A GLOSSARY OF TERMS AS COMMONLY USED IN HEALTH CARE

Compiled by the Alpha Center

March 1993

Acknowledgement

This glossary has been compiled and periodically updated and edited by the Alpha Center. Major sources of original definitions include:

- A Discursive Directory of Health Care prepared by the staff of the Subcommittee on Health and the Environment of the Committee of Interstate and Foreign Commerce, U.S. House of Representatives, February 1976.
- Hospital Administration Terminology prepared by the American Hospital Association in 1982.
- Compilation of Acronyms and Terms prepared by the Health and Life Sciences Division, Office of Technology Assessment, U.S. Congress, August 1986.
- The McGraw-Hill Essential Dictionary of Health Care prepared by Lee Hyde, M.D., New York: McGraw-Hill Book Company, 1988.
- American Medical News, glossary of Medicare terminology compiled by Howard Larkin, July 6/13, 1992, p. 17-20.

CONTENTS

DEFINITIONS

acceptability: The level of satisfaction expressed by consumers with the availability, accessibility, cost, quality, continuity, and degree of courtesy and consideration afforded them by the health care system.

access: Often defined as the potential and actual entry of a population into the health care system and by features such as private or public insurance coverage. The probability of entry is also dependent upon the wants, resources, and needs that patients may bring to the care-seeking process. Actual entry into the system is describe by utilization rates and subjective evaluations of care. Ability to obtain wanted or needed services may also be influenced by the distance one has to travel, waiting time, total income, and whether one has a regular source of care.

accreditation: A process whereby a program of study or an institution is recognized by an external body as meeting certain predetermined standards. For facilities, accreditation standards are usually defined in terms of physical plant, governing body, administration, and medical and other staff. Accreditation is often carried out by organizations (such as the Joint Commission on Accreditation of Hospitals) created for the purpose of assuring the public of the quality of the accredited institution or program. In some situations, the state or Federal Government recognizes accreditation in lieu of, accepts it as the basis for, or requires it as a condition for, licensure or other mandatory approvals. Public or private payment programs often require accreditation as a condition of payment for covered services. Accreditation may either be permanent, once obtained, or may be given for a specified period of time. Unlike a license, accreditation is not a condition of lawful practice but is intended as an indication of high quality practice. Where payment is effectively conditioned on accreditation, however, it may have the same effect as licensure. See also certification and Joint Commission on Accreditation of Healthcare Organizations.

active intervention: An active intervention is a prevention strategy which requires the direct participation of the individual him/herself to be effective (e.g., weight loss programs). See also passive intervention.

Activities of Daily Living (ADL): An index or scale which measures a patient's degree of independence in bathing, dressing, using the toilet, eating, and moving around the house.

Actual Charge: One of the factors determining a physician's payment for a service under Medicare; equivalent to the billed or submitted charge. See Customary, Prevailing, and Reasonable.

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

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

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

adjusted historical payment basis (AHPB): Similar to but differing in important ways from, the old prevailing charge, the AHPB is a crucial

factor in calculating Medicare payments during the transition to the full resource-based relative value scale payment schedule in 1996. Like the old prevailing charge, the AHPB for each service is based on the average charge for that service in each of the aproximately 230 Medicare localities. Unlike the prevailing charge, the AHPB includes all charges for a given service in a locality regardless of provider status, combining figures for physicians of all specialities and, in some cases, non-physician providers as well. The result not only eliminates specialty differentials, it also lowers the average for some services below the prevailing charge for fully licensed physicians.

adverse selection: A tendency for utilization of health services in a population group to be higher than expected or estimated. This higher utilization could be due to a greater need for health services among the population (high percentage of aged, pregnant, or feeble) or due to a higher use of medical services for reasons of access, price, etc. From an insurance perspective, adverse selection occurs when persons with poorer-than-average life expectancy or health status apply for or continue to receive insurance coverage to a greater extent than persons with average or better health expectations. See also favorable selection.

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

alcoholism: A chronic disease manifested by intake of alcoholic beverages in excess of dietary uses, social uses and norms of the community, and which to some extent interferes with the drinker's health and/or his or her social or economic functioning. The definition of alcoholism in both theory and practice is highly variable. Some definitions require either excessive drinking or interference with the drinker's functions rather than both; other definitions require physical signs of drug dependence in addition to the above. There are various systems in use for separating different types of alcoholism and grading its severity. See also drug abuse.

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

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

alternatives to long-term institutional care: The whole range of health, nutritional, housing, and social services designed to keep persons out of institutions, such as skilled nursing facilities, which provide care on a long-term basis. The goal is to provide the range of services necessary to allow the person to continue to function in the home and community environment. Alternatives to long-term care usually focus on the aged, disabled, and retarded, and include day care centers, foster homes, or homemaker services.

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

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

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

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

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

approved amount: Physician payment for a service that includes the Medicare payment amount plus the patient's 20% co-payment.

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

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

assignment: Practice of accepting as payment in full the amount approved by Medicare or other payer. For Medicare, physicians accepting assignment receive 80% of the approved amount from Medicare and bill patients for the remaining amount, once the patient's deductible is met.

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

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

balance billing: Practice of billing patients for payments exceeding the Medicare or other payer-approved amount. Physicians not participating in Medicare may balance-bill Medicare patients, but no more than 120% of the approved amount for non-participating physicians.

baseline adjustment: A 6.5% reduction in the conversion factor used by Medicare to translate the adjusted RBRVS into dollar payments. The baseline adjustment was substituted in the final payment reform regulations after a storm of objections to reductions in the proposed rule of about 10%, including a "behavioral offset" to

compensate for projected volume increases by physicians hoping to replace income lost to payment cuts.

behavioral offset: A proposed reduction in the conversion factor used by Medicare to translate the adjusted RBRVS into dollar payments. The reduction was to compensate for volume increases that HCFA projected would result from physicians trying to maintain income in the face of lower payments. The proposal ignited a storm of protest by the AMA and other medical groups, who argued HCFA had no basis for assuming volume increases. The behavioral offset was dropped from the final pyament reform regulations, replaced by the baseline adjustment.

Blue Cross plan: A nonprofit, tax exempt insurance plan providing coverage for hospital care and related services. The individual plans should be distinguished from their national association, the Blue Cross Association. Historically, the plans were largely the creation of the hospital industry and designed to provide hospitals with a stable source of revenue, although formal association between Blue Cross and the American Hospital Association ended in 1972. A Blue Cross plan must be a nonprofit community service organization with a governing body whose membership includes a majority of public representatives.

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

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

budget neutrality: A requirement in the legislation mandating Medicare physician payment reform that total expenditures be no more than would have been spent if the old customary, prevailing and reasonable charge system were maintained. The budget neutrality requirement prompted a number of adjustments to the conversion factor used to translate the RBRVS into dollar payments, including the highly controversial behavioral offset.

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

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

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

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

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

capitation: A method of payment for health services in which an individual or institutional provider is paid a fixed amount for each person served, without regard to the actual number or nature of services provided to each person in a set period of time, usually a year. Capitation is the characteristic payment method in health maintenance organizations but is unusual for most physicians' services. It also refers to a method of Federal support of health professional schools. Under these authorizations, each eligible school receives a fixed payment, called a "capitation grant," from the Federal Government for each student enrolled. See also fee-for-service and Health Maintenance Organization.

carrier: Regarding Medicare, private companies that administer Medicare Part B (physician insurance) services under contract with HCFA. There are 54 carriers around the nation; most are Blue Cross/Blue Shield plans or commercial health insurance companies.

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

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

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

catastrophic health insurance: Health insurance which provides protection against the high cost of treating severe or lengthy illnesses or disability. Generally such policies cover all, or a specified percentage of medical expenses above an amount that is the responsibility of another insurance policy up to a maximum limit of liability). Under proposed national catastrophic health insurance proposals, protection would typically begin after an individual or family unit had incurred medical expenses equal to a specified dollar amount (e.g., $2,000 within a 12-month period) or had been in a medical institution for a specified period (e.g., 60 days). In theory, individuals would be liable for all costs up to the specified limits. However, in the absence of any effective prohibition against doing so, they could be expected to obtain health insurance protection for costs below the catastrophic limits.

Medicare's Catastrophic Coverage Act of 1988 provides a limit on out of pocket expenditures that was not present in the original program.

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

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

Certificate of Need (CON): A certificate issued by a governmental body to an individual or organization proposing to construct or modify a health facility, acquire major new medical

equipment, modify a health facility, acquire major new medical equipment, or offer a new or different health service. Such issuance recognizes that a facility or service, when available, will meet the needs of those for whom it is intended. CON is intended to control expansion of facilities and services by preventing excessive or duplicative development of facilities and services. See also capital expenditure review.

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

CHAMPUS (Civilian Health and Medical Program of the Uniformed Services): A Department of Defense program supporting private sector care for military dependents.

charity care: Generally refers to physician and hospital services provided to persons who are unable to pay for the cost of services, especially low-income persons, uninsured and underinsured people. A high proportion of the costs of charity care is derived from services for children and pregnant women (e.g., neonatal intensive care cases). This case load is often shifted to public hospitals and other institutions supported by taxes. See also uncompensated care and indigent care.

chronic care: Care and treatment rendered to individuals whose health problems are of a long-term and continuing nature. Rehabilitation facilities, nursing homes, and mental hospitals may be considered chronic care facilities.

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

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

coinsurance: A cost-sharing requirement under a health insurance policy. It provides that the insured party will assume a portion or percentage of the costs of covered services. The health insurance policy provides that the insurer will reimburse a specified percentage (such as 80 percent) of all, or certain specified, covered medical expenses in excess of any deductible amounts payable by the insured. The insured is then liable for the remainder of the costs until the maximum liability, if any, under the insurance policy is reached. See also deductible.

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

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

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

community rating: A method of calculating health plan premiums using the average cost of actual or anticipated health services for all subscribers within a specific geographic area. The premium does not vary for different groups or subgroups of subscribers on the basis of their specific claims experience.

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

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

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

Comprehensive Health Planning (CHP): Health planning that encompasses all personal factors and community programs which impact on people's health.

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

consumer: One who may receive or is receiving health services. While all people at times consume health services, a consumer, as the term is used in health legislation and programs, is usually someone who is never a provider, i.e., is not associated in any direct or indirect way with the provision of health services.

Continuing Medical Education (CME): Formal education obtained by a health professional after completing his or her degree and full-time postgraduate training. For physicians, some states require CME (usually 50 hours per year) for continued licensure, as do some specialty boards for certification.

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

contribution margin: Revenue from sales less all variable expenses. See gross margin.

conversion factor (CF): A multiplier Medicare uses to translate geographically adjusted values from the RBRVS into dollar payment amounts for specific services. The 1992 conversion factor is $31.001, so a service with an adjusted relative value of 1.00 would be paid at $31, a service with a relative value of 2.00 at $62, etc. The conversion factor will be updated annually.

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

cost: Expenses incurred in the provision of services or goods. Many different kinds of costs are defined and used (see allowable, direct, indirect, and operating costs). Charges, the price of a service or amount billed an

individual or third party, may or may not be the same as, or based on, costs.

Hospitals often charge more for a given service than it actually costs in order to recoup losses from providing other services where costs exceed feasible charges.

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

cost center: An accounting device whereby all related costs attributable to some "financial center" within an institution, such as an activity, department, or program (e.g., a hospital burn center), are segregated for accounting or reimbursement purposes.

cost containment: A set of steps to control or reduce inefficiencies in the consumption, allocation, or production of health care services which contribute to higher than necessary costs. Inefficiencies in consumption can occur when health services are inappropriately utilized; inefficiencies in allocation exist when health services could be delivered in less costly settings without loss of quality; and inefficiencies in production exist when the costs of producing health services could be reduced by using a different combination of resources.

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

cost-effectiveness analysis: A method of comparing alternative ways for achieving a specific set of results. Alternatives are compared on the basis of the ratio of the cost of each alternative to its estimated future effect on objectives which need not be measured in financial terms.

cost-shifting: The condition which occurs when health care providers (physicians, clinics, laboratories, hospitals, etc.) are not reimbursed or not fully reimbursed for providing health care so charges to those who pay must be increased. Typically results from providing health care to the medically indigent or the Medicare patients.

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

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

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

current (gross) margin: See operating margin (based on current costs.

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

Customary Charge: One of the factors determining a physician's payment for a service under Medicare. Calculated as the physician's median charge for that service over a prior 12-month period. See Customary, Prevailing, and Reasonable.

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

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

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

default: Failure to pay debt service when due.

defined benefit: Funding mechanisms for pension plans that can also be applied to health benefits. Typical pension approaches include: (1) pegging benefits to a percentage of an employee's average compensation over his entire service or over a particular number of years; (2) calculation of a flat monthly payment; (3) setting benefits based upon a definite amount for each year of service, either as a percentage of compensation for each year of service or as a flat dollar amount for each year of service.

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

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

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

dental health services: All services designed or intended to promote, maintain, or restore dental health including educational, preventive, and therapeutic services.

Department of Health and Human Services (DHHS): Department of the federal government responsible for administering health and social welfare programs, including Medicare and the federal portion of Medicaid.

depreciation: See capital depreciation.

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

Diagnosis Related Groups (DRGs): Groupings of diagnostic categories drawn from the

International Classification of Diseases and modified by the presence of a surgical procedure, patient age, presence or absence of significant comorbidities or complications, and other relevant criteria. DRGs are the case-mix measure used in Medicare's prospective payment system. See also case mix.

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

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

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

drug abuse: Persistent or sporadic drug use inconsistent with or unrelated to acceptable medical or cultural practice. The definition of drug abuse is highly variable, sometimes also requiring excessive use of a drug, unnecessary use (thus incorporating recreational use), dependence, or illegal use. See also alcoholism.

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

effectiveness: A particular application of efficacy, i.e., it reflects the performance of an intervention under ordinary conditions by the average practitioner for the typical patient.

efficacy: The probability of benefit to individuals in a defined population from a medical technology applied to a given medical problem under ideal conditions of use.

efficiency: "Productive" efficiency describes the performance of a service or delivery of medical care of a given quality with the least expenditure of resources. "Allocative" efficiency concerns not only whether care is provided as cheaply as possible given its costs and quality, but also whether the costs expended for the additional care are worth the benefits to be gained.

electronic media claim (EMC): Claims submitted electronically. All Medicare carriers and many commercial insurers are equipped to receive claims via modem, computer tape or computer disc.

Emergency Medical Services (EMS): Services utilized in responding to the perceived individual need for immediate treatment for medical, physiological, or psychological illness or injury.

Employee Retirement Income Security Act (ERISA): A federal act, passed in 1974, that established new standards and

reporting/disclosure requirements for employer-funded pension and health benefit programs. To date, self-funded health benefit plans operating under ERISA have been held to be exempt from state insurance laws.

epidemic: A group of cases of a specific disease or illness clearly in excess of what one would normally expect in a particular geographic area. There is no absolute criterion for using the term epidemic; as standards and expectations change, so might the definition of an epidemic, e.g., an epidemic of violence.

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

etiology: Cause. A term used by epidemiologists.

evaluation: In health services research, a systematic analysis of the degree to which a program or initiative has achieved, or is capable of achieving, its goals and objectives. In medicine, an analysis of a patient's condition.

evaluation and management services (E/M): Sometimes characterized as congnitive services, these are patient evaluation and management functions performed during patient office visits, outpatient visits and hospital visits or consultations. They consist largely of taking patient history, patient examination and medical decision-making. These three factors form the primary basis for assigning new E/M codes developed by the CPT editorial panel for 1992 and adopted by Medicare as part of payment reform. Under payment reform, Medicare will generally pay more for E/M services relative to procedural services than under the old CPR system.

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

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

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

exposure: A general term used to describe contact with a risk factor. An exposure can be a physical agent (e.g., radiation) or a behavior (i.e., excessive drinking).

Extended Care Facility (ECF): Previously used in Medicare to mean a skilled nursing facility which qualified for participation in Medicare. In 1972, the law was amended to use the more generic term "skilled nursing facility" (SNF) for both Medicare and Medicaid. See also nursing home and skilled nursing facility.

family practice: A form of specialty practice in which physicians provide continuing comprehensive primary care within the context of the family unit. See also general practice and primary care.

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

fee-for-service: Method of billing for health services under which a physician or other practitioner charges separately for each patient encounter or service rendered. This is the usual method of billing by the majority of the country's physicians. Under a fee-for-service payment system, expenditures increase if the fees themselves increase, if more units of service are provided or if more expensive services are substituted for less expensive ones. This system contrasts with salary, per capita, or other prepayment systems, where the payment

to the physician is not changed with the number of services actually used. See also capitation.

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

federal poverty level: The federal definition of poverty varies by family size and can change from year to year. As an example, in 1989 the annual income level for a family of three that would be equal to the federal poverty level was approximately $10,200.

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

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

Foreign Medical Graduate (FMG): A physician who graduated from a medical school outside of the United States, usually Canada. U.S. citizens who go to medical school abroad are classified as foreign medical graduates (sometimes distinguished as USFMGs), just as are foreign-born persons who are not trained in a medical school in this country. U.S. citizens represent only a small portion of the FMG group.

gaming: the practice of tailoring documentation and billing practices to take maximum advantage of peculiarities of reimbursement systems and policies. This term can refer to legitimate strategies for maximizing receipts, such as billing for visits performed outside a global service package. More frequently it refers to questionable or even fraudulent activities such as itemizing and billing separately components of a service or altering coding patterns to avoid audits.

gap: Used to describe the difference between "what is" and "what ought to be". A gap between projected and desired levels of utilization, for example, indicates a need for health services. The term is also used to describe the group of individuals who need, but are not eligible for, certain health programs.

general practice: A form of practice in which physicians without specialty training provide a wide range of primary health care services to patients. See also family practice and specialist.

geographic practice cost index (GPCI): Pronounced "gypsies," these indices are used to modify Medicare payments to reflect differences in physician costs in different areas. GPCI values have been developed for the cost of living, practice costs and professional liability costs in each Medicare locality relative to the national average.

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

global charge: The sum of the professional and technical components of a service when both are provided and billed by the same physician.

goal: A statement of expectations of desired, attainable levels of health status and/or health system performance.

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

arrangements.

guaranteed issuance: A requirement that a health insurer is required to provide health insurance to all applicants for insurance without regard to pre-existing conditions or other risk factors such as age, sex, or medical history.

guaranteed renewability: A requirement for health insurers to renew health insurance for all individuals currenlty insured by the health insurance company.

habilitation: The continuous process by which the individual develops the ability to participate in normal life activities and functions effectively in society. Habilitation is distinguished from rehabilitation, which implies restoration or return to prior functioning following an accident or illness, while habilitation is used for similar activities undertaken for individuals born with limited functional ability. This term is used within the context of developmental disability to denote assistance rendered to the developmentally disabled individual in performing societal roles. See also rehabilitation and Developmental Disability.

handicapped: As defined by Section 504 of the Rehabilitation Act of 1973, any person who has a physical or mental impairment which substantially limits one or more major life activity, has a record of such impairment, or is regarded as having such an impairment.

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

Health Care Financing Administration (HCFA): The government agency within the Department of Health and Human Services which manages the Medicare and Medicaid programs (Titles XVIII and XIX of the Social Security Act) and conducts research to support those programs.

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

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

health insurance: Financial protection against the medical care costs arising from disease or accidental bodily injury. Such insurance usually covers all or part of the medical costs of treating the disease or injury. Insurance may be obtained on either an individual or a group basis.

Health Insurance Purchasing Cooperative (HIPC): An important element of the "managed competition" theory, "health insurance purchasing cooperative," would be "an intermediary between the consumer and the competing health plans" that would "manage" the market by selecting qualified plans, standardizing benefits and providing quality information. In some reform proposals, HIPCs, may be voluntary joint purchasing arrangements of employers or individuals, though in most proposals, all purchasers in the geographic area or defined subgroups thereof (e.g. small employers or individuals buying coverage on their own) would have to take part. HIPCs could contract with any willing insurer that meets minimum quality and financial standards, or they might have the power to limit the number of participating insurers.

Health Maintenance Organization (HMO): An entity with four essential attributes: (1) An organized system providing health care in a geographic area, which accepts the responsibility to provide or otherwise assure the delivery of (2) an agreed-upon set of basic and supplemental health maintenance and treatment services to (3) a voluntarily enrolled group of persons and (4) for which services the entity is reimbursed through a predetermined, fixed, periodic prepayment made by, or on behalf of, each person or family unit enrolled. The payment is fixed without regard to the amounts of actual services provided to an individual enrollee. The HMO is responsible for providing most health and medical care services required by enrolled individuals or families, and these services are specified in the contract between the HMO and the enrollees. The HMO must employ or contract with health care providers who undertake a continuing responsibility to provide services to its enrollees. Individual practice associations involving groups or independent physicians can be included under the definition. See also capitation.

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

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

Health Professional Shortage Area (HPSA): An area or group which the U.S. Department of Health and Human Services designates as having an inadequate supply of health care providers. HPSAs can include: (1) an urban or rural geographic area, (2) a population group for which access barriers can be demonstrated to prevent members of the group from using local providers, or (3) medium and maximum-security correctional institutions and public or non-profit private residential facilities.

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

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

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

Health Systems Agency (HSA): A health planning agency created under the National Health Planning and Resources Development Act of 1974. HSAs were usually nonprofit private organizations and served defined health service areas as designated by the states.

Hill-Burton: Coined from the names of the principal sponsors of the Public Law 79-725 (the Hospital Survey and Construction Act of 1946); this program provided Federal support for the construction and modernization of hospitals and other health facilities. Hospitals that have received Hill-Burton funds

incur an obligation to provide a certain amount of charity care.

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

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

hospice: A program which provides palliative and supportive care for terminally ill patients and their families, either directly or on a consulting basis with the patient's physician or another community agency. Originally a medieval name for a way station for crusaders where they could be replenished, refreshed, and cared for, hospice is used here for an organized program of care for people going through life's "last station." The whole family is considered the unit of care, and care extends through their period of mourning.

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

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

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

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

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

indigent care: Health services provided to the poor or those unable to pay. Since many indigent patients are not eligible for Federal or state programs, the costs which are covered by Medicaid are generally recorded separately from indigent care costs. See also charity care

and uncompensated care.

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

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

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

Instrumental Activities of Daily Living (IADL): An index or scale which measures a patient's degree of independence in aspects of cognitive and social functioning including shopping, cooking, doing housework, managing money, and using the telephone.

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

Intermediate Care Facility (ICF): An institution which is licensed under state law to provide, on a regular basis, health-related care and services to individuals who do not require the degree of care or treatment which a hospital or skilled nursing facility is designed to provide, but who, because of their mental or physical condition, require care and services (above the level of room and board) which can be made available to them only through institutional facilities. Public institutions for care of the mentally retarded or people with related conditions are also included. The distinction between "health-related care and services" and "room and board" has often proven difficult to make but is important because ICFs are subject to quite different regulations and coverage requirements than institutions which do not provide health-related care and services. See also nursing home.

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

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

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

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

life safety code: A fire safety code prepared by the National Fire Protection Association. The provisions of this code relating to hospitals and nursing facilities must (except in instances where a waiver is granted) be met by facilities certified for participation under Medicare and Medicaid. The code is based on optimum (non minimum) standards.

limiting charge: Limit set by law on how much non-participating physicians may bill Medicare patients.

locality: Geographic areas defined by Medicare for determining payment amounts. There are now about 230 Medicare localities, some covering entire states, others counties, groups of counties or metropolitan areas. Payment reform reduces wide variations in payments among localities, sometimes within a few miles of each other, experienced under the old CPR system.

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

Magnetic Resonance Imaging (MRI): a method of imaging body tissues using the response or resonance of the nuclei of the atoms of one of the bodily elements, typically hydrogen or phosphorus, to externally applied magnetic fields. This relatively new form of diagnostic radiology is very expensive and presumptively safe.

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

managed care: Any form of health plan that initiates selective contracting to channel patients to a limited number of providers and that requires utilization review to control unnecessary use of health services.

managed competition: Managed competition is a purchasing strategy designed to obtain maximum value for money for employers and consumers. It uses rules for competition, derived from microeconomic principles, to reward with more subscribers and revenue those health plans that do the best job of improving quality, cutting cost and satisfying patients. The "best job" is both in the judgement of the sponsor, armed with data and expert advice, and informed cost-conscious consumers. The rules of competition must be designed and administered so as not to reward health plans for selecting good risks, segmenting markets or otherwise defeating the goals of managed competition. (See, "Managed Competition in Health Care Financing and Delivery: History, Theory and Practice," by Alain Enthoven, 1993.)

margin: Revenue less specified expenses. See contribution margin, gross margin and current margin.

maximum allowable actual charge (MAAC): Limit on amount non-participating physicians could bill Medicare patients under the old CPR system. Will be phased out by the limiting charge in 1993.

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

Medicaid notch: The reduction in real income that occurs when increased earnings removes a person from not only public cash-assistance programs, and from Medicaid.

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

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

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

Medicare (Title XVIII): A nationwide health insurance program for people aged 65 and over, for persons eligible for social security disability payments for two years or longer, and for certain workers and their dependents who need kidney transplantation or dialysis. Health insurance protection is available to insured persons without regard to income. Monies from payroll taxes and premiums from beneficiaries are deposited in special trust funds for use in meeting the expenses incurred by the insured. It consists of two separate but coordinated programs: hospital insurance (Part A) and supplementary medical insurance (Part B).

Medicare Economic Index (MEI): Used to update Medicare payments, the MEI is a measure of general and medical inflation. Under the new system the MEI will update the conversion factor used to transform relative value units into dollar payment amounts. The increases will be subject to limits imposed by the Medicare volume performance standards, which require payment cuts if service volume grows beyond a certain point.

Medicare payment schedule: A new basis for setting physician Medicare pyaments, the payment schedule replaced the old CPR system on Jan. 1, 1992, and is the cornerstone of payment reform. It is based on the RBRVS developed at the Harvard University School of Public Health. The Harvard RBRVS takes into account the resource cost of physician work, practice overhead and professional liability insurance. RBRVS values are adjusted for geographic differences in practice costs and multiplied by a conversion factor to arrive at a dollar payment figure. Payment schedule amounts include both 80% paid by Medicare and the 20% patient co-payment. Transition to the full Medicare payment schedule will be complete in 1996.

Medicare volume performance standard (MVPS): A national spending goal for Medicare Part B services, the MVPS will be used to control spending growth by cutting physician payments if volume grows faster than projected. Essentially, if the MVPS is exceeded in one year, physician payment updates are cut the next year. The cuts are made by reducing the Medicare Economic Index to compensate for the amount actual Part B expenditures exceeded the MVPS target. That, in turn, reduces the conversion factor by which Medicare multiplies relative values for each service to arrive at a dollar payment amount.

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

mental health: The capacity in an individual to function effectively in society. Mental health is a concept influenced by biological, environmental, emotional, and cultural factors and is highly variable in definition, depending on time and place. It is often defined in practice as the absence of any identifiable or

significant mental disorder and sometimes improperly used as a synonym for mental illness.

mental health services: Comprehensive mental health services, as defined under some state laws and Federal statutes such as the Alcohol, Drug Abuse, and Mental Health Block Grant, include: inpatient care, outpatient care, day care, and other partial hospitalization and emergency services; specialized services for the mental health of children; specialized services for the mental health of the elderly; consultation and education services; assistance to courts and other public agencies in screening catchment area residents considered for referral for inpatient treatment in a state mental health facility; follow-up care for catchment area residents discharged from mental health facilities or who would require inpatient care without such halfway house services; and specialized programs for the prevention, treatment and rehabilitation of alcohol and drug abusers.

mental illness: All forms of illness in which psychological, emotional, or behavioral disturbances are the dominating feature. The term is relative and variable in different cultures, schools of thought, and definitions. It includes a wide range of types (such as psychosis, neurosis, and organic brain syndrome) and severities.

merit good: A good or service which is societally sanctioned and deemed worthy of use or consumption by the general population. Often, a merit good is publicly provided or subsidized in order to ensure widespread availability. Primary education is an example of a merit good which is made compulsory by the government. See also public good.

modernization: Remodeling, renovation, or sometimes, replacement of health facilities and equipment to bring them up to current construction standards, into compliance with fire and safety codes, or to meet contemporary health delivery needs and capabilities.

morbidity: The extent of illness, injury, or disability in a defined population. It is usually expressed in general or specific rates of incidence or prevalence. Sometimes it is used to refer to any episode of disease. See also mortality.

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

natural history of disease: This term refers to the fact that virtually all illnesses and diseases have certain predictable and regular patterns associated with them, i.e., a natural history. Understanding something of a natural history of a disease is a necessity if an effective intervention program is to be implemented.

need: In health services, need has a normative connotation (i.e., the amount of a good or service which should be consumed). Because of the technical nature of medical care, this value judgment is generally made by the health professional, rather than the consumer of the services. In health planning, need is the appropriate amount of health facilities and services required for a given area.

neighborhood health center: An ambulatory health care program usually serving a catchment area which has scarce or nonexistent health services or a population with special health needs; often known as a community health center. Community health centers attempt to coordinate Federal, state, and local resources in single organization capable of delivering both health care and related social services to a defined population. While such centers may not directly provide all types of health care, they usually take responsibility or arrange for all medical services needed by their patients. Other ambulatory centers providing health services in areas of medical underservice include family health centers and community

health networks. See also community health center.

non-participating physician (non-par): A physician who has elected not to sign a Medicare participation agreement.

nurse: An individual whose primary responsibility is the provision of nursing care. A nurse can be defined as a professional qualified by education and authorized by law to practice nursing. There are many different types, specialties, and grades of nurses whose names are generally descriptive of their special responsibilities (such as charge or head, hospital, private or private duty, public health, school, and licensed practical nurses).

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

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

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

occupational health services: Health services concerned with the physical, mental, and social well-being of an individual in relation to his or her working environment and with the adjustment of individuals to their work. The term applies to more than the safety of the workplace and includes health and job satisfaction. In the United States, the principal Federal statute concerned with occupational health is the Occupational Safety and Health Act administered by the Occupational Safety and Health Administration (OSHA) and the National Institute of Occupational Safety and Health (NIOSH).

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

operating cost: In the health field, the financial requirements necessary to operate an activity which provides health services. These costs normally include the costs of personnel, materials, overhead, depreciation, and interest.

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

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

outlier: A point in a statistical distribution that is outside a certain range, usually defined as two or three standard deviations from the mean. Often refers to a case or hospital stay that is unusually long or expensive for its type, or to a physician practice that uses an abnormally high

or low volume of resources.. Under DRG reimbursement, outliers are given exceptional treatment (subject to peer review organization review).

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

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

participating physician (par): A physician who has signed a Medicare participation agreement, which binds the physician to accept assignment on all Medicare claims within the calendar year.

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

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

peer review: Generally, the evaluation by practicing physicians or other professionals of the effectiveness and efficiency of services ordered or performed by other members of the profession (peers). Frequently, peer review refers to the activities of the Professional Review Organizations, but it also refers to review of research by other researchers. See also utilization review.

Physician Assistant (PA): A specially trained and licensed or otherwise credentialed individual who performs tasks, which might otherwise be performed by a physician, under the direction of a supervising physician. The PA is also known as a physician extender and by many other essentially synonymous terms.

Physician Payment Review Commission (PPRC): In 1986, the Congress created the Physician Payment Review Commission to advise it on reforms of the methods used to pay physicians under the Medicare program. The Commission has conducted analyses of physician payment issues, provided a forum for groups representing physicians, beneficiaries, and other interests to present their views, and worked closely with the Congress to bring about comprehensive reforms in Medicare physician payment policy. Its recommendations formed the basis of 1989 legislation that created a new payment system consisting of a resource-based fee schedule, limits on the amount physicians may charge patients above the fee schedule amount, and Volume Performance Standards, coupled with expanded federal support for effectiveness research and the development of practice guidelines, to control expenditure growth.

physician work: One of three factors used to determine the relative value of physician services, the other two being practice expense and professional liability insurance costs. The physician work component reflects the time, technical skill, training and physical and mental effort required to provide a service.

planning: The conscious design of a desired future state (described in a plan by its goals and objectives); including: description of, and selection among, alternative means of achieving the goals and objectives; the conduct of the activities necessary to the design process (such as data gathering and analysis); and the activities necessary to assure that the plan is achieved.

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

policy: A course of action adopted and pursued by a government, party, statesman, or other individual or organization; any course of action adopted as proper, advantageous, or expedient. The term is sometimes used less actively to describe any stated position on matters at issue, i.e., an organization's policy statement on national health insurance. Policies bear the same relationship to rules (regulations) as rules do to law, except that unlike regulations, they do not have the force of law.

portability: The ability for an individual to transfer from one health insurer to another health insurer without regard to pre-existing conditions of other risk factors

poverty area: An urban or rural geographic area with a high proportion of low income families. Normally, average income is used to define a poverty area, but other indicators, such as housing conditions, illegitimate birth rates, and incidence of juvenile delinquency, are sometimes added to define geographic areas with poverty conditions.

practice expense: One of three factors used to determine the relative value of physician services, the other two being physician work and professional liability insurance costs. The practice expense component reflects practice overhead involved in providing a service, including rent, staff salary and benefits, and medical equipment and supplies.

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

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

pre-existing condition: An individual's medical condition that existed prior to his or her purchase of a particular insurance plan. Costs related to treating condition would not be paid by the new insurer.

Preferred Provider Arrangement (PPA): Selective contracting with a limited number of health care providers (hospitals, physicians, and allied professionals), often at reduced or pre-negotiated rates of payment. See also preferred provider organization.

Preferred Provider Organization (PPO): Formally organized entity generally consisting of hospital and physician providers. The PPO provides health care services to purchasers usually at discounted rates in return for expedited claims payment and a somewhat predictable market share. Utilization review is an integral part of the PPO system. In this model, consumers have a choice of using PPO or non-PPO providers; however, financial incentives are built in to benefit structures to encourage utilization of PPO providers. Provider efficiency is generally the primary criteria used by prudent purchasers in selecting a PPO arrangement. The efficiency variable is paramount. However, many purchasers also recognize the critical importance of utilization and quality controls.

prepayment: Usually refers to any payment to a provider for anticipated services (such as an expectant mother paying in advance for maternity care). Sometimes prepayment is distinguished from insurance as referring to payment to organizations which, unlike an insurance company, take responsibility for

arranging for, and providing, needed services as well as paying for them (such as health maintenance organizations, prepaid group practices, and medical foundations).

Prevailing Charge: One of the factors determining a physician's payment for a service under Medicare. Currently set at the 75th percentile of customary charges of all physicians in the locality. See also Customary Charge, and Customary, Prevailing and Reasonable.

prevalence: The number of cases of disease, infected persons, or persons with some other attribute, present at a particular time and in relation to the size of the population from which drawn. It can be a measurement of morbidity at a moment in time, e.g., the number of cases of hemophilia in the country as of the first of the year. See also incidence.

preventive medicine: Care which has the aim of preventing disease or its consequences. It includes health care programs aimed at warding off illnesses (e.g., immunizations), early detection of disease (e.g., Pap smears), and inhibiting further deterioration of the body (e.g., exercise or prophylactic surgery). Preventive medicine developed following discovery of bacterial diseases and was concerned in its early history with specific medical control measures taken against the agents of infectious diseases. With increasing knowledge of nutritional, malignant, and other chronic diseases, the scope of preventive medicine has been extended. It is now assumed that most, if not all, medical problems are preventable at some stage of their development. Preventive medicine is also concerned with general preventive measures aimed at improving the healthfulness of the environment. In particular, the promotion of health through altering behavior, especially using health education, is gaining prominence as a component of preventive care.

primary care: Basic or general health care focused on the point at which a patient ideally first seeks assistance from the medical care system. It usually deals with the care of the simpler and more common illnesses. The primary care provider should also assume ongoing responsibility for the patient in maintaining health and treating disease. Primary care is considered comprehensive when the primary provider takes responsibility for the overall coordination of the care of the patient's health problems, be they biological, behavioral, or social. The appropriate use of consultants and community resources is an important part of effective primary care. Such care is generally provided by physicians but is increasingly provided by other personnel such as nurse practitioners or physician assistants. See also family practice, secondary care, and tertiary care.

primary prevention: The prevention of an illness or disease before any symptoms manifest themselves.

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

professional component: Portion of payment for a service covering physician work, practice costs and professional liability insurance as opposed to the technical component, which covers the use of equipment and supplies and technician salaries.

professional liability insurance (PLI) component: One of three factors used to determine the relative value of physician services, the other two being physician work and practice expenses. The PLI component reflects the cost of insurance indemnifying physicians against professional liability claims for a particular service.

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

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

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

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

public good: A good or service whose benefits may be provided to a group at no more cost than that required to provide it for one person. The benefits of the good are indivisible and individuals cannot be excluded. For example, a public health measure that eradicates smallpox protects all, not just those paying for the vaccination. A public good may be contrasted with private goods, such as bread, which, if consumed by one person, cannot be consumed by another person. See also merit good.

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

Public Health Service (PHS) Act: One of the principal acts of Congress providing legislative authority for Federal health activities. The act contains the authority for public health programs, biomedical research, and health personnel training.

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

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

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

regression analysis: Given data on a dependent variable and an independent variable, regression analysis involves finding the "best" mathematical model (within some restricted form) to describe the dependent variable as a function of the independent variable or to predict the dependent from the independent variable. Multiple regression analysis considers a dependent variable as a function of more than one independent variable.

rehabilitation: The combined and coordinated use of medical, social, educational, and vocational measures for training or retraining individuals disabled by disease or injury to the highest possible level of functional ability. Several different types of rehabilitation are distinguished (vocational, social, psychological, medical, and educational). Habilitation is used for similar activities undertaken for individuals born with limited functional ability as compared with rehabilitation for people who have lost abilities because of disease in injury. See also developmental disability, disability, and habilitation.

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

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

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

relative value scale (RVS): An index of physician services that assigns values to individual services relative to other services. Such scales are generally based on historical charges (charge-based) or on resources consumed to provide services (resource-based). Various relative value scales have been used by insurers as the basis of payment schedules. Typically, relative values are multiplied by conversion factor to arrive at a dollar payment amount.

relative value studies (also California Relative Value Studies): Coded listing of professional services with unit values to indicate relative complexity as measured by time, skill and overhead costs. Third party payers often assign a dollar value to units to calculate provider reimbursement.

relative value unit (RVU): Basic element of measure for the Medicare RBRVS. Each service is assigned relative value units for physician work, practice expenses and professional liability insurance. The three added together are the relative value of the service.

resource-based relative value scale (RBRVS): An RVS that is based on resource costs.

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

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

risk or risk factor: Risk is a term used by epidemiologists to quantify the likelihood that something will occur. For example, if you smoke cigarettes; you will have a ten times greater risk of developing lung cancer. A risk factor is something which either increases or decreases an individual's risk of developing a disease. However, it does not mean that, if exposed, an individual will definitely contract a particular disease.

screening: The use of quick procedures to differentiate apparently well persons who

have a disease or a high risk of disease from those who probably do not have the disease. It is used to identify high risk individuals for more definitive studies. Multiple screening (or multiphasic screening) is the combination of a battery of screening tests for various diseases performed by technicians under medical direction and applied to large groups of apparently well persons.

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

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

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

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

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

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

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

shared services: The coordinated, or otherwise explicitly agreed upon, sharing of responsibility for provision of medical or nonmedical services on the part of two or more otherwise independent hospitals or other health programs. The sharing of medical services might include, for example, an agreement that one hospital provide all pediatric care needed in a community and no obstetrical services while another provide obstetrics and no pediatrics. Examples of shared nonmedical services would include joint laundry or dietary services for two or more nursing homes. Common laundry services purchased by two or more heath programs from an independent retailer of laundry services are not usually thought of as shared services unless the health programs own or otherwise control the retailer.

Skilled Nursing Facility (SNF): A nursing care facility participating in the Medicaid and Medicare programs which meets specified requirements for services, staffing and safety. See also extended care facility and nursing home.

Sole Community Hospital (SCH): A hospital which (1) is more than 50 miles from any

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

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

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

spend down: The amount of expenditures for health care services, relative to income, that qualifies an individual for Medicaid in states that cover categorically eligible, medically indigent individuals. Eligibility is determined on a case-by-case basis. For example, a low-income person with high health care expenditures is more likely to "spend down" his/her resources and become eligible for Medicaid sooner than a higher income person with the same medical needs.

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

standards: Generally, a measure set by a competent authority as the rule for measuring quantity or quality. Conformity with standards is usually a condition of licensure, accreditation, and sometimes, payment for services. Standards may be defined most often in relation to: the actual or predicted effects of care; the performance or credentials of professional personnel; and the physical plant, governance and administration of facilities and programs.

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

survey: An investigation in which information is systematically collected. A population survey may be conducted by face-to-face inquiry, by self-completed questionnaires, by telephone, by postal service, or in some other way. Each method has its advantages and disadvantages. For instance, a face-to-face survey (interview) may be a better way than a self-completed questionnaire to collect information on attitudes or feelings, but it is more costly. Existing medical or other records may contain accurate information, but not about a representative sample of the population. The generalizability of results depends upon the extent to which the surveyed population is representative.

symptomatic: Someone who has symptoms of a disease or illness is symptomatic. Someone who has smoked all their life and has a heavy cough is said to be symptomatic. A heavy life-long smoker who has not yet developed symptoms is said to be pre-symptomatic.

technical component: Portion of payment for physician services covering equipment, supplies and technician salary, as opposed to the professional component which covers physician work, practice overhead and professional liability costs.

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

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

tertiary prevention: Prevention activities which focus on the individual after a disease or illness has manifested itself. The goal is to reduce long-term effects and help individuals better cope with symptoms. For example, cardiac rehabilitation programs provide tertiary prevention. See also primary and secondary prevention.

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

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

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

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

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

unbundle: the practice of billing separately, for higher reimbursement, components of an intergral service. Also known as code fragmentation.

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

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

uninsured: People who lack public or private health insurance.

upcode: the practice of coding services at a higher

level than justified by their content.

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

utilization: Use; commonly examined in terms of patterns or rates of use of a single service or type of service, e.g., hospital care, physician visits, prescription drugs. Measurement of utilization of all medical services in any given period is often done in terms of dollar expenditures. Use is also expressed in rates per unit of population at risk for a given period, e.g., number of admissions to a hospital per 1,000 persons over 65 per year or number of visits to a physician per person per year for family planning services.

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

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

waivers: An administrative device contained in law used to eliminate or override a regulatory or legal requirement.

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

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

A

AAMC	Association of American Medical Clinics; Association of American Medical Colleges
AAPCC	Adjusted Average Per Capita Cost
AAPS	American Association of Physicians and Surgeons
ADA	American Dietetic Association; American Dental Association
ADAMHA	Alcohol, Drug Abuse and Mental Health Administration
ADL	Activities of Daily Living
AFDC	Aid To Families With Dependent Children
AGPA	American Group Practice Association
AHEC	Area Health Education Center
AHPB	Adjusted Historical Payment Basis
ANA	American Nurses Association
AHA	American Hospital Association
ANHA	American Nursing Homes Association
AOA	American Optometric Association; American Osteopathic Association
APA	Administrative Procedures Act
APHA	American Pharmaceutical Association
APHA	American Public Health Associations; American Protestant Hospital Association
ASTHO	Association of State and Territorial Health Officials

B

BCA	Blue Cross Association

C

CAP	Community Action Program
CAT	Computerized axial tomography
CBO	Congressional Budget Office
CCHP	Consumer Choice Health Plan
CCU	Coronary Care Unit
CDC	Centers for Disease Control (formally the Communicable Disease Center)
CF	Conversion Factor
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CHC	Community Health Center
CMHC	Community Mental Health Center
CME	Continuing Medical Education
CMP	Competitive Medical Plan
COB	Coordination of Benefits
COG	Council of Governments
CON	Certificate of Need
COTH	Council of Teaching Hospitals
CPA	Certified Public Accounts
CPHA	Commission on Professional and Hospital Activities
CPI	Consumer Price Index
CPR	Customary, Prevailing, and Reasonable
CPT-4	Current Procedural Terminology, Fourth Edition

CRVS	California Relative Value Studies
CT	Computer Tomographic (scanners)

D

DD	Developmental disability
DDS	Doctor of Dental Surgery
DEA	Drug Enforcement Administration
DHHS	Department of Health and Human Services
DMD	Doctor of Dental Medicine
DO	Doctor of Osteopathy
DRG	Diagnosis-Related Group
DVM	Doctor of Veterinary medicine

E

ECF	Extended Care Facility
E/M	Evaluation and Management Services
EMC	Electronic Media Claim
EMS	Emergency Medical Services
EPA	Exclusive Provider Arrangement
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment Program
ER	Emergency Room
ERISA	Employee Retirement Income Security Act
ESRD	End Stage Renal Disease
ET	Expenditure Target

F

FAH	Federation of American Hospitals
FDA	Food and Drug Administration
FEHBP	Federal Employees Health Benefits Program
FICA	Federal Insurance Contributions Act
FMG	Foreign Medical Graduate
FNP	Family Nurse Practitioner
FTC	Federal Trade Commission
FY	Fiscal Year

G

GHAA	Group Health Association of American
GP	General Practitioner
GPCI	Geographic Practice Cost Index

H

HCFA	Health Care Financing Administration
(D)HHS	Department of Health and Human Services
HIAA	Health Insurance Association of American
HIPC	Health Insurance Purchasing Cooperative
HMO	Health Maintenance Organization

HPSA	Health Professional Shortage Area
HSA	Health Systems Agency; Health Service Area

I

IADL	Instrumental Activities of Daily Living
ICDA	International Classification of Diseases, Adapted
ICF	Intermediate Care Facility
ICF/MR	Intermediate Care Facility for the Mentally Retarded
ICU	Intensive Care Unit
IOM	Institute of Medicine of the National Academy of Sciences
IPA	Independent Practice Association

J

JCAHO	Joint Commission on Accreditation of Healthcare Organizations

L

LOS	Length of Stay
LPN	Licensed Practical Nurse
LSC	Life Safety Code
LVN	Licensed Vocational Nurse

M

MAAC	Maximum Actual Allowable Charge
MAF	Medical Assistance Facility
MAP	Medical Audit Program
MCAT	Medical College Admission Test
MCH	Maternal and Child Health Program
MEDLARS	Medical Literature and Analysis Retrieval System
MEI	Medicare Economic Index
MMIS	Medicaid Management Information System
MR	Mentally Retarded
MRI	Magnetic Resonance Imaging
MSA	Metropolitan Statistical Areas
MVPS	Medicare Volume Performance Standard

N

NACo	National Association of Counties
NCHS	National Center for Health Statistics
NCHSR/HCTA	National Center for Health Services Research/Health Care Technology Assessment
NGA	National Governor's Association
NHSC	National Health Service Corps
NICU	Neonatal Intensive Care Unit
NIH	National Institute of Health
NIMH	National Institute of Mental Health
NIOSH	National Institute of Occupational Safety and Health
NLM	National Library of Medicine

NP	Nurse Practitioner
NPRM	Notice of Proposed Rulemaking

O

OAA	Old Age Assistance
OASDHI	Old Age Survivors, Disability, and Health Insurance Program
OMB	Office of Management and Budget
OPD	Outpatient Department
OR	Operating Room
OSHA	Occupational Safety and Health Administration or Act
OT	Occupational Therapy or Therapist
OTA	Office of Technology Assessment

P

P.L.	Public Law
PA	Physician Assistant
PartA	Part A Hospital Insurance Program of Medicare
PartB	Part B Supplementary Medical Insurance Program of Medicare
PAS	Professional Activities Survey
PDR	Physician's Desk Reference
PHS	U.S. Public Health Service
PLI	Professional Liability Insurance Component
PMA	Pharmaceutical Manufacturers Association
PPA	Preferred Provider Arrangement
PPO	Preferred Provider Organization
PPRC	Physician Payment Review Commission
PPS	Prospective Payment System (Medicare)
PRO	Professional Review Organization
ProPAC	Prospective Payment Assessment Commission
PT	Physical Therapy or Therapist

R

RBRVS	Resource-Based Relative Value Scale
RFP	Request for Proposal
RN	Registered Nurse
RVS	Relative Value Scale
RVU	Relative Value Unit

S

SCH	Sole Community Hospital
SHP	State Health Plan
SNF	Skilled Nursing Facility
SSA	Social Security Administration
SSI	Supplemental Security Income

T

Title XVIII	Medicare

Title XIX	Medicaid

U

UCR	Usual, Customary and Reasonable
UHDDS	Uniform Hospital Discharge Data Set
UR	Utilization Review
USP	U.S. Pharmacopeia

V

VA	Veterans Administration
VNA	Visiting Nursing Association
VR	Vocational Rehabilitation

W

WBGH	Washington Business Group on Health
WHO	World Health Organization

Clinton Presidential Records
Digital Records Marker

This is not a presidential record. This is used as an administrative marker by the William J. Clinton Presidential Library Staff.

This marker identifies the place of a publication.

Publications have not been scanned in their entirety for the purpose of digitization. To see the full publication please search online or visit the Clinton Presidential Library's Research Room.

MENDING THE FLAWS IN THE SMALL-GROUP MARKET

by W. David Helms, Anne K. Gauthier, and Daniel M. Campion

Prologue: *One of the truths that has emerged from Washington's ongoing debate over reforming the small-group health insurance market is that the major obstacle to broader coverage is its unaffordability. But that has raised the question, What would be considered affordable insurance for a small employer? One of the interesting lessons that emerges from this paper written by David Helms and his colleagues at the Alpha Center, based on their experience directing The Robert Wood Johnson Foundation's Health Care for the Uninsured Program, is that most small employers are not interested in making health insurance available for their workers, even if premium reductions averaging between 25 and 50 percent below prevailing rates are offered. The authors view the result as an important message: "While it is clear to us that voluntary efforts to expand coverage, particularly in the small-group market, will not achieve universal access, our society has to date been unwilling or unable to move to a mandatory system." Helms is president of the Alpha Center, a Washington-based health policy center that he started in 1976. Helms holds a doctorate in public administration and economics from Syracuse University. Anne Gauthier, who formerly worked for the congressional Office of Technology Assessment and the National Leadership Commission on Health Care, is associate director of the Alpha Center. She holds a master's degree in health administration from the University of Massachusetts. Daniel Campion, an associate at the Alpha Center, received a master's degree in public and private management from Yale University. The Alpha Center directs two major programs for The Robert Wood Johnson Foundation: the State Initiatives in Health Care Financing Reform Program and the Health Care Financing and Organization Initiative.*

Clinton Presidential Records
Digital Records Marker

This is not a presidential record. This is used as an administrative marker by the William J. Clinton Presidential Library Staff.

This marker identifies the place of a publication.

Publications have not been scanned in their entirety for the purpose of digitization. To see the full publication please search online or visit the Clinton Presidential Library's Research Room.

NUMBER 1
OCTOBER 1992

STATE INITIATIVES IN HEALTH CARE REFORM

States Developing Broad Spectrum of Plans to Increase Access and Control Costs

State Initiatives in Health Care Financing Reform is a $25.5 million program of The Robert Wood Johnson Foundation to support states' efforts to achieve comprehensive health care reforms. "State governments are being challenged to do what the federal government up to now has been unable to do: implement health care reform," said Steven A. Schroeder, M.D., president of the Foundation, who announced the program's grantees in August. The program is intended, he explained, "not only to help states develop new ideas and test models for reform, but for federal policymakers to learn from these state-based experiments as they consider what should be included in a national health policy."

A total of 35 proposals were received by the Foundation and reviewed by an independent national advisory committee comprised of experts in the field of health care financing and delivery. Twelve states have been awarded grants totaling $8.4 million to develop implementation plans for their reform strategies during the first phase of the program. Grantees include: Arkansas, Colorado, Florida, Iowa, Minnesota, New Mexico, New York, North Dakota, Oklahoma, Oregon, Vermont, and Washington. After developing their plans, the states can request additional support for up to three years to implement their reforms.

The states' proposals "span the political and ideological spectrum of health care reform strategies," observed Nancy Barrand, senior program officer at the Foundation and originator of the State Initiatives program. Cost control initiatives range from creating statewide "global" health care budgets, to setting expenditure targets, to relying on managed care delivery systems. Approaches for expanding insurance include a single state-run insurance program, state-initiated insurance cooperatives, promoting greater use of the federal Earned Income Tax Credit to pay for health insurance premiums, and "play-or-pay" programs requiring employers to offer coverage to workers or contribute to a state insurance pool. While all the states share the ultimate goal of reducing the number of uninsured, Barrand explained, "we are hoping to test what works and, equally important, what won't work or may be less effective in expanding access."

The states are at various stages in the reform process. Some have already adopted major reform legislation and have moved the

PROGRAM DIRECTOR'S NOTE

This is the inaugural issue of *State Initiatives in Health Care Reform*, the newsletter for The Robert Wood Johnson Foundation's State Initiatives in Health Care Financing Reform Program. It provides an overview of the program, highlighting the broad range of reforms being pursued by the program's 12 grantees, and features summaries of each state's project. Future issues will focus on the activities and analyses being carried out by specific projects and explore health reform issues of common interest to both states and the national government.

Please feel free to share copies of *State Initiatives in Health Care Reform* with your colleagues. Persons wishing to be added to the newsletter's mailing list should write to the Alpha Center, 1350 Connecticut Avenue, N.W. Suite 1100, Washington, DC 20036. Additional comments or suggestions would also be welcomed.

W. David Helms, Ph.D.
President, Alpha Center

CONTENTS

Clinton Presidential Records
Digital Records Marker

This is not a presidential record. This is used as an administrative marker by the William J. Clinton Presidential Library Staff.

This marker identifies the place of a publication.

Publications have not been scanned in their entirety for the purpose of digitization. To see the full publication please search online or visit the Clinton Presidential Library's Research Room.

NUMBER 2
FEBRUARY 1993

IN HEALTH CARE REFORM

Leaders of State Health Care Reform Efforts Meet

Does ERISA Prevent States from Implementing Comprehensive Health Care Reform?

Virtually all comprehensive health care reform strategies now under consideration by the states face legal challenge under the federal Employee Retirement Income Security Act of 1974 (ERISA). Unless Congress is willing to amend the law, most states will be blocked from implementing their plans to expand health insurance coverage for the uninsured through major changes in their health care financing systems. Some reform measures may require states to apply for and receive waivers from Medicare or Medicaid requirements before being put into effect, but states have no such recourse for broad-based proposals that run up against ERISA's preemption authority since there is no statutory provision for exemptions or waivers.

That was the message from ERISA experts to representatives of the *State Initiatives* project staffs attending The Robert Wood Johnson Foundation's State Initiatives in Health Care Financing Reform Workshop, held in Washington, D.C., last October. "There is no loophole" in ERISA, concluded David Abernethy, staff, House Ways and Means Committee, Subcommittee on Health, and moderator of a panel discussion on the need for regulatory and legislative flexibility. If states, including the twelve Foundation grantees, are to proceed with their reform efforts, clearly new federal legislation is needed to relieve them of ERISA's strictures, he said.

ERISA's Preemption Authority Detailed

Panel member Phyllis Borzi, counsel for employee benefits, House Education and Labor Committee, Subcommittee on Labor Management Relations, described how ERISA constrains states from implementing major health care reforms. ERISA covers all employee welfare benefit plans, including health plans, that are "established or maintained by employers," she said. "To the extent that there is an employer involved in the provision of health benefits to employees," that plan is regulated by ERISA, Borzi explained.

Under ERISA, states have the authority to regulate the contracts, financial conditions, and other activities of insurance companies; but they are prohibited from regulating employers' benefit plans. Because states have authority to regulate and tax insurance carriers, they can control premium rates and mandate benefits in employee plans purchased from an insurer. States have virtually no authority when employers provide coverage through self-insured plans. ERISA also preempts states from mandating employers to provide health insurance or specific health benefits. In addition, the state cannot tax employers' benefit plans. According to the National Governors' Association's "Flexibility and Waiver Authority for Health Care Reform: A Primer for States," about 60 percent of employees work for employers with self-insured benefit plans that are not subject to state insurance regulations.

Many of the strategies states have proposed, to date, to finance expanded coverage to their growing uninsured populations will be challenged. New Jersey has already faced such a challenge with respect to its surcharge on hospital patient bills to finance care for the uninsured and its inclusion of an additional surcharge to finance uncompensated care through its hospital rate-setting methodology.

CONTENTS