial system, and managing the U.S. Government's finances and resources effectively.

Dependent A beneficiary who is covered by virtue of a family relationship with the beneficiary who has the health plan coverage. For example, one person has health insurance or an HMO through work, and that individual's spouse and children, the dependents, also have coverage under that contract.

Designated Health Services *or* **DHS** A specifically defined set of services that relate to the self-referral prohibition found in the Stark Law. Pursuant to 42 C.F.R §411.351 and subject to certain exceptions and exclusions found in relevant law and regulation, DHS generally means any of the following services (i) Clinical laboratory services; (ii) Physical therapy, occupational therapy, and outpatient speech-language pathology services; (iii) Radiology and certain other imaging services; (iv) Radiation therapy services and supplies; (v) Durable medical equipment and supplies; (vi) Parenteral and enteral nutrients, equipment, and supplies; (vii) Prosthetics, orthotics, and prosthetic devices and supplies; (viii) Home health services; (ix) Outpatient prescription drugs; and (x) Inpatient and outpatient hospital services.

Diabetes Self-Management Education and Support *or* **DSMES** A set of national standards developed by CMS and the American Diabetes Association for the education of individuals with diabetes targeted to helping such individuals manage their disease process over their life span.

Diagnosis Coding A numeral coding system that is used to specify diseases, conditions, injuries, services and items provided to patients.

Diagnosis Related Groups *or* **DRGs** A statistical system of classifying any inpatient stay into groups for the purposes of payment. Factors used to determine the DRG payment amount include the diagnosis involved as well as the hospital resources necessary to treat the condition. Also used by a few states for all payers and by many private health plans (usually non-HMO) for contracting purposes. Hospitals are paid a fixed rate for inpatient services corresponding to the DRG group assigned to a given patient.

Diagnostic and Statistical Manual of Mental Disorders *or* **DSM-V** (or whatever revision) The manual published by the American Psychiatric Association and used to provide a diagnostic coding system for mental and substance abuse disorders.

Digital Imaging and Communication in Medicine *or* **DICOM** Developed by the Medical Imaging Technology Association (MITA) it is an international standard for medical images and related information. It defines the formats for medical images that can be exchanged with the data and quality necessary for clinical use.

Direct Contract Model A managed care health plan that contracts directly with private practice physicians in the community rather than through an intermediary, such as an IPA or a medical group. A common type of model in open-panel HMOs.

Direct Contracting A term describing a provider or integrated health care delivery system contracting directly with employers rather than through an insurance company or managed care organization. A superficially attractive option that occasionally works when the employer is large enough. Not to be confused with direct contract model.

Direct Graduate Medical Education *or* **DGME** Medicare reimburses certain teaching hospitals for GME expenses; however, it does not pay for a teaching hospital's actual costs, it will only pay for its share of direct GME costs. DGME payments are the product of a hospital's total approved DGME costs and a hospital's Medicare patient load percentage.

Discharge Against Medical Advice *or* **DAMA** *See* **Against Medical Advice** *or* **AMA**.

Discharge Planning That part of utilization management that is concerned with arranging for care or medical needs to

facilitate discharge from the hospital. It includes a system of expediting transfer of a patient to a more cost-effective health care facility.

Discounted Fee-for-Service A payment model under which providers agree to accept a percentage of reduction from their fees as payment in full for their services.

Discovery Sample In the context of claims auditing, a discovery sample, also known as a probe sample, is a subset of records used to measure the impact of a certain variable. Auditors will often collect a probe sample to validate the hypothesis that certain claims are being billed in error. A discovery sample may also be used to estimate the impact of a provider's proposed resolution to a payment dispute across all affected claims in a given period. The sample should be large enough to provide confidence in the result, but small enough to limit administrative burden.

Disease Management A system of planning and coordination of medical and social services needed for a patient with a chronic condition or a complex set of conditions, including social determinants.

Disenrollment The process of termination of coverage from a health plan. Voluntary termination would include a beneficiary quitting because he or she simply wants out. Involuntary termination would include a beneficiary leaving the plan because of changing jobs. A rare and serious form of involuntary disenrollment is when a plan terminates a beneficiary's coverage against the beneficiary's will. This is usually only allowed (under state and federal laws) for gross offenses such as fraud, abuse, nonpayment of premium or copayments or a demonstrated inability to comply with recommended treatment plans.

Dispense as Written *or* **DAW** The instruction from a physician to a pharmacist to dispense a brand name pharmaceutical rather than a generic substitution.

Disproportionate Share Hospital *or* **DSH** Payments made by Medicare or a State's Medicaid program to hospitals designated as serving a "disproportionate share" of low-income or uninsured patients. These payments are in addition to the regular payments that hospitals receive for providing inpatient care to Medicare and Medicaid beneficiaries. States have some discretion in determining how much eligible hospitals receive, but the amount of federal matching funds that a state can use to make payments to DSH hospitals is capped at an amount specified in the federal Medicaid statute. The Affordable Care Act reduces the amount of both Medicare and Medicaid DSH funds distributed by the federal government as more people become insured.

Do-Not-Resuscitate Order *or* **DNR** A legally authorized physician order written either in the hospital or on a legal form to withhold cardiopulmonary resuscitation (CPR) or advanced cardiac life support (ACLS), in respect of the wishes of a patient in case their heart were to stop or they were to stop breathing.

Doctor of Osteopathic Medicine *or* **DO** A Doctor of Osteopathic Medicine is generally a medical doctor who has been trained to take a "whole person" approach to medicine, treating the entire person rather than just symptoms. DOs are also trained to focus on preventive health care and to help patients develop attitudes and lifestyles.

Doctor of Medicine *or* **MD** The graduate degree bestowed upon those who have completed medical school.

Donut Hole Most Medicare drug plans have a coverage gap, often called the "donut hole". The coverage gap begins after the beneficiary has used a certain amount for covered drugs ($5,030 in 2024). Between this amount and the catastrophic amount of $7,400 in out-of-pocket costs for covered drugs, a beneficiary pays 25% of covered drug costs. The coverage gap will be gradually phased out under the ACA.

DRG Creep The placement of patients in a higher-value DRG than is warranted by the patient's condition to receive increased Medicare reimbursement.

DRG Payment Window The period of time before a patient's admission to the hospital when the services provided to the patient are eligible for Medicare reimbursement. Between the advent of a prospective payment system in 1983 and 1990, hospitals were eligible for reimbursement for outpatient services performed in the 24 hours prior to admission. In 1990, Congress expanded the DRG payment window to include services provided during the three days prior to admission and expanded services to include not only outpatient services, but services furnished by any entity wholly owned or operated by the hospital.

Drug Discount Program *or* **340B** A federal program requiring drug manufacturers to provide outpatient drugs to eligible health care organizations/covered entities at significantly reduced prices.

Drug Utilization Review *or* **DUR** DUR is a targeted UR program for the utilization of pharmaceuticals. *See also* **Utilization Management** *or* **Utilization Review**.

Dual Choice Sometimes referred to as Section 1310 or mandating, this term refers to the requirements in the federal HMO

regulations that any health benefits plan offered by an employer of not less than 25 employees must include the option of membership in a federally-qualified HMO. The HMO's service area must be located where at least 25 such employees reside. The act puts the onus on HMOs themselves to enforce this requirement. This provision was "sunsetted" in 1995.

Dual Option The offering of both an HMO and a traditional insurance plan by one carrier.

Dual-Eligible A term used to describe an individual who is eligible for Medicare and for some level of Medicaid benefits. To promote better coordination of Medicare and Medicaid services for dual eligibles, the ACA created a Federal Coordinated Healthcare Office within CMS.

Duplicate Claims When the same claim is submitted more than once, usually because payment has not been received quickly. Can lead to duplicate payments and incorrect data in the claims file.

Duplicate Coverage Inquiry *or* **DCI** A document used in COB when one plan contacts another to inquire about dual coverage of medical benefits.

Durable Medical Equipment *or* **DME** Medical equipment that is not disposable (that is, is used repeatedly) and is only related to care for a medical condition. Examples include wheelchairs, home hospital beds and so forth. An area of increasing expense, particularly in conjunction with case management. DME is covered under Medicare Part B.

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies *or* **DMEPOS** The CMS and Medicare designation for a group of products including DME, other durable products and certain supplies. CMS has specific coverage, billing and other regulatory requirements that relate to DMEPOS, such as a competitive bidding process for businesses delivering DMEPOS to beneficiaries.

Durable Power of Attorney for Healthcare A generic term referring to a type of power of attorney where an individual name's someone else to make decisions about his or her health care when they cannot make decisions for themselves. It gives the "agent" instructions about the kinds of medical treatment the principal does or does not want in specified circumstances. Most states make a distinction between a general power of attorney which cannot be used for this person and a durable power of attorney for health care.

E

e-Prescribing The process by which prescribing practitioners use electronic systems to transmit prescriptions.

Early Intervention Program *or* **EIP** A program of services and supports available to babies and young children with developmental delays and disabilities. Programs may include speech therapy, physical therapy, and other types of services based on the needs of the child and family. The program is publicly funded and provides services for free or at reduced cost.

Effective Date The day that health plan coverage goes into effect or is modified.

Effectiveness of Care *or* **EOC** The ability of a clinical intervention to have a meaningful effect on patients in normal clinical conditions.

Electronic Clinical Quality Measures *or* **ECQM** CMS developed tools that help measure and track the quality of health care services that eligible hospitals and critical access hospitals provide, as generated by a provider's EHR. Health care providers are required to electronically report eCQMs, which use data from EHRs and/or health information technology systems to measure health care quality.

Electronic Data Interchange *or* **EDI** Computer-to-computer exchange of health care documents or data in a standard electronic format between business partners.

Electronic Drug Registration and Listing System *or* **eDRLS** eDRLS is an electronic database maintained by the FDA in which all drug establishments that formulate, develop, manufacture, distribute, process or pack drugs that are marketed in the U.S. must register. Additionally, all drug establishments that formulate, develop, manufacture, process or pack drugs that are marketed in the U.S. must list all of their marketed products through the eDRLS.

Electronic Health Record *or* **EHR** EHR is an electronic version of a patient's medical history that is usually maintained by a health care provider or supplier over time and may include key administrative clinical data relevant to that patient's care, including, for example, demographics, progress notes, problems, medications, vital signs, past medical history, immunizations, laboratory data, and radiology reports. The EHR automates access to information and has the potential to streamline the provider's workflow. The EHR also can support other care-related activities directly or indirectly through various interfaces, including evidence-based decision support, quality management, and outcomes reporting.

Electronic Medical Record *or* **EMR** *See* **Electronic Health Record** *or* **EHR**.

Eligibility The conditions imposed for coverage under a health plan, such as employment status, age, dependency status, and premium payments.

Eligible Expense *See* **Allowed Charge** *or* **Allowed Amount**

Emergency Department *or* **ED** A department within a hospital that is staffed 24 hours a day, 7 days a week, and provides unscheduled outpatient services to patients whose condition requires immediate care. *Also known as* an **Emergency Room** *or* **ER**.

Emergency Medical Services *or* **EMS** An integrated pre-hospital medical care delivery system to provide urgent and emergency medical care at the scene or during out-of-hospital patient transportation in an ambulance.

Emergency Medical Technician *or* **EMT** A medical paraprofessional who gives emergency care to individuals at the scene or during out-of-hospital patient transportation in an ambulance. They can provide basic medical and first-aid care until an individual can get help at a hospital or other medical facility.

Emergency Medical Treatment and Labor Act of 1986 *or* **EMTALA** A federal law enacted as part of COBRA, it requires hospitals with emergency departments to screen and provide stabilizing treatment within its capacity to any individual with an emergency medical condition who comes to the hospital, regardless of the person's health insurance status or ability to pay. Participating hospitals and physicians that violate EMTALA face stiff civil penalties and expose themselves to substantial civil liability and/or termination of their Medicare provider agreement.

Emergency Room *or* **ER** *See* **Emergency Department** *or* **ED**.

Employee Assistance Program *or* **EAP** An employer-based intervention program designed to assist employees. EAPs can cover a broad range of issues, like alcohol or substance misuse, child or elder care, relationship challenges, financial or legal problems, wellness matters and traumatic events.

Employee Health Services *or* **EHS** Employee health services are often basic health or wellness programs, such as preventive services, immunizations, physical examinations, and medical screening tests, provided to employees on-site at a workplace.

Employee Retirement Income Security Act of 1974 *or* **ERISA** A comprehensive piece of legislation that sets minimum standards for most voluntarily established retirement and health plans in private industry to provide protection for individual beneficiaries in these plans.

Employee Welfare Benefit Plan A plan that provides benefits other than pension benefits, such as death, disability, and medical benefits.

Employer Healthcare Tax Credit An incentive mechanism designed to encourage employers to offer health insurance to their employees. The tax credit enables employers to deduct an amount, usually a percentage of the contribution they make toward their employees' premiums, from the federal taxes they owe.

Employer Mandate A provision, such as in the ACA, which requires all employers, or at least all employers meeting size or revenue thresholds, to offer health benefits that meet a defined standard, and pay a set portion of the cost of those benefits on behalf of their employees.

Employer Pay-or-Play An approach that would require employers to offer and pay for health benefits on behalf of their employees, or to pay a specified dollar amount or percentage of payroll into a designated public fund. The fund would provide a source of financing for coverage for those who do not have employment-based coverage.

Encounter An outpatient or ambulatory visit by a patient or beneficiary of a health plan at a provider. If the beneficiary is covered by a fee-for-service plan, an encounter will generate a claim. In capitated plans, the encounter is still the visit, but no claim is generated.

Enhanced Ambulatory Patient Group, 3M™ *or* **EAPG** A methodology of coding out-patient claims that captures current changes in clinical practice and resource use to provide a broader, more inclusive classification of outpatient care.

Enhanced Primary Care *or* **EPC** *See* **Advanced Primary Care** *or* **APC**.

Enrolled Group A group of individuals, e.g., an employer's employees, who have signed up and are therefore eligible for benefits under a health plan.

Enrollee *See* **Beneficiary** *or* **Member**.

Entitlement Program Federal programs, such as Medicare and Medicaid, for which people who meet eligibility criteria have a federal right to benefits. Changes to eligibility criteria and benefits require legislation. The federal government is required to spend the funds necessary to provide benefits for individuals in these programs, unlike the discretionary programs for which spending is set by Congress through the appropriations process. Enrollment in these programs cannot be capped and neither states nor the federal government may establish waiting lists.

Episode of Care An episode of care refers to all the treatments and services related to the treatment of a condition. For acute conditions, the episode refers to all treatment and services from the onset of the condition to its resolution. For chronic conditions, the episode refers to all services and treatments received over a given period of time, commonly one year.

Episode Payment Model *or* **EPM** A model of payment for health care treatment services structured to provide a discounted payment or set a pre-determined price against which actual payments are retrospectively reconciled, that is specific to conditions for a discrete timeframe.

ERISA-Qualified or Non-qualified Health and Welfare Benefit Plan An ERISA-qualified health and welfare benefit plan is a plan, generally, but not always, in written form, established or maintained by an employer, an employee organization, or both for the purpose of providing employees and their dependents, through the purchase of insurance or otherwise, with medical, surgical, or hospital care or benefits in the event of sickness, accident, disability, death, or unemployment. ERISA preempts state laws that relate to the qualified health and welfare benefit plan, except those that regulate insurance.

Error Rate An error rate is a measure of the frequency with which an item within a sample does not meet all desired

criteria. In the health care regulatory compliance context, error rates within a sample are used as an efficient way to measure the impact of a provider's failure to meet all requirements for billing and reimbursement.

Essential Health Benefits A benchmark level of benefits created by the ACA that is meant to ensure a health plan provides a comprehensive set of covered services. Essential health benefits must include items and services within at least 10 categories, including ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance abuse disorder services; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventative and wellness services and chronic disease management; and pediatric services, including oral and vision care. Plans both within and outside of the health insurance exchange will be required to offer at least this level of coverage. Cost-sharing will be limited to the current HSA limits. The Secretary of HHS is required to define and annually update the benefit package.

Estimated Length of Stay *or* **ELOS** An estimation of an individual patient's LOS. *See* **Length of Stay** *or* LOS and **Average Length of Stay** *or* **Average Length of Stay** *or* **ALOS**.

Ethics in Patient Referrals Act of 1989 The law generally prohibits physicians from making patient referrals for Designated Health Services (DHS) to entities in which the physician or an immediate family member has a financial interest (ownership or compensation). *Most commonly known as* the **Stark Law**, a reference to the law's sponsor in Congress, former Rep Fortney "Pete" Stark (D-CA) *Also known as* the **Physician Self-Referral Prohibition** *or* the **Physician Self-Referral Law**. *See* **Stark I** and **Stark II**

Eunice Kennedy Shriver National Institute of Child Health and Human Development *or* **NICHD** An institute of NIH, it leads research and training to understand human development, improve reproductive health, enhance the lives of children and adolescents, and optimize abilities for all.

Evaluation and Management *or* **E/M** A health care professional treatment services process that translates to a subset of medical billing codes, CPT® codes, and associated documentation. E/M codes are used to seek reimbursement from third party payors, including Medicare and Medicaid. The codes vary by the intensity and significance of the patient encounter.

Evidence of Insurability A form that documents whether an individual is eligible for health plan coverage when the individual does not enroll through an open enrollment period. For example, if an employee wants to change health plans in the middle of a contract year, the new health plan may require evidence of insurability.

Exclusion The OIG has the statutory and regulatory authority to exclude individuals and entities from participating in federally funded health care programs. Exclusion action can be taken in response to program-related fraud and abuse, patient abuse, defaults on Health Education Assistance Loans, and licensing board actions. Health care providers are prohibited from employing or contracting with individuals who are excluded from federal health care programs. The GSA also maintains an exclusion database for individuals and entities that have been excluded from contracting with the federal government by any federal agency.

Exclusive Provider Organization *or* **EPO** Combines elements of PPOs and HMOs. Like a PPO, EPOs contract with a preferred group of providers. Like an HMO, enrollees in an EPO must use those providers to be eligible for reimbursement or sacrifice reimbursement altogether.

Experience Rating A method of setting health insurance premium rates based on the actual health care costs of a group or groups.

Experimental Medical Procedure A medical practice, procedure, or treatment still in a trial stage that is, being tested on humans or animals. For distinction in meaning *See* **Investigational Medical Procedure**.

Explanation of Benefits *or* **EOB** The form that a payer or claims administrator sends to the beneficiary that summarizes how a claim was processed and paid by the payer.

Extended Care Facility *or* **ECF** A facility, or portion of a facility, which offers subacute care, providing treatment services for patients requiring inpatient care but who do not currently require continuous hospital services. *See* **Skilled Nursing Facility** *or* **SNF and Nursing Facility** *or* **NF**.

External Review Process to appeal health plan benefit denials based on the issuer's or plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, as well as rescissions of coverage, regardless of whether the rescission has an effect on a specific benefit at the time. Plans must include a description of the external review process with the summary plan description, policy, or similar document provided to enrollees.

Extracontractual Benefits Health care benefits beyond what the beneficiary's actual policy covers. These benefits are provided by a plan to reduce utilization. For example, a plan may not provide coverage for a hospital bed at home, but it is more cost-effective for the plan to provide such a bed than to keep admitting a beneficiary to the hospital.

The Early and Periodic Screening, Diagnostic and Treatment *or* **EPSDT** A benefit that provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. The benefit also includes follow-up diagnostic and treatment services to correct conditions identified during a screening, without regard to whether the state Medicaid plan covers those services for adult beneficiaries.

F

F Tag A cross-reference to a specific regulatory requirement within the Code of Federal Regulations used by State Survey Agencies on a CMS Form 2567 Statement of Deficiencies. For example, "F550" refers to the regulatory requirements found in 42 CFR §483.10 – Resident's Rights. A full list of the F Tags exists in the CMS State Operations Manual, Appendix PP - Guidance to Surveyors for Long-Term Care Facilities.

Facility Acquired Condition *or* **FAC** *See* **Healthcare-Acquired Condition** *or* **HAC**

Faculty Practice Plan *or* **FPP** A form of group practice organized around a teaching program. It may be a single group encompassing all the physicians providing services to patients at the teaching hospital and clinics, or it may be multiple groups drawn along specialty lines (for example, psychiatry, cardiology, or surgery).

Fair Market Value *or* **FMV** In broad terms, it is the current price that a buyer in the open market is willing to pay to purchase a certain asset. FMV plays a critical role in meeting applicable exceptions to the Stark Law or meeting safe harbors to the AKS and evaluating certain tax-exempt considerations. Stark Law regulations provide specific definitions of FMV in 42 C.F.R. §411.351. FMV is often a range and not a specific number.

False Claims Act *or* **FCA** While often used in relation to the Civil False Claims Act, 31 U.S.C. § 3279 *et seq*., this acronym can also refer to the Criminal False Claims Act, 18 U.S.C. § 287. The civil FCA imposes liability, including substantial monetary penalties and treble damages, on any individual or entity that knowingly presents or causes to be presented a false or fraudulent claim of payment or approval to the federal government. The criminal FCA imposes penalties of up to five years of imprisonment and fines on "whoever makes or presents to [the federal government]. . . any claim . . . knowing such claim to be false, fictitious, or fraudulent. . ."

Family Deductible *See* **Annual Deductible Combined**

Federal Coordinated Healthcare Office *or* **FCHCO** Created by the ACA, a CMS office that is charged with ensuring more effective integration of benefits under Medicare and Medicaid for individuals eligible for both programs and improving coordination between the federal government and states in the delivery of benefits for such individuals.

Federal Emergency Management Agency *or* **FEMA** A federal agency that is responsible for coordinating federal government resources to help people before, during and after disasters.

Federal Employee Health Benefit Acquisition Regulations *or* **FEHBARS** The regulations applied to OPM's purchase of health care benefits programs for federal employees.

Federal Employee Health Benefits Program *or* **FEHB** The health insurance program for federal employees and their families. The FEHBP is administered by the U.S. Office of Personnel Management (OPM).

Federal Financial Participation *or* **FFP** *See* **Federal Medical Assistance Percentage** *or* **FMAP**

Federal Housing Administration *or* **FHA** A unit of HUD that provides mortgage insurance on single-family, multifamily, residential care facilities, manufactured home, and hospital loans made by FHA-approved lenders throughout the U.S. and its territories.

Federal Insurance Contributions Act *or* **FICA** Federal law establishing payroll taxes to fund the Social Security and Medicare programs.

Federal Medical Assistance Percentage *or* **FMAP** The portion paid by the federal government to states for their share of expenditures for providing Medicaid services and for administering the Medicaid program and certain other human service programs. *Also known as* **Federal Financial Participation** *or* **FFP**.

Federal Poverty Level *or* **FPL** Published by HHS on an annual basis, it is an economic measure used to decide whether the income level of an individual or family qualifies them for certain federal benefits and programs, such as housing vouchers, Medicaid, and CHIP. HHS updates its poverty guidelines, illustrating the set minimum amount of income that a family needs for food, clothing, transportation, shelter, and other necessities, once a year, adjusted for inflation.

Federal Sentencing Guidelines Guidelines developed by the U.S. Sentencing Commission to help eliminate discrepancies in the sentencing of defendants. Though the Guidelines were originally mandatory, because of subsequent U.S.

Supreme Court case law, they are now considered advisory only. The guidelines include Section §8B2.1 – Effective Compliance and Ethics Program which is often used as the standard for creating and implementing regulatory compliance programs in health care organizations. *See* **Compliance Program**.

Federally Qualified Health Center *or* **FQHC** FQHCs are safety net providers that primarily provide primary and specialty care services typically furnished in an outpatient clinic. FQHCs include community health centers, migrant health centers, health care for the homeless health centers, public housing primary care centers, and health center program "lookalikes." They also include outpatient health programs or facilities operated by a tribe. FQHCs are paid based on the FQHC Prospective Payment System.

Federally Qualified Health Maintenance Organization An HMO that has met federal standards delineated in the federal HMO Act for legal and organizational status, financial viability, marketing, and health service delivery systems. Federally qualified HMOs are required to provide or arrange for basic necessary services with no limitation as to time, cost, frequency, extent, or kind of services provided.

Federation of American Hospitals *or* **FAH** A national industry association representing tax-paying community hospitals and health systems throughout the U.S.

Federation of State Medical Boards *or* **FSMB** An organization of U.S. state medical and osteopathic regulatory board. It supports its members with the best regulatory practices, licensing and discipline policies and guidance in many other areas.

Fee Schedule A listing of the maximum fees that a health plan will pay for certain items and services. *Also referred to as* **Fee Maximums** *or* a **Fee Allowance Schedule**.

Fee-For-Service *or* **FFS** A payment model under which health care providers are paid for each service encounter they provide, as compared to a bundled or capitated payment.

Fellow of the American College of Healthcare Executives *or* **FACHE** A professional credential awarded by ACHE. *See* **American College of Healthcare Executives** *or* **ACHE**

Fellow of the Healthcare Financial Management Association *or* **FHFMA** A professional credential awarded by HFMA. *See* **Healthcare Financial Management Association** *or* **HFMA**

Fiscal Intermediary *or* **FI** *See* **Medicare Administrative Contractor** *or* **MAC** A private companies contracted by Medicare to adjudicate and pay claims. Medicaid programs can also utilize FIs. *Also known as* a **Medicare Administrative Contractor** *or* **MAC**.

Fiscal Year *or* **FY** A one-year period of time that a company or government uses for accounting purposes and preparation of its financial statements. In cost-based reimbursement, it may also be used for the cost reporting period.

Flexible Benefits Plan *or* **Flex Plan** A plan offered by an employer to employees that allows them to choose a variety of options in benefits up to a certain total amount. The employee then can tailor their benefits package among health coverage, life insurance, child-care, and so forth to optimize benefits for their particular needs. *Also known as* a **Cafeteria Plan**.

Flexible Spending Account An account managed by an employer for employees to set aside pre-tax dollars for medical, dental, and other expenses not covered by their health plan, including beneficiary payments (coinsurance, copayments, and deductibles) or any portion of the premium the beneficiary is responsible for paying.

Food and Drug Administration *or* **FDA** A federal government agency within HHS that is responsible for protecting the public health by ensuring the safety, efficacy, and security of human and veterinary drugs, biological products, and medical devices; and by ensuring the safety of our nation's food supply, cosmetics, and products that emit radiation.

Foreign Medical Graduate *or* **FMG** *See* **International Medical Graduate** *or* **IMG**.

Form 990 Form 990 - Return of Organization Exempt from Income Tax is the primary tool the IRS uses to collect information on, oversee the activities of and to enforce federal tax laws governing tax exempt status for tax-exempt organizations. The Form 990 requires disclosures relating to transactions among officers, key employees, board members, and hospitals. It also requires hospitals to justify the favorable tax treatment that they receive. For example, Schedule H requires tax-exempt hospitals to include certain information to demonstrate compliance with the community benefit standard. Form 990 is a publicly-available document intended to ensure transparency and accountability.

Formulary A listing of drugs that a physician may prescribe. The list may be one that a health plan has developed or one

that a health system or health care provider has developed. In most instances, the physician is requested or required to use only formulary drugs unless there is a valid medical reason to use a nonformulary drug.

Foundation Model Refers to an integrated health care delivery system in which a nonprofit foundation is responsible for providing the income to a medical group that is exclusive with the foundation. The foundation is usually, but not necessarily, associated with a nonprofit hospital and is often found in states with corporate practice of medicine prohibitions.

Fragmented Claims Billing separately for items, services or procedures provided in a patient encounter rather than using a global billing code covering all of these items and services, when billing separately results in a higher payment rate.

Fraud Knowing and willful deception or misrepresentation or a reckless disregard of the facts, with the intent to receive an unauthorized benefit.

Fraud Alerts The OIG has issued Fraud Alerts as a way of informing the health care industry about prohibited practices. The alerts are generally brief documents that describe conduct that OIG perceives as violating the fraud and abuse laws.

Fraud and Abuse A general term referring to inappropriate or illegal activities targeted at health benefit plans, both federal and commercial. *See* **Fraud** *and* **Abuse**.

Fraud and Abuse Laws State and federal laws applying to health benefits, including Medicare and Medicaid, designed to prohibit false or improper claims, paying or receiving kickbacks, and self-referral arrangements.

Fraud Enforcement and Recovery Act of 2009 *or* **FERA** Among addressing certain other types of financial fraud, the act amended the FCA in significant ways. It expands liability for retaining money owed to the government; it expands protection for whistle-blowers; allows relators to access information from government subpoenas; effectively expands the statute of limitations for FCA actions, specifying that government complaints relate back to earlier filed whistleblower complaints for purposes of the statute of limitations; and lastly, makes some changes apply retroactively.

Freestanding Ambulatory Surgery Center *or* **FASC** A distinct ASC entity that is not part of a larger institution and is operated exclusively for the purpose of providing surgical services to patients not requiring hospitalization. *See* **Ambulatory Surgery Center** *or* **ASC**

Freestanding Emergency Department *or* **FSED** A licensed facility that is structurally separate and distinct from a hospital and provides emergency care. *Also known as* a **Freestanding Emergency Center** *or* **Freestanding Emergency Room**.

Freestanding Outpatient Surgical Center *See* **Freestanding Ambulatory Surgery Center** *or* **FASC**.

Full Capitation A term that refers to the bucket of reimbursement that a physician group or organization may receive for a given patient population intended to cover all professional expenses for the patient population, not just for the services the group or organization provides itself. Full capitation rarely, if ever, includes capitation for institutional services. The group is then responsible for subcapitating or otherwise reimbursing other physicians for services to its patient population.

G

Gag Clause In relation to provider agreements with health plans, a term prohibiting the provider from communicating with patients regarding the provider's treatment recommendations, such as more expensive, but potentially more effective, treatment options. Most states have enacted statutes or regulations prohibiting gag clauses.

Gatekeeper A primary care provider who coordinates a patient's care with specialists and hospitals in a managed care model. Typically, the gatekeeper physician must authorize specialty care or services before that care is rendered.

General Services Administration *or* **GSA** A U.S. agency that is essentially responsible for the back-office functions of the federal government. It provides workplaces by constructing, managing, and preserving government buildings and by leasing and managing commercial real estate. It handles procurement functions and IT solutions. It also promotes best management practices and efficient government operations through the development of governmentwide policies. It maintains an exclusion database for individuals and entities that have been excluded from contracting with the federal government.

Generic Drug An unbranded drug that is equivalent to a brand-name drug but usually less expensive. Most managed care organizations that provide drug benefits cover generic drugs but may require a beneficiary to pay the difference in cost between a generic drug and a brand-name drug or pay a higher copay unless there is no generic equivalent.

Geographic Adjustment Factor *or* **GAF** The Medicare program uses this measure to adjust fee-for-service payment rats for hospitals and providers according to the geographic location in which the providers practice.

Geographic Practice Cost Index *or* **GPCI** A Medicare adjustment factor that includes local geographic area estimates of how hard the provider has to work, what the practice expenses are, and what malpractice costs are. The GPCI reflects one-fourth the difference between the area average and the national average.

Geometric Mean Length of Stay *or* **GMLOS** This is the national mean length of stay for each DRG as determined and published by CMS.

Global Capitation A capitation payment that covers all medical expenses, including professional and institutional expenses but may not necessarily cover optional benefits *(*e.g., pharmacy). *Also referred to as* **Total Capitation**.

Graduate Medical Education *or* **GME** A general term that refers to several types of formal medical education, such as internship, residency, subspecialty and fellowship programs, pursued after receipt of an M.D. or D.O. degree. This education is usually necessary for state licensure and board certification.

Grandfathered Plan A health plan that was in place on March 23, 2010 when the Affordable Care Act was enacted, is exempt from complying with some parts of the law, so long as the plan does not make significant changes to its policy, such as eliminating or reducing benefits to treat a specific disease or condition, significantly increasing cost-sharing, or reducing the employer contribution toward the premium, among others. Once a health plan makes such a change to their policy, it becomes subject to all the requirements of the ACA.

Grievance Procedure A formal process for the resolution of health plan beneficiaries' or providers' complaints, generally mandated by state law or under federal standards.

Group The plan beneficiaries who are covered by virtue of receiving health plan coverage under a single policy whether through an employer or otherwise.

Group Model HMO An HMO that contracts with a medical group for the provision of health care services. The relationship between the HMO and the medical group is generally close, although there are wide variations in the relative independence of the group from the HMO. A form of closed-panel health plan.

Group Practice A professional business engaged in the practice of medicine or dentistry with associated physicians or dentists (such as specialists in different fields) working as partners or as partners and employees. Group Practice also has a specific meaning defined in the Stark Law regulations.

Group Practice Without Walls *or* **GPWW** A group practice in which the members of the group come together legally but continue to practice in private offices scattered throughout the service area.

Group Purchasing Organization *or* **GPO** An entity authorized to act as a purchasing agent for a group of individual providers or health care organizations. A GPO often negotiates pricing and contractual terms with vendors on behalf of its members. Members can choose whether or not to participate in the negotiated contractual arrangements.

Grouper A set of software programming algorithms that systematically define the health care services that belong to multiple distinct health care episodes.

Guarantee Issue/Renewal Requires insurers to offer and renew coverage, without regard to health status, use of services, or pre-existing conditions. This ACA requirement ensures that no one will be denied coverage for any reason.

H

HCFA-1500 *See* **CMS 1500** and **UB-04/UB-92**

Health Care and Education Affordability Reconciliation Act of 2010 *or* **HCEARA** A reconciliation bill that the 111th Congress enacted into law on March 30, 2010, which made several changes to the ACA that was enacted 7 days earlier. Among other things, the changes included increasing tax credits to buy insurance, lowering the penalty for not buying insurance, and closing the Medicare Part D "donut hole."

Health Care Financing Administration *or* **HCFA** *See* **Centers for Medicare and Medicaid Services** *or* **CMS**

Health Care Fraud and Abuse Control Program *or* **HCFAC** Efforts to combat fraud were consolidated and strengthened under HIPAA. The Act established a comprehensive program to combat fraud committed against all health plans, both public and private. The legislation required the establishment of a national Health Care Fraud and Abuse Control Program under the joint direction of the U.S. Attorney General and the Secretary of HHS acting through the OIG.

Health Care Plan A universal term for an arrangement in which any person (usually an insurer) undertakes to provide, arrange for, pay for, or reimburse any part of the cost of any health care services in exchange for the payment of a premium from the covered person.

Health Care Quality Improvement Program *or* **HCQIP** In 1992, HCFA established this program, which promotes partnerships between PROs (now QIOs) and hospitals, health plans and physicians. These partnerships profile patterns of medical care, identify areas in which treatment could be improved, assist in the development of quality improvement efforts, and measure improvement.

Health Equity Generally, is the state in which everyone has a fair and just opportunity to attain their highest level of health.

Health Information Exchange *or* **HIE** An electronic information exchange that allows providers and patients to appropriately access and securely share patient medical information electronically. There are three key forms of health information exchange: (1) a Directed Exchange with the ability to send and receive secure information electronically between care providers to support coordinated care; (2) a query-based exchange with the ability for providers to find and/or request information on a patient from other providers, often used for unplanned care; and (3) a Consumer Mediated Exchange with the ability for patients to aggregate and control the use of their health information among providers

Health Information Management *or* **HIM** A combination of business, science, and information technology practices that are utilized to acquire, analyze and protect digital and traditional medical information.

Health Information Management System Society *or* **HIMSS** An industry association for HIM professionals that offers expertise in health innovation, public policy, workforce development, research and digital health transformation.

Health Information Service Provider *or* **HISP** A network service operator that allows for clinical data exchange on a national level through Direct Secure Messaging. It manages security and transportation for an HIE.

Health Information Sharing and Analysis Center *or* **Health-ISAC** A community of critical infrastructure owners and operators within the health care and public health sector focused on sharing timely, actionable and relevant information with each other including intelligence on threats, incidents and vulnerabilities in relation to preventing, detecting, and responding to cybersecurity and physical security events.

Health Information Technology *or* **HIT** *or* **Health IT** Involves the processing, storage, and exchange of health information in an electronic environment. Widespread use of HIT within the health care industry is designed to improve the quality of health care, prevent medical errors, reduce health care costs, increase administrative efficiencies, decrease paperwork, and expand access to affordable health care.

Health Information Technology for Economic and Clinical Health Act *or* **HITECH** Included in ARRA, the law incentivized the adoption and use of health information technology, expanded Health Information Exchanges,

strengthened the privacy and security provisions of HIPAA, and increased penalties for violations. *See* **American Recovery and Reinvestment Act of 2009** *or* **ARRA**

Health Insurance Association of America *or* **HIAA** Merged with the American Association of Health Plans to form America's Health Insurance Plans in 2004. *See* **America's Health Insurance Plans** *or* **AHIP**.

Health Insurance Exchange An arrangement through which insurers offer smaller employers and individuals health plans for purchase. Under the ACA, state-based health insurance exchanges were established to set standards for what benefits are to be covered, how much insurers can charge, and the rules insurers must follow to participate in the insurance market. Individuals and small employers will then be able to select their coverage within this organized arrangement.

Health Insurance Marketplace *See* **Health Insurance Exchange**

Health Insurance Portability and Accountability Act of 1996 *or* **HIPAA** HIPAA addresses the privacy and security of health data. (45 C.F.R §§ 160.103, 164.302, 164.500). A large piece of health care legislation which provides, among other things, for the continuity of health care, non-discrimination, payment integrity, and the privacy and security of health information. Title I of HIPAA protects health insurance coverage for workers and their families when they change or lose their jobs. Title II of HIPAA, known as the Administrative Simplification provisions, requires the establishment of national standards for electronic health care transactions and national identifiers for providers, health plans, and employers. The Administrative Simplification provisions also address the security and privacy of health data. The standards are meant to improve the efficiency and effectiveness of the nation's health care system by encouraging the widespread use of electronic data interchange in the U.S. health care system.

Health IT *See* **Health Information Technology** *or* **HIT**.

Health Maintenance Organization *or* **HMO** A system of health care delivery that not only pays for the care, but also arranges for the provision of services. HMO beneficiaries must receive care from a participating provider who has contracted with the HMO. In a majority of HMO models, beneficiaries choose a primary care physician from a panel of physicians affiliated with the HMO. The primary care physician serves as a gatekeeper, authorizing all visits to a specialist.

Health Plan Employer Data and Information Set *or* **HEDIS®** Developed by the NCQA with considerable input from the employer community and the managed care community, HEDIS® is an ever-evolving set of data reporting standards. HEDIS® is designed to provide some standardization in performance reporting for financial, utilization, membership, and clinical data so that employers and others can compare performance among plans and across organizational structures.

Health Professional Shortage Area *or* **HPSA** A designation used by the Bureau of Health Workforce at the HRSA to identify areas and population groups within the U.S. that are experiencing a shortage of health professionals. There are three categories of HPSA designations: primary medical, dental, and mental health.

Health Reimbursement Arrangement *or* **HRA** A tax-exempt account that can be used to pay for current or future qualified health expenses. HRAs are established benefit plans funded solely by employer contributions, with no limits on the amount an employer can contribute. HRAs are often paired with a high-deductible health plan, but do not have to be.

Health Resources and Services Administration *or* **HRSA** HRSA, an agency of HHS, is the primary federal agency for improving access to health care by strengthening the health care workforce, building healthy communities, and achieving health equity. HRSA's programs provide health care to people who are geographically isolated as well as economically and/or medically vulnerable.

Health Savings Account *or* **HSA** Employers may make HSAs available so their employees or individuals can obtain HSAs from most financial institutions. Employers and employees can contribute to the plan. In order to open an HSA, an individual must have health coverage under an HSA-qualified high-deductible health plan.

Healthcare Common Procedure Coding System *or* **HCPCS** A set of codes used by Medicare that describes services and procedures. HCPCS includes CPT® codes but also has codes for services not included in CPT®, such as DME and ambulance. Although HCPCS is nationally defined, there are provisions for local use of certain codes. HCPCS Level I codes are CPT® codes, Level II codes are for suppliers and non-CPT® codes, and Level III are locally set codes.

Healthcare Facilities Accreditation Program *or* **HFAP** A not-for-profit health care provider accrediting organization with CMS deeming authority. It was merged into ACHC.

Healthcare Financial Management Association *or* **HFMA** An industry association of health care finance professionals and organizations from hospitals and health systems, provider organizations, physician practices, business partners and payer markets.

Healthcare Fraud Prevention Partnership *or* **HFPP** A voluntary public-private partnership between the federal government, state agencies, law enforcement, private health plans, and health care anti-fraud associations.

Healthcare Integrity and Protection Data Bank *or* **HIPDB** Established by HIPAA, the purpose of the HIPDB was to help combat health care fraud and abuse. The HIPDB was merged in the NPDB in 2013. *See* **National Practitioner Databank** *or* **NPDB**.

Healthcare-Acquired Condition *or* **HAC** A medical condition or complication that a patient develops during an in-patient stay, which was not present at admission. The ICD-10 has a list of HACs. *Also known as* **Hospital Acquired Condition** *or* **Facility Acquired Condition** *or* **FAC**.

Healthcare-Acquired Infection *or* **HAI** A type of HAC, an infection that a patient develops during an in-patient stay, which was not present at admission.

High Deductible Health Plan *or* **HDHP** A health plan with a higher deductible than a traditional insurance plan. The monthly premium is usually lower, but the beneficiary pays more health care costs before the insurance company starts to pay its share. An HDHP can be combined with an HSA.

High-Risk Pool State programs designed to provide health insurance to residents who are considered medically uninsurable and are unable to buy coverage in the individual market.

Home Health Agency *or* **HHA** An organization that provides certain part-time or intermittent medical, nursing, therapy, and personal care services to individuals in their homes pursuant to a comprehensive care plan. HHA is also a defined type of provider that can participate in Medicare Part A and Medicaid.

Home Health Care A wide range of health care services that can be given in an individual's home for an illness or injury. Home health care can be less expensive, more convenient, and just as effective as care in a hospital or skilled nursing facility.

Home Health Value-Based Purchasing Model *or* **HHVBP** CMS implemented this payment model on January 1, 2016 to improve the quality and delivery of home health care services to Medicare beneficiaries with specific goals to provide incentives for better quality care with greater efficiency; study new potential quality and efficiency measures for appropriateness in the home health setting; and enhance the current public reporting process.

Hospice and Palliative Nurses Association *or* **HPNA** Professional association for nurses primarily engaged in the field of hospice and palliative care. The Association also has a credential for nurses specializing in this field.

Hospice Care A concept of care provided to terminally ill patients and their families that emphasizes emotional and spiritual needs and coping with pain and death rather than the cure. Hospice care prioritizes comfort and quality of life by reducing pain and suffering. Hospice care provides an alternative to therapies focused on life-prolonging measures that may be difficult, be likely to cause more symptoms, or are not aligned with a person's goals.

Hospital Consumer Assessment of Healthcare Providers and Systems *or* **HCAHPS** A national, standardized, publicly reported survey of patients' perspectives of hospital care. *Also known as* the **CAHPS Hospital Survey**.

Hospital Inpatient Quality Reporting Program *or* **HIQRP** *or* ***HQR*** A CMS program that collects quality data from hospitals that participate in Medicare. The goal of the program is to drive quality improvement through measurement and transparency by publicly displaying data to help consumers make more informed decisions about their health care.

Hospital Outpatient Department *or* **HOPD** Department of a hospital in which outpatients, persons who have not been admitted as an inpatient, are receiving hospital ambulatory services such as physician services, therapy services, clinic services, or same day surgery services.

Hospital Outpatient Quality Data Reporting Program *or* **HOP QDRP** A pay for quality data reporting program implemented by CMS for outpatient hospital services. The program was mandated by the Tax Relief and Healthcare Act of 2006, which requires hospitals to submit data on measures on the quality of care furnished by hospitals in outpatient settings. Hospitals failing to report data receive a 2-percentage point reduction in payment to their OPPS payments and copayments for all applicable services.

Hospital Quality Alliance *or* **HQA** Created in 2002, it is a national public-private collaboration that is committed to making meaningful, relevant, and easily understood information about hospital performance accessible to the public

and to informing and encouraging efforts to improve quality in hospital patient care.

Hospital Quality Initiative *or* **HQI** CMS initiative to improve the quality of care that hospitals provide and to distribute clearly defined and objective data about hospital performance. The program provides incentives for hospitals to improve care and emphasizes public accountability.

Hospital Readmissions When a patient is discharged from a hospital, then later readmitted to a hospital for care within a certain number of days often for the same or similar condition. The number of hospital readmissions is often used to measure quality of care in a hospital and other care settings.

Hospital Readmissions Reduction Program *or* **HRRP** A Medicare value-based purchasing program that encourages hospitals to improve communication and care coordination to better engage patients and caregivers in discharge plans and, in turn, reduce avoidable readmissions.

Hospital Research and Educational Trust *or* **HRET** A not-for-profit research and education affiliate of AHA with a mission to transform health care through research and education.

Hospital-Specific Relative Value *or* **HSRV** A measure used in the calculation of DRGs, the HSRV weights include adjustments to reduce the effect on weights of the differences among hospitals in how they set charges.

Hospitalist A physician whose primary professional focus is the general medical care of hospitalized patients / inpatients.

Hours Per Patient Day *or* **HPPD** Generally, a calculation of the total number of nursing staff hours provided during a particular day. Used as a budget and productivity measure.

I

Iatrogenic Illnesses occurring as a result of medical treatment or examination.

Improving Medicare Post-Acute Care Transformation Act of 2014 *or* **IMPACT Act** Congress passed this Act on September 18, 2014 to change and improve Medicare's post-acute care services and how they are reported. The Act requires LTCHs, SNFs, HHAs, and IRFs to submit standardized patient assessment data with regard to quality measures, resource use, and other measures.

Income-Related Premium Premiums for Medicare Part B and Part D that apply to higher-income Medicare beneficiaries. The Medicare Modernization Act of 2003 established an income-related Part B premium that took effect in 2007, requiring higher-income Medicare beneficiaries to pay a greater share of average Part B costs. The Affordable Care Act froze the threshold for the income- related Part B premium at 2010 levels through 2019. The ACA also created an income-related Part D premium, effective in 2011, using the same surcharge percentages and income thresholds as for Part B. Similar to the Part B premium provision, the income thresholds for the Part D income-related premium are not indexed to increase annually.

Incurred But Not Reported *or* **IBNR** The amount of money that the plan should accrue for medical expenses that it knows nothing about yet. These are medical expenses (i.e. claims) that have transpired that the authorization system has not captured and for which claims have not yet been received by the insurer.

Incurred but Unpaid Claims Claims that may not have been paid as of some specific date. May include reported and unreported claims. *See also* **Incurred but Not Reported** *or* **IBNR**.

Indemnity Insurance A type of insurance plan whereby the insurer reimburses the beneficiary for incurred medical costs that are covered under the beneficiary's plan. Under most indemnity plans, there are no provider networks, so the beneficiary can go to any provider they choose. However, if the provider does not accept the insurer's indemnity plan, the beneficiary may be balance-billed by the provider for the amount not covered under the plan.

Independent Payment Advisory Board *or* **IPAB** Established by the ACA, a board of 15 members appointed by the President and confirmed by the Senate for six-year terms. The board is tasked with submitting proposals to Congress to reduce Medicare spending by specified amounts if the projected per beneficiary spending exceeds the target growth rate. If the Board fails to submit a proposal, the Secretary of HHS is required to develop a detailed proposal to achieve the required level of Medicare savings. The Secretary is required to implement the Board's (or Secretary's) proposals, unless Congress adopts alternative proposals that result in the same amount of savings. The Board is prohibited from submitting proposals that would ration care, increase taxes, change Medicare benefits or eligibility, increase beneficiary premiums and cost-sharing requirements, or reduce low-income subsidies under Part D.

Independent Review Organization *or* **IRO** IROs act as a third-party medical review resource designed to provide objective, unbiased medical determinations that support effective decision making based on medical evidence. IROs may assist providers in developing evidence to obtain reimbursement and are often required in CIAs.

Indian Health Service *or* **IHS** The Indian Health Service is an agency within HHS responsible for providing federal health services to American Indians and Alaska Natives. It is the principal federal health care provider and health advocate for Indian people, and its goal is to raise their health status to the highest possible level.

Indicator Measurement System *or* **IMS** The continuous data collection and periodic feedback about specific patient care performance measures, or indicators. An indicator is a quantitative measure of an aspect of care. It is not a direct measure of quality; rather it is a screen or flag which indicates areas for more detailed analysis. Such a system has been developed in the context of meeting future accreditation needs by the Joint Commission on Accreditation of Healthcare Organizations.

Indirect Medical Education *or* **IME** The additional payments granted to hospitals that have residents in an approved medical education program to reflect the higher costs of patient care of teaching hospitals relative to non-teaching hospitals for a Medicare discharge.

Individual Insurance As opposed to group insurance, coverage provided under a contract issued to one individual or family at a time, usually requiring evidence of insurability. Also called direct pay coverage in some instances.

Individual Insurance Market The market where individuals who do not have group (usually employer-based) coverage purchase private health insurance. *Also referred to as* the **Non-Group Market**.

Individual Mandate A requirement that all individuals obtain health insurance. Massachusetts was the first state to impose an individual mandate that all adults have health insurance. The ACA established an individual mandate to obtain health insurance, applicable to all Americans with some hardship and income-based exemptions.

Individual Practice Association Model HMO An HMO in which individual practitioners see patients enrolled in the HMO in addition to treating their own patients who are not enrolled in the HMO. *Also referred to as* an **Individual Practice Association** *or* **IPA**.

Individual Practice Association *or* **IPA** An IPA is a network of providers that contracts to deliver health care services to HMOs, PPOs, employers, unions, and other payers. The IPA, in turn, enters into participating provider or similar agreements wherein its constituent physician-owners agree to provide medical services to beneficiaries of plans with which the IPA contracts. ACOs are typically organized as IPAs or PHOs.

Individually Identifiable Health Information *or* **IIHI** Individually identifiable health information" means any information, including demographic information collected from an individual, that: (A) is created or received by a health care provider, health plan, employer, or health care clearinghouse; and (B) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual, and (i) identifies the individual; or (ii) with respect to which there is a reasonable basis to believe that the information can be used to identify the individual.

Informed Consent Legal right of all adults, with no upper age limit, to make their own decisions regarding medical, financial, and daily living matters.

Infusion Nurses Society *or* **INS** An international nonprofit organization representing infusion nurses and other clinicians who are engaged in the specialty practice of infusion therapy. It provides resources to help navigate the rapid technological advances and dramatic shifts in health care delivery.

Injuries Injuries caused by the medical treatment itself, not the underlying disease.

Inpatient An individual patient who stays in a hospital while they are receiving treatment.

Inpatient Prospective Payment System *or* **IPPS** A payment system that provides flat rate payments based on the average charges across all hospitals for specific medical diagnosis to most inpatient acute-care hospitals in regard to Medicare admissions.

Inpatient Psychiatric Facility *or* **IPF** A hospital that has an organized psychiatric services unit. A hospital that is licensed to provide psychiatric care services in an inpatient setting.

Inpatient Quality Reporting *or* **IQR** An organization that has a contract with a managed care plan to deliver services in return for a single capitation rate. The IPA in turn contracts with individual providers to provide the services either on a capitation basis or on a fee-for-service basis. The typical IPA encompasses all specialties, but an IPA can be solely for primary care, or it may be a single specialty. An IPA may also be the "PO" part of a PHO.

Inpatient Rehabilitation Facility *or* **IRF** Freestanding rehabilitation hospitals and units in acute care hospitals that provide intensive rehabilitation programs.

Inpatient Rehabilitation Facility-Patient Assessment Instrument *or* **IRF-PAI** The patient assessment instrument used in inpatient rehabilitation facilities and hospitals for patients receiving sub-acute rehabilitation services.

Institute for Healthcare Improvement *or* **IHI** A private, non-profit, organization founded with the mission of improving health and health care worldwide.

Institute for Safe Medication Practices *or* **ISMP** A 501c (3) non-profit organization dedicated to preventing medication errors through the use of a voluntary practitioner medication error reporting program.

Institute of Medicine *or* **IOM** This organization is part of the National Academy of Sciences in Washington, DC.

Institutional Cost Report *or* **ICR** A uniform report that requires the expenses, revenues, assets, liabilities, and statistical information of a hospital to be filed annually.

Institutional Review Board *or* **IRB** Panel that prospectively reviews and approves biomedical or behavioral protocols involving human subjects that are supported with federal funds. Mandated by the National Research Act of 1973.

Insurance Exchange A marketplace provided by an entity that offers insurance coverage that is otherwise unavailable elsewhere, with the distinction of the coverage being for unusual or nonstandard risks. These are also marketplaces where consumers can compare and buy individual insurance plans.

Integrated (Carve-Out) Plan Method of combining two or more benefit plans to prevent a duplication of benefits or over insurance.

Integrated Care The provision of health care services in a coordinated manner across the entire care continuum; characterized by a high degree of collaboration and communication among health professionals, the patient and family, involving sharing among team members of information related to patient care and the development of a comprehensive treatment plan to address biological, psychological, and social needs of the patient, and treatment-delivery models in which physicians work together to coordinate their patients' care. *Also referred to as* **Coordinated Care**.

Integrated Delivery and Financing Network *or* **IDFN** *See* **Integrated Delivery System**

Integrated Delivery and Financing System *or* **IDFS** *See* **Integrated Delivery System**

Integrated Delivery Network *or* **IDN** An organization that owns and operates a network of several health care facilities. These facilities include hospitals, care centers, physician groups, clinics, surgery centers, and more.

Integrated Delivery System *or* **IDS** A system of health care providers organized to span a broad range of health care services. An IDS should be able to access the market on a broad basis, optimize cost and clinical outcomes, accept and manage a full range of financial arrangements to provide a set of defined benefits to a defined population, align financial incentives of the participants (including physicians), and operate under a cohesive management structure. Includes IHOs, IPAs, PHOs, MSOs, the equity model, staff model HMOs, and the foundation model. *See also* **Integrated Delivery Network** *or* **IDN**.

Integrated health care organization *or* **IHO** An IDS that is predominantly owned by physicians.

Intensive Care Unit *or* **ICU** Specialized units of a hospital tasked with the care and treatment of patients in critical, serious, or urgent condition. *Also known as* **Intensive Treatment Unit** *or* **ITU** *or* **Critical Care Unit or CCU**.

Intensive Case Management *or* **ICM** A full range of services that aims to provide long term care for individuals with severe mental illness that have the distinction of not requiring immediate admission.

Intergovernmental Transfer *or* **IGT** The transfer of funds between different levels of government, this can include state owned or operated health care providers in addition to local governments and non-state-owned health care providers. Most often applied in the context of Medicaid.

Interim Payment System *or* **IPS** A generic term that often refers to a payment system that Medicare has implemented as a step towards a new model of payment system for a particular provider type.

Intermediate Care Facility *or* **ICF** A licensed facility designed to provide assistive long term nursing care under the direction of a physician, for residents that do not need continuous skilled nursing care.

Intern A physician who is in training, has completed medical school, obtained a medical degree, but is not yet licensed to practice medicine.

Internal Investigation An internal investigation is a factual review and legal analysis that may be conducted by the organization through its compliance officers, internal audit departments, outside counsel, or a combination of all of the aforementioned parties. There are a variety of reasons that may lead an organization to make the decision to conduct an internal investigation. These may stem from information gathered from employee exit interviews, compliance hotline calls, external requests, patient or family complaints, government agency contact, or Medicare/Medicaid contractor referrals.

International Classification of Disease *or* **ICD** A medical classification list of standardizing and classifying diseases created by the WHO whereby any disease imaginable is given a particular code to help facilitate the operations of health care organizations. The system is currently in its 10^{th} revision which the U.S. has adopted. A Clinical Modification (CM) exists and is used by physicians to classify and code all diagnoses, symptoms, and procedures recorded in unison with hospital care.

International Medical Graduate *or* **IMG** A physician who received a medical degree from a medical school located outsides the U.S. of America and Canada with the distinction of not being accredited by a U.S. accrediting body.

Interoperability The ability of two or more health systems to exchange health information and use the information upon reception.

Investigational Medical Procedure Ongoing clinical observation of an approved agent with respect to immediate and long-term effectiveness, complications, consequences and care. *See* **Experimental Medical Procedure** (for distinction in meaning).

iQIES *See* **Quality Improvement and Evaluation System** *or* **QIES**

J

The Joint Commission on the Accreditation of Healthcare Organizations *or* **JCAHO** *See* **Joint Commission**

Joint Commission *or* **The Joint Commission** A nonprofit organization that performs accreditation reviews primarily on hospitals, other institutional facilities, and outpatient facilities. Many payers require participating hospitals to be accredited by the Joint Commission. A majority of hospitals use Joint Commission accreditation as a means for being certified in the Medicare and Medicaid programs because of its deemed status. *Formerly known as* the **Joint Commission on the Accreditation of Healthcare Organizations** *or* **JCAHO**.

Joint Commission Resources *or* **JCR** An affiliate of the Joint Commission. It disseminates information regarding accreditation, standards development and compliance, best practices, and health care quality improvement and patient safety through a variety of services and products tailored to the needs and expectations of its health care organization partners.

Joint Operating Company *or* **JOC** A not-for-profit parent to two or more affiliating hospitals. Usually created with the expectation that it will qualify as a Section 501(c)(3) organization and will enter JOAs with the participating hospitals.

Joint-Operating Agreement / Arrangement *or* **JOA** Transactions between two hospitals or health systems in which both parties are affiliated yet operate independently in certain regards, such as keeping power over the board of directors and assets. Often referred to as a virtual merger, while the hospitals retain separate boards of directors, they turn over management to a separate company, usually a JOC.

L

Lag Study A report that tells managers how old the claims that are being processed are and how much is paid out each month (both for that month and for any earlier months, by month) and compares these with the amount of money that was accrued for expenses each month. A powerful tool used to determine whether the plan's resources are adequate to meet all expenses.

Large Group Health Plan A group health plan that covers employees of an employer that has 101 or more employees. In some states large groups are defined as 51 or more employees.

Leading Age *or* **LA** The national association of nonprofit aging services providers and other mission-driven organizations serving older adults.

Length of Stay *or* **LOS** A health care data metric that measures the length of time elapsed between an in-patient's admittance and discharge. *See also* **Estimated Length of Stay** *or* **ELOS** and **Average Length of Stay** *or* **ALOS**.

Licensed Practical Nurse *or* **LPN** A graduate of a school of practical nursing whose qualifications have been examined by a state board of nursing and who has been legally authorized to practice as a licensed practical or vocational nurse. LPNs (or LVNs) are licensed by a state to provide routine or basic patient care under the direction of a registered nurse or a physician. *See* **Licensed Vocational Nurse** *or* **LVN**.

Licensed Vocational Nurse *or* **LVN** *See* **Licensed Practical Nurse** *or* **LPN**.

Licensure Permission granted by a state, under requirements and conditions established by statute and regulation, to an individual or entity to engage in a particular type of activity. For example, practice medicine, nursing, or social work; or operate a hospital, nursing facility, or home health agency.

Life Care at Home *or* **LCAH** Concept of health care finance and delivery program models that resemble a CCRC while allowing an elderly person to live at home instead of at a centralized location.

Lifetime Benefit Maximum A cap on the amount of money insurers will pay toward the cost of health care services over the lifetime of the insurance policy. Lifetime benefits maximums are prohibited under the Affordable Care Act.

Lifetime Limit *See* **Lifetime Benefit Maximum**.

Limited Cost Sharing Plan A health plan defined by the ACA that is available to members of federally recognized Native American tribes and Alaska Native Claims Settlement Act (ANCSA) Corporation shareholders regardless of income or eligibility for premium tax credits. Individuals enrolled in this type of plan generally, among other features, don't pay co-payments, deductibles, or coinsurance when getting care through an Indian health care provider and don't need to have their income verified in order to enroll.

Line of Business A health plan (e.g., an HMO, EPO, or PPO) that is set up as a line of business within a larger organization, usually an insurance company. This legally differentiates it from a freestanding company, or a company set up as a subsidiary. It may also refer to a unique product type (e.g., Medicaid) within a health plan.

Living Will A type of advance directive in the form of a written statement detailing a person's desires regarding their medical treatment in circumstances in which they no longer have capacity or are no longer able to express informed consent.

Loading Factor Amount added to the net premium rate determined for a group insurance plan to cover the possibility that losses will be greater than statistically expected because of older average age, hazardous industry, large percentage of unskilled employees, or adverse experience.

Local Coverage Determination *or* **LCD** Guidance from a particular MAC on whether they will reimburse a supplier or provider for a particular item or service. An LCD does not apply in any other MAC's jurisdiction. The MAC can issue an LCD only if Medicare has not addressed coverage for the item or service in a national coverage determination. *See* **Medicare Administrative Contractor** *or* **MAC**.

Long Term Care Hospital *or* **LTCH** An acute care setting that focuses on patients who, on average, stay more than 25 days. LTCHs provide care to patients with medically complex problems. These complex diagnoses include – but are

not limited to – traumatic brain injury, conditions requiring prolonged mechanical ventilation, paralysis, very significant wound care, and other conditions resulting in organ failure – resulting in the patient requiring a hospital-level of care for an extended period.

Long-Term Care *or* **LTC** Continuum of maintenance, custodial, and health services to the chronically ill, disabled, or with behavioral/mental disabilities. Services may be provided on an inpatient, outpatient, or at-home basis.

Long-Term Disability *or* **LTD** There is no one specific definition of long-term disability. Insurance policies, employee benefits, government benefits can all define the exact nature of it differently for specialized purposes, such as qualifying for benefits.

Loss Ratio *See* **Medical Loss Ratio**.

Lost Work Day Injury and Illness *or* **LWDII** Under applicable OSHA regulations, employers are required to keep records of employee lost work days due to employment-related injury or illness.

Low Utilization Payment Adjustment *or* **LUPA** Under the Medicare home health PDGM, each of the case-mix groups has a threshold to determine if the period of care would receive a LUPA. The LUPA threshold ranges between 2 and 6 visits. If a home health agency provides fewer than the threshold # of visits, they will be paid a standardized per visit payment, or a LUPA, instead of a payment for a 30-day period of care.

Low Volume Adjustment *or* **LVA** *See* **Low Volume Hospital**.

Low Volume Hospital *or* **LVH** In the Medicare program, hospitals that qualify as low volume hospitals, can receive an upward payment adjustment. The Bipartisan Budget Act of 2018 modified the definition of a low-volume hospital and the methodology for calculating the payment adjustment for low-volume hospital. Under these changes, to qualify, a hospital must have less than 3,800 total discharges and be located more than 15 road miles from the nearest IPPS hospital, and the applicable percentage increase is based on a continuous, linear sliding scale ranging from an additional 25% payment adjustment for low-volume hospitals with 500 or fewer discharges to 0% additional payment for low-volume hospitals with more than 3,800 discharges.

M

Major Complication or Comorbidity *or* **MCC** A secondary diagnosis that in turn increases the resources needed to care for a patient.

Major Medical Expense Insurance *See* **Major Medical Insurance**

Major Medical Insurance Coverage characterized by larger maximum limits, which is intended to cover the costs associated with a major illness or injury. Major medical insurance policies are required to comply with the ACA requirement that they cover the "essential health benefits" but can require higher premium payments. Such contracts may contain internal limits and usually are subject to deductibles and coinsurance. *Also referred to as* **Major Medical Expense Insurance**.

Malpractice An act or omission on part of a physician during the course of treatment that deviates from accepted norms and results in injury to the patient.

Mammogram Quality Standards Act of 1992 *or* **MQSA** A federal law that required HHS to establish standards for mammography facilities that would be enforced through stringent accreditation, certification, and inspection of both equipment and personnel.

Managed Care A type of health plan under which the provision, quality, and cost of care are coordinated for enrolled beneficiaries.

Managed Care Organization *or* **MCO** A broad term used to describe a system of health care delivery that tries to manage the cost of the health care, the quality of health care, and access to health care. The term encompasses a variety of health care delivery organizations, including health maintenance organizations (HMOs), preferred provider organizations (PPOs), physician/hospital organizations (PHOs) and exclusive provider organizations (EPOs).

Managed Indemnity Plan *or* **MIP** A type of plan that allows the insured individual to choose their own doctors and hospital on the condition that the insurance company pays a predetermined percentage of the incurred charges, and the individual pays the difference.

Management Information System (or Service) *or* **MIS** The common term for the computer hardware and software that provides the support for managing the plan or a department or group that administers and maintains such computer hardware and software.

Management Services Agreement *or* **MSA** A contract between two distinct business entities that facilitates a business relationship.

Management Services Organization *or* **MSO** A form of integrated health-delivery system. Sometimes similar to a service bureau, the MSO often actually purchases certain hard assets of a physician's practice and then provides services to that physician at fair market rates. MSOs are usually formed as a means to contract more effectively with managed-care organizations, although their simple creation does not guarantee success. *See also* **Service Bureau**.

Mandated Benefits Benefits that a health plan is required to provide by law. This is generally used to refer to benefits above and beyond routine insurance type benefits, and it generally applies at the state level, where there is high variability from state to state. Common examples include invitro fertilization, defined days of inpatient mental health or substance abuse treatment, and other special condition treatments. Self-funded plans are exempt from mandated benefits under ERISA.

Market Basket A data set created by taking a group of related costs and using it as a means of setting certain types of reimbursement rates.

Master Group Contract This is the actual contract between a health plan and a group that purchases coverage. The master group contract provides specific terms of coverage, rights, and responsibilities of both parties. *Also known as* a **Master Policy**.

Master Policy *See* **Master Group Contract**

Material Misrepresentation A false or misleading statement on an application for an insurance policy that influences the

insurer's decision as to the prospective insured's insurability. These statements may create the basis for rescinding the policy.

Maximum Allowable Charge (or cost) *or* **MAC** The maximum, although not the minimum, that a provider or supplier may charge a health plan for something. This term is also often used in pharmacy contracting; a related term, used in conjunction with professional fees, is fee maximum.

Maximum Daily Hospital Benefit Maximum amount payable for hospital room and board per day of hospital confinement.

Maximum Out-of-Pocket Cost The largest amount of money a beneficiary will ever need to pay for covered services during a contract year. The maximum out-of-pocket cost includes deductibles and coinsurance. Once this limit is reached, the health plan pays for all services up to the maximum coinsurance. Once this limit is reached, the health plan pays for all services up to the maximum level of coverage. This applies mostly to non-HMO plans such as indemnity plans, PPOs, and POS plans.

McCarran-Ferguson Act (Public Law 15) Legislation stipulating that federal law would apply to the insurance business only to the extent that it was not regulated by state law.

Meaningful Use The minimum standards for electronic health records set by the U.S. Government.

Medicaid Expansion The Affordable Care Act of 2010 allowed states to expand their Medicaid programs to cover individuals between the ages of 19 and 65, specifically parents and adults without dependent children, with incomes up to 113% of the federal poverty level. The ACA required the federal government to pay for 100% of the cost to expand Medicaid to this new population for three years, in which the matching rate was then phased down to 90% in 2020 and all subsequent years.

Medicaid Fraud Control Unit *or* **MFCU** Entities located in 49 states and the District of Columbia funded jointly by state and federal money that are charged with investigating and pursuing convictions against health care providers who defraud the Medicaid program. These units are usually affiliated with the state Attorney General's office and directed by an assistant attorney general. An MFCU's authority is concurrent with OIG at the DHHS.

Medicaid Integrity Contractor *or* **MIC** The Deficit Reduction Act of 2005 established the Medicaid Integrity Program (MIP) and Medicaid Integrity Contractors (MICs). A MIC ensures that: (1) paid claims were for services provided and properly documented; (2) services were billed properly, using correct and appropriate procedure codes; (3) services provided were covered services; and (4) services were paid according to federal and state laws, regulations, and policies.

Medicaid Management Information System *or* **MMIS** A computerized system for processing medical claims.

Medicaid *or* **Medical Assistance** A federal and state-funded program administered, in part, by CMS and participating states that finance health care and health benefits for low-income persons and certain categorically eligible individuals, such as indigent pregnant women and children. Medicaid provides medical benefits to persons who meet certain criteria and whose incomes fall beneath specified limits. States receive federal matching funds and are free to design their programs within federal parameters. Demonstration projects, especially for managed care, may receive waivers from certain requirements imposed by the federal government.

Medicaid Waivers Authority granted by the Secretary of HHS to allow a state to continue receiving federal Medicaid matching funds even though it is no longer in compliance with certain requirements of the Medicaid statute. States can use waivers to implement home and community-based services programs, managed care, and to expand coverage to populations who are not otherwise eligible for Medicaid.

Medical Assistance *or* **MA** *See* **Medicaid** A term for a variety of programs intended to provide medical cost assistance for those who are unable to afford medical insurance. An older term for the Medicaid program.

Medical Care Evaluation *or* **MCE** A component of a quality assurance program that looks at the process of medical care.

Medical Device Innovation, Safety & Security Consortium *or* **MDISS** A nonprofit organization dedicated to the safety and security of medical devices with a focus on advancing public health and quality health care.

Medical Device Vulnerability Intelligence Program for Evaluation and Response *or* **MD-VIPER** A cybersecurity program in relation to medical devices.

Medical Home A model of care that focuses on accessible services by facilitating partnerships between all facets of primary care with the goal of maximal health outcomes. This model is primarily patient centered in nature and

encourages providers to meet patients where they are in their conditions.

Medical Loss Ratio *or* **MLR** The ratio between the cost to deliver medical care and the amount of money that was taken in by a plan. This ratio is a portion of an insurer's premium revenue that is spent on payment medical claims and submitted by providers and beneficiaries and quality improvement activities, as compared to the portion that is retained to cover insurer's administrative costs. Insurance companies often have a medical loss ratio of 92% or more; tightly managed HMOs may have medical loss ratios of 75% to 85%, although the overhead (or administrative cost ratio) is concomitantly higher. The medical loss ratio is dependent on the amount of money brought in as well as on the cost of delivering care; thus, if the rates are too low, the ratio may be high even though the actual cost of delivering care is not really out of line. The Affordable Care Act requires that health insurance issuers submit data on the MLR and, starting in 2012, requires them to issue rebates to enrollees if this percentage does not meet minimum standards. MLR requires insurance companies to spend at least 80% or 85% of premium dollars on medical care.

Medical Necessity or Medically Necessary Term used by insurers to describe medical treatment that is appropriate and rendered in accordance with generally accepted standards of medical practice. The plan standard for determining that services or supplies should be covered, often dictated by state law or government program requirement.

Medical Orders for Life-Sustaining Treatment *or* **MOLST** A medical order written by a medical professional that aids in giving individuals will severe illness more autonomy over their treatment via the specification of the forms of treatment they would like to receive.

Medical Policy Refers to the policies of a health plan regarding what will be paid for as medical benefits. Routine medical policy is linked to routine claims processing and may even be automated in the claims system; for example, the plan may only pay 50% of the fee of a second surgeon or may not pay for two surgical procedures done during one episode of anesthesia. This also refers to how a plan approaches payment policies for experimental or investigational care and payment for noncovered services in lieu of more expensive covered services.

Medical Review Criteria Systemically developed statements that can be used to appropriateness of specific health care decisions, services, and outcomes.

Medical Savings Account *or* **MSA** A specific type of savings account that allows an individual to set aside money to pay for qualified medical expenses on a pre-tax basis. *Also known as* a **Health Savings Account** *or* **HSA**.

Medically Under-Served Area *or* **MUA** An area in which there is a shortage of primary health care services for residents.

Medicare The federal health insurance program, administered by CMS, that provides health coverage and medical benefits generally for those over age 65 and people with qualifying disabilities. Medicare is made up of four parts, composed of: Medicare Part A (hospital services, extended care facilities, hospices), Medicare Part B (physician and other types of care not covered under Part A), Medicare Part C (direct contracting with man- aged care organizations), and Medicare Part D (prescription drug). The "traditional" fee-for-service Medicare program (Parts A and B) was established in 1965 as Title XVIII of the Social Security Act.

Medicare + Choice *or* **M+C** *See* **Medicare Advantage Plan**.

Medicare Access and CHIP Reauthorization Act of 2015 *or* **MACRA** A landmark payment system for Medicare physician reimbursement that replaces Medicare's sustainable growth rate. The concept of MACRA's payment reform is to shift health care away from the existing practice of paying for volume to paying for volume – improving outcomes and patient care utilizing efficiency and coordination – all through MACRA's aptly named Quality Payment Program that establishes two new payment systems, or tracks, for clinicians. Overall, is meant to strengthen Medicare access by improving physician payments and making other improvements and to reauthorized the Children's Health Insurance Program.

Medicare Administrative Contractor *or* **MAC** Private companies that administer the Medicare program, Parts A and B, durable medical equipment, home health, and hospice within their geographic jurisdictions. MAC's jurisdictions are defined on a state-by-state level, but an individual MAC may be in charge of administering several states. MACs were formerly known as fiscal intermediaries (FIs) or carriers. In the realm of billing and reimbursement, MACs have the most direct interaction with health care providers. They collect and evaluate cost reports and issue notices of program reimbursement, which settle the amount that a provider will be reimbursed for care provided during a fiscal year. MACs have the ability to re-open cost reports to ensure that payment was properly calculated.

Medicare Advantage Plan *or* **MA** Managed care plans to enable Medicare beneficiaries to obtain benefits through private insurance plans. Medicare program that offers a full range of coverage options by providing a choice between the

traditional fee-for-service program or enrollment in an HMO, preferred-provider organization, point-of-service plan, provider sponsored organization, or an insurance plan operated in conjunction with a medical savings account. Formerly known as Medicare + Choice Plans (M+C), this was enacted as part of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub. L. 108-173, 117 Stat. 2066).

Medicare and Medicaid Patient and Program Protection Act *or* **MMPPPA** A 1987 federal law that broadened the grounds for excluding health care providers from participation in Medicare and Medicaid programs. This statute also granted the OIG the authority to exclude from Medicare and state health care program participation individuals or entities who violate the law, even if there has been no criminal conviction.

Medicare Cost Contract A plan which provides the full Medicare benefit package. *See also* **Medicare Cost Plan**.

Medicare Cost Plan A plan in which enrollees have access to a network of doctors and hospitals and may have additional benefits beyond what's provided by original Medicare.

Medicare Cost Report A mandated, annual report that must be submitted by Medicare-certified institutional providers to a Medicare Administrative Contractor detailing and monitoring the expenses of the health care organization.

Medicare Dependent Hospital *or* **MDH** A term that applies to a program operated CMS in relation to the assistance of hospitals that have greater than sixty percent of their inpatient days or discharges from Medicare patients and 100 or fewer beds. Additionally, these hospitals are usually located in rural areas.

Medicare Geographic Classification Review Board *or* **MGCRB** A board that makes determinations on geographic reclassification requests of hospitals. Usually in the context of hospitals trying to reclassify to a higher wage area to receive higher payments under their inpatient prospective payment system.

Medicare Improvements for Patients and Providers Act of 2008 *or* **MIPPA** MIPPA allows for grants to low-income seniors and persons with disabilities assistance to pay for Medicare costs.

Medicare Outpatient Observation Notice *or* **MOON** A notice that hospitals and CAHs are required to provide Medicare beneficiaries that informs them that they are outpatients in reception of observation and are not inpatients of a hospital or critical access hospital.

Medicare Part A *or* **Part A** Part A of the Medicare program covers inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care. Medicare eligible beneficiaries do not pay a monthly premium for Part A if they have paid Medicare taxes while working for a certain amount of time. *See* **Medicare**. *Also referred to as* **Hospital Insurance**.

Medicare Part B *or* **Part B** Part B covers of the Medicare program covers certain doctors' services, outpatient care, medical supplies, and preventive services. Medicare eligible beneficiaries pay a Part B premium amount in order to get the coverage. In some cases, if your modified adjusted gross income is above a certain amount, the beneficiary pays the standard premium amount and an Income Related Monthly Adjustment Amount (IRMAA). IRMAA is an extra charge. *See* **Medicare**. *Also referred to as* **Medical Insurance** *or* **Outpatient Coverage**.

Medicare Part C *or* **Part C** *See* **Medicare Advantage**

Medicare Part D *or* **Part D** Medicare Part D covers the cost of prescription drugs (including many recommended shots or vaccines). To get Medicare drug coverage, a beneficiary must join a Medicare-approved plan that offers drug coverage. Premium costs differ according to the plan chosen. Medicare Advantage plans may also include Part D coverage. *See* **Medicare** *and* **Medicare Advantage**

Medicare Payment Advisory Commission *or* **MedPAC** An independent congressional agency established to advise the U.S. Congress on issues affecting the Medicare Program.

Medicare Physician Fee Schedule *or* **MPFS** A comprehensive listing of the fees used by Medicare to compensate doctors and other providers.

Medicare Prescription Drug, Improvement, and Modernization Act of 2003 *or* **MMA** Signed into law on December 8, 2003, as the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, the MMA brought about the most sweeping changes to the federal health insurances program for the elderly and disabled, including adding a prescription drug benefit under Medicare Part D. Providers, physicians, payers, manufacturers, suppliers, employers, and beneficiaries all have been affected profoundly by these changes. The MMA also provided initiatives for Medicare beneficiaries to have more choices in health care and better coverage for preventive care. Further, the MMA removed certain restrictions on health savings accounts.

Medicare Provider Analysis and Review *or* **MedPAR** A data set that contains a record for one hundred percent of Medicare beneficiaries who use hospital inpatient services.

Medicare Risk Contract An agreement established to accept fixed dollar imbuements per Medicare enrollee. Usually applied in the context of an HMO or a competitive medical plan.

Medicare Secondary Payer Statute A federal statute providing that when payment sources in addition to Medicare are available, those sources are primary payers and Medicare is secondary.

Medicare SELECT A 50-state Medicare demonstration program that permits Medicare supplemental insurance companies (Medigap insurers) to offer a preferred provider organization policy to Medicare recipients. Medicare SELECT policies may waive or reduce deductible and coinsurance payments if the plan participant uses a network provider. Plan participants are free to choose a non-network provider, but the Medicare SELECT policies may restrict or eliminate payment of deductibles and coinsurance that the policy would otherwise cover.

Medicare Severity Diagnosis Related Group *or* **MS-DRG** A particular set of patient attributes which include principal diagnosis, specific secondary diagnosis, procedures, sex, and discharge status.

Medicare Shared Savings Program *or* **MSSP** Congress created this program to facilitate coordination and cooperation among providers to improve the quality of care for Medicare fee-for-service beneficiaries and reduce unnecessary costs.

Medicare Supplemental Insurance A private insurance program specifically tailored to cover those costs not covered by "traditional" fee-for-service Medicare; generally, Medigap policies pay coinsurance and deductibles. *See* **Medigap**.

Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 *See* **Balanced Budget Refinement Act of 1999** *or* **BBRA**.

Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 *See* **Benefits Improvement and Protection Act of 2000** *or* **BIPA**.

Medicare, Medicaid, and SCHIP Extension Act of 2007 *or* **MMSEA** A federal law that expanded and extended provision of the Social Security Act (SSA) relating to Medicare and Medicaid, as well as the State Children's Health Insurance Program.

Medication Administration Record *or* **MAR** A formal record of the administration of medicine in a health care setting.

Medication-assisted Treatment *or* **MAT** A permit or type of permit needed to administer care along a whole patient approach that consists of the use of counseling and therapeutic approaches to treat addiction and substance use disorders. In order to dispense treatment of this type, certification is required through SAMHSA and a DEA certification is required.

Medigap An optional extra insurance that an individual may purchase from private health insurance companies to assist in the payment of out-of-pocket costs. *Also referred to as* **Medical Supplemental Insurance**.

Member Months The total of all months for which each beneficiary is covered. For example, if a plan had 10,000 beneficiaries in January and 12,000 members in February, the total member months for the year to date as of March 1 would be 22,000.

Member(s) A person or persons enrolled and eligible to receive health care coverage under a benefit plan. *Also referred to as* **Enrollee**, **Beneficiary**, **Participant**, *or* **Customer**.

Memorandum of Understanding *or* **MOU** An agreement between two or more parties where an intended line of action is agreed upon.

Mental Health Parity and Addiction Equity Act *or* **MHPAEA** A federal law that requires health insurers and group health plans to provide parity to mental health and substance use disorder benefits in relation to surgical and medical care benefits.

Merit-based Incentive Payment System *or* **MIPS** A program that determines Medicare payment adjustments.

Methadone Maintenance Treatment *or* **MMT** The use of methadone to treat opioid dependence.

Metropolitan Statistical Area *or* **MSA** A central geographical area based on a county or counties with at least one urbanized area with a population of at least 50,000 and all adjacent counties that have economic ties to the specified central area.

Midlevel Practitioner Physician's assistants, clinical nurse practitioners, nurse midwives, and the like. Nonphysicians who deliver medical care, generally under the supervision of a physician but for less cost.

Minimum Data Set *or* **MDS** A federally mandated comprehensive assessment of residents functional and health needs in Medicare and Medicaid certified nursing homes.

Minimum Essential Coverage The minimum level of benefits that must be included in a health plan in order for an individual to be considered insured. Under the Affordable Care Act, if an individual does not have minimum essential coverage and does not qualify for an exemption, they will be subject to a penalty under the individual mandate.

Minimum Essential Coverage *or* **MEC** Any insurance coverage or plan that meets the requirement for having health coverage set forth by the Affordable Care Act.

Mixed Model A managed care plan that mixes two or more types of delivery systems. This has traditionally been used to describe an HMO that has both closed panel and open panel delivery systems.

Modified Risk Person who cannot meet the normal health requirements of a standard health insurance policy.

Modifiers While CPT® billing codes are often extremely specific, it sometimes arises that more information is necessary to fully explain why a procedure was performed. This is often accomplished through the use of modifiers, which are extra digits added on the end of a CPT® code. The amount that CMS or other payers will reimburse may change based on the modifier used. Modifiers can be found in the CPT® and HCPCS code books.

Money Laundering Statute A federal statute that prohibits any monetary transaction in excess of $10,000 where the money was obtained from certain specified unlawful activities, including theft of federal funds or mail or wire fraud.

Morbidity Frequency and severity of sicknesses and accidents in a well-defined class or classes of disability, illness, and sometimes accidents.

Morbidity and Mortality Weekly Report *or* **MMWR** The U.S. Centers for Disease Control and Prevention's main epidemiological digest that is published weekly.

Morbidity Table Actuarial statistics showing the expected average frequency and duration of disability, illness, and sometimes accidents.

Mortality Death rate in a group of people as determine from prior experience.

Mortality Table Exhibit showing the incidence of death in various age groups.

Most Favored Nation A contractual clause typically requested by an MCO in a managed care contract that requires the provider to offer the MCO the best (lowest) payment rate that the provider is willing to accept from any other MCO.

Multiple Employer Trust *or* **MET** *See* **Multiple Employer Welfare Association** *or* **MEW**.

Multiple Employer Welfare Association *or* **MEWA** A group of employers who band together for purposes of purchasing group health insurance, often through a self-funded approach to avoid state mandates and insurance regulation. By virtue of ERISA, such entities are regulated little, if at all. Many MEWAs have enabled small employers to obtain cost-effective health coverage, but some MEWAs have not had the financial resources to withstand the risk of medical costs and have failed, leaving the members without insurance or recourse. In some states, MEWAs and METs are no longer legal.

Multispecialty Group A medical group made up of different specialty physicians. May or may not include primary care.

N

National Academy of Medicine *or* **NAM** One of three academies that make up the National Academies of Sciences, Engineering, and Medicine in the U.S. It is a private nonprofit institution that works outside of government to provide objective advice on matters of science, technology, and health. It is an independent, evidence-based scientific advisor. It includes members from across the globe and partners with organizations worldwide to address challenges that affect all. Additionally, there are more than 2,000 members that have been elected by their peers in recognition of outstanding achievement.

National Association for Healthcare Quality *or* **NAHQ** A non-profit organization that develops standard quality competencies and certifications in health care quality. *See* **Certified Professional in Healthcare Quality** *or* **CPHQ.**

National Association for Home Care and Hospice *or* **NAHC** A national trade organization representing home care and hospice organizations. It advocates for provider organizations and the nurses, therapists, aides, and other caregivers employed by such organizations to provide in-home services.

National Association of Children's Hospitals and Related Institutions *or* **NACHRI** *See* **Children's Hospital Association** *or* **CHA**.

National Association of Insurance Commissioners *or* **NAIC** A national organization of insurance regulators that provides expertise, data, and analysis for insurance commissioners to effectively regulate the industry and protect consumers. It also develops model insurance legislation.

National Association of Long-Term Care Administrator Boards *or* **NAB** A membership organization of state regulatory boards and agencies responsible for the licensure of long-term care administrators and individual members of each state regulatory board representing the profession.

National Breast and Cervical Cancer Early Detection Program *or* **NBCCEDP** A program of the CDC, designed to improve access to breast and cervical cancer screening. In 1990, Congress passed the Breast and Cervical Cancer Mortality Prevention Act, which directed CDC to create the program. The program funds award recipients in all 50 states, the District of Columbia, 2 U.S. territories, 5 U.S.-Affiliated Pacific Islands, and 13 American Indian and Alaska Native tribes or tribal organizations. In 2000, Congress passed the Breast and Cervical Cancer Prevention and Treatment Act, which allowed states to offer those who are diagnosed with cancer in the NBCCEDP access to treatment through Medicaid. In 2001, with passage of the Native American Breast and Cervical Cancer Treatment Technical Amendment Act, Congress explained that this option also applies to American Indian and Alaska Native women who are eligible for health services provided by the Indian Health Service or by a tribal organization.

National Cancer Institute *or* **NCI** One of the primary NIH divisions, it is the federal government's principal agency for cancer research and training. NCI leads, conducts, and supports cancer research across the U.S. to advance scientific knowledge and help all people live longer, healthier lives. It leads the National Cancer Program and is the largest funder of cancer research in the world, managing a broad range of research, training, and information dissemination activities.

National Center for Advancing Translational Sciences *or* **NCATS** A center of the NIH, NCATS' mission is to catalyze the generation of innovative methods and technologies that will enhance the development, testing, and implementation of diagnostics and therapeutics across a wide range of human diseases and conditions.

National Center for Assisted Living *or* **NCAL** A division of the American Healthcare Association, it is dedicated to serving the needs of the assisted living community through national advocacy, education, networking, professional development, and quality initiatives. *See also* **American Health Care Association** *or* **AHCA**

National Center for Complementary and Integrative Health *or* **NCCIH** A center of the NIH, NCCIH works to define, through rigorous scientific investigation, the usefulness and safety of complementary and integrative health interventions and their roles in improving health and health care.

National Center for Health Statistics *or* **NCHS** A division within the CDC responsible for collecting, analyzing, and disseminating timely, relevant, and accurate U.S. health data and statistics. Its products and services inform the public and guide program and policy decisions to improve the U.S. health care system.

National Coalition for Cancer Survivorship *or* **NCCS** An advocacy organization founded by and for cancer survivors with a mission to advocate for quality cancer care. It works with legislators and policy makers to represent cancer patients and survivors in efforts to improve their quality of care and quality of life after diagnosis.

National Committee for Quality Assurance *or* **NCQA** A non-profit accrediting provider for health plans, it uses measurement, transparency, and accountability to drive improvement in the quality of health care services. It manages HEDIS, a data set that compiles quality data. It also administers accreditation, certification, and recognition programs for health plans and patient-centered medical homes. *See* **Health Plan Employer Data and Information Set** *or* **HEDIS®**

National Comprehensive Cancer Network *or* **NCCN** The NCCN is a not-for-profit alliance of 33 cancer centers in the U.S. It develops resources for numerous stakeholders in the health care delivery system. It promotes the importance of continuous quality improvement and recognizes the significance of creating clinical practice guidelines appropriate for use by patients, clinicians, and other health care decision-makers around the world.

National Continuing Education Review Service *or* **NCERS** A service of NAB that is responsible for approving the content and quality of continuing education programs for nursing home administrators.

National Correct Coding Initiative *or* **NCCI** A CMS program that promotes correct coding methodologies and reduces improper coding. It has the overall goal of reducing improper payments of Medicare Part B and Medicaid claims.

National Council Licensure Examination-Practical Nurse *or* **NCLEX-PN** Developed and owned by the NCSBN, the NCLEX is a nationwide examination for the licensing of nurses in the U.S., Canada, and Australia. The NCLEX-PN is taken by graduates of nursing schools seeking a license as a practical nurse or similar level of licensure.

National Council Licensure Examination-Registered Nurse *or* **NCLEX-RN** Developed and owned by the NCSBN, the NCLEX is a nationwide examination for the licensing of nurses in the U.S., Canada, and Australia. The NCLEX-RN is taken by graduates of nursing schools seeking a license as a registered nurse.

National Council of ISACs *or* **NCI** Formed in 2003, the NCI comprises 27 organizations. It is a coordinating body designed to maximize information flow across the private sector, critical infrastructures, and government. Information Sharing and Analysis Centers (ISAC) to assist critical infrastructure owners and operators to protect their facilities, personnel, and customers from cyber and physical security threats and other hazards. ISACs collect, analyze, and disseminate actionable threats to their members and provide members with tools to mitigate risks and enhance resiliency. ISACs reach deep into their sectors, communicating critical information far and wide and maintaining sector-wide situational awareness.

National Council of State Boards of Nursing, Inc *or* **NCSBN** An independent, not-for-profit organization of nursing regulatory bodies that act and collaborate together on matters of common interest and concern affecting public health, safety and welfare, including the development of nursing licensure examinations.

National Coverage Determinations *or* **NCD** A decision or determination issued by CMS that establishes coverage limitations for particular items and services. When reaching these decisions, CMS employs an evidence-based process with opportunities for public participation. In some cases, CMS' own research is supplemented by an outside technology assessment and/or consultation with the Medicare Evidence Development & Coverage Advisory Committee. NCDs are generally developed on a case-by-case basis and are not published through typical notice-and-comment rulemaking, which may limit the public's ability to anticipate changes in policy. In the absence of a national coverage policy, an item or service may be covered at the discretion of the Medicare contractors based on an LCD. *See* **Local Coverage Decision** *or* **LCD**.

National Database of Nursing Quality Indicators *or* **NDNQI** Originally a program of the American Nurses Association and managed at the University of Kansas Medical Center School of Nursing, it was acquired by Press Ganey in 2014. The database is nursing-sensitive quality indicators database that contains unit-level information about 600+ measures relevant to nursing performance, patient and workforce experience, and health outcomes. The data is derived from a combination of administrative documentation and medical records.

National Drug Code *or* **NDC** *or* **NDC Number** A unique three segment identifier provided by the FDA as a universal product identifier for human drugs. Section 510 of the Federal Food, Drug, and Cosmetic Act, 21 U.S.C. §360, requires a registered drug establishment to provide the FDA with a current list of all drugs manufactured, prepared, propagated, compounded, or processed by it for commercial distribution. Drug products reported to the FDA are assigned an NDC. All NDCs are compiled into the eDRLS database.

The National Eye Institute *or* **NEI** An institute of the NIH, its mission is to conduct and support research, training, health

information dissemination, and other programs with respect to blinding eye diseases, visual disorders, mechanisms of visual function, preservation of sight, and the special health problems and requirements of the blind.

National Government Services *or* **NGS** A MAC that also provides other federal health care agencies and business process services and information technology services.

National Health Information Sharing and Analysis Center *or* **NH-ISAC** *See* **Health-ISAC**.

National Healthcare Safety Network *or* **NHSN** A health care-associated infection tracking system administered by the CDC. NHSN provides facilities, states, regions, and the nation with data needed to identify problem areas, measure progress of prevention efforts, and ultimately eliminate health care-associated infections. NHSN also allows health care facilities to track blood safety errors and important health care process measures such as health care personnel influenza vaccine status and infection control adherence rates.

National Heart, Lung, and Blood Institute *or* **NHLB** An institute of NIH, it provides global leadership for research, training, and education programs to promote the prevention and treatment of heart, lung, and blood diseases and enhance the health of all individuals so that they can live longer and more fulfilling lives. It also stimulates basic discoveries about the causes of disease, enables the translation of basic discoveries into clinical practice, fosters training and mentoring of emerging scientists and physicians, and communicates research advances to the public.

National Human Genome Research Institute *or* **NHGRI** An institute of the NIH, it is devoted to advancing health through genome research. Its work encompasses a broad range of research aimed at expanding understanding of human biology and improving human health. In addition, a critical part of its mission continues to be the study of the ethical, legal, and social implications of genome research.

National Institute for Occupational Safety and Health *or* **NIOSH** An institute within the NIH, it serves as a research agency focused on the study of worker safety and health, and empowering employers and workers to create safe and healthy workplaces.

National Institute of Allergy and Infectious Diseases *or* **NIAID** An institute of the NIH, its research strives to understand, treat, and ultimately prevent the myriad infectious, immunologic, and allergic diseases that threaten millions of human lives.

National Institute of Arthritis and Musculoskeletal and Skin Diseases *or* **NIAMS** An institute of the NIH, it supports research into the causes, treatment, and prevention of arthritis and musculoskeletal and skin diseases, the training of basic and clinical scientists to carry out this research, and the dissemination of information on research progress in these diseases.

National Institute of Biomedical Imaging and Bioengineering *or* **NIBIB** An institute of the NIH, its mission is to use engineering to transform the understanding of disease and its prevention, detection, diagnosis, and treatment.

National Institute of Dental and Craniofacial Research *or* **NIDCR** An institute of the NIH, it provides leadership for a national research program designed to understand, treat, and ultimately prevent the infectious and inherited craniofacial-oral-dental diseases and disorders that compromise millions of human lives.

National Institute of Diabetes and Digestive and Kidney Diseases *or* **NIDDK** An institute of the NIH, it conducts and supports medical research and research training, disseminates science-based information on diabetes and other endocrine and metabolic diseases; digestive diseases, nutritional disorders, and obesity; and kidney, urologic, and hematologic diseases, to improve people's health and quality of life.

National Institute of Environmental Health Sciences *or* **NIEHS** An institute of the NIH, its mission is to discover how the environment affects people in order to promote healthier lives.

National Institute of General Medical Sciences *or* **NIGMS** An institute of the NIH, it supports basic research that increases understanding of biological processes and lays the foundation for advances in disease diagnosis, treatment, and prevention. NIGMS-funded scientists investigate how living systems work at a range of levels, from molecules and cells to tissues, whole organisms and populations. The Institute also supports research in certain clinical areas, primarily those that affect multiple organ systems.

National Institute of Mental Health *or* **NIMH** An institute of the NIH, it provides leadership dedicated to understanding, treating, and preventing mental illnesses through basic research on the brain and behavior, and through clinical, epidemiological, and services research.

National Institute of Neurological Disorders and Stroke *or* **NINDS** An institute of the NIH, its mission is to seek fundamental knowledge about the brain and nervous system and to use that knowledge to reduce the burden of

neurological disease. To accomplish this goal, it supports and conducts basic, translational, and clinical research on the normal and diseased nervous system. It also fosters the training of investigators in the basic and clinical neurosciences, and seeks better understanding, diagnosis, treatment, and prevention of neurological disorders.

National Institute of Nursing Research *or* **NINR** An institute of the NIH, its mission is to lead nursing research to solve pressing health challenges and inform practice and policy optimizing health and advancing health equity into the future.

National Institute on Aging *or* **NIA** An institute of the NIH, it leads a national program of research on the biomedical, social, and behavioral aspects of the aging process; the prevention of age-related diseases and disabilities; and the promotion of a better quality of life for all older Americans.

National Institute on Alcohol Abuse and Alcoholism *or* **NIAAA** An institute of the NIH, it conducts research focused on improving the treatment and prevention of alcoholism and alcohol-related problems to reduce the enormous health, social, and economic consequences of this disease.

National Institute on Deafness and Other Communication Disorders *or* **NIDCD** An institute of the NIH, it conducts and supports biomedical research and research training on normal mechanisms as well as diseases and disorders of hearing, balance, smell, taste, voice, speech, and language.

National Institute on Drug Abuse *or* **NIDA** An institute of the NIH, its mission is to advance science on the causes and consequences of drug use and addiction and to apply that knowledge to improve individual and public health.

National Institute on Minority Health and Health Disparities *or* **NIMH** An institute of NIH, its mission is to lead scientific research to improve minority health and eliminate health disparities. It plans, reviews, coordinates, evaluates and conducts minority health and health disparities research and activities of the NIH; promotes and supports the training of a diverse research workforce; translates and disseminates research information; and fosters innovative collaborations and partnerships.

National Institutes of Health *or* **NIH** Made up of 27 Institutes and Centers, each with a specific research agenda, often focusing on particular diseases or body systems, NIH is the nation's premier medical research institution as well as funder of research. NIH's mission is to seek fundamental knowledge about the nature and behavior of living systems and the application of that knowledge to enhance health, lengthen life, and reduce illness and disability. It includes the: NCI, NEI, NHLBI, NHGRI, NIA, NIAAA, NIAID, NIAMS, NIBIB, NICHD, NIDCD, NIDCR, NIDDK, NIDA, NIEHS, NIGMS, NIMH, NIMHD, NINDS, NINR, NLM, NIH-CC, CIT, CSR, FIC, NCATS, and NCCIH.

National Labor Relations Act *or* **NLRA** A federal law enacted in 1935 to protect the rights of employees and employers, to encourage collective bargaining, and to curtail certain private sector labor and management practices, which can harm the general welfare of workers, businesses, and the U.S. economy.

National Labor Relations Board *or* **NLRB** An independent federal agency created by the NLRA and vested with the power to safeguard employees' rights to organize, engage with one another to seek better working conditions, choose whether or not to have a collective bargaining representative negotiate on their behalf with their employer, or refrain from doing so. It acts to prevent and remedy unfair labor practices committed by private sector employers and unions, as well as conducts secret-ballot elections regarding union representation. The agency is bifurcated; it is governed on one side by a five-person Board and on the other side by a General Counsel. Board Members and the General Counsel are appointed by the President with the consent of the Senate.

National Library of Medicine *or* **NLM** A unit of the NIH, NLM collects, organizes, and makes available biomedical science information to scientists, health professionals, and the public. The Library's Web-based databases, including PubMed/Medline and MedlinePlus, are used extensively around the world. NLM conducts and supports research in biomedical communications; creates information resources for molecular biology, biotechnology, toxicology, and environmental health; and provides grant and contract support for training, medical library resources, and biomedical informatics and communications research.

National Practitioner Data Bank *or* **NPDB** A web-based repository of reports containing information on medical malpractice payments and certain adverse actions related to health care practitioners, providers, and suppliers maintained by HHS. Established by Congress in 1986, it is a workforce tool that prevents practitioners from moving state to state without disclosure or discovery of previous damaging performance. Federal regulations authorize eligible entities to report to and/or query the NPDB. Individuals and organizations who are subjects of these reports have access to their own information. The reports are confidential and not available to the public.

National Provider Identifier *or* **NPI** The Administrative Simplification provisions of HIPAA mandated the adoption of

standard unique identifiers for health care providers and health plans to improve the efficiency and effectiveness of the electronic transmission of health information. CMS developed the National Plan and Provider Enumeration System (NPPES) to assign these unique identifiers. The unique identifiers are referred to as NPIs.

National Quality Forum *or* **NQF** A not-for-profit, nonpartisan, membership-based organization that works to catalyze improvements in health care by measures and standards that serve as a critically important foundation for initiatives to enhance health care value, make patient care safer, and achieve better outcomes.

National Safety Council *or* **NSC** A nonprofit, public service organization promoting health and safety in the U.S. Members include more than 55,000 businesses, labor organizations, schools, public agencies, private groups, and individuals. It focuses on areas where the greatest number of preventable injuries and deaths occur, including workplace safety, prescription medication abuse, teen driving, cell phone use while driving and safety in homes and communities.

Negotiated Rate *See* **Allowed Charge** *or* **Allowed Amount**

Network Model HMO An HMO that contracts with multiple physician groups and providers to deliver health care to members. This model is distinguished from group model plans that contract with a singular medical group, IPAs that contract through an intermediary, and direct contract model plans that contract with individual physicians in the communities.

Never Event First introduced in 2001 by Ken Kizer, MD (CEO of the NQF at the time), the term refers to serious medical errors that should never occur. Since the initial "never event" list was developed in 2002 by NQF, it has been revised multiple times, and now consists of 29 "serious reportable events" grouped into 7 categories: surgical or procedural events, product or device events, patient protection events, care management events, environmental events, radiologic events, and criminal events. The DRA of 2005 required HHS to select at least two conditions (as never events) that are: (1) high cost, high volume, or both; (2) identified through ICD-9-CM coding as a complicating condition or major complicating condition that, when present as a secondary diagnosis at discharge, results in payment at a higher MS-DRG; and (3) reasonably preventable through application of evidence-based guidelines. Such conditions are referred to as "hospital-acquired conditions." Beginning October 1, 2007, the DRA required hospitals to report on claims for discharges, whether the selected conditions were present on admission. In its 2008 IPPS Final Rule, CMS selected eight conditions in furtherance of this mandate. These included seven conditions identified by the NQF as "never events." Eleven states have mandated reporting of these incidents whenever they occur, and an additional 16 states mandate reporting of serious adverse events (including many of the "never events"). Health care facilities are accountable for correcting systematic problems that contributed to the event, with some states mandating performance of a root cause analysis and reporting results thereafter.

NIH Clinical Center *or* **NIH-CC** A unit of the NIH, it is the premier U.S. research hospital that provides a versatile clinical research environment enabling the NIH mission to improve human health by investigating the pathogenesis of disease; conducting first-in-human clinical trials with an emphasis on rare diseases and diseases of high public health impact; developing state-of-the-art diagnostic, preventive, and therapeutic interventions; training the current and next generations of clinical researchers; and, ensuring that clinical research is ethical, efficient, and of high scientific quality.

Non-Participating *or* **Nonpar** A term that refers to a health care provider or supplier that does not participate in a particular health plan, i.e. has not entered into a provider agreement with the health plan.

Nurse Practitioner *or* **NP** A type of advanced practice nurse and mid-level practitioner. NPs are trained to assess patient needs, order and interpret diagnostic and laboratory tests, diagnose disease, formulate and prescribe medications and treatment plans without the supervisions of a physician.

Nursing Home Quality Initiative *or* **NHQI** An effort, begun in 2004, by CMS to improve the quality of nursing home care by promoting awareness and use of quality measures to nursing homes, referral sources, and consumers.

O

Obamacare *See* **Affordable Care Act of 2010** *or* **ACA**

Observation Services Observation services or observation care is a defined set of specific, clinically appropriate services, which include ongoing short-term treatment, assessment, and reassessment before a decision can be made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital. Payment rates differ for observation vs in-patient services and CMS requires hospitals to notify patients via the MOON.

Occupancy Rate Measure of inpatient health facility use, determined by dividing available bed days by patient days. It measures the average percentage of occupied beds in a hospital, either for the entire institution or for one department or service.

Occupational Mix Adjustment A factor in the hospital inpatient prospective payment system, it is a measure of a mix of employees for a limited number of hospital occupational categories and the varying labor costs associated with those categories.

Occupational Safety and Health Act *or* **OSHA / OSH Act of 1970** Passed in 19070, the Occupational and Safety Health Act was designed to ensure worker and workplace safety. The goal was to make sure employers provide workers a place of employment free from recognized hazards to safety and health, such as exposure to toxic chemicals, excessive noise levels, mechanical dangers, heat or cold stress, or unsanitary conditions. In order to establish standards for workplace health and safety, the Act also created the National Institute for Occupational Safety and Health (NIOSH) as the research institution for the Occupational Safety and Health Administration (OSHA). OSHA is a division of the U.S. Department of Labor that oversees the administration of the Act and enforces standards in all 50 states.

Occupational Safety and Health Administration *or* **OSHA** An agency within the DOL and created by the Occupational Safety and Health Act of 1970. Congress created the OSHA to ensure safe and healthy working conditions for workers by setting and enforcing standards and by providing training, outreach, education, and assistance.

Office for Advancement of Telehealth *or* **OAT** An office within HRSA, it is designed to promote telehealth as a way to improve health care in rural, urban, and underserved communities. It supports the telehealth efforts of HHS to expand access and improve health outcomes.

Office for Civil Rights *or* **OCR** An office within HHS responsible for preventing unlawful discrimination of individuals receiving services from HHS-conducted or HHS-funded programs and that any such persons can freely exercise their rights. One of its more significant responsibilities is to develop and disseminate technical assistance materials relating to and enforcing compliance with HIPAA.

Office of Audit Services *or* **OAS** An office within the HHS OIG that conducts independent audits of HHS programs and/or HHS grantees and contractors. These audits: (i) examine the performance of HHS programs and/or grantees in carrying out their responsibilities and provide independent assessments of HHS programs and operations; and (ii) help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

Office of Evaluations and Inspections *or* **OEI** An office within the HHS OIG that conducts national evaluations of HHS programs from a broad, issue-based perspective. The evaluations focus on preventing fraud, waste, and abuse. It also: (i) monitors the impact its recommendations and evaluations have on HHS programs by tracking legislative or regulatory changes, documented savings, improved coordination efforts and other benchmarks; (ii) provides congressional staff with technical assistance and briefings on proposed or completed work; (iii) works in concert with other OIG offices to identify vulnerabilities in HHS programs and recommend changes; and (vi) oversees the state MFCUs.

Office of Inspector General *or* **OIG** *or* **HHS OIG** The OIG is an agency of HHS charged with the responsibility to fight waste, fraud, and abuse in HHS programs and to improve the efficiency of Medicare, Medicaid and more than 100 other HHS programs. The majority of the agency's resources go towards the oversight of Medicare and Medicaid programs that represent a significant part of the federal budget and that affect this country's most vulnerable citizens. It is the primary enforcement authority for fraud and abuse in federal health care programs and has authority to impose civil penalties and program exclusions. The office is divided into three sections: (i) OAS; (ii) OEI; and (ii) OI.

Office of Investigations *or* **OI** An office within the HHS OIG that conducts criminal, civil and administrative investigations of fraud and misconduct related to HHS programs, operations and beneficiaries. It also: (i) operates an OIG Hotline, which allows the reporting of suspected fraud, waste and abuse; (ii) coordinates with the DOJ and other law enforcement authorities to leverage resources and fraud-fighting efforts; (iii) provides protective services to the HHS Secretary and participates in public safety and security management activities; and (iv) works in concert with other OIG offices to develop appropriate enforcement actions and recommend fixes to aspects of HHS programs vulnerable to fraud.

Office of Management and Budget *or* **OMB** An office within the White House, it oversees the implementation of the Executive Branch functions of the U.S. Government. It carries out its mission through the following: budget development and execution; oversight of executive agency performance, procurement, financial management, and information technology; coordination and review of all significant federal regulations from executive agencies, privacy policy, information policy, and review and assessment of information collection requests; clearance and coordination of legislative and other materials, including agency testimony, legislative proposals, and other communications with Congress, and coordination of other Presidential actions; and clearance of Presidential Executive Orders and memoranda to agency heads prior to their issuance.

Office of Personnel Management *or* **OPM** The federal agency that administers FEHBP. This is the agency with which a managed care plan contracts to provide coverage for federal employees.

Office of Rural Health Policy *or* **ORHP** An office within HRSA, it coordinates activities related to rural health care HHS. It administers grant programs providing funds to 50 State Offices of Rural Health (SORH) to support on-going improvements in care, and to small rural hospitals through the Medicare Rural Hospital Flexibility Grant (Flex) program. It also supports innovative programs that encourage network development among rural health care providers; upgrades in emergency medical services; and places and trains the health care workforce in rural communities. Finally, to enhance its advisory capacity, it supports a robust research program, which provides pertinent and timely information about the status of rural health and effects of policy that can contribute to understanding the unique challenges in rural areas, how they impact these communities and the entire health care system.

Office of the National Coordinator for Health Information Technology *or* **ONC** Located within HHS, it is responsible for the Executive Branch's health IT efforts and is a resource to the entire health system to support the adoption of health information technology and the promotion of nationwide, standards-based health information exchange to improve health care.

OIG Annual Work Plan The OIG issues an annual "Work Plan," which is a projection of the subject areas the OIG intends to focus its attention on during the upcoming fiscal year. The OIG Work Plan serves as a roadmap for understanding the OIG's priorities for the coming year. OIG updates the Annual Work Plan on its website on a monthly basis.

OIG Compliance Program Guidance The OIG has released compliance program guidance for a variety of health care providers and other stakeholders in the health care industry, including guidance directed at hospitals, home health agencies, physicians, durable medical equipment companies, ambulance suppliers, and nursing facilities, among others. These are published on the OIG website and serve as a useful reference in developing and updating an organization's compliance program.

OIG Open Letter From time to time, the OIG issues letters to health care providers, suppliers and stakeholders alerting them to OIG fraud and abuse concerns; OIG policies and processes; inviting them to engage in anti-fraud initiatives; and updating them on ongoing projects to fight fraud, waste, and abuse in federal health care programs.

OIG Provider Self-Disclosure Protocol *or* **SDP** If an organization detects evidence of possible fraud or abuse, it may voluntarily make a report under the OIG Provider Self-Disclosure Protocol (SDP). The SDP provides guidance on how to investigate potentially fraudulent conduct, quantify damages, and report the conduct to the OIG to resolve an entity's potential liability under the OIG's civil monetary penalty authorities.

OIG Subpoena The OIG subpoena power permits the OIG to compel documentary information but not testimonial information. An OIG subpoena may request documents for use in criminal, civil or administrative investigations. The OIG may also serve a subpoena on parties who have no immediate connection with HHS. OIG subpoenas are a primary method that investigators and prosecutors use to obtain information in health care fraud and abuse investigations.

Olmstead Decision An important and significant disability rights decision of the U.S. Supreme Court, Olmstead v. L.C., 527 U.S. 581 (1999), addressed discrimination against individuals with mental disabilities. The Court decided mental illness is a form of disability and that "unjustified isolation" of a person with a disability is a form of discrimination

under Title II of the ADA. The Court held that under the ADA, individuals with mental disabilities have the right to live in the community rather than in institutions if, in the words of the opinion of the Court, "the State's treatment professionals have determined that community placement is appropriate, the transfer from institutional care to a less restrictive setting is not opposed by the affected individual, and the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities."

Omnibus Budget Reconciliation Act *or* **OBRA** An often-used name for annual congressional tax and budget reconciliation legislation. Most of these acts contain language important to health care and public social programs.

One-Day Stay Observation services are short-term treatments and assessments provided to Medicare outpatients to determine whether they require further treatment as inpatients or can be discharged. The Two-Midnight Rule governing inpatient reimbursement suggests that most one-day stays may be presumptively ineligible for inpatient status. One-day stays have been on the OIG's Work Plan since 2000 and have been under heavy scrutiny ever since. In some instances, the DOJ and the OIG have treated one-day stay inpatient billing issues as Medicare fraud, launching investigations under the FCA.

Onset of Condition Date an illness or disease first manifested itself – generally when treatment and advice were first sought or when symptoms were such that an ordinarily prudent person would seek diagnosis, care, or treatment.

Open Enrollment Period The period when an individual may change health plans or enroll in a new plan; usually occurs once per year. A general rule is that most managed care plans will have around half their membership up for open enrollment in the fall for an effective date of January 1.

Open Panel HMO A managed care plan that contracts (either directly or indirectly) with private physicians to deliver care in their own offices.

Open-Access HMO A type of HMO benefit plan under which enrollees may see in-network specialists without a referral and access providers outside the HMO network. This type of plan usually imposes higher out-of-pocket costs on the enrollee when accessing out-of-network providers. *Also known as a* **Point-of-Service Plan**.

Operating Room *or* **OR** A specially equipped room or suite within a hospital or ambulatory surgical center that is designed for the performance of surgical procedures.

Opioid Treatment Program *or* **OTP** Treatment Programs for individuals diagnosed with an OUD that provide MAT. OTPs must be certified by SAMHSA and accredited by an independent, SAMHSA-approved accrediting body.

Opioid Use Disorder *or* **OUD** A chronic disorder, with serious potential consequences including disability, relapses, and death. The DSM 5 describes opioid use disorder as a problematic pattern of opioid use leading to problems or distress, with at least two other symptoms occurring within a 12-month period.

Organ Procurement Organization *or* **OPO** Not-for-profit organizations responsible for recovering organs from U.S. donors for transplantation. There are 56 OPOs, each mandated by federal law to perform this life-saving mission in their assigned donation service area. An OPO's role is to assess donor potential, collect and convey accurate clinical information, and follow national policies for offering organs. OPOs work with UNOS.

OSHA PEL *See* **Permissible Exposure Limits** *or* **PEL**

Out-of-Network *or* **OON** This refers to a health care provider or supplier that is not in-network with a particular health care payer/insurer because the provider or supplier has not signed an agreement to participate in the payer/insurer's network agreeing to accept the negotiated rates.

Out-of-Pocket Costs Medical expenses that an insured party must pay that are not covered under the insurance contract.

Out-of-Pocket Maximum A yearly cap on the amount of money that individuals are required to pay out-of-pocket for health care costs, excluding the premium. The ACA required new health plans offered beginning in 2014 to include an out-of-pocket maximum.

Outcome and Assessment Information Set *or* **OASIS** A nurse or therapist from a Medicare HHA uses the OASIS to assess a patient's condition. The information from the OASIS is then used to determine a 30-day payment rate pursuant to the PDGM payment model for HHAs.

Outcome-Based Quality Improvement *or* **OBQI** A Medicare-certified HHA process, using OASIS data, that allows for the measurement of selected evidence-based process quality measures. HHAs are provided with feedback reports from the OASIS data collected and transmitted to their respective state agencies. HHAs can use the OBQI outcome

measures as part of a systematic approach to continuously improve the quality of care they provide. OBQI Outcome Reports include 37 risk-adjusted outcome measures.

Outpatient Department *or* **OPD** A department or clinic within a hospital designed for the treatment of patients with health problems who visit for diagnosis or treatment, but do not require a bed or to be admitted for overnight care.

Outpatient Prospective Payment System *or* **OPPS** The reimbursement system Medicare uses for a hospital or community mental health center outpatient care services provided to patients with Medicare. Reimbursement varies with the location of the hospital or clinic.

Outpatient Quality Reporting Program *or* **OQR** A pay for quality data reporting program implemented by CMS for outpatient hospital services. It requires hospitals to submit data on measures of the quality of care furnished in outpatient settings. Hospitals who fail to meet administrative, data collection and submission, validation, and publication requirements receive a 2-percentage point reduction in payment for failing to meet these requirements.

Overhead Expense Insurance A form of health insurance for business owners designed to help off-set continuing business expenses during an owners' total disability.

Overpayment An overpayment is a payment made by a federal health care program or commercial health insurer to a provider or supplier that exceeds the amount due and payable according to an agreement with the payor and/or existing laws and regulations.

P

P4P *See* **Pay for Performance**

Package Pricing *See* **Bundled Payment**.

Palliative Care Specialized medical care for people living with a serious illness, such as cancer or heart failure. Patients in palliative care may receive medical care for relief of their symptoms and the stress of the illness. It is meant to enhance quality of life for both the patient and the family.

Part B Extract & Summary System *or* **BESS** *See* **Part B National Summary Data File** *or* **PBNSDF**.

Part B National Summary Data File *or* **PBNSDF** PBNSDF is a Medicare Part B claims data set maintained by CMS that contains procedural, condition, or description subheadings. Each data set displays the allowed services, allowed charges, and payment amounts by HCPC/CPT® codes and prominent modifiers. The file is updated annually. *Formerly known as* **Part B Extract & Summary System** *or* **BESS.**

Partial Hospitalization Program *or* **PHP** A structured behavioral health treatment program where patients participate for a significant portion of a day, three to five days per week and return home at night.

Participant *See* **Beneficiary** *or* **Member**

Participating Provider *or* **Par Provider** A provider who has signed an agreement with a payer to accept the payer's members as patients, to abide by the payer's policies and accept the contracted payment rate as payment in full.

Patient Abuse Patient abuse generally refers to the knowing infliction of physical or psychological harm or the knowing deprivation of goods or services that are necessary to meet essential needs or to avoid physical or psychological harm.

Patient Encounter *See* **Encounter**

Patient Representative A health care patient representative is someone empowered to make or communicate health care decisions on behalf of an incompetent patient. It can also refer to an individual who serves as the first point of contact with patients when they visit a health care provider. They may check-in patients, get patient information, collect payments, assist with necessary paperwork, and fulfill other customer service or administrative duties.

Patient Review Instrument *or* **PRI** A medical evaluation tool that determines whether or not an individual is eligible for skilled nursing home placement.

Patient Safety Indicator *or* **PSI** Developed by AHRQ they are specifically intended to measure the occurrence rate of potentially preventable complications or adverse events that patients experience during hospital stays.

Patient Self-Determination Act of 1990 *or* **PSDA** A federal law mandating that hospitals, skilled nursing facilities, hospice organizations, home health organizations, and HMO's ensure that patients: (i) are informed of their right to be involved in making decisions with regard to the medical care they receive; (ii) are asked about advanced directives, and to document any wishes the patient might have with regard to the care they want or do not want; (iii) are not discriminated against as a result of exercising advanced directives; and (iv) have their advanced directives implemented in accordance with State law. It also requires education programs including advanced directives, bioethics, patient wishes, and the concept of patient self-determination be provided by the entities covered by the law.

Patient-Centered Medical Home *or* **PCMH** A model of primary care that AHRQ defines as encompassing five functions and attributes: (i) comprehensive care, (ii) patient-centered; (ii) coordinated care; (iv) accessible services; and (v) quality and safety. This model of primary care is primarily targeted to chronically ill patients, in which the patient is assigned to a primary care provider who coordinates and monitors the patient's health status and interactions with other treating providers. The Medical Home model focuses on a team approach to early intervention and active care management to reduce the need and intensity of health services later on.

Patient-Centered Outcomes Research Institute *or* **PCORI** An independent, nonprofit research organization that funds comparative clinical effectiveness research, CER. Research which compares two or more medical treatments, services, or health practices to help patients and other stakeholders make better informed decisions about their health and health care choices.

Patient-Driven Groupings Model *or* **PDGM** The BBA of 2018 included several requirements for home health payment reform to be effective as of January 1, 2020. These requirements included the elimination of the use of therapy thresholds for case-mix adjustment and a change from a 60-day unit of payment to a 30-day period payment rate. The statutorily required provisions in the BBA of 2018 resulted in the Patient-Driven Groupings Model. Under the PDGM, each 30-day period is grouped into one of twelve clinical groups based on the patient's principal diagnosis. The reported principal diagnosis provides information to describe the primary reason for which patients are receiving home health services under the Medicare home health benefit.

Pay for Performance *or* **P4P** A provider payment model which pairs financial incentives/disincentives to provider performance. The model is part of recent public policy priorities to transition health care to value-based medicine that links reimbursement to metric-driven outcomes, proven best practices, and patient satisfaction. *Also known as* **Value-Based Payment** *or* **VBP**.

Paycheck Protection Program and Healthcare Enhancement Act *or* **PPPCHE** Signed into law on April 24, 2020, the Paycheck Protection Program and Healthcare Enhancement Act was fourth major piece of legislation designed to address the COVID-19 pandemic. The Act included provisions to address the domestic outbreak, primarily including additional funds to add to the Provider Relief Fund created by the CARES Act and funds for additional COVID testing.

Payer An entity, such as Medicare, Medicaid, a Blue Cross/Blue Shield insurer, HMO, a commercial insurance company, or self-insured employer or welfare benefit fund that is legally responsible for payment of a provider's claims for health care services rendered to plan members.

Payment Allowance *See* **Allowed Charge** *or* **Allowed Amount**

Peer Review A process where a committee comprised of clinicians evaluates the quality of an individual physicians' clinical work to ensure that prevailing standards of care are being met. *See also* **Peer Review Organization** *or* **PRO** and **Quality Improvement Organization** *or* **QIO**.

Peer Review Organization *or* **PRO** *See* **Quality Improvement Organization** *or* **QIO**.

Pending Claim A claim that has been presented to a health care payer and received by that payer but has not been approved, denied, finished or completed.

PEPPER Report The Program for Evaluating Payment Patterns Electronic Report is a comparative data report that summarizes a provider's Medicare claims data statistics for services vulnerable to improper Medicare payments.

Per Cause Deductible A flat amount that an insured must pay toward the eligible medical expenses resulting from each illness before the insurance company will make any benefit payments.

Per Diem Cost A daily cost measure.

Per Member Per Month *or* **PMPM** A cost or payment measure based on each enrolled member each month in a particular health plan.

Per Member Per Year *or* **PMPY** A PMPM payment is the type of payment used in a capitation arrangement. Under this arrangement a health plan pays a provider a fixed dollar amount for each member enrolled in the plan who accesses, or may access, services from the provider, regardless of how many or how few times the member accesses such services.

Per Thousand Members Per Year *or* **PTMPY** A common way of reporting utilization. The most common example is hospital utilization, expressed as days per thousand members per year.

Periodic Interim Payment *or* **PIP** A type of bi-weekly Medicare payment that institutional providers can apply for and receive. Payments are based on the provider's estimated reimbursement.

Permissible Exposure Limits *or* **PEL** A legal limit set by OSHA relating to employee exposure to a chemical substance or physical agent. OSHA has the authority to set PELs pursuant to the OSH Act of 1970. *Also referred to as* **OSHA PELs**.

Permitted Rate *or* **Permitted Charge** *See* **Allowed Charge** *or* **Allowed Amount**

Personal and Incidental Allowance *or* **PIA** That portion of the Supplemental Security Income/State Supplemental Program (SSI/SSP) payment designated for the personal expenses of the consumer.

Personal Care Aid *See* **Personal Care Assistant** *or* **PCA**

Personal Care Assistant *or* **PCA** An individual who assists elderly, chronically ill or persons with disabilities with his or her ADLs in an individual's home. *Also known as* a **Personal Care Aid** *or* **Personal Care Attendant**.

Personal Care Attendant *See* **Personal Care Assistant** *or* **PCA**

Personal Care *or* **PC** Personal care is a service (approved in a State's approved Medicaid plan, waiver, or a demonstration) that is provided to Medicaid beneficiaries in the community rather than in institutional settings. They are a range of human assistance provided to persons with disabilities and chronic conditions to enable them to accomplish activities of daily living or instrumental activities of daily living. An independent or agency PCA may provide these services and they are different than home health aide services provided through the Medicaid or Medicare home health benefit.

Personal Care Services *or* **PCS** *See* **Personal Care** *or* **PC**.

Personal Emergency Response System *or* **PERS** A communications device and monitoring system that enable certain individuals, such as those with chronic conditions, disability or the elderly, at high risk, to secure help in an emergency.

Personal Protective Equipment *or* **PPE** Equipment worn to minimize exposure to hazards that cause serious workplace injuries and illnesses. Such as injuries and illnesses may result from contact with chemical, radiological, physical, electrical, mechanical, or other workplace hazards. Personal protective equipment may include items such as gloves, safety glasses and shoes, earplugs or muffs, hard hats, respirators, or coveralls, vests and full body suits.

Pharmaceutical Research and Manufacturers of America *or* **PhRMA** An industry association that represents biopharmaceutical manufacturers and research companies. It conducts advocacy for public policies that encourage the discovery of important, new medicines. Develops and disseminates codes of conduct for its members and conducts educational and other programs.

Pharmacy Benefit Manager *or* **PBM** An intermediary between insurance carriers and pharmaceutical manufacturers they create formularies, negotiate rebates (discounts paid by a drug manufacturer to a PBM) with manufacturers, process claims, create pharmacy networks, review drug utilization, and occasionally manage mail-order specialty pharmacies.

PhRMA Code A code of ethics adopted by PhRMA relating to interactions with health care professionals. The code introduced and reinforced some broad restrictions and prohibitions on interactions between health care professionals and pharmaceutical companies. For example, companies that provide, market, and manufacture medical products are advised not to pay for entertainment activities or recreation (*e.g.*, sporting events and equipment, theater, skiing) for health care professionals who are not company employees.

Physician Hospital Organization *or* **PHO** Either legally organized or informal organizations that connect hospitals with the organized medical staff. They can be developed for the purpose of contracting with managed care plans.

Physician Payment Sunshine Act *or* **The Sunshine Act** Enacted as part of the ACA, it requires applicable manufacturers of drugs, medical devices, and biologicals that produce products reimbursable by Medicare or Medicaid to report any payments or other transfers of value made to physicians or teaching hospitals. Certain manufacturers and group purchasing organizations must also report if they are owned by physicians.

Physician Practice Management Company *or* **PPM** An organization that manages physicians' practices. PPMs often provide full-service management and administrative services, including information technology, back-office, billing and compliance, human resources and many other services.

Physician Self-Referral Law *See* **Ethics in Patient Referrals Act of 1989, Stark I** *and* **Stark II**

Physician Self-Referral Prohibition *See* **Ethics in Patient Referrals Act of 1989, Stark I** *and* **Stark II**

Physician's Assistant *or* **PA** A type of licensed clinical professional that practices medicine under the direction and supervision of a licensed physician.

Physicians Orders for Life-Sustaining Treatment *or* **POLST** *See* **Medical Orders for Life Sustaining Treatment** *or* **MOLST**.

Plan Sponsor Organization The entity responsible for sponsoring a health benefit plan and for the payment of health care claims. Plan Sponsors can include insurers, self-funded employers, unions, and other entities that underwrite the cost of health benefit plans.

Plan-Do-Study-Act *or* **PDSA** A method to test a process change that is implemented. It uses four steps to guide the thinking process by breaking it down into steps and then evaluating the outcome, improving on it, and testing again.

Point-of-Service or POS A health plan in which members do not have to choose how to receive services until they need them. The most common use of the term applies to a plan that enrolls each member in both an HMO (or HMO-like) system and an indemnity plan.

Point-of-Service Plan *See* **Open-Access HMO**

Policy Holder The owner of a health insurance policy. In group insurance, the legal entity (employer, union, trustee, creditor) to whom an insurer issues a contract. *Also referred to as* the **Policy Owner**.

Policy Owner *See* **Policy Holder**.

Population Health Portability Characteristic of an insurance policy that allows an insured to accumulate and transfer insurance benefits from one employer to another or from an employer to a nongroup or personal policy.

Post-Acute Care Payment Reform Demonstration *or* **PAC-PRD** Undertaken in 2006, it developed a uniform assessment instrument for acute hospitals and four PAC settings.

Potentially Preventable Readmission *or* **PPR** Measures used by CMS to address quality of care in SNF, IRF, LTCH, and HHA setting. Readmissions that are categorized as PPRs are considered unplanned or potentially preventable with the proper care and services and occur within a 30-day post-acute hospital discharge window.

PPACA *See* **Affordable Care Act of 2010** *or* **ACA**.

Practice Guidelines Systematically developed guidelines, statements or policies to assist professional practitioners and patient decisions about appropriate health care for specific clinical circumstances.

Pre-Admission Screening and Annual Resident Review *or* **PASARR** A federal requirement to review and screen nursing home residents to help ensure that individuals are not inappropriately placed in nursing homes for long term care. It requires Medicaid-certified nursing facilities to: (i) evaluate all applicants for serious mental illness (SMI) and/or intellectual disability (ID): (ii) offer all applicants the most appropriate setting for their needs (in the community, a nursing facility, or acute care settings): and (iii) provide all applicants the services they need in those settings.

Preadmission Certification *See* **Precertification** *or* **Precert**.

Preadmission Review *See* **Precertification** *or* **Precert.**

Preamble Congress delegates authority to establish specific rules to administrative agencies, such as CMS and OIG. In many instances, these rules (also called regulations) are made effective by publication in a government periodical called the Federal Register. The law requires administrative agencies to explain the rules they promulgate. These explanations are commonly found in the preamble to a rule. In the preamble, the agency generally takes account of the comments it received in its proposed rule and explains how the final rule may differ from the proposed rule. In many cases, the preamble is a source of significant insight into the meaning of often obtuse regulatory language. It is not uncommon for a preamble to be several times longer than the rule it explains. Proposed rules are often published with preambles as well; in that case, the preamble will explain the rationale behind the proposal and seek responses to specific questions where the agency desires public input.

Precertification *or* **Precert** A utilization management technique that requires a beneficiary to receive or obtain certification or authorization from a health plan for the provision of items or services (inpatient or outpatient) covered by the plan. The process often involves medical necessity reviews against criteria established by the plan. Most plans provide that failure to obtain precertification results in a financial penalty to either the provider or the beneficiary. *Also known as* **Preadmission Certification** *or* **Preadmission Review**.

Preemption Federal law preempts any State law that is inconsistent with federal law.

Preexisting Conditions Limitation Restriction on payments for those charges directly resulting from an accident or illness for which the insured received care or treatment within a specified period of time (for example, three months) prior to the date of insurance. Pre-existing condition exclusions are prohibited by the ACA.

Preferred Provider Organization *or* **PPO** Entities that supply networks of health care providers to employer health benefit plans and health insurance carriers. Providers contracting with PPOs typically agree to abide by procedures designed by the PPO to control the utilization and cost of health services and to accept the PPO's reimbursement structure and payment levels. PPOs provide incentives for enrollees to use network providers. Individuals may choose a nonparticipating provider and still receive coverage, although they will pay a higher coinsurance or deductible amount.

Premium The amount paid, often on a monthly basis, for health insurance. The cost of the premium may be shared between employers or government purchasers and individuals.

Premium Subsidies A fixed amount of money or a designated percentage of the premium cost that is provided to help people purchase health coverage. Premium subsidies are usually provided on a sliding scale based on an individual's or family's income. The ACA provides premium subsidies through refundable pre-tax credits to individuals with certain income levels as a percentage of the federal poverty level and who purchase policies through the health insurance exchanges beginning in 2014.

Premium Tax Credits A refundable tax credit that helps eligible individuals and families with low or moderate income afford health insurance purchased through a Health Insurance Marketplace. To get this credit, you must meet certain requirements and file a tax return.

Prepaid Health Plan *or* **PHP** Often a type of managed care plan without a gatekeeper component, a PHP also is structured to pay medical service providers a fixed amount based on the number of people enrolled, regardless of services received by the enrollee.

Prepaid Health Service Plan *or* **PHSP** *See* **Prepaid Health Plan** *or* **PHP**.

Prescription Drug Monitoring Program *or* **PDMP** State programs that use electronic databases to track controlled substance prescriptions. They can provide enforcement authorities with timely information about prescribing and patient behaviors that contribute to the misuse of controlled substances.

Preventive Care Health care that emphasizes the early detection and treatment of diseases. The focus on prevention is intended to keep people healthier for longer, thus reducing health care costs over the long term. The ACA requires new qualified health plans and Medicare to provide coverage without cost-sharing for certain preventive services. The law also included incentives for states to offer the same coverage in their Medicaid programs.

Primary Care First contact and continuing health care, including basic or initial diagnosis and treatment, health supervision, management of chronic conditions, preventive health services, and appropriate referral.

Primary Care Case Manager *or* **PCCM** An early type of managed care program in Medicaid managed care. The state program would designate PCPs as case managers to function as gatekeepers and reimbursing those PCPs using traditional Medicaid fee-for-service as well as paying them a nominal management fee, such as $2 to $5 PMPM.

Primary Care First *or* **PCF** A Medicare voluntary, five-year alternative payment model to reduce spending by preventing avoidable inpatient hospital admissions and improve quality and access to care for all beneficiaries, particularly those with complex chronic conditions and serious illness. The model specifically aims to reward value and quality by offering an innovative payment structure to support delivery of advanced primary care.

Primary Care Physician *or* **PCP** A physician (M.D. - Medical Doctor or D.O. - Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient. The physician is often an internist, pediatrician, family practitioner, or general practitioner but can also include obstetrician/gynecologists.

Primary Care Provider Primary care providers provide Primary Care services and are physicians, physician assistants, nurses, and nurse practitioners. *See* **Primary Care** *and* **Primary Care Physician** *or* **PCP**

Primary Medical Group *or* **PMG** A group practice made up of primary care physicians, although some may have obstetrician/gynecologists as well.

Private Inurement Situation in which a nonprofit business operates in such a way as to provide more than incidental financial gain to a private individual; for example, if a nonprofit hospital pays too much money for a physician's practice or fails to charge fair market rates for services provided to a physician.

Probe Sample *See* **Discovery Sample**.

Professional Services Agreement *or* **PSA** A general acronym for a contract for professional services that can be between a physician or other health care professional and a professional employer, provider, commercial payor, managed care organization, or other authorized entity for the provision of professional services.

Professional Standards Review Organization *or* **PSRO** An organization responsible for determining whether care and services provided were medically necessary and meet professional standards regarding eligibility for reimbursement under the Medicare and Medicaid programs.

Program of All-Inclusive Care for the Elderly *or* **PACE** Federal Medicare and Medicaid program through which qualifying individuals receive comprehensive community care, rather than being placed in a nursing home.

Program Safeguard Contractor *or* **PSC** *See* **Zone Program Integrity Contractor** *or* **ZPIC**.

Prospective Payment System *or* **PPS** A reimbursement system in which Medicare payment is made based on a predetermined, fixed amount. The payment amount for a particular service is derived based on the classification system of that service (e.g., DRGs for inpatient hospital services).

Prospective Rating Method of renewal rating for health plans that adjusts the rates for the coming policy year in accordance with such factors as known credible past experience, insurance industry and insurance company trends, general business trends (for example, inflation and deflation), current manual rates, and so forth.

Prospective Review Reviewing the need for medical care before the care is rendered. *See* **Precertification**.

Protected Health Information *or* **PHI** Is specifically defined in the HIPAA privacy rule as individually identifiable health information that is (i) transmitted by electronic media; (ii) maintained in electronic media; or (iii) transmitted or maintained in any other form or medium subject to specific exclusions. *See* **Individually Identifiable Health Information** *or* **IIHI**.

Provider Any organization, institution, or individual that provides health care services to patient on an in-patient or out-patient basis (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier, etc.). The term is also a term used in specific regulatory and contractual scenarios such as being a Medicare or Medicaid provider or a provider in a commercial insurance plan, i.e. entering into a provider agreement with those programs or plans.

Provider Discounts Element of network-based managed care programs whereby financial arrangements are negotiated with providers to reduce fees for medical services rendered.

Provider Payment Rates The total payment a provider, hospital, or community health center receives when they provide medical services to a patient. Providers are compensated for patient care using a set of defined rates based on illness category and the type of service administered.

Provider Reimbursement Manual *or* **PRM** The primary Medicare manual that provides guidance on institutional provider reimbursement in the Medicare program.

Provider Reimbursement Review Board *or* **PRRB** An independent panel to which a certified Medicare provider of services may appeal if it is dissatisfied with a final determination by its MAC or by CMS.

Provider Relief Fund *or* **PRF** Established by the CARES Act and expanded in subsequent legislation, the fund was meant to help providers "prevent, prepare for, and respond to coronavirus" and to "reimburse. . .eligible health care providers for health care related expenses or lost revenues that are attributable to coronavirus." $178 billion in provider relief funds were allocated. Providers have returned over $10 billion in funds because they did not need the money or could not meet the terms and conditions relating to the use of the funds.

Provider Self-Disclosure Protocol A component of the OIG's activities that provides health care providers with the opportunity to self-disclose any potential fraudulent acts. Self-disclosure may reduce the possibility that the OIG will subject the provider to a complete audit and investigation, or bring an exclusion action against the provider. In addition, the provider might be liable for a lower amount of fines and penalties due to its cooperation with the government.

Provider Sponsored Network *or* **PSN** A network developed by providers, whether as a vertically integrated with both physicians and hospitals or as a physician-only network. Formed for the purpose of direct contracting with employers and government agencies. A PSN may even end up being an HMO, but its origins are with sponsoring providers rather than non-providers.

Provider Statistical and Reimbursement Report *or* **PS&R** A tool for institutional health care providers that is disseminated by the MAC. The report accumulates statistical and reimbursement data applicable to the processed and finalized Medicare Part A claims of the provider.

Provider-Based Department *or* **PBD** A Medicare or Medicaid definition of a facility or organization that is either created by, or acquired by, a main provider for the purpose of furnishing health care services of the same type as those furnished by the main provider under the name, ownership, and financial and administrative control of the main provider. A department of a provider comprises both the specific physical facility that serves as the site of services of a type for which payment could be claimed under the Medicare or Medicaid program, and the personnel and equipment

needed to deliver the services at that facility. A department of a provider may not by itself be qualified to participate in Medicare.

Provider-Sponsored Organization *or* **PSO** *See* **Provider Sponsored Network** *or* **PSN**.

Public Health Service *or* **PHS** The U.S. Public Health Service is a component of the DHHS and often referred to formally as The Commissioned Corps of the U.S. Public Health Service, or USPHS Commissioned Corps. Its mission is to work on advancing public health. Officers with the PHS serve in agencies across the government, as physicians, nurses, dentists, veterinarians, scientists, engineers and other professionals to fight disease, conduct research, and care for patients in underserved communities across the nation and throughout the world.

Purchasing Pool Health insurance providers pool the health care risks of a group of people in order to make the individual costs predictable and manageable. For health coverage arrangements to perform well, the risk pooling should balance low and high-risk individuals such that expected costs for the pool are reasonably predictable for the insurer and relatively stable over time.

Pursue and Pay Refers to a health plan not paying for a benefit until alternate sources of payment (for example, another plan) have been pursued.

Q

Qualified Beneficiary A qualified beneficiary is an individual who is a covered employee, the employee's spouse, and the employee's dependent children who are covered under the group health plan on the day before a qualifying event that is a termination of employment or reduction in hours. In some situations, a retired employee, the retired employee's spouse, and the retired employee's dependent children are also classified as qualified beneficiaries. The term also includes an individual who must in certain circumstances be offered COBRA coverage under a group health plan, and children born to or adopted by a covered employee during a period of COBRA coverage.

Qualified Health Plan Insurance plans that have been certified as meeting a minimum benchmark of benefits (i.e. the essential health benefits) under the Affordable Care Act. This will allow consumers to verify that the plan they have purchased will meet at least the minimum requirements of the individual mandate.

Qualifying Event An occurrence (such as death, termination of employment, divorce, etc.) that triggers an insured's protection under COBRA, which requires continuation of benefits under a group insurance plan for former employees and their families who would otherwise lose health care coverage. An event that permits a member to modify his or her health benefits coverage.

Quality Assurance (older term) or **Quality Management** (newer term) *or* **QA** The process of assuring that health care services being rendered to patients meet certain predetermined quality criteria. Hospitals, insurers, PHOs, and other entities can each have their own measures and programs.

Quality Assurance and Performance Improvement *or* **QAPI** The coordinated application of two mutually-reinforcing aspects of a quality management system: Quality Assurance (QA) and Performance Improvement (PI), which takes a systematic, comprehensive, and data-driven approach to maintaining and improving safety and quality.

Quality Improvement and Evaluation System *or* **QIES** *or* **iQIES** The data collection platform that providers and vendors use to submit patient assessment data to CMS. CMS has upgraded QIES to iQIES and started to require providers to transition data submission to the enhanced iQIES platform in phases.

Quality Improvement Organization *or* **QIO** Formerly known as peer-review organizations (PRO), quality improvement organizations are independent, private organizations established under TEFRA, generally operating at the state level, that review medical necessity, as well as quality and cost of care for Medicare and Medicaid programs. A QIO usually comprises of health quality experts, clinicians, and consumers. QIOs work under the direction of CMS to assist Medicare providers with quality improvement and review quality concerns for the protection of beneficiaries and the Medicare Trust Fund. CMS identifies the core functions of the QIO Program as: (1) improving quality of care for beneficiaries; (2) protecting the integrity of the Medicare Trust Fund by ensuring that Medicare pays only for services and goods that are reasonable, necessary, and provided in the most appropriate setting; and (3) protecting beneficiaries by expeditiously addressing individual complaints, such as beneficiary complaints, provider-based notice appeals, violations of EMTALA, and other related responsibilities as articulated in QIO-related law. QIOs conduct reviews primarily in connection with inpatient hospital care.

Quality Management (newer term) or **Quality Assurance** (older term) *or* **QM** The process of assuring that health care services being rendered to patients meet certain predetermined quality criteria. Hospitals, insurers, PHOs, and other entities can each have their own measures and programs.

Quality Payment Program *or* **QPP** MACRA authorized CMS to institute the QPP. The QPP gave CMS the ability to reward high-value, high-quality Medicare clinicians with payment increases – while at the same time reducing payments to those clinicians who weren't meeting performance standards. The program establishes a model of funding that rewards clinicians who provide high-quality patient-centered care. QPP has two distinct tracks, one is the Merit-based Incentive Payment System (MIPS) and the other is the Alternative Payment Models (APM).

QualityNet A website established by CMS that provides public health care quality improvement news, resources, data reporting tools, and applications used by health care providers. It is a one-stop shop for CMS quality programs, provides information on quality data reporting programs associated with the Hospital Inpatient Quality Reporting Program, Hospital Outpatient Quality Reporting Program, Ambulatory Surgical Center Quality Reporting Program,

Inpatient Psychiatric Facility Quality Reporting Program, PPS-Exempt Cancer Hospital Quality Reporting Program, and End-Stage Renal Disease Quality Incentive Program.

***Qui Tam* Action** Abbreviation of the Latin phrase "*qui tam pro domino rege quam pro si ipso in hac parte sequitur*," which means, "He who brings the action for the King as well as for himself." *Qui tam* provisions of a statute allow a private person to bring a civil action on behalf of both the U.S. and himself and to share in part of the monetary recovery. The individual bringing the *qui tam* action can receive between 15% and 25% of whatever is recovered from the lawsuit, with the remainder going to the government.

***Qui Tam* Relator** The private person who may bring a lawsuit on behalf of the U.S. Government as well as herself, based on her knowledge of wrongdoing. A relator is often a current or former employee or an employee of a competitor or subcontractor of the organization accused of wrongdoing.

R

RAT-STATS RAT-STATS is a free statistical software package that providers can download from the OIG website to assist in a claims review. The package, created by OIG in the late 1970s, is also the primary statistical tool for OIG's Office of Audit Services. Among other tasks, the software assists the user in selecting random samples and estimating improper payments. Although OIG does not require the use of RAT-STATS, many providers download the software in their efforts to fulfill the claims review requirements for CIAs or the Provider Self-Disclosure Protocol.

Rate The amount of money that a group or individual must pay to the health plan for coverage. Usually a monthly fee.

Rating Determining the cost of a given unit of insurance for a given year.

Readmissions Reduction Program *or* **RRP** *See* **Hospital Readmissions Reduction Program** *or* **HRRP**.

Reasonable and Customary Charge or RCC *See* **Reasonable and Customary Charges** *or* **R&C**.

Reasonable and Customary Charges *or* **R&C** Reasonable and Customary charges or R&C is the maximum amount an insurer will consider eligible for reimbursement to non-participating providers based on its survey of prevailing fees in a geographic area. Health plan members may be liable for the difference between the provider's charge and R&C when they receive services from a non-participating provider. *Also known as* **Usual, Customary, and Reasonable Fees** *or* **UCR**.

Recovery Audit Contractor *or* **RAC** Created by the Modernization Act of 2003 (MMA), RACs are private contractor organizations tasked with the identification and recover of improper Medicare payments paid to health care providers under fee-for-service (FFS) Medicare plans. Section 302 of the Tax Relief and Healthcare Act of 2006 required DHHS to make the program permanent by January 1, 2010. As implemented by CMS, RACs are required to identify both overpayments and underpayments, and are paid on a contingency fee basis.

Regional Health Information Organization *or* **RHIO** A RHIO is made up of a group of organizations within a specific area that share health care-related information electronically according to accepted health care information technology (HIT) standards. A RHIO typically oversees the means of information exchange among various provider settings, payers and government agencies.

Reinsurance Insurance purchased by a health plan to protect it against extremely high-cost cases, i.e. catastrophic losses. The ACA provided for a temporary federal reinsurance program for employers that insure early retirees over age 55 who are not eligible for Medicare. *See* **Stop-Loss Insurance**.

Relative Value Study *or* **RVS** A guide that attempts to show in a general way by a unit or point designation the relationship among the time, competency, experience, severity, and other factors required to perform services under usual conditions. Such a study becomes a schedule when dollar conversion factors are applied.

Renewal Rating Insurer's review of the premium rates and claim experience for a group plan from which the necessity of rate changes is determined.

Renewal Underwriting Review of the financial experience of a group case and the establishment of the renewal premium rates and terms under which the insurance may be continued.

Rescission Voiding of an insurance contract from its date of issue by the insurer because of material misrepresentation on the application for insurance. The act of recission must take place within the contestable period or Time Limit on Certain Defenses. The policy is treated as never having been issued and the sum of all premiums paid plus interest, less any claims paid, is refunded. Under the ACA, insurers will only be able to rescind policies in cases of fraud.

Reserves In the health plan context, these are amounts set aside by health plans and other risk-assuming entities to assure adequate funds to meet incurred but not reported (IBNR) claims and expenses. In the regulatory context, reserves may also mean the funds deemed to be available on a statutory accounting basis to meet carrier expenses, including but not limited to claim expenses.

Resident A generic term for an individual patient or client that resides in an in-patient or congregate care living facility such as a senior housing facility, nursing home or long-term behavioral health facility.

Resident Assessment Instrument *or* **RAI** *See* **Patient Review Instrument** *or* **PRI**.

Resident Assessment Protocol *or* **RAP** Part of the SNF / NF care-planning process, RAPs are problem-oriented frameworks for additional assessment based on problem identification items.

Residential Care Facility *or* **RCF** A generic term of a type of in-patient or congregate care setting for the elderly or disabled.

Resource-Based Relative Value Scale *or* **RBRVS** A fee schedule that uses a complex formula to determine the payment due a physician for patient services. Factors that are considered in determining the payment due include the resources used, practice expenses, malpractice expenses, geographic location, and whether the services were provided on an outpatient or inpatient basis. Medicare began phasing in this PPS in 1992. The practical effect has been to diminish reimbursement for procedures such as cardiac surgery and raise reimbursement for primary care office visits.

Respite Care Often used in the HHA or Hospice context, it refers to temporary institutional care of a client or patient in order to provide relief for their usual caregiver.

Restraint Potentially utilized in home or in-patient care setting, restraints can take several forms. Physical restraints limit a patient's movement. Chemical restraints are any form of psychoactive medication used not to treat illness, but to intentionally inhibit a particular behavior or movement. Environmental restraints control a patient's mobility. The use of restraints is generally prohibited unless absolutely necessary to a patient's care.

Retrospective Rating Method of experience rating that adjusts the final premium of a risk in accordance with the experience of that risk during the term of the policy for which the premium is paid.

Retrospective Reimbursement Method of payment to providers by a third party after costs or charges have actually been incurred by insureds.

Retrospective Review Reviewing health care costs after the care has been rendered. There are several forms of retrospective review. One form looks at individual claims for medical necessity, billing errors, or fraud. Another form looks at patterns of costs rather than individual cases.

Risk Management Management activities aimed at lowering an organization's legal and financial exposure to professional liability and civil liability in general.

Risk Pools A method in some states in which persons who can afford private health insurance but who are uninsurable for medical reasons can obtain access to health insurance.

Rural Health Clinic *or* **RHC** Established by the Rural Health Clinic Services Act of 1977, a rural health clinic is a clinic located in a rural, medically under-served area and has a separate reimbursement structure from a standard medical office under the Medicare and Medicaid programs.

RX Refers to a drug that requires a prescription or the prescription itself. The origin of why "RX" is used has different explanations. A common explanation is that "Rx" has Latin roots in the word "recipere," meaning "to take" and further the word became, by the late 1500s, "recipe," meaning a "medical prescription."

S

Safe Harbor Regulatory or statutory provisions that shield certain specific financial or business arrangements from criminal prosecution or program exclusion. Safe harbor provisions are contained in the federal Anti-Kickback Statute and its accompanying regulations.

Safety Net Health care providers who deliver health care services to patients regardless of their ability to pay. These providers may consist of public hospital systems, community health centers, local health departments, and other providers who serve a disproportionate share of uninsured and low-income patients.

Safety Net Hospital *See* **Safety Net**.

Schedule H Defined by NAIC model legislation, Schedule H is the Accident and Health Exhibit of an insurer's Annual Statement. Its purpose is to show the profitability of various categories of health insurance business.

Section 1115 Waiver Section 1115 of the Social Security Act gives the Secretary of DHHS authority to approve experimental, pilot, or demonstration projects that are found by the Secretary to be likely to assist in promoting the objectives of the Medicaid program.

Section 125 Plan A Section 125 plan allows employees to receive specified benefits, including health benefits, on a pre-tax basis. Section 125 plans enable employees to pay for health insurance premiums on a pre-tax basis, whether the insurance is provided by the employer or purchased directly in the individual market.

Section 1557 Section 1557 of the ACA provides that an individual shall not, on the basis of race, color, national origin, sex, age or disability be excluded from participation in, or be denied the benefits of or subjected to discrimination under any health program or activity that receives federal financial assistance. On May 13, 2016, OCR issued a Final Rule implementing Section 1557 of the ACA.

Self-Insurance or Self-Funded Plan A health plan where the risk for medical cost is assumed by the employer, union, or other entity sponsoring the plan rather than an insurance company or managed care plan. Under ERISA, self-funded plans are exempt from state laws and regulations, such as premium taxes and mandatory benefits. Self-funded plans often contract with insurance companies or third-party administrators to administer the benefits.

Self-Referral Disclosure Protocol *or* **SRDP** On September 23, 2010, CMS released its SRDP to facilitate the resolution of actual or potential violations of the Stark Law. The SRDP is open to all health care providers and suppliers but is limited to violations of the Stark Law. The SRDP is separate from the CMS Stark Law advisory opinion process and cannot be used to obtain a CMS determination as to whether a violation of the Stark Law has occurred. CMS may make referrals to the OIG and/or the DOJ if it concludes that the disclosed matter requires a referral to law enforcement for resolution of non-Stark violations.

Serious Adverse Event *or* **SAE** In the clinical trials and research context, a SAE is an adverse event that results in death, requires either inpatient hospitalization or the prolongation of hospitalization, is life-threatening, results in a persistent or significant disability/incapacity, or results in a congenital anomaly/birth defect. Other medical events, based upon appropriate medical judgment, may also be considered SAEs if a trial participant's health is at risk and intervention is required to prevent a negative outcome.

Service Area The geographic area in which an MCO provides access to primary care. The service area is usually specifically designated by regulators (state or federal), and the HMO is prohibited from marketing outside the service area. May be defined by county or by ZIP code. It is possible for an MCO to have more than one service area and for the service areas to be either contiguous (that is, they actually border each other) or noncontiguous (that is, there is a geographic gap between the service areas).

Service Bureau A weak form of integrated delivery system in which a hospital (or other organization) provides services to a physician's practice in return for a fair market price. May also try to negotiate with managed care plans, but generally is not considered an effective negotiating mechanism.

Service Intensity Weight *or* **SIW** These are the cost weights established for any given DRG and they indicate the relative cost of the average cost of the patient in the DRG as compared to the average cost of all patients in all DRGs.

Service Plan A health plan that has direct contracts with providers but is not necessarily a managed care plan. The archetypal service plans are Blue Cross and Blue Shield plans. The contract applies to direct billing of the plan by providers (rather than billing of the member), a provision for direct payment of the provider (rather than reimbursement of the member), a requirement that the provider accept the plan's determination of UCR and not balance bill the member in excess of that amount, and a range of other terms. May or may not address issues of utilization and quality.

Shadow Pricing The practice of setting premium rates at a level just below the competition's rates whether or not those rates can be justified. In other words, the premium rates could actually be lower, but to maximize profit the rates are raised to a level that will remain attractive but result in greater revenue. This practice is generally considered unethical and, in the case of community rating, possibly illegal.

Shared Savings Program Enacted as part of the ACA to enable ACOs that meet certain quality benchmarks to receive a portion of cost savings from the Medicare program.

Sherman Act The first major anti-trust legislation, it was enacted in 1890. The Act outlaws "every contract, combination, or conspiracy in restraint of trade," and any "monopolization, attempted monopolization, or conspiracy or combination to monopolize." Penalties for violating the Act can be severe. They include both civil and criminal penalties. Individuals and businesses that violate the Act may be prosecuted by the Department of Justice. Criminal prosecutions are typically limited to intentional and clear violations such as when competitors fix prices or rig bids. The Sherman Act imposes criminal penalties of up to $100 million for a corporation and $1 million for an individual, along with up to 10 years in prison. Under federal law, the maximum fine may be increased to twice the amount the conspirators gained from the illegal acts or twice the money lost by the victims of the crime, if either of those amounts is over $100 million.

Silent PPO An organization that utilizes the assignment clause of the provider contract and sells or leases rights to the fee discounts contained in the contract to other health plans, sometimes without the provider's knowledge or specific consent.

Single Service Plan A medical or health plan involving only one benefit such as vision, dental, or mental health.

Site-Neutral Site-neutrality is the concept of a health plan paying the same amount for the same outpatient services regardless of whether the service is performed in a hospital, ambulatory surgical center, or physician's office.

Skilled Nursing Care Skilled nursing care generally is provided by trained registered nurses or other licensed professionals in a medical setting under a doctor's supervision. *See* **Skilled Nursing Facility** *or* **SNF**.

Skilled Nursing Facility *or* **SNF** A facility that meets specific Medicare regulatory certification requirements and primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.

Social Determinants of Health Non-medical factors that can affect an individual's health status, whether a health condition can be effectively managed and whether an individual can comply with a treatment plan. Examples of social drivers include poverty, homelessness and lack of access to healthy food.

Social Security Act *or* **SSA** Initially enacted in 1935, it established a system of federal old-age benefits, and enabled the States to provide for aged persons, blind persons, dependent and crippled children, maternal and child welfare, public health, and the administration of their unemployment compensation laws, It also established a Social Security Board and made provisions for raising revenue to support the new social security system. One of the larger amendments to the Act included the establishment of the Medicare and Medicaid programs. *See also* **Social Security Administration** *or* **SSA**.

Social Security Administration *or* **SSA** The federal agency created by the Social Security Act that is responsible for the administration of retirement, disability, survivor, and family benefits, and enrolling individuals in Medicare. It also provides Social Security Numbers, as unique identifiers required to work, handle financial transactions, and determine eligibility for certain government services. Also refers to the Social Security Act.

Socialized Medicine A health care system in which the government operates and administers health care facilities and employs health care professionals.

Society for Healthcare Strategy and Market Development *or* **SHSMD** A professional membership group that is part of AHA**.** It represents specific professionals involved in health care, including but not limited to those focused on marketing, digital engagement, communications, strategic planning, and business development.

Special Enrollment Period Is a time outside the yearly Open Enrollment Period when one can sign up for health insurance.

Special Needs Plan *or* **SNP** Created by the Medicare Modernization Act of 2003, A SNP is a MA (Medicare Part CA) coordinated care plan (CCP) specifically designed to provide targeted care and limit enrollment to special needs individuals. A special needs individual could be any one of the following: an institutionalized individual, a dual eligible, or an individual with a severe or disabling chronic condition, as specified by CMS.

Specialty Care Physician *or* **SCP** A physician who is not a PCP.

Specialty Medical Group *or* **SMG** A medical group made up predominantly of specialty physicians. May be a single-specialty group or a multispecialty group.

Specialty Network Manager A term used to describe a single specialist (or perhaps a specialist organization) that accepts capitation to manage a single specialty. Specialty services are supplied by many different specialty physicians, but the network manager has the responsibility for managing access and cost and is at economic risk.

Spending Down Gradual depletion of one's assets until indigent, thus qualifying for Medicaid benefits. Usually associated with nursing home or long-term care.

Staff Model HMO An HMO that employs providers directly, and those providers see members in the HMO's own facilities. A form of closed panel HMO. A different use of this term is sometimes applied to vertically integrated health care delivery systems that employ physicians but in which the system is not licensed as an HMO.

Stark I Colloquial name for the physician self-referral prohibitions introduced to Congress in 1988 by California representative Fortney "Pete" Stark. The initial Stark Law became effective January 1, 1992, and generally provides that a physician or an immediate family member who has a financial relationship with an entity may not refer a Medicare patient to that entity for clinical laboratory services, unless an applicable exception exists. In addition, the law prevents an entity with which a physician has a financial relationship from billing Medicare or a beneficiary for clinical laboratory services furnished pursuant to a prohibited referral. *See* **Ethics in Patient Referrals Act of 1989** *and* **Stark II**

Stark II The 1993 amendments to Stark I that extend the physician self-referral restrictions to Medicaid services and beneficiaries and expand the referral and billing prohibitions to 10 additional designated health services reimbursable by Medicare or Medicaid. The 10 services are (1) physical therapy, (2) occupational therapy, (3) radiology services, including magnetic resonance imaging, computerized axial tomography scans and ultrasound services, (4) radiation therapy services and supplies, (5) DME and supplies, (6) parenteral and enteral nutrients, equipment and supplies, (7) prosthetics, orthotics, and prosthetic devices, (8) home health services and supplies, (9) outpatient prescription drugs, and (10) inpatient and outpatient hospital services. Stark II became effective on January 1, 1995. The statute contains many exceptions, which can be grouped into categories applicable to all financial relationships, to ownership and investment interests, and to compensation arrangements. *See* **Ethics in Patient Referrals Act of 1989** *and* **Stark I**

Stark Law *See* **Ethics in Patient Referrals Act of 1989**, **Stark I** *and* **Stark II**

The State Children's Health Insurance Program *or* **SCHIP** *See* **Children's Health Insurance Program** *or* **CHIP**.

Statistical Claim Another term for an encounter whereby data are entered by an MCO's claims department but no FFS payment is made. Occurs in a capitated environment.

Statistical Sampling Where a participating provider is audited for compliance, the auditing entity will often choose to use statistical sampling methods rather than investigating each and every claim for reimbursement. The use of statistical sampling to determine overpayments is supported by statute. While disputes may arise over the sampling methods used by auditors, providers find little success in challenging the validity of sampling generally. Currently, CMS's statistical sampling and extrapolation methodology guidelines appear in its Medicare Program Integrity Manual (MPIM). Though statistical sampling has been upheld in courts as an accepted method of estimating Medicare overpayments, courts have not adopted specific guidelines for sampling methodologies.

Step-Rate Premium Rating structure in which the premiums increase periodically at predetermined times, such as policy years or attained ages.

Stop-Loss Insurance A form of reinsurance that provides protection for medical expenses above a certain limit, generally on a year-by-year basis. This may apply to an entire health plan or to any single component. For example, the health plan may have stop-loss reinsurance for cases that exceed $100,000. After a case hits $100,000, the plan receives 80% of expenses in excess of $100,000 back from the reinsurance company for the rest of the year. Another example would

be the plan providing a stop-loss to participating physicians for referral expenses greater than $2,500. When a case exceeds that amount in a single year, the plan no longer deducts those costs from the physician's referral pool for the remainder of the year.

Sub-Acute Care A model of step-down care after an acute care hospital stay. *See* **Sub-Acute Care Facility**. *Also referred to as* **Post-Acute Care**.

Subacute Care Facility A health facility that is a step down from an acute care hospital. May be a nursing home or a facility that provides medical care but not surgical or emergency care.

Subrogation The process by which an insurance carrier may recover from another carrier or party benefits paid on behalf of an insured, where the legal obligation to pay benefits with regard to a claim rests with the other carrier or party. A health plan would seek to recover from an auto insurer for expenses caused by an auto accident.

Subscriber The individual or member who has health plan coverage by virtue of being eligible on his or her own behalf rather than as a dependent.

Substance Use Disorder *or* **SUD** A treatable mental disorder that affects a person's brain and behavior, leading to their inability to control their use of substances like legal or illegal drugs, alcohol, or medications.

Summary Plan Description *or* **SPD** The summary of health plan benefits, coverage, and limitations issued to participants in self-insured health benefit plans.

Supplemental Medical Insurance Another term for Medicare Part B coverage. *See* **Medicare Part B**

Supplemental Nutrition Program for Women, Infants, and Children *or* **WIC** A USDA grant program that provides federal grants to states for supplemental foods, health care referrals, and nutrition education for low-income pregnant, breastfeeding, and non-breastfeeding postpartum women, and to infants and children up to age 5 who are found to be at nutritional risk.

Supplemental Security Income *or* **SSI** A program created by the SSA, that provides monthly payments to people with disabilities and older adults who have little or no income or resources.

Supplier Any company, person, or agency that provides a medical item or service, e.g., a wheelchair or walker. Often used to refer to a business that provides an item of durable medical equipment that is reimbursed by Medicare Part B.

Surgicenter *See* **Ambulatory Surgery Center** *or* **ASC**.

Surplus Amount by which the value of an insurer's assets exceeds its liabilities.

Swing Bed A Medicare Part A designation that allows certain hospitals, particularly those in smaller communities, to switch Medicare-certified in-patient acute care beds to skilled care status.

T

Targeted Probe and Educate *or* **TPE** A CMS program designed to assist providers and suppliers in reducing claim denials and appeals via the use of one-on-one help.

Tax Deduction A deduction is an amount that a person/family can subtract from their adjusted gross income when calculating the amount of tax that they owe.

Tax Equity Fiscal Responsibility Act of 1982 *or* **TEFRA** Tax Equity and Fiscal Responsibility Act. One key provision of this act prohibits employers and health plans from requiring full-time employees between the ages of 65 and 69 to use Medicare rather than the group health plan. Another key provision codifies Medicare risk contracts for HMOs and CMPs.

Tax Relief and Healthcare Act On December 9, 2006, Congress passed the Tax Relief and Health Care Act of 2006. The Act provided for extensions and modifications of certain previously or soon to be expired tax relief provisions, extensions of certain expiring energy provisions, health savings account provisions and other general tax relief provisions. These included but are not limited to allowing individuals to make tax-deductible contributions to an Archer MSA to pay for health care expenses, one-time-only rollovers from Health FSAs and HRAs into HSAs, and a repeal of the annual deductible limitation on HSA contributions.

Teaching Hospital A hospital or medical setting in affiliation with a medical school that provides medical education and technical training.

Telecommunications Device for the Deaf *or* **TDD** A specialized electronic device that aids in communication over a telephone line by providing a teleprinter.

Telehealth A means of providing health care remotely via the use of technology.

Telemedicine The remote diagnosis and or treatment of a patient through telecommunication technology.

Telepsychiatry A form of remote medical services that uses technology to administer psychiatry services.

Temporary Assistance for Needy Families Tax Credit *or* **TANF** A tax credit is an amount that a person or family can subtract from the amount of income tax that they owe. If a tax credit is refundable, the taxpayer can receive a payment from the government to the extent that the amount of the credit is greater than the amount of tax they would otherwise owe.

Termination Date The day that health plan coverage is no longer in effect.

Tertiary Care Highly specialized medical care that usually is administered over a long period of time.

Third-Party Administrator *or* **TPA** A firm that performs administrative functions for insurance companies, HMOs, or other organizations that contract, for an administrative fee, to provide claims review, processing, payment, network administration, and other administrative services to a third party at risk, such as a self-insured employer or plan. TPAs do not issue insurance policies nor assume insurance risk, but may arrange for the provision of medical services through a contracted network. The plan with whom the TPA contracts, whether insured or self-insured, bears the insurance risk. Typically, the TPA pays claims from a bank account owned and directly funded by the plan sponsor or from a bank account controlled by the TPA, but only after the TPA has received funds from the plan sponsor to fund the claims being paid.

Third-Party Liability *or* **TPL** *See* **Coordination of Benefits** *or* **COB**.

Third-Party Payer Any organization, public or private, that pays or insures health or medical expenses on behalf of beneficiaries or recipients, such as Blue Cross and Blue Shield, commercial insurance companies, Medicare, and Medicaid. A person generally pays a premium for coverage in all such private and in some public programs. The organization then pays bills on the insured's behalf. These payments, called third-party payments, are distinguished by the separation between the individual receiving the service (the first party), the individual or institution providing it (the second party), and the organization paying for it (the third party).

Time-Loss Management The application of managed care techniques to workers' compensation treatments for injuries

or illnesses to reduce the amount of time lost on the job by the affected employee.

Tort A civil wrong, leading to the imposition of liability, based on the violation of an obligation other than a breach of contract. *See* **Negligence**.

Total Capitation The term used when an organization receives capitation for all medical services, including institutional and professional. The more common term is global capitation.

Total Quality Improvement *or* **TQI** A governing strategy that seeks to improve the quality of services and products by empowering and holding employees accountable at all stages of the job process.

Transforming Clinical Practices Initiative *or* **TCPI** A federal program created by the CMS with the purpose of providing technical assistance to clinicians in order to assist in their development of quality improvement strategies.

Transitional Care The care a patient receives when transitioning between different units of care.

Transitional Care Unit *or* **TCU** A specialized type of nursing facility that aids in the transition of a patient staying in a hospital to another level of care or out of care entirely.

Trend Factor A modeled prediction of by what degree health care costs will rise over the next policy year.

Triage In health plans, this refers to the process of sorting out requests for services by members into those who need to be seen right away, those who can wait a little while, and those whose problems can be handled with advice over the phone.

Tricare The federal program administered by the Department of Defense that provides health care coverage to families of military personnel, military retirees, certain spouses and dependents of such personnel and certain others. Formerly CHAMPUS.

Triple Aim A framework that describes an approach to optimizing the performance of health care systems.

True Out of Pocket *or* **TrOOP** The out-of-pocket payments that Medicare Part D beneficiaries make and that count towards the plan's annual out-of-pocket threshold. These costs determine when a beneficiary's catastrophic coverage will begin.

Twenty-Four-Hour Care An ill-defined term that essentially means that health care is provided 24 hours per day regardless of the financing mechanism. Applies primarily to the convergence of group health, workers' compensation, and industrial health all under managed care.

Two-Midnight Rule A rule that established Medicare payment policy regarding the benchmark criteria that should be used when determining whether inpatient admission is reasonable and payable under Medicare Part A. Generally, inpatient admissions are payable under Part A if the admitting practitioner expects the patient to require a hospital stay that crosses at least two midnights and the medical record supports that reasonable expectation. There has been ongoing industry criticism and legal challenge regarding this rule.

U

U.S. Department for Housing and Urban Development *or* **HUD** HUD administers federal programs that provide housing and community development assistance. It also works to ensure fair and equal housing opportunity for all. It has certain programs that provide financing for or insured mortgages for certain types of housing for seniors and individuals with disabilities.

U.S. Department of Health and Human Services *or* **HHS** *See* **Department of Health and Human Services** *or* **HHS** *or* **DHHS**.

U.S. Government Accountability Office *or* **GAO** A U.S. agency headed by the Comptroller General and that resides in the legislative branch of government. Considered the congressional watchdog, it provides Congress and the heads of executive agencies with timely, fact-based, non-partisan information that can be used to improve government and save taxpayer funds. Its work is done at the request of congressional committees or subcommittees or is statutorily required by public laws or committee reports.

UB-04/UB-92 The common claim form used by hospitals to bill for services. Some managed care plans demand greater detail than is available on the UB-04 or UB-92, requiring hospitals to send additional itemized bills.

Unbundling The practice of a provider billing for multiple components of service that were previously included in a single fee. For example, if dressings and instruments were included in a fee for a minor procedure, the fee for the procedure remains the same, but there are now additional charges for the dressings and instruments.

Uncompensated Care *or* **UCC** The health services provided by a hospital, often to those who do not have insurance or cannot afford to pay for the cost of care, that do not subsequently receive reimbursement.

Underinsured People who have health insurance but who face out-of-pocket health care costs or limits on benefits that may affect their ability to access or pay for health care services.

Underwrite *or* **Underwriting** The assumption of the economic risk of loss for medical claims incurred by a person or persons. Also, the analysis of a group that is done to determine rates or to determine whether the group should be offered coverage at all.

Underwriting Profit Insurer's profit from its insurance operations as distinguished from its investment earnings.

Uniform Clinical Data Set *or* **UCDS** A data tool that is used in the extraction of information from medical records to allow for appropriate risk adjustment when assessing a patient for treatment.

Uniform Hospital Discharge Data Set *or* **UHDDS** A metric that functions as the core data set of inpatient admissions.

Uniform Policy Provisions Law *or* **UPPL** Statutory policy provisions of health insurance policies that specify some of the rights and obligations of the insured and the insurer. These provisions, with some modifications, are part of the insurance laws of all 50 states and the District of Columbia.

United Network for Organ Sharing *or* **UNOS** UNOS is a non-profit serving as the U.S. transplant system under contract with the federal government. It has a network of transplant hospitals, organ procurement organizations, and thousands of volunteers who make sure donations and recipients are connected. It utilizes data and advances in science and technology to administer the transplant system, increase the number of organs recovered and the number of transplants performed, and ensure patients across the nation have equitable access to transplants.

Universal Coverage A system that provides health coverage to all residents.

Universal Data System *or* **UDS** An annual reporting system used to obtain standardized information regarding the performance and operation of health centers delivering services to vulnerable populations and underserved communities.

Upcoding Using improper billing codes to charge Medicare or Medicaid for an item or service to receive higher payments than would ordinarily be due for the treatment of a patient.

Urgent Care *or* **Urgent Care Center** A walk-in clinical setting designed to address minor injuries and illnesses when

they are non-life threatening.

Usual, Customary, and Reasonable Fees *or* **UCR** Usual, customary, or reasonable. A method of profiling prevailing fees in an area and reimbursing providers on the basis of that profile. One common technology is to average all fees and choose the 80th or 90th percentile, although a plan may use other technologies to determine what is reasonable. Sometimes this term is used synonymously with a fee allowance schedule when that schedule is set relatively high. *Also known as* **Reasonable and Customary Charges** *or* **R&C**

Utilization The frequency and/or intensity of consumption of health care resources.

Utilization Management *or* **UM** The process by which health care services are monitored to examine their appropriateness and quality.

Utilization Management/Utilization Review *or* **UM/UR** UM/UR is the process of evaluating the appropriateness and/or medical necessity of health services. The goal of UM/UR is to ensure that the most medically appropriate services are rendered to patients in the most appropriate clinical setting. UM/UR is designed to avoid overutilization of health care resources. UM/UR may be performed by both payers and providers. Failure to follow a health plan's UM/UR policies and procedures may result in a reduction or denial of a provider's payment.

Utilization Review *or* **UR** Program designed to reduce unnecessary hospital admissions and to control the length of stay for inpatients through the use of preliminary evaluations, concurrent inpatient evaluations, or discharge preplanning.

Utilization Review Organization *or* **URO** A freestanding organization that does nothing but utilization review, usually on a remote basis using the telephone and paper correspondence. It may be independent or part of another company, such as an insurance company that sells utilization review services on a stand-alone basis.

V

Value-Based Payment *or* **VBP** *See* **Value-Based Purchasing**.

Value-Based Purchasing *or* **VBP** A payment reform under which hospitals and other providers are provided bonuses based upon their performance against quality measures. For example, the Affordable Care Act established a Medicare value-based purchasing program for hospitals and required the development of similar programs for skilled nursing facilities, home health agencies, and ambulatory surgical centers, and the testing of pilot programs for other providers, including psychiatric hospitals, long-term care hospitals, rehabilitation hospitals, and hospice programs.

Variable Deductible Deductible amount applied to a particular sickness or injury that is the greater of either the minimum deductible stated in the policy or an amount equal to all benefit payments received from any other medical expense coverage for the same eligible expenses.

VHA, Inc. f/k/a Voluntary Hospitals of America *or* **VHA** *See* **Vizient, Inc.**

Visiting Nurses Association *or* **VNA** An organization that provides home health care and or hospice services through a network of nurses, therapists, social workers, and other health care providers for patients who are homebound, recovering from an illness or injury, or living with a disability or chronic condition.

Vizient, Inc. A large member-owned consulting and advocacy company that works with and for its diverse membership which includes academic medical centers, pediatric facilities, community hospitals, integrated health delivery networks, and non-acute health care providers. The company grew out of the original Voluntary Hospitals of America industry organization.

Volume Discount Premium rate reduction application to new group case coverages that is based on total case premium (for specific coverages) or total premium and premium per certificate (employee).

Volume Loading Premium rate increase applicable to new group case coverages that is based on the total case premium (for specified coverages) or total premium and premium per certificate (employee).

Voluntary Refund Where a provider recognizes that it may have received money from federal health care programs (an overpayment) to which it is not entitled, it may issue a voluntary refund. These voluntary refunds are not related to any open accounts receivable. Such refunds are typically made by submitting adjustment bills, but they occasionally submit refunds via check. Providers need to be aware that the acceptance of a voluntary refund as repayment for the claims specified in no way affects or limits the rights of the federal government to pursue any appropriate remedies arising from or relating to these or any other claims.

W

Wage Index Most often a measure of average hourly wages in a particular geography. Wage indices are used by CMS in many different prospective payment methodologies. For example, Section 1886(d)(3)(E) of the SSA requires that, as part of the methodology for determining prospective payments to hospitals, CMS the Secretary must adjust the standardized amounts "for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level." This adjustment factor is the wage index. We currently define hospital geographic areas (labor market areas) based on the definitions of Core-Based Statistical Areas (CBSAs) established by the Office of Management and Budget and announced in December 2003. The wage index also reflects the geographic reclassification of hospitals to another labor market area in accordance with sections 1886(d)(8)(B) and 1886(d)(10) of the Act.

Wellness Programs Employer provided programs provided to employees to lessen health risks and thus avoid more serious health problems.

Whistleblower A generic term for an individual who informs on a person or organization engaged in illegal or illicit activity. There are several federal and state laws that provide compensation to individuals who act as whistleblowers as well as protection from issues like retaliation by an employer. *See* **Qui Tam Relator**.

Whistleblower Action *See* **Qui Tam Action, False Claims Act** *or* **FCA**.

Wire Fraud Laws Federal laws prohibit the use of wire, radio, or television communication in interstate or foreign commerce for the purpose of executing a scheme to defraud.

Workers' Compensation A form of social insurance provided through state-run insurance programs or private property-casualty insurers. Workers' compensation provides medical benefits and replacement of lost wages that result from injuries or illnesses that arise from the workplace; in turn, the employee cannot normally sue the employer unless true negligence exists. Workers' compensation is often heavily regulated under state laws that are significantly different from those used for group health insurance and is often the subject of intense negotiation between management and organized labor.

Workers' Compensation Board *or* **WCB** A generic term that often refers to the state agency responsible for overseeing the workers' compensation insurance scheme in a particular state.

Worksheet S-10 Worksheet S-10 is an element of a hospital's Medicare cost report and is used by CMS to determine the amount of uncompensated care provided by a hospital. Hospitals and Critical Access Hospitals complete Worksheet S-10.

Wraparound Plan Commonly used to refer to insurance or health plan coverage for copays and deductibles that are not covered under a member's base plan. This is often used for Medicare.

Y

Yates Memo A memorandum entitled *Individual Accountability for Corporate Wrongdoing* that Deputy Attorney General Sally Quillian Yates issued on September 9, 2015, which announced that the DOJ will seek accountability from the individuals involved in corporate misconduct. The memo outlines six key issues for prosecutors to focus on in pursuit of corporate wrongdoing.

Z

Zero Down The practice of a medical group or provider system distributing all the capital surplus in a health plan or group (except for required reserves) to the members of the group rather than retaining any capital or reinvesting it in the group or plan.

Zone Program Integrity Contractor *or* **ZPIC** Replaced Program Safeguard Contractors. They perform certain integrity functions as contractors for CMS and related to Medicare Parts A and B, DMEPOS, Home Health and Hospice, and Medicare-Medicaid data matching. The primary function of ZPICs is to investigate instances of suspected fraud, waste, and abuse. ZPICs are expected to develop investigations early, and in a timely manner, take immediate action to ensure that Medicare Trust Fund monies are not inappropriately paid. They are also expected to identify any improper payments that are to be recouped by the MAC. *Formerly known as* **Program Safeguard Contractor** *or* **PSC**.