2020

Glossary of Health Care Terms

MHA

MISSOURI HOSPITAL ASSOCIATION

GLOSSARY

A

abuse — a range of improper behaviors or billing practices, including but not limited to the following:

- billing for a noncovered service
- misusing codes on the claim. For example, the way the service is coded on the claim does not comply with national or local coding guidelines or is not billed as rendered.
- inappropriately allocating costs on a cost report

Academic Medical Center — a group of related institutions including a teaching hospital or hospitals, a medical school and its affiliated faculty practice plan, and other health professional schools.

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

Accountable Care Act — In March 2010, Congress passed and the President signed into law the Affordable Care Act, which is a comprehensive health care reform law.

accountable care organizations — an entity charged with the coordination of patient care services for original Medicare populations.

accreditation — approval by an authorizing agency for institutions and programs meeting or exceeding a set of predetermined standards

Accrual — a technique for determining medical costs for enrollees over a set period so that money can be set aside in a claims reserve to be used for medical costs incurred during that period. Revenues recognized as services are rendered independent of when payment is received.

acquisition — The purchase of all or substantially all the assets of a corporation (such as a hospital) by cash, other compensation, asset exchange, or gift of majority voting control.

activities of daily living (ADL) — activities performed as part of a person's daily routine of self-care, such as bathing, dressing, toileting and eating

acuity — degree or severity of illness

acute care — hospital care given to patients who generally require a stay of several days that focuses on a physical or mental condition requiring immediate intervention and constant medical attention, equipment and personnel

acute care bed need methodology — a formula used to determine hospital bed needs

Admission Discharge Transfer (ADT) — ADT is a common electronic messaging type initiated by a Health Information System to inform other information systems that a patient has been admitted, discharged or transferred. Additionally, ADT messages are generated when important demographic data about the patient has changed, such as name, insurance or next of kin, or that some visit information has changed, such as patient location or attending physician.

adjusted patient days — annual patient days adjusted by a ratio of outpatient revenue to total revenue. This allows hospitals to account for both inpatient and outpatient activity.

administrative costs — costs related to activities, such as utilization review, marketing, medical underwriting, commissions, premium collection, claims processing, insurer profit, quality assurance and risk management, for purposes of insurance

administrative data — information that is collected, processed and stored in automated information systems. Administrative data include enrollment or eligibility information, claims information and managed care encounters The claims and encounters may be for hospital and other facility services, professional services, prescription drug services, laboratory services, etc.

administratively necessary days (AND) — days deemed by a managed care reviewer to be unnecessary for clinical care at an inpatient level and thus reimbursed at a lower rate

admission — formal acceptance by hospital or other inpatient health care facility of a patient who is to be provided with room, board, and continuous nursing service in the hospital or facility where patients remain at least overnight.

admission date — the date a patient is admitted for inpatient care, outpatient service or start of care For hospice, it’s the effective date of election of hospice benefits.

admitting diagnosis code — code indicating a patient’s diagnosis at admission

admitting physician — the doctor responsible for admitting a patient to a hospital or other inpatient health facility

admitting privileges — the authorization given by a health care organization’s governing body to medical practitioners who request the privilege of admitting and/or treating patients. Privileges are based on a provider’s license, training, experience and education.

advance beneficiary notice (ABN) — a notice that a doctor or supplier should give a Medicare beneficiary when furnishing an item or service for which Medicare is expected to deny payment. ABNs only apply to individuals enrolled in the original Medicare plan. They do not apply to individuals enrolled in a Medicare managed care plan or private fee-for-service plan.

advance directive — a document that patients complete to direct their medical care when they are unable to communicate their own wishes because of a medical condition

advanced life support (ALS) — ALS generally refers to pre-hospital medical care that paramedics provide to patients who have suffered trauma or a medical emergency.

advanced practice nurse (APN) — a registered nurse who is approved by the board of nursing to practice nursing in a specified area of advanced nursing practice. APN is an umbrella term given to a registered nurse who has met advanced educational and clinical practice requirements beyond the two-to-four years of basic nursing education required of all R.N.s. There are four types: 1) certified registered nurse anesthetist (CRNA); 2) clinical nurse specialist (CNS); 3) nurse practitioner (N.P.); and 4) certified nurse midwife (CNM).

adverse drug event (error) — any incident in which the use of medication (drug or biologic) at any dose, a medical device or a special nutritional product may have resulted in an adverse outcome in a patient

adverse event — an injury resulting from a medical intervention that is not because of the patient's underlying condition

adverse selection — among applicants for a given group or individual health insurance program, the tendency for those with an impaired health status or who are prone to higher-than-average utilization of benefits to be enrolled in disproportionate numbers in lower deductible plans

advocate — a person who offers support or protects a patient's rights

affiliation — an agreement, usually formal, between two or more otherwise independent hospitals, programs or providers describing their relationship to each other.

Affordable Care Act — federal legislation enacted into law in 2010 and designed to reduce the number of uninsured Americans, improve health care quality and reduce growth in health spending. The full name is the Patient Protection and Affordable Care Act of 2010.

aftercare — services following hospitalization or rehabilitation, individualized for each patient's needs. Aftercare gradually phases the patient out of treatment while providing follow-up attention to prevent relapse.

against medical advice (AMA) — the self-discharge of a patient who leaves a health care facility against the advice of his or her physician or the medical staff.

Agency for Healthcare Research and Quality (AHRQ) — a federal agency within the Public Health Service responsible for research on quality, appropriateness, effectiveness and cost of health care. The AHRQ also centralizes access to state inpatient data. www.ahrq.gov

algorithm — a rule or procedure containing conditional logic for solving a problem or accomplishing a task. Guideline algorithms concern rules for evaluating patient care against published guidelines. Criteria algorithms concern rules for evaluating criteria compliance. Algorithms may be expressed in written form, graphic outlines, diagrams or flow charts that describe each step in the work or thought process.

allied health personnel — specially trained and often licensed health care workers other than physicians, dentists, optometrists, chiropractors, podiatrists and nurses. The term sometimes is used synonymously with paramedical personnel, all health workers who perform tasks that must otherwise be performed by a physician or health workers who do not usually engage in independent practice.

allopathic — one of two schools of medicine that treats disease by inducing effects opposite to those produced by the disease. The other school of medicine is osteopathic.

allowable costs — charges for services rendered or supplies furnished by health providers that qualify as covered expenses for insurance purposes

all patient diagnosis related groups (APDRG) — an enhancement of the original DRGs, designed to apply to a population broader than that of Medicare beneficiaries, who are predominantly older individuals. The APDRG set includes groupings for pediatric and maternity cases, as well as services for HIV-related conditions and other special cases.

alternative delivery — an alternative to the traditional inpatient care system, such as ambulatory care, home health care and same-day surgery

alternative medicine — treatment procedures that are not supported by mainstream medicine, often because of lack of supporting experimental data

ambulatory care — care given to patients who do not require overnight hospitalization. Services are provided on an outpatient basis to patients who are able to move about and are not confined to a hospital bed.

ambulatory care sensitive conditions — medical conditions for which physicians broadly concur that a substantial proportion of cases should not advance to the point where hospitalization is needed if they are treated in a timely fashion with adequate primary care and managed properly on an outpatient basis

ambulatory patient group (APG) — system of classification for outpatient hospital services based on payment of facility costs per visit and not including physician services, telephone contacts, home visits, long-term care or acute inpatient care. This system, similar to DRGs, is used as a financing mechanism to reimburse hospitals for services rendered. *See also* **diagnosis related group (DRG)**.

ambulatory payment classification (APC) — groups or groupings of medical procedures and services used as a basis for reimbursement under the Medicare outpatient prospective payment system

ambulatory setting	an institutional health setting, such as a surgery center, clinic or other outpatient facility, in which organized health services are provided on an outpatient basis. Ambulatory care settings also may be mobile units of service, such as mobile mammography or magnetic resonance imaging.
ambulatory surgery	surgical services provided for patients who are admitted and discharged on the same day of surgery. Ambulatory surgery also is called in-and-out surgery, outpatient surgery or same-day surgery.
ambulatory surgery center (ASC)	a freestanding or hospital-based facility, with an organized professional staff, that provides surgical services to patients who do not require an inpatient bed. Also called ambulatory surgical center (ASC), surgical center or surgicenter. *See also* **freestanding ambulatory surgical facility**.
ambulatory visit group (AVG)	a counterpart of the DRG classification system designed for use in ambulatory care settings rather than hospital settings. *See also* **diagnosis related group (DRG)**.
American Accreditation HealthCare Commission, Inc. (AAHC/URAC)	a second corporate name used by the Utilization Review Accreditation Commission, an independent, not-for-profit corporation that develops national standards for utilization review and managed care organizations. www.urac.org
American College of Healthcare Executives (ACHE)	an international professional society of nearly 30,000 health care executives; based in Chicago — www.ache.org
American Health Care Association (AHCA)	a trade association representing nursing homes and long-term care facilities in the United States; based in Washington, D.C. — www.ahcancal.org/Pages/Default.aspx
American Health Information Management Association (AHIMA)	the dynamic professional association representing specially educated health information management professionals. AHIMA members earn credentials in health information management through a combination of education, experience and performance on national certification exams. www.ahima.org
American Hospital Association (AHA)	a national association representing allopathic and osteopathic hospitals in the United States; based in Washington, D.C., with operational offices in Chicago — www.aha.org
American Medical Association (AMA)	a national association organized into local and regional societies representing more than 700,000 medical doctors in the United States; based in Chicago — www.ama-assn.org
American Nurses Credentialing Center (ANCC)	ANCC certification signifies that a nurse has attained specific knowledge, skills and abilities in a specific specialty field.

American Osteopathic Association (AOA) — a national association organized into local and regional societies representing more than 43,000 osteopathic physicians in the United States; based in Chicago. The AOA also provides accreditation for hospitals and colleges of osteopathic medicine. www.osteopathic.org

Americans with Disabilities Act (ADA) — a federal law prohibiting employers with more than 25 employees from discriminating against any individual with a disability who can perform the essential functions, with or without accommodations, of the job that the individual holds or wants — www.ada.gov

ancillary services — professional services by a hospital or other inpatient health program. These may include X-ray, drug, laboratory or other services.

anesthesiologist assistant (A.A.) — assists the anesthesiologist in developing and implementing the anesthesia care plan. The A.A. program generally is two years in length. A bachelor's degree is a prerequisite.

Annual Licensing Survey — an annual report of health care statistics that hospitals are required by law to file with the Missouri Department of Health and Senior Services (DHSS)

annual payment update — the rate of payment increase to hospitals for services provided to patients

antikickback statute — a federal law prohibiting the paying or receiving of remuneration in exchange for the referral of patients or business paid by a federal health care program

antitrust — a situation in which a single entity, such as an integrated delivery system, controls enough of the practices in any one specialty in a relevant market to have monopoly power (i.e., the power to increase prices)

any willing provider — a term used to describe legislation requiring health plans to accept every physician, hospital or other practitioner who wants to participate in the health plan's provider panels

approved health care facility or program — a facility or program that is licensed, certified or otherwise authorized pursuant to the laws of the state to provide health care and that is approved by a health plan to provide the care described in a contract and is willing to accept the contractual terms and conditions

APS — formally Associated Purchasing services, APS is a for-profit group purchasing company organized in the state of Missouri. It is a wholly-owned subsidiary of The Health Alliance of MidAmerica, LLC.

assigned claim — a claim submitted for a service or supply by a provider who accepts Medicare assignment

assignment — an agreement by a physician that he or she will bill Medicare directly and will accept the government payment as the total payment. A physician cannot bill the patient for the balance.

assistant physician a Missouri category of physician licensure for medical school graduates who have not completed a medical residency program and are authorized to provide primary care services under the supervision of a fully licensed physician

assisted living a type of living arrangement in which personal care services, such as meals, housekeeping, transportation and assistance with activities of daily living, are available as needed to people who still live on their own in a residential facility. In most cases, the "assisted living" residents pay a regular monthly rent. Then, they typically pay additional fees for the services they receive.

associate degree in nursing (ADN) a degree received after completing a two-year nursing education program at a college or university that qualifies a nurse to take a national licensing exam (NCLEX) to become a registered nurse

Association of American Medical Colleges (AAMC) As an association of medical schools, teaching hospitals and academic societies, the AAMC works with its members to establish a national agenda for medical education, biomedical research and health care. www.aamc.org

attending physician the licensed physician who normally would be expected to certify and recertify the medical necessity of the services rendered and/or who has primary responsibility for a patient's medical care and treatment

attestation to affirm to CMS the ability to meet the requirements for meaningful use, thereby becoming eligible for incentive payments under the CMS meaningful use incentive program. (typically used in connection with meaningful use) See https://www.cms.gov/EHRIncentivePrograms/32_Attestation.asp#TopOfPage

automatic enrollment process a process by which individuals or families who are found eligible for one type of government assistance program automatically are registered in and covered by a public health insurance plan

average adjusted per capita cost (AAPCC) payment rates used by the Centers for Medicare & Medicaid Services (CMS) to reimburse managed care organizations for care delivered to Medicare enrollees

average daily census (ADC) the average number of inpatients per day. The ADC is calculated by dividing the total number of days patients stayed in the hospital during a certain period by the total number of calendar days in that same period.

average length of stay (ALOS) a standard hospital statistic used to determine the average amount of time between admission and departure for patients in a diagnosis related group (DRG), an age group, a specific hospital or other factors

B

bachelor of science in nursing (BSN) a degree received after completing a four-year college or university program that qualifies a graduate nurse to take a national licensing exam (NCLEX) to become a registered nurse

balance billing — a provider's billing of a covered person directly for charges above the amount reimbursed by the health plan (i.e., difference between billed charges and the amount paid). This may or may not be allowed, depending on the contractual arrangements between the parties.

Balanced Budget Act of 1997 (BBA) — a federal law that makes numerous changes to various titles of the Social Security Act, contains significant changes to the Medicare and Medicaid programs and creates a new Title XXI, the State Children's Health Insurance Program (SCHIP). Original estimates projected a reduction of Medicare outlays by $116 billion throughout five years, but more recent projections estimate the impact to be more than $200 billion.

Balanced Budget Refinement Act of 1999 (BBRA) — a federal law that restores an estimated $17 billion to the Medicare program. The law provides relief for hospitals and includes special packages for rural and teaching hospitals, nursing homes and home health agencies.

behavioral health care — mental health services, including services for alcohol and substance abuse

benchmarking — a method of comparing the procedures and results of a process, system or operation under study with a similar process, system or operation under study that generally is recognized as outstanding

beneficiary — a person designated by an insuring organization as eligible to receive insurance benefits

Benefits Improvement and Protection Act of 2000 (BIPA) — a federal law that, among other provisions, restores an estimated $11.5 billion throughout five years to hospitals under Medicare, Medicaid and other federal and state health care programs

bioterrorism — the intentional use of any microorganism, virus, infectious substance or biological product, either engineered as a result of biotechnology or naturally occurring. Bioterrorism may be used to cause death, disease or other biological malfunction to influence the conduct of government or civilians.

birthing center — a facility, other than a hospital's maternity facilities or a physician's office, which provides a setting for labor, delivery and immediate post-partum care, as well as immediate care of newborn infants

board certified — a clinician who has passed the national examination in a particular field. Board certification is available for most physician specialties, as well as for many allied medical professions.

board eligible — the term referring to the period when a physician may take a specialty board examination for certification after graduating from a board-approved medical school, completing an accredited training program, and practicing for a specified length of time.

boutique hospital — a limited service hospital designed to provide one medical specialty, such as orthopedic or cardiac care

breadth of coverage — the range of individuals eligible for health insurance coverage

bundled billing	the practice of combining all of the medical expenses for a procedure into one charge, such as hospitalization for maternity care
bundled payment	the reimbursement of health care providers (such as hospitals and physicians) in which providers are paid for each service rendered to a patient as a "lump sum" per patient regardless of how many services the patient receives

C

capitation (CAP)	a stipulated dollar amount established to cover the cost of health care delivered for a person or group of persons. The term usually refers to a negotiated per capita rate to be paid periodically, usually monthly, to a health care provider. The provider is responsible for delivering or arranging the delivery of all health services required by the covered person(s) under the conditions of the contract.
carrier	the Medicare Part B claims processing contractor
case management	a system of assessment, treatment planning, referral and follow-up that ensures the provision of services according to patients' needs. It also can include the coordination of payment and reimbursement for care.
case manager	a health care professional who monitors the allocation and coordination of patients' overall care
case mix	the distribution of patients into categories reflecting differences in severity of illness or resource consumption
case mix index	a measure of relative severity of medical conditions of a hospital's patients
census	the number of patients, excluding newborns, receiving care each day during a reporting period
Centers for Disease Control and Prevention (CDC)	an agency within the U.S. Department of Health and Human Services (HHS) that serves as the central point for consolidating disease control data, health promotion and public health programs; based in Atlanta — www.cdc.gov
Centers for Medicare & Medicaid Services (CMS)	an agency within the U.S. Department of Health and Human Services (HHS) responsible for administering the Medicare and Medicaid programs; formerly called the Health Care Financing Administration (HCFA) — www.cms.hhs.gov/default.asp
certificate of medical necessity	a form required by Medicare that allows patients to use certain durable medical equipment prescribed transactions and is maintained by the Health Care Code Maintenance Committee
certificate of need (CON)	a designation authorizing an activity, such as constructing or modifying hospitals, purchasing certain medical equipment or providing new health care services

certified application counselor — The Federally-facilitated Marketplace will designate organizations to certify application counselors who perform many of the same functions as Navigators and non-Navigator assistance personnel—including educating consumers and helping them complete an application for coverage. An online application will be available at the end of July 2013 for organizations who want to become Marketplace-designated organizations that can certify application counselors. These groups might include community health centers or other health care providers, hospitals, or social service agencies.

certified electronic health records technology — is any EHR system or module which offers the necessary technological capability, functionality, and security to meet all meaningful use criteria

certified nurse-midwife (CNM) — a registered nurse who has graduated from a nurse-midwifery education program accredited by the American College of Nurse-Midwives (ACNM) Division of Accreditation (DOA) and has passed a national certification examination to receive the professional designation of certified nurse-midwife — www.midwife.org

certified nursing assistant (CNA) — an aide to health professionals in facilities, such as hospitals, clinics and nursing homes. CNAs provide patients with basic care and services, as well as social and emotional support. CNAs must be high school graduates, receive on-the-job training in a hospital, clinic or nursing home and complete a certification class through a community college or vocational or technical school.

certified registered nurse anesthetist (CRNA) — a registered nurse who has completed two years of additional training in anesthesia and is qualified to serve as an anesthetist under a physician's supervision — www.aana.com

charge description master (CDM) — the list of the lines of services provided in a facility, with each line containing a charge number and other data components. The charge number is used to generate a bill for the services, supplies and pharmaceuticals provided to the patient during an episode of care.

charity care — health care services provided free of charge or at a substantial discount

Children's Health Insurance Program (CHIP) — a state-administered program funded partly by the federal government that allows states to expand health coverage to uninsured, low-income children not eligible for Medicaid. https://www.cms.gov/home/chip.asp

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

Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) — *See* **Tricare**.

Civilian Health and Medical Program of the Veterans Administration (CHAMPVA)
CHAMPVA is a health care benefits program for qualifying dependents and survivors of veterans. Under CHAMPVA, the Department of Veterans Affairs shares the cost of covered health care services and supplies with eligible beneficiaries. www.va.gov/hac/aboutus/programs/champva.asp

Clinical Laboratory Improvement Amendments (CLIA)
a federal law designed to establish national quality standards for laboratory testing. The law covers all laboratories that engage in testing for assessment, diagnosis, prevention or treatment purposes.

clinical nurse specialist (CNS)
a licensed registered nurse who has graduate preparation (a master's degree or doctorate) in nursing as a clinical nurse specialist and is a clinician in a specialized area of nursing practice — www.nacns.org

clinical performance measure
a method or instrument to estimate or monitor the extent to which the actions of a health care practitioner or provider conform to practice guidelines, medical review criteria or standards of quality

clinical practice guidelines
reports written by experts who carefully have studied if a treatment works and which patients are most likely to be helped by it

clinical trials
one of the final stages of a long and careful research process to help patients live longer, healthier lives. Clinical trials help doctors and researchers find better ways to prevent, diagnose or treat diseases by testing the safety and efficacy of new types of medical care.

closed panel
medical services delivered in a health insuring corporation (HIC)-owned health center or satellite clinic by physicians who belong to a specially formed but legally separate medical group that only serves the HIC

***Code of Federal Regulations* (CFR)**
a publication of the federal government that consists of all regulations of federal departments and agencies — www.gpoaccess.gov/fr/

code set
Under HIPAA, this is any set of codes used to encode data elements, such as tables of terms, medical concepts, medical diagnostic codes or medical procedure codes. This includes both the codes and their descriptions. Also see Part II, 45 CFR 162.103.

coinsurance
a cost-sharing requirement under a health insurance policy in which the insured will assume a portion or percentage of the costs of covered services. After the deductible is paid, this provision obligates the subscriber to pay a certain percentage of any remaining medical bills, usually 20 percent.

community benefit
the value returned to a community by the presence of a health care facility

community care network
collaborative relationships among local providers organized to deliver a broad scope of health services. The network is responsible for an enrolled population and would be paid a fixed annual payment per enrollee. Health needs of the community would be identified early and met efficiently.

Community Health Information Network (CHIN) — a community-based activity focusing on developing a shared information database and retrieval system on patients, their medical histories and clinical and diagnostic tests

Community Health Needs Assessment — Technique for developing a profile of community health that measures factors inside and outside the traditional medical service and public health definitions and practices. Needs assessments identify gaps in health care services; identify special targeted populations; identify health problems in the community; identify barriers to access to health care services and estimate projected future needs.

community rating — establishing insurance rates based on the average cost of providing health services to all people in a geographic area without adjusting for each individual's medical history or likelihood of using medical services

comorbidity — a pre-existing condition that, linked to a principal diagnosis, causes an increase in the length of stay by at least one day in approximately 75 percent of cases

computed axial tomography (CAT) scanner — diagnostic equipment that produces cross sectional images of the head and/or body. Also known as CT scanner (computed tomography).

computed tomography (CT) scanner — *See* **computed axial tomography (CAT) scanner**.

Computerized Needs-oriented Quality Measurement Evaluation System (CONQUEST) — CONQUEST was developed by the Agency for Healthcare Research and Quality as a tool that permits users to collect and evaluate health care quality measures to find those suited to or adaptable to their needs. CONQUEST has interlocking databases describing "measures" and clinical "conditions."

computerized physician order entry — refers to any system in which clinicians directly enter medication orders, tests and procedures into a computer system, which then transmits the order directly to the pharmacy

condition report — as related to patients, generally includes treated and released; good; fair; serious; and critical

Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) — Congress passed the landmark Consolidated Omnibus Budget Reconciliation Act (COBRA) health benefit provisions in 1986. The law amends the Employee Retirement Income Security Act (ERISA), the Internal Revenue Code and the Public Health Service Act to provide continuation of group health coverage that otherwise would be terminated.

Consumer Assessment of Healthcare Providers and Systems (CAHPS) — a public-private initiative to develop standardized surveys of patients' experiences with ambulatory and facility-level care

Consumer Price Index (CPI) — a measure of the average change in prices throughout time in a marketbasket of goods and services — www.bls.gov/cpi/home.htm

contact hour — 50 minutes of an approved organized learning activity that is either a didactic or clinical experience

continuous quality improvement (CQI) — an approach to organizational management that emphasizes meeting and exceeding consumer needs and expectations, use of scientific methods to continually improve work processes and the empowerment of all employees to engage in continuous improvement of their work processes

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

coordination of benefits — provisions and procedures used by third-party payers to determine the amount payable when a claimant is covered by two or more health plans

copayment — a type of cost-sharing which requires the insured or subscriber to pay a specified flat dollar amount, usually on a per-unit-of-service basis, with the third-party payer reimbursing some portion of the remaining charges

corporate practice of medicine — a state law doctrine prohibiting any person or entity other than a licensed physician from holding itself out as a provider of professional medical services, from billing in its name for such professional medical services or from owning or controlling a professional medical delivery system

Correct Coding Initiative (CCI) — developed by the Centers for Medicare & Medicaid Services (CMS) to promote national correct coding methodologies and eliminate improper coding. CCI edits are based on coding conventions defined in the AMA's Current Procedural Terminology (CPT) Manual, current standards of medical and surgical coding practice, input from specialty societies and analysis of current coding practice.

coverage — all or part of an individual's health care costs are paid, either by insurance or by the government

covered entity — under HIPAA, a health plan, health care clearinghouse or health care provider that transmits any health information in electronic form

credentialing — the process of reviewing a practitioner's academic, clinical and professional abilities, as demonstrated in the past, to determine if criteria for clinical privileges are met

critical access hospital (CAH) — a federal designation under which hospitals receive cost-based reimbursement for Medicare services. Hospitals must meet certain criteria, such as size, length of stay and proximity to other facilities, to be designated a CAH.

critical pathway — standardized specifications for care developed by a formal process that incorporates the best scientific evidence of effectiveness with expert opinion

Current Population Survey (CPS)	a monthly survey of about 50,000 households conducted by the U.S. Bureau of the Census and the U.S. Bureau of Labor Statistics. The CPS is the primary source of information on the labor force characteristics of the U.S. population. www.census.gov/cps/
current procedural terminology (CPT)	a system of classifying health care procedures to determine costs. Each procedure has a five-digit CPT code.
customary, prevailing and reasonable (CPR)	current method of paying physicians under Medicare. Payment for a service is limited to the lowest of the physician's billed charge for the service, the physician's customary charge for the service or the prevailing charge for that service in the community.

D

D-codes	subset of the HCPCS Level II medical codes identifying certain dental procedures. It replicates many of the Current Dental Terminology codes and will be replaced by the CDT.
deductible	out-of-pocket expenses that must be paid by the health insurance subscriber before the insurer will begin reimbursing the subscriber for additional medical expenses
deemed status	a hospital is "deemed qualified" to participate in the Medicare program if it is accredited by the Joint Commission, thus avoiding the need for a duplicative Medicare accreditation survey.
demographic data	data that describe the characteristics of enrollee populations within a managed care entity. Demographic data include but are not limited to age, sex, race/ethnicity and primary language.
Department of Health and Human Services (HHS)	administers many of the social programs at the federal level managing the health and welfare of Americans. (It is the "parent" of the Centers for Medicare & Medicaid Services.)
Department of Veterans Affairs (VA)	a federal agency responsible for veterans, including VA hospitals and veterans' benefits (previously Veterans' Administration)
depth of coverage	the level of coverage a health insurance plan provides
Det Norske Veritas	CMS approved accrediting body
diagnosis code	corresponds to the principal diagnosis chiefly responsible for causing hospitalization plus additional conditions that coexisted at the time of admission or developed subsequently that affected the treatment received or the length of stay (*See* **International Classification of Diseases**.)
diagnosis related group (DRG)	a hospital classification system that groups patients by common characteristics requiring treatment. *See also* **ambulatory visit group (AVG)**.

disability	for Social Security purposes, the inability to engage in substantial gainful activity by reason of any medically determinable physical or mental impairment that can be expected to result in death or to last for a continuous period of not less than 12 months. Special rules apply for workers ages 55 or older whose disability is based on blindness. The law generally requires that a person be disabled continuously for five months before he or she can qualify for a disabled worker cash benefit. An additional 24 months is necessary to qualify under Medicare.
discharge planning	the evaluation of patients' health needs for appropriate care after discharge from inpatient settings
disproportionate share hospital (DSH)	a hospital that provides care to a large number of patients who cannot afford to pay and/or do not have insurance
disproportionate share hospital (DSH) payment	In Missouri, it is reimbursements made to offset some of each hospitals costs of treating uninsured patients.
diversion	routing patients to other hospitals because an emergency department is at maximum capacity
do not resuscitate (DNR)	an advance directive that patients may make to forego cardiopulmonary resuscitation or other resuscitative efforts. (*See* **advance directive**.)
doctor of osteopathy (D.O.)	a licensed physician who is a graduate from an accredited school of osteopathic medicine
dual-eligible	a person who is eligible for two health insurance plans, often referring to a Medicare beneficiary who also qualifies for Medicaid benefits
durable medical equipment (DME)	equipment that can stand repeated use that primarily is used for medical purposes and is appropriate for use at home. Examples include hospital beds, wheelchairs and oxygen equipment.
durable medical equipment, prosthetics, orthotics and	the system for Medicare's method of paying suppliers for medical equipment
durable power of attorney	a document in which individuals select another person to act on their behalf in the event they become incapacitated. The document may identify specific activities, such as managing the incapacitated person's financial affairs. If the document allows the agent to make health care decisions, it must be drafted in a manner that meets statutory requirements for a health care durable power of attorney. (*See* **advance directive**.)

E

electrocardiogram (ECG/EKG) a test that records the electrical activity of the heart. An ECG measures the rate and regularity of heartbeats, as well as the size and position of the chambers, the presence of any damage to the heart and the effects of drugs or devices used to regulate the heart, such as a pacemaker.

electroencephalogram (EEG) a test to detect abnormalities in the electrical activity of the brain

eligibility/Medicare Part A Individuals are eligible for premium-free (no cost) Medicare Part A (Hospital Insurance) if:

- they are 65 or older and receive, or are eligible for, retirement benefits from Social Security or the Railroad Retirement Board, or

- they are younger than 65 and have received Railroad Retirement disability benefits for the prescribed time and meet the Social Security Act disability requirements, or

- they or their spouse had Medicare coverage through government employment, or

- they are younger than 65 and have end-stage renal disease (ESRD).

Individuals who are not eligible for premium-free Medicare Part A may buy Part A by paying a monthly premium if:

- they are 65 or older

they are enrolled in Part B and are a U.S. resident and are either a citizen or an alien lawfully admitted for permanent residence. In this case, participants must have lived in the United States continuously during the five years immediately before the month during which they enroll in Part A.

eligibility/Medicare Part B

- Individuals automatically are eligible for Part B if they are eligible for premium-free Part A. Individuals also are eligible for Part B if they are not eligible for premium-free Part A but are 65 or older AND a U.S. resident or a citizen or an alien lawfully admitted for permanent residence. In this case, participants must have lived in the United States continuously during the five years immediately before the month during which they enroll in Part B.

emergency department (ED) the component of a health care organization responsible for delivering emergency services

emergency medical services (EMS) a system of health care professionals, facilities and equipment providing emergency care

emergency medical technician (EMT) a person certified to provide pre-hospital emergency medical treatment

Emergency Medical Treatment and Labor Act (EMTALA)	a federal law mandating that all patients who come to a hospital's emergency department must receive an appropriate medical screening regardless of their ability to pay. The law requires patients to be stabilized before they are transferred to another facility.
emergency preparedness plan	a process designated to manage the consequences of natural disasters or other major emergency disruptions to the ability to provide care and treatment.
Employee Retirement Income Security Act (ERISA)	a federal law that exempts self-insured health plans from state laws governing health insurance, including contributions to risk pools, prohibitions against disease discrimination and other state health reforms
Environmental Protection Agency (EPA)	a federal and state agency responsible for programs to control air, water and noise pollution, solid waste disposal and other environmental concerns — www.epa.gov
evidence	signs that something is true or false. Doctors can use published studies as evidence that a treatment works or does not work.
exclusions	clauses in an insurance contract that deny coverage for select individuals, groups, locations, properties or risks
experience rating	a system used by insurance companies to evaluate the risk of an individual or group by examining the applicant's health history

F

failure modes and effects analysis (FMEA)	a systematic method of identifying and preventing problems (errors) before they occur
False Claims Act	a federal law imposing liability for treble damages and fines of $5,000 to $10,000 for knowingly submitting a false or fraudulent claim for payment to the federal government
false negative	occurs when the medical record contains evidence of a service that does not exist in the encounter data. This is the most common problem in partially or fully capitated plans because the provider does not need to submit an encounter to receive payment for the service and therefore may have a weaker incentive to conform to data collection standards.
false positive	occurs when encounter data contain evidence of a service that is not documented in the patient's medical record. Assuming the medical record contains complete information on the patient's medical history, a false positive may be considered a fraudulent service. However, in a fully capitated environment, the provider would receive no additional reimbursement for the submission of a false positive encounter.

Family Care Safety Registry (FCSR) — Established by law, Missouri's Family Care Safety Registry ensures that backgrounds of persons caring for children, the elderly and the physically or mentally disabled can be screened easily and provides families and other employers with a method to easily obtain information from various state agencies from a single source. www.dhss.mo.gov/FCSR

federal financial participation (FFP) — the portion paid by the federal government to states for their share of expenditures for providing Medicaid services and for administering the Medicaid program and certain other human service programs. Also called federal medical assistance percentage (FMAP).

federal fiscal year (FFY) — the federal government's accounting year, which begins Oct. 1 and ends Sept. 30.

federal medical assistance percentage (FMAP) — the share of medical assistance expenditures under each state's Medicaid program paid by the federal government. The share is determined annually by a formula comparing the state's average per capita income level with the national income average.

federal poverty guidelines — the official annual income level for poverty as defined by the federal government. Under the 2010 guidelines, the federal poverty level for a family of four is $22,050.

Federal Register — an official publication of the federal government providing final and proposed regulations based on federal legislation

Federal Reimbursement Allowance (FRA) — a provider assessment imposed on hospitals to provide funding for the state Medicaid program http://web.mhanet.com/aspx/navigation/policy_advocacy.aspx?navid=31&pnavid=1

federally qualified health center (FQHC) — Medicare-approved facilities that receive or are eligible to receive funding under one of three Public Health Service Act (PHSA) grant programs. FQHCs primarily provide Part B services and some preventive services not covered by Medicare.

Federation of American Hospitals (FAH) — a trade association comprised of proprietary or investor-owned hospitals

fee-for-service — the traditional payment method for health care services whereby patients pay doctors, hospitals and other providers directly for services rendered

fee schedule — a comprehensive fee listing used by either a health care plan or the government to reimburse providers on a fee-for-service basis

first responder — uses a limited amount of equipment to perform initial assessment and intervention and is trained to assist other emergency medical services (EMS) providers. For example, at the scene of a cardiac arrest, the first responder would be expected to notify EMS (if not already notified) and initiate CPR with an oral airway and a barrier device.

fiscal intermediary — the Medicare Part A claims processing contractor

fiscal note	an analysis by the Legislative Budget Office of the financial impact of proposed state legislation
fiscal year	any entity's accounting year
flexible spending account (FSA)	the vehicle by which medical and/or dependent care expenses can be paid with pretax dollars, resulting in tax savings for the participant
Food and Drug Administration (FDA)	an agency within the federal government responsible for regulations pertaining to food and drugs sold in the United States — www.fda.gov
freestanding emergency center (FEC)	a health care facility that is physically separate from a hospital and whose primary purpose is the provision of immediate, short-term medical care for minor, but urgent, medical conditions. Also called urgent care.
full capitation	health plans or primary care case managers are paid for providing services to enrollees through a combination of capitation and fee-for-service reimbursements
full-time equivalent (FTE)	a standardized accounting of the numbers of full-time and part-time employees

G

gaps	costs or services not covered under the original Medicare plan
gatekeeper	a primary care physician responsible for overseeing and coordinating all aspects of a patient's medical care and pre-authorizing specialty care
general practitioner	a physician whose practice is based on a broad understanding of all illnesses and who does not restrict his/her practice to any particular field of medicine
governance	the legal authority and responsibility for the public health system.
governing body	the legal entity ultimately responsible for hospital policy, organization, management, and quality of care. Also called the governing board, board of trustees, commissioners, or directors. The governing body is accountable to the owners(s) of the hospital, which may be corporation, the community, local government, or stockholders.
global fee	a single fee that encompasses every procedure or test performed during hospitalization
graduate medical education (GME)	medical education as an intern, resident or fellow after graduating from a medical school
group insurance	any insurance policy or health services contract by which groups of employees, and often their dependents, are covered under a single policy or contract issued by an employer or other group entity

group model HMO — a health maintenance organization that contracts with a multispecialty medical group to provide care for HMO members. Members are required to receive medical care from a physician within the group unless a referral is made outside the network.

group practice association — a formal arrangement of three or more physicians or other health professionals providing health services. Income is pooled and redistributed to group members according to a prearranged plan.

guaranteed issue — a requirement that health plans and insurers accept everyone who applies for coverage and guarantee the coverage will be renewed as long as the applicant pays the premium

H

The Health Alliance of MidAmerica LLC (The Alliance) — Created in 1999, The Health Alliance of MidAmerica LLC is the first corporate affiliation between two state hospital associations, the Kansas Hospital Association and the Missouri Hospital Association.

health care acquired condition (HCAC) — serious conditions that patients may get during stay in a health care setting and is not covered by Medicare

health care durable power of attorney — a document in which individuals select another individual to make health care decisions for them in the event they become incapacitated. A health care durable power of attorney should be distinguished from a living will, a document drafted by an individual that provides direction regarding medical care if the individual becomes incapacitated by terminal illness or permanent unconsciousness. (*See* **advance directive**.)

Healthcare Common Procedural Coding System (HCPCS) — a medical code set that identifies health care procedures, equipment and supplies for claim submission purposes and used in HIPAA transactions. HCPCS Level I contains numeric CPT codes, which are maintained by the American Medical Association. HCPCS Level II contains alphanumeric codes used to identify various items and services that are not included in the CPT medical code set. HCPCS Level III contains alphanumeric codes that are assigned by Medicaid state agencies to identify additional items and services not included in levels I or II. These usually are called "local codes."

Healthcare Cost and Utilization Project (HCUP) — a federal study undertaken by the Agency for Healthcare Research and Quality to create a national database for research into the efficacy and costs of U.S. health care.

Healthcare Cost and Utilization Project Quality Indicators (HCUP QIs) — HCUP QIs comprise a set of 33 clinical performance measures that inform hospitals' self-assessments of inpatient quality of care, as well as state and community assessments of access to primary care. Developed by the Agency for Healthcare Research and Quality, HCUP QIs span three dimensions of care: potentially avoidable adverse hospital outcomes, potentially inappropriate utilization of hospital procedures and potentially avoidable hospital admissions.

Healthcare Financial Management Association	an organization for the improvement of the financial management of health care-related organizations. The HFMA sponsors some HIPAA educational seminars.
Health Care Issues Committee of the Missouri Hospital Association (Issues Committee)	a political action committee used to support or oppose ballot issues. Commonly referred to as Issues Committee, the Issues Committee was formed in 2001.
Health Care Quality Improvement Program	Medicare's health care quality improvement program; a national effort to improve the quality, efficiency and effectiveness of services provided to beneficiaries
health information exchange	the transmission of healthcare-related data among facilities, health information organizations (HIO) and government agencies according to national standards
health information technology	the area of IT involving the design, development, creation, use and maintenance of information systems for the healthcare industry
Health Information Technology for Economic and Clinical Health Act (HITECH)	created in 2009, to stimulate the adoption of electronic health records (EHR) and supporting technology as part of the American Recovery and Reinvestment Act of 2009 (ARRA), an economic stimulus bill
Health Insurance Association of America (HIAA)	a corporate member association of health and accident insurance companies based in Washington, D.C. — www.hiaa.org
Health Insurance Flexibility and Accountability (HIFA) Initiative	a Section 1115 demonstration waiver approach, introduced in August 2001, that encourages innovative state programs to increase the number of individuals with health insurance coverage
Health Insurance Portability and Accountability Act of 1996 (HIPAA)	requires the U.S. Department of Health and Human Services (HHS) to adopt national standards for electronic health care transactions and includes regulations related to electronic health care transactions, health information privacy and security requirements. In some cases, regulations have expanded the scope of HIPAA to include non-electronic transactions.
Health Insurance Premium Payment (HIPP) Program	a Medicaid program which pays the cost of health insurance premiums, coinsurance and deductibles for Medicaid-eligible people who have access to employer-sponsored insurance
health maintenance organization (HMO)	an entity that offers prepaid, comprehensive health coverage for both hospital and physician services with specific health care providers using a fixed fee structure or capitated rates

Health Plan Employer Data and Information Set (HEDIS®)	a set of performance measures designed to standardize the way health plans report data to employers. HEDIS® measures five major areas of health plan performance: quality, access and patient satisfaction, membership and utilization, finance and descriptive information on health plan management.
health professional shortage area (HPSA)	Formerly health manpower shortage area, a health professional shortage area is an area or group that the U.S. Department of Health and Human Services designates as having an inadequate supply of health care providers.
Hospital Research and Educational Trust (HRET)	an organization, in partnership with AHA, created to advance ideas and practices beneficial to health care practitioners, institutions, consumers, and society at large
Health Resources and Services Administration (HRSA)	an agency of the U.S. Department of Health and Human Services (HHS) that ensures quality health care is available to low-income, uninsured, isolated, vulnerable and special-needs populations
Health savings account (HSA)	is a tax-advantaged medical savings account available to taxpayers in the United States who are enrolled in a high-deductible health plan
health systems agency (HSA)	a health planning agency created under the National Health Planning and Resources Development Act of 1974. HSAs usually were nonprofit private organizations and served defined health service areas as designated by the States.
HEALTHPAC	*See* **Political Action Committee for Health**.
Hill Burton Act	federal legislation enacted in 1947 to support the construction and modernization of health care institutions
holographic will	a will handwritten by the testator
home health agency	an organization providing medical, therapeutic or other health services in patients' homes
hospice	a facility or program that is licensed, certified or otherwise authorized by law that provides supportive care of the terminally ill
hospital affiliation	a hospital that is owned, leased, managed or affiliated with a system
hospital acquired condition (HAC)	serious conditions that patients may get during an inpatient hospital stay and is not covered by Medicare
Hospital Consumer Assessment of Health Plans Survey (HCAHPS)	a nationally standardized survey developed by CMS and AHRQ for measuring how patients perceive the care they receive in hospitals
Hospital Emergency Administrative Radio (HEAR) network	allows two-way emergency communications over a private network of radio frequencies. Among its primary uses are communications from ambulances to hospitals and from hospitals to hospitals. The HEAR network began operating in 1969.

Hospital Industry Data Institute (HIDI)	the data company of the Missouri Hospital Association. A comprehensive, hospital-founded organization that collects, analyzes and provides comparative data to member hospitals. Services are available to MHA members and other hospitals through partnership with their state hospital associations.
Hospital Inpatient Quality Reporting (IQR)	originally mandated by Section 501(b) of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003. This section of the MMA authorized CMS to pay hospitals that successfully report designated quality measures a higher annual update to their payment rates
Hospital Insurance Program	the compulsory portion of Medicare which relates to hospital care
Hospitals in Pursuit of Excellence (HPOE)	is the American Hospital Association's strategic platform to accelerate performance improvement and support health reform implementation in the nation's hospitals and health systems
hospital marketbasket	components of the overall cost of health care used in determining the U.S. Consumer Price Index
Hospital Marketbasket Index (HMBI)	an inflationary measure of the cost of goods and services purchased by health care facilities, often used to determine growth in reimbursement rates
Hospital Performance Project	is a cooperative health data effort between the Missouri Hospital Association and Missouri hospitals to provide individual, aggregate and comparative hospital data on selected, nationally defined indicators of inpatient health care quality and patient safety to assist participating hospitals in the evaluation of quality of care.
Hospital Preparedness Program (HPP)	Provides leadership and funding through grants and cooperative agreements to states, territories and large metropolitan areas to improve capacity and enhance community and hospital preparedness for public health emergencies. The program is managed by the Office of the Assistant Secretary for Preparedness and Response.
Hospital Quality Initiative (HQI)	a Centers for Medicare & Medicaid Services project that includes demonstration projects and the Hospital Compare Web site. Its goals are to improve the care provided by the nation’s hospitals and to provide quality information to consumers and others.
hospitalist	physician specialists in inpatient medicine who spend at least 25 percent of their professional time serving as the physicians-of-record for inpatients, returning the patients back to the care of their primary care providers at the time of hospital discharge

I

ICD, ICD-N-CM and ICD-N-PCS International Classification of Diseases, with "N" = "9" for Revision 9 or "10" for Revision 10. "CM" stands for clinical modification, and "PCS" is an abbreviation for procedure coding system.

incidence the frequency of new occurrences of a condition within a defined time interval. The incidence rate is the number of new cases of specific disease divided by the number of people in a population during a specified period of time, usually one year.

indemnity insurer an insurance company offering selected coverage within a framework of fee schedules, limitations and exclusions as negotiated with subscriber groups, generally paying providers' fees according to services rendered

indemnity plan an insurance program in which a covered person is reimbursed for covered expenses at an established rate

independent practice association (IPA) a health care delivery model in which an association of independent physicians contracts with health maintenance organizations and preferred provider organizations for physicians' services. IPA physicians practice in their own offices and continue to see fee-for-service patients.

Independent Payment Advisory Board (IPAB) created in 2010, through the Patient Protection and Affordable Care Act to reduce the rate of growth in Medicare without affecting coverage or quality

indicator a key clinical value or quality characteristic used to measure, throughout time, the performance, processes and outcomes of an organization or some component of health care delivery

indigent medical care care provided to patients who are unable to pay for it

inpatient an individual who has been admitted to a hospital for at least 24 hours

inpatient prospective payment system (IPPS) a system of payment for the operating costs of acute care hospital inpatient stays under Medicare Part A (Hospital Insurance) based on prospectively set rates.

integrated delivery system collaboration between physicians and hospitals for a variety of purposes. Some models of integration include physician-hospital organizations, management-service organizations, group practices without walls, integrated provider organizations and medical foundations.

intensive care unit (ICU) a unit of a hospital for the treatment and continuous monitoring of patients with life-threatening conditions

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

intermediary	a private company that has a contract with Medicare to pay Part A and some Part B bills
intermediate care facility	a facility providing a level of medical care that is less than the degree of care and treatment that a hospital or skilled nursing facility is designed to provide but greater than the level of room and board
International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)	the classification of morbidity and mortality information for statistical purposes and for the indexing of hospital records by disease and operations for data storage and retrieval
International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS)	developed to replace Volume 3 of the ICD-9-CM. ICD-10-PCS uses a multiaxial, seven character alpha numerical code structure, which provides a unique code for all substantially different procedures and allows new procedures to be easily incorporated as new codes
Institutional Review Board (IRB)	An organizational committee, mandated in 1981 and since governed by the U.S. Department of Health and Human Services, designated to review and approve biomedical research involving humans as subjects.

J

(The) Joint Commission	Founded in 1951, the Joint Commission evaluates and accredits health care organizations in the United States, including hospitals, health plans and other care organizations providing home care, mental health care, laboratory, ambulatory care and long-term services. Formerly called the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) — www.jointcommission.org
Joint Commission Resources Inc. (JCR)	a subsidiary of the Joint Commission designed to distribute consulting and publication services — www.jcrinc.com
joint venture	a loose form of affiliation, essentially contractual in nature, that preserves the prior legal identity of each party participating in the venture

K

Kansas City Metropolitan Healthcare Council (KCMHC)	The Kansas City Metropolitan Healthcare Council is a regional office of The Health Alliance of MidAmerica LLC, which was formed in 1999 to serve members of the Kansas and Missouri hospital associations in the metropolitan bistate area of Kansas City. The KCMHC's primary goals are local representation and advocacy for member hospitals, increased public awareness and media communication, and networking for joint community projects.

L

length of stay (LOS)	the number of days a patient stays in a hospital or other health care facility
licensed practical nurse (LPN)	a graduate from a one-year vocational or technical nursing program who has been licensed by the state
licensed social worker (LSW)	an individual who is licensed by the state to practice social work
Life Safety Code	standards of construction, protection and occupancy that are necessary to minimize danger to life from fire, smoke, fumes and panic. The Joint Commission and the Medicaid and Medicare programs require compliance with the code. The code is adopted and published by the National Fire Protection Association and also is known as the NFPA 101.
living will	a legal document generated by an individual to guide providers on the desired medical care in cases when the individual is unable to articulate his or her own wishes. (*See* **advance directive**.)
long-term acute care hospital (LTAC)	a hospital specializing in treating patients with serious and often complex medical conditions requiring a longer length of stay than customarily provided by a traditional acute care hospital. LTACs provide care for such conditions as respiratory failure, nonhealing wounds and other diseases that are medically complex. Also called long-term care hospitals (LTCH).
long-term care (LTC)	care given to patients with chronic illnesses who usually require a length of stay longer than 30 days
long-term care hospital (LTCH)	*See* **long-term acute care hospital (LTAC)**.

M

magnetic resonance imaging (MRI)	a diagnostic technique that uses radio and magnetic waves, rather than radiation, to create images of body tissue and to monitor body chemistry

malpractice failure of an individual rendering services to a patient to use the level of skill or education commonly applied under similar circumstances

managed care systems and techniques used to control the use and cost of health care services; a general term for organizing doctors, hospitals and other providers into groups to enhance the quality and cost-effectiveness of health care

managed care organization entities that serve Medicare or Medicaid beneficiaries on a risk basis through a network of employed or affiliated providers. The term generally includes HMOs, PPOs and point of service plans. Other organizations may establish managed care programs to respond to Medicaid managed care. These organizations include federally qualified health centers, integrated delivery systems and public health clinics.

managed care plan In most managed care plans, patients only can visit doctors, specialists or hospitals on the plan's list except in an emergency. Plans must cover all Medicare Part A and Part B health care. Some managed care plans cover extra benefits, such as extra days in the hospital.

marketbasket *See* **hospital marketbasket**.

marketbasket index *See* **Hospital Marketbasket Index**.

meaningful use providers show they're using certified EHR technology in ways that can be measured significantly in quality and in quantity

Medicaid a state-administered program funded partly by the federal government that provides health care services for certain low-income persons and certain aged, blind or disabled individuals. The program is approximately a 40/60 state/federal match. www.cms.hhs.gov/home/medicaid.asp

Medicaid and CHIP Payment Access Commission (MACPAC) established to review Medicaid and CHIP access and payment policies and to advise Congress on issues affecting Medicaid and CHIP

Medical Clinical Data Abstraction Center a CMS service for providing accurate, reliable, efficient and cost-effective clinical data abstraction, validation, adjudication and entry operation to support QIOs as appropriate

Medical Consumer Price Index an inflationary statistic measuring the cost of all purchased health care services

medical doctor (M.D.) a licensed physician who is a graduate of an accredited medical school and practices allopathic medicine

medical error the failure of a planned action to be completed as intended (error of execution) or the use of a wrong plan to achieve an aim (error of planning)

Medical Executive Committee Generally composed of the elected or appointed officers and chairs of clinical departments or divisions of the medical staff organization.

medical home — an approach to providing comprehensive primary care for children, youth and adults. The PCMH is a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family

medical loss ratio — the percentage of individuals premium dollars that an insurance company spends on providing individuals with health care and improving the quality of care, versus how much is spent on administrative and overhead costs and, in many cases, high salaries or bonuses

medical malpractice insurance — insurance purchased by a person or entity, such as a doctor or hospital, that pays as much as the limits of the policy for damages to a patient caused by malpractice

medical savings account (MSA) — a health insurance option consisting of a high-deductible insurance policy and tax-advantaged saving account. Individuals pay for their own health care up to the annual deductible by withdrawing form the savings account or paying out of pocket. The insurance policy pays for most or all costs of covered services once the deductible is met. Also called a health savings account (HSA).

medically necessary — services or supplies that are proper and needed for the diagnosis or treatment of a patient's medical condition; are provided for the diagnosis, direct care and treatment of a patient's medical condition; meet the standards of good medical practice in the local area; and aren't mainly for the convenience of the patient or the physician

Medicare — a federally funded program providing health insurance primarily for individuals ages 65 and older entitled to Social Security — www.medicare.gov

Medicare Advantage — a program under which eligible Medicare enrollees can elect to receive benefits through a managed care program that places providers at risk for those benefits; formerly called Medicare+Choice. *See* **Medicare Part C**.

Medicare Geographic Classification Review Board — five person board, established by Congress in 1990, to review hospital requests for geographic reclassification for Medicare prospective-payment-system (PPS) purposes. To be reclassified, hospitals generally must be located in an adjacent county and pay wages equal to at least 85 percent of those paid by hospitals in the area for which classification is being requested.

Medicare Part A — the Medicare program that covers inpatient hospital services and services furnished by other health care providers, such as nursing homes, home health agencies and hospices. Part A coverage automatically is provided for individuals entitled to Medicare.

Medicare Part B — the Medicare program that covers outpatient, physician and medical supplier services. Part B coverage is optional and must be purchased separately through monthly premium payments.

Medicare Part C — the Medicare program under which eligible beneficiaries can elect to receive benefits through private plans, including preferred provider organizations, provider-sponsored organizations, private fee-for-service plans and medical savings accounts coupled with high-deductible insurance plans. Previously known as Medicare+Choice, the program was renamed Medicare Advantage under the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), which created new regional PPOs; special needs plans for dual eligibles, the institutionalized or those with severe and disabling conditions; and new private drug plans that became effective January 2006.

Medicare Part D — is a federal program to subsidize the costs of prescription drugs for Medicare beneficiaries in the United States. It was enacted as part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) and went into effect on January 1, 2006.

Medicare Payment Advisory Commission (MedPAC) — congressional entity resulting from combining the Physician Payment Review Commission and the Prospective Payment Assessment Commission. Created in 1997 to provide advice on Medicare payment issues, it recommends policies and procedures regarding allowable Medicare charges.

Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) — an act amending title XVIII of the Social Security Act to provide a voluntary prescription drug benefit under the Medicare program and to strengthen and improve Medicare

Medigap — a policy guaranteeing to pay a Medicare beneficiary’s coinsurance, deductible and copayments and provide additional health plan or non-Medicare coverage for services up to a predefined benefit limit. In effect, the product pays for the portion of the cost of services not covered by Medicare.

Medical Savings Account (MSA) — A health insurance option consisting of a high-deductible insurance policy and tax-advantaged saving account. Individuals pay for their own health care up to the annual deductible by withdrawing form the savings account or paying out of pocket. The insurance policy pays for most or all costs of covered services once the deductible is met. Also called a health savings account (HSA).

MHA Health Institute (MHI) — the educational arm of the Missouri Hospital Association. MHI activities focus on educational programming for health care professionals, assistance and educational programming for personal membership groups and grant resources.

MHA Management Services Corporation (MSC) — MHA Management Services Corporation is a wholly owned for-profit subsidiary of MHA formed in 1988. MSC develops and provides high-quality, market-driven programs and services to hospitals in Missouri.

midlevel practitioner (MLP) — nurses, physician assistants, midwives and other health professionals who can operate somewhat independently, as long as they are under the sponsorship of a practicing physician and are licensed to do so by their respective state licensing authority

minimum data set (MDS)	a core set of screening, clinical and functional status elements forming the foundation of the comprehensive assessment of all residents of long-term care facilities certified to participate in Medicare or Medicaid. The MDS is used to classify a nursing facility resident into a case mix classification.
Missouri Health Information Organization	a nonprofit organization that is a public-private collaboration between the state of Missouri and healthcare stakeholders - patients, providers, physicians, hospitals and other health organizations - dedicated to improving public health and patient care through secure and efficient exchange of clinical information
Missouri Register	an official Missouri publication that provides final and proposed rulemakings for state legislation. The secretary of state publishes the *Missouri Register* twice each month.
MO HealthNet (MHD)	Missouri's Medicaid program. In 2007, the Missouri General Assembly passed Medicaid reform legislation that changed the name of the state program to MO HealthNet. The Missouri Division of Medical Services, which oversees the medical assistance program, also was renamed MO HealthNet Division.
morbidity	incidents of illness and accidents in a defined group of individuals
morbidity rate	the rate of illness in a population. The number of people ill during a time period divided by the number of people in the total population.
mortality	incidents of death in a defined group of individuals
mortality rate	The death rate often made explicit for a particular characteristic, such as gender, sex or specific cause of death. Mortality rate contains three essential elements: the number of people in a population exposed to the risk of death (denominator), a time factor and the number of deaths occurring in the exposed population during a certain time period (the numerator).
most-favored-nation clause (MFN)	a provision requiring the contracting physician, hospital or group to provide an insurer with the lowest price it charges any other insurer

N

measures application partnership	a public-private partnership convened by the National Quality Forum (NQF). MAP was created for the explicit purpose of providing input to the Department of Health and Human Services (HHS) on the selection of performance measures for public reporting and performance-based payment programs.
National Board of Medical Examiners (NBME)	a nonprofit organization responsible for preparing and administering qualifying examinations for physicians — www.nbme.org
National Cancer Registry	a unit within the National Institutes of Health that provides updates on the latest cancer diseases, research and diagnosis

National Center for Health Services Research (NCHSR) — a division within the U.S. Department of Health and Human Services (HHS) that supports analyses and evaluations of the health care system and its financing, and underwrites the development and testing of new approaches to improve the distribution, use and cost-effectiveness of services

National Center for Health Statistics (NCHS) — a division within the U.S. Department of Health and Human Services (HHS) responsible for gathering data on illness and disability, producing the vital statistics of the nation and tracking the use and availability of health services and resources — www.cdc.gov/nchs

National Committee for Quality Assurance (NCQA) — a nonprofit organization created to improve patient care quality and health plan performance in partnership with managed care plans, purchasers, consumers and the public sector — www.ncqa.org

National Healthcare Safety Network — a component for hospitals to monitor adverse reactions and incidents associated with receipt of blood and blood products

National Institutes of Health (NIH) — a division within the U.S. Department of Health and Human Services (HHS) that is responsible for most of the agency's medical research programs — www.nih.gov

National Pharmaceutical Stockpile (NPS) — *See* **Strategic National Stockpile (SNS)**.

National Practitioner Data Bank (database) — a computerized information system that contains a record of malpractice claims, privileges actions, and other disciplinary actions. It was created to ensure that incompetent health care professionals do not move from one state to another.

National Provider Identifier (NPI) — a standardized 10-character alphanumeric identifier assigned to a health care provider. Mandated by HIPAA, it is used for billing purposes.

navigator — Navigators will have a vital role in helping consumers prepare electronic and paper applications to establish eligibility and enroll in coverage through the Marketplace. This includes steps to help consumers find out if they qualify for insurance affordability programs (including a premium tax credit, cost sharing reductions, Medicaid and the Children's Health Insurance Program), and if they're eligible, to get enrolled. Navigators will also provide outreach and education to consumers to raise awareness about the Marketplace, and will refer consumers to ombudsmen and other consumer assistance programs when necessary. Navigators can play a role in all types of marketplaces. They'll be funded through state and federal grant programs, and must complete comprehensive training.

neonatal — the part of an infant's life from the hour of birth through the first 27 days, 23 hours and 59 minutes; the infant is referred to as newborn throughout this period

network provider — a contractual relationship between a health insurance plan and one or more hospitals whereby the hospital provides the inpatient benefits offered by the plan

nosocomial infection — infections acquired by patients while hospitalized

nuclear medicine — the use of radioisotopes to study and treat disease, especially in the diagnostic area

nuncupative will — an oral statement intended as a last will made in anticipation of death

nurse practitioner (N.P.) — a registered nurse who has completed additional training beyond basic nursing education and who provides primary health care services in accordance with state nurse practice laws or statutes

nursing home — a residence that provides a room, meals and help with activities of daily living and recreation. In general, nursing home residents have physical or mental problems that keep them from living on their own and usually require daily assistance.

Nursing Home Quality Initiative (NHQI) — a 2002 initiative created by the Centers for Medicare & Medicaid Services (CMS) to publicize a number of quality indicators in nursing homes. The information first appeared in newspaper ads throughout the country.

nursing levels of education

licensed practical nurse (LPN) — requires one year of formal nursing training at a vocational or technical school

registered nurse (R.N.) — requires two to three years of education at a hospital school for nursing

associate degree in nursing (ADN) — requires two years of education at a college or university

bachelor of science in nursing (BSN) — requires four years of education at a college or university

master of science in nursing (MSN) — usually requires two years of prescribed study beyond a bachelor's degree

a doctorate of philosophy (Ph.D.) — a postgraduate academic degree

nursing quality indicators — a set of 10 nursing-sensitive indicators linking nursing interventions to patient outcomes

O

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

Occupational Safety and Health Administration (OSHA) — a federal agency within the U.S. Department of Labor responsible for establishing standards to promote and enforce employee safety in the workplace — www.osha.gov

occupational therapist (O.T.)	a health care professional in rehabilitation who helps patients regain, develop and build skills for independent functioning. A four-year baccalaureate degree is required.
Office of Inspector General (OIG)	the enforcement arm within the U.S. Department of Health and Human Services (HHS) that oversees investigations of alleged violations of Medicare and Medicaid laws and rules. Most federal agencies have their own OIG. www.oig.hhs.gov
Office of Professional Standard Review Organizations	the health standards and quality bureau of the Centers for Medicare & Medicaid Services (CMS)
Office of Public Health Preparedness (OPHP)	Created in January 2005, the Office of Public Health Preparedness directs the Department of Health and Human Services' efforts to prepare for, protect against, respond to and recover from all acts of bioterrorism and other public health emergencies that affect the civilian population.
ombudsman	a neutral party who works with enrollees, managed care organizations/prepaid health plans and providers, as appropriate, to resolve individual enrollee's problems
Omnibus Budget Reconciliation Act (OBRA)	annual tax and budget reconciliation acts of Congress, which often affect employee benefits, pension plans and Medicare
operating margin	margin of net patient care revenues in excess of current operating requirements
organ procurement	the process of retrieving organs and/or tissues from a donor
organ procurement organization (OPO)	a nonprofit, federally funded organization charged with many responsibilities in the organ transplantation process
ORYX®	the integration of performance measurement into the Joint Commission's accreditation process. Each accredited facility must select vendors that have been approved by the Joint Commission for the performance measurement system.
osteopathic	a school of medicine using manipulative measures in treating patients in addition to the diagnostic and therapeutic measures of medicine. The other school is allopathic.
out-of-area benefits	the coverage allowed to health maintenance organization members for emergency and other situations outside the HMO's prescribed geographic area
out-of-pocket costs	health care costs patients must pay because they are not covered by Medicare or other insurance
outcome	the result of performance or nonperformance of a function or process

outcome data — data that measure the health status of people enrolled in managed care resulting from specific medical and health interventions, such as the incidence of measles among plan enrollees during the calendar year

outcome measures — assessments to gauge the treatment results for a particular disease or condition. Outcome measures include the patient's perception of restoration of function, quality of life and functional status, as well as objective measures of mortality, morbidity and health status.

outlier — a patient case that falls outside of the established norm for diagnosis related groups

outpatient — a person who receives health care services without being admitted to a hospital

outpatient prospective payment system (OPPS) — a method of financing health care that mandates payments in advance for the provision of outpatient services; based on ambulatory payment classification

outpatient surgery — *See* **ambulatory surgery**.

P

palliative care — usually provided at the end of life or to help manage chronic conditions. Emotional, social, spiritual, psychological and cultural symptoms are addressed in addition to physical symptoms to achieve the best possible quality of life.

participating provider — a health care provider who has a contractual arrangement with a health care service contractor, a health maintenance organization, a preferred provider organization, independent practice association or other managed care organization

patient advocate — a hospital employee whose job is to speak on a patient's behalf and help patients get any information or services they need

patient days — each calendar day of health care provided to a hospital inpatient under the terms of his or her insurance, usually beginning at midnight

Patient Protection and Accountable Care Act (PPACA) — In March 2010, Congress passed the Patient Protection and Accountable Care Act (PPACA) and the President signed it into law. PPACA enacts comprehensive health insurance reforms that, in theory, will hold insurance companies more accountable, lower health care costs, guarantee more health care choices, and enhance the quality of health care for all Americans.

Patient Self-Determination Act (PSDA) — a federal law requiring health care facilities to determine if a new patient has a living will and/or durable power of attorney for health care and consider the patient's wishes when developing their treatment plans

payer — a public or private organization that pays for or underwrites coverage for health care expenses

peer review — the evaluation of quality of total health care provided by medical staff with equivalent training

peer review organization (PRO) — *See* **quality improvement organization (QIO)**.

per diem — a method of payment in which a provider receives a fixed payment for each day of service provided to a patient

per member per month (PMPM) — the amount of money paid or received on a monthly basis for each individual enrolled in a managed care plan, often referred to as capitation

performance assessment — the analysis and interpretation of performance measurement data to transform it into useful information for purposes of continuous performance improvement

performance improvement project — projects that examine and seek to achieve improvement in major areas of clinical and nonclinical services. These projects usually are based on information such as enrollee characteristics, standardized measures, utilization, diagnosis and outcome information, data from surveys, grievance and appeals processes. They measure performance at two periods of time to ascertain if improvement has occurred. These projects are required by the state and can be chosen by managed care organizations/prepaid health plans or prescribed by the state.

performance measures — quantitative or qualitative measures of the care and services delivered to enrollees (process) or the end result of that care and services (outcomes). Performance measures can be used to assess other aspects of an individual or organization's performance, such as access and availability of care, utilization of care, health plan stability, beneficiary characteristics, and other structural and operational aspects of health care services.

personal membership group (PMG) — membership organizations within the health care industry, primarily composed of employees of MHA-member institutions or others who provide services to the hospital industry. PMGs sign agreements with MHA to establish affiliations for mutual support in furthering their respective goals and objectives and promoting professional growth within various health professions through educational programming. http://web.mhanet.com/aspx/navigation/education_networking.aspx?navid=27&pnavid=3

physical therapist (P.T.) — a health care professional who evaluates and treats patients with health problems resulting from injury or disease. P.T.s assess joint motion, muscle strength and endurance, function of the heart and lungs and performance of activities required in daily living, among other responsibilities.

physician assistant (P.A.) — a health care professional licensed to practice medicine with physician supervision. P.A.s conduct physical exams, diagnose and treat illnesses, order and interpret tests, counsel on preventive health care and assist in surgery.

physician-hospital organization (PHO) a legal entity formed and owned by one or more hospitals and physician groups to obtain payer contracts and to further mutual interests; one type of integrated delivery system

point-of-service (POS) an insurance plan where members need not choose how to receive services until the time they need them, also known as an open-ended HMO

Political Action Committee for Health (HEALTHPAC) a state political action committee that makes contributions to candidates for state offices. The Political Action Committee for Health, commonly referred to as HEALTHPAC, was formed in 1980 as a separate segregated fund.

Political Action Committee of the Missouri Hospital Association (PAC of MHA) a federal political action committee that makes contributions to federal candidates. Formed in 1994, the Political Action Committee of the Missouri Hospital Association commonly is referred to as PAC of MHA

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

portability the ability to move from job to job without losing health care benefits because of one's health status or a pre-existing health condition

positron emission tomography (PET) an imaging technique that tracks metabolism and responses to therapy; used in cardiology, neurology and oncology; particularly effective in evaluating brain and nervous system disorders

power of attorney a document that allows individuals to appoint someone they trust to make decisions about their medical care. This type of advance directive also may be called a health care proxy, appointment of health care agent or a durable power of attorney for health care.

pre-admission testing (PAT) patient tests performed on an outpatient basis before admission to the hospital

pre-existing condition an illness or other medical condition that a patient has experienced before the effective date of insurance coverage

preferred provider organization (PPO) a panel of physicians, hospitals and other health care providers of services to an enrolled group for a fixed periodic payment

present on admission present at the time the order for inpatient admission occurs — conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery

prevalence the number of existing cases of a disease or condition in a given population at a specific time

preventive care	comprehensive care emphasizing priorities for prevention, early detection and early treatment of conditions, generally including routine physical examination and immunizations
primary care	entry-level care that may include diagnostic, therapeutic or preventive services
private coverage	health insurance provided by a private organization and purchased through an employer or by an individual
procedure	action taken to fix a health problem or to learn more about it. For example, surgery, tests and putting in an IV (intravenous line) are procedures.
prospective payment system (PPS)	a method of reimbursement in which Medicare payment is made in advance based on a predetermined, fixed amount. The payment amount for a particular service is derived based on the classification system of that service, such as DRGs for inpatient hospital services.
protected health information (PHI)	individually identifiable health information transmitted or maintained in any form or medium, which is held by a covered entity or its business associate
provider	a hospital, physician, group practice, nursing home, pharmacy or any individual or group of individuals that provides a health care service
Provider Reimbursement Review Board (PRRB)	a federal board responsible for making decisions about provider appeals of Medicare reimbursement issues
provider-sponsored organization (PSO)	a provider-owned entity certified by the Centers for Medicare & Medicaid Services (CMS) to participate in the Medicare Advantage program and to assume risk for benefits provided to Medicare beneficiaries
public coverage/ public health insurance	insurance coverage provided through the state and/or federal government, such as Medicaid, Medicare and the Children's Health Insurance Program (CHIP)
Public Health Service (PHS)	a federal agency responsible for public health services and programs, including biomedical research. The PHS is comprised of the eight health agency divisions of the U.S. Department of Health and Human Services (HHS) and the Commissioned Corps. www.usphs.gov

Q

qualified health plans	Under the Affordable Care Act, starting in 2014, an insurance plan that is certified by the Health Insurance Marketplace, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements. A qualified health plan will have a certification by each Marketplace in which it is sold.

qualified Medicare beneficiary (QMB)	a Medicare beneficiary whose Part B premium and coinsurance is covered by Medicaid because he or she is at or below the federal poverty level
quality	a measure of how well health plans keep members healthy or treat them when they are sick. Good quality health care means doing the right thing at the right time, in the right way, for the right person and achieving the best possible results.
quality assurance (Q.A.)	a formal set of activities to review and improve the quality of services provided. Quality assurance includes quality assessment and corrective actions to remedy any deficiencies identified in the quality of direct patient, administrative and support services.
quality improvement (Q.I.)	a continuous effort to provide services at the highest level of quality at the lowest level of cost
quality improvement organization (QIO)	an entity established by the Tax Equity and Fiscal Responsibility Act of 1982 to review quality of care and appropriateness of admissions, readmissions and discharges for Medicare and Medicaid. These organizations are held responsible for maintaining and lowering admission rates and reducing lengths of stay while ensuring against inadequate treatment. QIOs formerly were known as patient review organizations (PRO).
quality indicator	a measure of the quality of health care provided; for example, length of stay, readmission rates and nosocomial infections
QualityWorks®	a performance measurement system software and patient safety data collection tool that helps your hospital collect, report and analyze clinical quality data. https://qxpert.quantros.com/mha/jsp/CMLogin.jsp

R

RACTrac	an online service that collects data from hospitals on a quarterly basis to assess the impact the Medicare Recovery Audit Contractor (RAC) program on hospitals nationwide
rate-setting	the determination by a government body of rates a health care provider may charge private-pay patients
recovery audit contractor	a program created through the Medicare Modernization Act of 2003 to identify and recover improper Medicare payments paid to healthcare providers under fee-for-service (FFS) Medicare plans
reasonable cost	Fiscal intermediaries and carriers use CMS guidelines to determine reasonable costs incurred by individual providers in furnishing covered services to enrollees. Reasonable cost is based on the actual cost of providing services, including direct and indirect cost of providers and excluding any costs that are unnecessary in the efficient delivery of services covered by a health insurance program.

referral	written approval from a primary care physician for a patient to see a specialist or receive certain services. In many Medicare managed care plans, patients need a referral before obtaining care from anyone except a primary care physician. Plans may not pay for care without a referral.
refined diagnosis related group (RDRG)	an expanded list of diagnosis related groups for determining a patient's severity of illness
rehabilitation	services to help patients recover from illnesses or injuries provided by nurses and physical, occupational and speech therapists. Examples include physical therapists helping patients walk and occupational therapists helping patients get dressed.
rehabilitation facility	a facility that provides medical, health-related, social, and/or vocational services to disabled persons to help them attain their maximum functional capacity.
reinsurance	insurance coverage obtained by providers and health plans to protect them from the extraordinary health care costs of beneficiaries who may have extensive, high-cost health care needs
resource-based relative value scale (RBRVS)	Medicare fee schedule for physician services that establishes a uniform payment in each geographic area for most of the approximately 7,000 medical procedures
respite care	relief for people providing care for others on a 24-hour basis. Respite care may be provided in homes, assisted living facilities or hospitals.
restraints	physical restraints are any manual method or physical or mechanical device, material or equipment attached to or adjacent to the resident's body that the individual cannot remove easily and restricts freedom of movement or normal access to one's body. Chemical restraints are any drug used for discipline or convenience and not required to treat medical symptoms.
retrospective reimbursement	payment made after-the-fact for services rendered on the basis of costs incurred by the facility
risk	the chance or possibility of loss, often employed as a utilization control mechanism within the health maintenance organization setting. Risk also is defined as the possibility of loss associated with a given population.
risk adjustment	altering health plan payments to account for a patient's health status
risk management	the function of identifying and assessing problems that could occur and bring about legal, clinical or financial loss
root cause	the most fundamental reason for the failure or inefficiency of a process; also called underlying cause

root cause analysis (RCA) — a process for identifying the basic factor(s) that underlie variation in performance, including the occurrence or possible occurrence of a sentinel event

routine notification — a system being proposed at the state and national levels requiring hospitals to call a regional phone number when death is imminent to determine if organs are suitable for transplantation

Rural Health Center — an outpatient facility in a non-urbanized area (per the U.S. Census Bureau) primarily engaged in furnishing physicians' and other medical health services in accordance with certain federal requirements designed to ensure the health and safety of the individuals served by the health center. Rural health centers serve areas designated for their shortage of personal health services or a health workforce.

Rural Health Network — an organization consisting of at least one critical-access hospital and at least one acute care hospital. Its provider participants enter into agreements regarding patient referral and transfer, the development and use of communication systems, and the provision of emergency and non-emergency transportation.

S

safety-net providers — providers who have a mission or mandate to deliver large amounts of care to uninsured or other vulnerable patients for example, public hospitals, teaching hospitals, community health centers or clinics

Section 1115 waiver — Section 1115 of the Social Security Acts authorizes the secretary of the U.S. Department of Health and Human Services (HHS) to approve experimental, pilot or demonstration projects promoting Medicaid's objectives. These waivers allow expanded eligibility under the Medicaid program.

Section 1915 (b) waiver — Section 1915 (b) waivers allow states to require Medicaid (MO HealthNet) participants to enroll in HMOs or other managed care plans. A 1915 (b) waiver program cannot negatively impact participant access or quality of care services and must be cost effective (cannot cost more than what the Medicaid (Mo HealthNet) program would have cost without the 1915 (b) waiver.

SEER (Surveillance, Epidemiology and End Results) Program — a program of the National Cancer Institute; an authoritative source of information on cancer incidence and survival in the United States — http://seer.cancer.gov

selective contracting — the practice of a managed care organization by which the MCO enters into participation agreements only with certain providers — not with all providers who qualify — to provide health care services to health plan participants as members of the MCO's provider panel

sentinel event — an unexpected occurrence involving death or serious physical or psychological injury or the risk of such an occurrence

skilled nursing facility (SNF) | a facility, either freestanding or part of a hospital, that accepts patients in need of rehabilitation and medical care that is of a lesser intensity than that received in the acute care setting of a hospital

small business health options program (SHOP) | The Small Business Health Options Program Marketplace helps small businesses provide health coverage to their employees. The SHOP Marketplace is open to employers with 50 or fewer full-time equivalent employees (FTEs). This includes non-profit organizations.

Social Security Administration (SSA) | the administrative branch of the federal government established in 1935 to provide old age and survivor benefits — www.ssa.gov

Sole Community Hospital | for Medicare purposes, a hospital which is more than 35 miles from any similar hospital, and meets other special criteria.

St. Louis Metropolitan Hospital Council (SLMHC) | Established in 1995, the St. Louis Metropolitan Hospital Council is a regional office of the Missouri Hospital Association designed to serve member hospitals in the bistate metropolitan area of St. Louis. The SLMHC's primary goals are local representation and advocacy for member hospitals, increased public relations and 5media communication and networking for joint community projects.

staff model HMO | health maintenance organization delivering health services through a group in which physicians are salaried employees who treat HMO members exclusively

staffing ratio | the total number of employees (FTE) divided by the average daily census in a defined unit or facility

Stark II | the commonly used name for federal laws and regulations banning physician referral to entities in which the physician has a financial relationship

state fiscal year (SFY) | the state government's accounting year, which begins July 1 and ends June 30

stop-loss protection | insurance purchased to protect against a single, overly large claim or an excessively high aggregated claim during a defined period. Stop-loss refers to the point at which the cost of a claim is covered by reinsurance.

Strategic National Stockpile (SNS) | Managed jointly by the U.S. Department of Homeland Security and the U.S. Department of Health and Human Services (HHS), the SNS program works to ensure the nation's public health capacity to respond to a national emergency. Plans are developed at the federal, state and local levels to receive, stage and dispense SNS assets. (formerly the National Pharmaceutical Stockpile) www.bt.cdc.gov/stockpile

subacute care | care given to patients who require less than a 30-day length of stay in a hospital and who have a more stable condition than those receiving acute care

supplemental medical insurance | private health insurance, also called Medigap insurance, designed to supplement Medicare benefits by covering certain health care costs that are not paid by the Medicare program

Supplemental Security Income (SSI) a federal program of income support for low-income, aged, blind and disabled persons; established by Title XVI of the Social Security Act. Qualification for SSI often is used to establish Medicaid eligibility.

Sustainable Growth Rate (SGR) The Medicare Sustainable Growth Rate was enacted by the Balanced Budget Act of 1997 and is a method currently used by the Centers for Medicare and Medicaid Services to control physician service spending.

swing-bed hospital a hospital or critical access hospital participating in Medicare that has approval of the Centers for Medicare & Medicaid Services (CMS) to use its beds, as needed, to provide either acute or post-hospital skilled nursing facility care and meets certain requirements — www.cms.hhs.gov/SNFPPS/03_SwingBed.asp

swing-beds acute care hospital beds that also can be used for a different level of care

system error an error that is not the result of an individual's action but the predictable outcome of a series of actions and factors that comprise a diagnostic or treatment process

T

Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) a federal law authorizing health plans to enter into arrangements with the Centers for Medicare & Medicaid Services (CMS) for cost and risk contracts

teaching hospital a hospital that has an accredited medical residency training program and typically is affiliated with a medical school

telemedicine health care consultation and education using telecommunication networks to transmit information

teletypewriter (TTY) a communication device used by people who are deaf, hard of hearing or have a severe speech impairment. A TTY consists of a keyboard, display screen and modem. Messages travel over regular telephone lines. People who don't have a TTY can communicate with a TTY user through a message relay center (MRC).

Temporary Assistance for Needy Families (TANF) provides transitional financial assistance to needy families. Federal and state governments share in its cost. The federal government provides broad guidelines and program requirements, and states are responsible for program formulation, benefit determinations and administration. Eligibility for benefits is based on the state's standard of need, as well as the income and resources available to the recipient. Replaces AFDC.

term limits a mechanism to limit the amount of time an elected official can serve in office. Members of the Missouri House of Representatives are limited to four two-year terms, and state senators are limited to two four-year terms. Term limits do not apply to members of Congress.

tertiary care highly specialized care given to patients who are in danger of disability or death

third-party administrator (TPA) a person or organization that manages the payment, processing and settlement of life, health, dental, disability and self-insured insurance claims for another person or organization

TITLE XVIII a section of the U.S. Social Security Act that authorizes and details the parameters of the Medicare Program

TITLE XIX a section of the U.S. Social Security Act that authorizes and details the parameters of the Medicaid Program

TITLE XXI a section of the U.S. Social Security Act that establishes the Children's Health Insurance Program

tomography a diagnostic technique that produces three-dimensional images of internal structures

tort a negligent or intentional civil wrong not arising out of a contract or statute that injures someone and for which the injured person may sue the wrongdoer for damages

transplant removing a functional organ from either a deceased or living donor and implanting it in a patient requiring a replacement organ

treatment actions to improve a health problem. For example, medicine and surgery are treatments.

triage the process by which patients are sorted or classified according to the type and urgency of their conditions

Tricare created by the U.S. Department of Defense, Tricare is a regionally managed health care program for active duty and retired members of the uniformed services and their families. (formerly the Civilian Health and Medical Program of the Uniformed Services — CHAMPUS)

Trustee a member of a hospital governing body. May also be referred to as a director or commissioner.

Turnover the rate at which an employer loses staff.

1. Voluntary turnover is when the employee initiates the termination. Some examples of "voluntary resignation" or termination would be those occuring as a result of new job, dissatisfaction, personal reasons, retirement or returning to school.

2. Involuntary turnover is when the employer initiates the termination. Some examples of "involuntary resignation" or termination would be those occuring as of result of: absenteeism, conduct, failed to obtain license, reduction in workforce, layoffs or reorganization

U

uncompensated care	all health care services for which a provider is not compensated, including bad debt and charity care
underinsured	individuals with health insurance that is not enough to cover all of their health care needs
underlying cause	the most fundamental reason for the failure or inefficiency of a process; also called root cause
uniform hospital discharge data set	a defined set of data that gives a minimum description of a hospital discharge. It includes data on age, sex, race, residence of patient, length of stay, diagnosis, physicians, procedures, disposition of the patient and sources of payment.
uninsured	people who lack health insurance of any kind
unlicensed assistive personnel	individuals trained to function in an assistive role to an LSN/RN or to others in the provision of student medication administration activities
unpreventable adverse event	an adverse event resulting from a complication that cannot be prevented given the current state of knowledge
upper payment limit (UPL)	a federal limit placed on fee-for-service reimbursement of Medicaid providers. Specifically, the UPL is the maximum a given state Medicaid program may pay a type of provider in the aggregate, statewide in Medicaid fee-for-service. The limit is determined as a reasonable estimate of the amount that would be paid for the services furnished by a group of providers under Medicare payment principles.
urgent care	a health care facility, physically separate from a hospital, that provides prescheduled, outpatient surgical services. Also called freestanding surgicenter, surgical center or surgicenter
U.S. Department of Health and Human Services (HHS)	a department within the executive branch of the federal government responsible for Social Security and federal health programs in the civilian sector — www.hhs.gov
U.S. House Committee on Energy and Commerce	a congressional committee whose primary jurisdiction includes most hospital- and health care-related issues. Members of this committee have significant influence over the development of federal health care policy and funding.
U.S. Senate Committee on Health, Education, Labor and Pensions (HELP)	a congressional committee whose primary jurisdiction includes most hospital- and health care-related issues. Members of this committee have significant influence over the development of federal health care policy and funding.
usual, customary and reasonable charges (UCR)	charges for health care services in a geographical area that are consistent with the charges of identical or similar providers in the same geographic area

utilization	the patterns of use of a service or type of service within a specified time, usually expressed in a rate per unit of population-at-risk for a given period (the number of hospital admissions per year per 1,000 persons in a geographic area)
utilization review (U.R.)	an evaluation of the necessity and appropriateness of the use of health care services, procedures and facilities

V

vacancy	Open (vacant) full-time positions divided by the total number of full-time employees.
validation	the process by which the integrity and correctness of data are established. Validation processes can occur immediately after a data item is collected or after a complete set of data is collected.
Value-Based Purchasing (VBP)	value-based incentive payments made in a fiscal year to hospitals that meet performance standards with respect to a performance period for the fiscal year involved
Veterans' Administration (VA)	*See* **Department of Veterans Affairs (VA)**.

W

workers' compensation	a state-mandated program providing insurance for work-related injuries and disabilities

ABBREVIATIONS

A

A^2E	Allied Association of Educators
A^2HA	Allied Association of Hospital Accountants
A.A.	anesthesiologist assistant
AAAASF	American Association for Accreditation of Ambulatory Surgery Facilities
AAHAM	American Association of Healthcare Administrative Management
AAHC	American Association of Healthcare Consultants
AAHC/URAC	American Accreditation HealthCare Commission
AAHP	American Association of Health Plans
AAHSA	American Association of Homes and Services for the Aging
AALC	Allied Association Legal Counsel
AAMC	Association of American Medical Colleges
AAMI	Association for the Advancement of Medical Instrumentation
AAPCC	average adjusted per capita cost
AARC	American Association of Respiratory Care
AARP	American Association of Retired Persons
ABMS	American Board of Medical Specialties
ABN	advance beneficiary notice
ABWA	American Business Women's Association
ACA	Accountable Care Act
ACA	Affordable Care Act
ACC	American College of Cardiology
ACHE	American College of Healthcare Executives
ACM	alternative and complementary medicine

ACNM	American College of Nurse-Midwives
ACO	Accountable Care Organization
ACOHA	American College of Osteopathic Hospital Administrators
ACR	adjusted community rating
ACS	American Cancer Society
ACS	American College of Surgeons
ADE	adverse drug event
ADT	Admission Discharge Transfer
ACU	automatic calling unit
ADA	American Diabetes Association
ADA	Americans with Disabilities Act
ADC	average daily census
ADL	activities of daily living
ADN	associate degree in nursing
ADS	alternate delivery systems
AEM	alternate equipment management
AFGE	American Federation of Government Employees
AFSCME	American Federation of State, County and Municipal Employees, AFL-CIO
AGPA	American Group Practice Association
AHA	American Heart Association
AHA	American Hospital Association
AHA/NDN	American Hospital Association/National Data Network
AHAPAC	American Hospital Association Political Action Committee
AHAS	Allied Healthcare Association Services LLC
AHCA	American Health Care Association
AHCPR	Agency for Health Care Policy and Research

AHHA	Association of Home Health Agencies
AHIMA	American Health Information Management Association
AHLA	American Health Lawyers Association
AHPA	American Health Planning Association
AHRQ	Agency for Healthcare Research and Quality
AIH	Association of Independent Hospitals
ALOS	average length of stay
ALS	advanced life support
Am.	amended
AMA	American Medical Association
AMCRA	American Medical Care and Review Association
ANA	American Nurses Association
ANCC	American Nurses Credentialing Center
AND	administratively necessary days
AOA	American Osteopathic Association
AOHA	American Osteopathic Hospital Association
AONE	American Organization of Nurse Executives
APC	ambulatory payment classification
APDRG	all patient diagnosis related group
APG	ambulatory patient group
APHA	American Protestant Hospital Association
APHA	American Public Health Association
APIC	Association for Professionals in Infection Control and Epidemiology Inc.
APN	advanced practice nurse
APS	Associated Purchasing Services
APU	annual payment update

ARRA	American Recovery and Reinvestment Act of 2009
ARRT	American Registry of Radiologic Technologists
ART	accredited record technician
ASAE	American Society of Association Executives
ASC	ambulatory surgical center
ASCP	American Society of Chemical Pathologists
ASHBEAMS	American Society of Hospital-Based Emergency Air Medical Services
ASHCSP	American Society for Hospital Central Service Personnel
ASHE	American Society for Healthcare Engineering
ASHET	American Society for Hospital Education and Training (AHA)
ASHMM	American Society for Healthcare Materials Management
ASHP	American Society of Hospital Pharmacists
ASHRM	American Society for Hospital Risk Managers (AHA)
ASNSA	American Society for Nursing Service Administrators (AHA)
ASO	administrative services only contract
ASPR	Assistant Secretary for Preparedness & Response
AUR	ambulatory utilization review
AVG	ambulatory visit group
AWI	area wage index

B

BBA	Balanced Budget Act of 1997
BBRA	Balanced Budget Refinement Act of 1999
BCA	Blue Cross Association
BC/BS	Blue Cross and Blue Shield Association

BC/BS of Kansas City	Blue Cross and Blue Shield of Kansas City
BC/BS of Missouri	Blue Cross and Blue Shield of Missouri
BIA	Bureau of Indian Affairs
BIPA	Benefits Improvement and Protection Act of 2000
BQA	Bureau of Quality Assurance
BRFSS	Behavioral Risk Factor Surveillance System
BSN	bachelor of science in nursing
BWC	Bureau of Workers' Compensation

C

CAC	certified application counselor
CAH	critical access hospital
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CAM	complementary and alternative medicine
CAP	capitation
CAT	computerized axial tomography
CAUTI	Catheter-Associated Urinary Tract Infection
CBO	Congressional Budget Office
CBSA	core-based statistical areas
CCs	complications or comorbidities
CCA	certified coding associate (AHIMA)
CCHD	critical congenital heart disease
CCI	correct coding initiative (CMS)
CCIIO	Federal Center for Consumer Information and Insurance Oversight
CCN	certification number (CMS) – replaces the Medicare Provider Number

C-CPI-U Chained Consumer Price Index for All Urban Consumers

CCR Cost-to-Charge Ratio

CCS certified coding specialist (AHIMA)

CCS-P certified coding specialist — physician-based (AHIMA)

CCU cardiac care unit

CDAC clinical data abstraction center

CDC Centers for Disease Control and Prevention

CDO chief data officer

CEHRT certified electronic health records technology

CERT Center for Emergency Response and Terrorism (DHSS)

CEU continuing education unit

CFO chief financial officer

CFR *Code of Federal Regulations*

CHA Catholic Health Association of the United States

CHA Center for Health Affairs

CHAMPUS Civilian Health and Medical Program of the Uniformed Services (now TRICARE)

CHAMPVA Civilian Health and Medical Program of the Veterans Administration

CHNA community health needs assessment

CHE certified healthcare executive

CHF congestive heart failure

CHIME Center for Health Information Management and Evaluation

CHIN Community Health Information Network

CHIP catastrophic health insurance plan

CHIP Children's Health Insurance Program (now SCHIP)

CHP certified in healthcare privacy (AHIMA)

CHPS certified in healthcare privacy and security (AHIMA)

CHS	certified in healthcare security (AHIMA)
CICU	cardiac intensive care unit
CLABSI	central-line associated-bloodstream infection
CLIA	Clinical Laboratory Improvement Amendments
CME	continuing medical education
CMHA	Conference of Metropolitan Hospital Associations
CMHC	community mental health center
CMI	case mix index
CMO	chief medical officer
CMS	Centers for Medicare & Medicaid Services
CNA	certified nursing assistant
CNM	certified nurse-midwife
CNS	clinical nurse specialist
COB	coordination of benefits
COBRA	Consolidated Omnibus Budget Reconciliation Act of 1986
COI	certificate of insurance
CON	certificate of need
CONQUEST	Computerized Needs-oriented Quality Measurement Evaluation System
CONTAC	Certificate of Need Technical Advisory Council
COO	chief operating officer
COPD	chronic obstructive pulmonary disease
CoPs	Conditions of Participations
CORE	Committee on Operating Rules for Information Exchange
CORF	comprehensive outpatient rehabilitative facility
COTH	Council of Teaching Hospitals and Health Systems (AAMC)
CPHA	Commission on Professional and Hospital Activities

CPHC	Committee to Preserve Health Care
CPHQ	certified professional in healthcare quality
CPI	consumer price index
CPI-U	consumer price index for all urban consumers
CPI-W	consumer price index for urban wage earners and clerical workers
CPOE	computerized physician order entry; computerized prescription order entry
CPR	cardiopulmonary resuscitation
CPR	customary, prevailing and reasonable
CPS	Center for Patient Safety
CPS	current population survey
CPT	current procedural terminology
CQI	continuous quality improvement
CQM	clinical quality measures
CRA	consumer reporting agency
CRBSI	catheter-related bloodstream infections
CRNA	certified registered nurse anesthetist
CSR	code of state regulations
CSR	Continuous Survey Readiness (Joint Commission)
CT	computed tomography
CUSP	Comprehensive Unit-based Safety Program
CVD	cardiovascular disease
CY	calendar year

D

D.A.	disability assistance
DCA	deferred compensation administrator

DHE	Missouri Department of Higher Education
DHSS	Missouri Department of Health and Senior Services
DIFP	Missouri Department of Insurance, Financial Institutions & Professional Registration
DME	durable medical equipment
DMEPOS	Durable Medical Equipment, Prosthetics, Orthotics, and Supplies
DMH	Missouri Department of Mental Health
DNV	Det Norske Veritas
DNR	do not resuscitate
D.O.	doctor of osteopathy
DOA	dead on arrival
DOH	Department of Health
DOJ	United States Department of Justice
DPS	Department of Public Safety
DRG	diagnosis-related group
DSA	digital subtraction angiography
DSH	disproportionate share hospital
DSR	disaster situation room
DSS	Missouri Department of Social Services
DVT	deep vein thrombosis

E

EACH	essential access community hospitals
EAP	employee assistance program
ECF	extended care facility
ECG/EKG	electrocardiogram
eCQMs	electronic clinical quality measures submission

ED	emergency department
EDI	electronic data interchange
EDL	Employee Disqualifications List
EDS	Electronic Data Systems Corporation
EEG	electroencephalogram
EHR	electronic health record
EMR	electronic medical record
EMS	emergency medical services
EMT	emergency medical technician
EMTALA	Emergency Medical Treatment and Labor Act (formerly Emergency Medical Treatment and Active Labor Act)
EOB	explanation of benefits
EPA	Environmental Protection Agency
EPO	exclusive provider organization
EPSDT	early periodic screening diagnosis and treatment program
ER	emergency room
eRx	Electronic Prescribing
ERISA	Employee Retirement Income Security Act
ESRD	end-stage renal disease

F

FACHE	Fellow of the American College of Healthcare Executives
FAH	Federation of American Hospitals
FASB	Financial Accounting Standards Board
FCRA	Fair Credit Reporting Act
FCSR	Family Care Safety Registry

FDA	Food and Drug Administration
FDO	formula-driven overpayment
FEHBP	Federal Employees Health Benefits Plan
FEMA	Federal Emergency Management Agency
FFP	federal financial participation
FFS	fee for service
FFY	federal fiscal year
FGI	Facility Guidelines Institute
FI	fiscal intermediary
FMAP	federal medical assistance percentage
FMEA	failure modes and effects analysis
FNP	family nurse practitioner
FOIA	Freedom of Information Act
FPL	federal poverty level
FQHC	federally qualified health center
FRA	Federal Reimbursement Allowance
FSA	flexible spending account
FTE	full-time equivalent
FY	fiscal year

G

GAF	geographic adjustment factor
GAO	Government Accountability Office
GCRB	Geographic Classification Review Board
GHAA	Group Health Association of America
GIS	geographic information system

GME graduate medical education

GPCI graduate practice cost index

H

HAC Hospital Advisory Council (St. Louis)

HAC hospital acquired condition or healthcare-acquired condition

HACHCA Heart of America Chapter for Healthcare Consumer Advocacy

HAI healthcare associated infections or hospital acquired infection

HAS hospital administrative services

HASS high alert surveillance system

H.B. House bill (state legislation only. *See* **H.R.** for federal legislation.)

HCAC health care acquired condition

HCAHPS hospital consumer assessment of health plans survey

HCFA Health Care Financing Administration (now the Centers for Medicare & Medicaid Services — CMS)

HCPCS Healthcare Common Procedural Coding System

HCUP Healthcare Cost and Utilization Project

HCUP QIs Healthcare Cost and Utilization Project Quality Indicators

HEALTHPAC Political Action Committee for Health

HEAR network Hospital Emergency Administrative Radio network

HEDIS® Health Plan Employer Data and Information Set

HELP U.S. Senate Committee on Health, Education, Labor and Pensions

HEN Hospital Engagement Network

HFMA Healthcare Financial Management Association

HFMEF Healthcare Financial Management Educational Foundation

HH home health

HHS	U.S. Department of Health and Human Services
HHSC	Health and Human Services Commission
HIAA	Health Insurance Association of America
HIAC	Health Industry Advisory Council
HIDI	Hospital Industry Data Institute
HIE	health information exchange
HIFA	Health Insurance Flexibility and Accountability Initiative
HIM	health information management
HIMA	Health Industry Manufacturers Association
HIPAA	Health Insurance Portability and Accountability Act of 1996
HIPC	Health Insurance Purchasing Cooperative
HIPP	Health Insurance Premium Payment Program
HIT	health information technology
HIX	health insurance exchanges
HMBI	hospital marketbasket index
HMO	health maintenance organization
HMSS	Hospital Management Systems Society
HOPQDRP	hospital outpatient quality data reporting program
Hospital IQR	hospital inpatient quality reporting
HPB	historic payment basis
HPOE	hospitals in pursuit of excellence
HPP	hospital preparedness program
HPSA	health professional shortage area
HQA	hospital quality alliance
HQI	Hospital Quality Initiative
HQRM	Healthcare Quality and Resource Management

H.R.	House resolution (federal legislation only. *See* **H.B.** for state legislation.)
HRET	Hospital Research and Educational Trust (AHA)
HRSA	Health Resources and Services Administration
HAS	health savings account
HSA	health systems agency
HSR	hospital specific rate
HVBP	hospital value-based purchasing

I

ICD-9-CM	International Classification of Diseases, Ninth Revision, Clinical Modification
ICD-10-PCS	International Classification of Diseases, 10th Revision, Procedure Coding System
ICF	intermediate care facility
ICN	intermediate care nursery
ICU	intensive care unit
IDS	integrated delivery system
IHF	International Hospital Federation
IHI	Institute for Healthcare Improvement
IHS	Indian Health Service
IMD	Medicaid Institutions for Mental Disease
IME	indirect medical education
I.O.	intermediary organization
IOM	Institute of Medicine
IPA	independent practice association
IPAB	Independent Payment Advisory Board
IPF	inpatient psychiatric hospital
IPFQR	Inpatient Psychiatric Facility Quality Reporting Program

IPPS	inpatient prospective payment system
IRB	institutional review board
IRF	inpatient rehabilitation facility
IQR	inpatient quality measures
IS	Information systems
ISMP	Institute for Safe Medication Practices
IT	information technology

J

TJC	The Joint Commission
JCR	Joint Commission Resources

K

KCMHC	Kansas City Metropolitan Healthcare Council
KHA	Kansas Hospital Association

L

LCP	licensed clinical psychologist
LCSW	licensed clinical social worker
LOS	length of stay
LPC	licensed professional counselor
LPN	licensed practical nurse
LRC	Legislative Research Council
LSW	licensed social worker
LTC	long-term care
LTCF	long-term care facility

LTCH	long-term care hospital
LVN	licensed vocational nurse
<u>M</u>	
MAC	maximum allowable costs
MACPAC	Medicaid and CHIP Payment Access Commission
MAC	Medicare Administrative Contractor
MAHVRP	Midwest Association for Healthcare Volunteer Resource Professionals
MAHA	Missouri Association of Hospital Auxiliaries
MAHC	Missouri Alliance for Home Care
MAHE	Missouri Association for Healthcare Education
MAHP	Missouri Association of Health Plans
MAHPMM	Missouri Association of Healthcare Purchasing and Materials Management
MAHPRM	Missouri Association for Healthcare Public Relations and Marketing
MAHRM	Missouri Association of Healthcare Risk Managers
MAOPS	Missouri Association of Osteopathic Physicians and Surgeons
MAP	measures application partnership
MARC	Mid-America Regional Council
MARCER	Mid-America Regional Council Emergency Rescue Committee
MASCP	Missouri Association of Skilled Care Professionals
MAST	Missouri Association of Surgical Technologists
MASWLHC	Missouri Association of Social Work Leaders in Health Care
MAWD	Missouri Assistance for the Working Disabled
MBQIP	Medicare Beneficiary Quality Improvement Project
MC+	Managed Care Plus
MCA	Missouri Chaplains Association
MCAP	Missouri Congressional Action Program

MCCs	major complications or comorbidities
MCE	MHA Center for Education
MCHCP	Missouri Consolidated Health Care Plan
MCR	modified community rating
M.D.	medical doctor
MDC	major diagnostic category
MDH	Medicare-dependent hospital
MDS	minimum data set
MEDIHC	military experience directed into health care
MedPAC	Medicare Payment Advisory Commission
MedPAR	Medicare Payment Analysis and Review
MEI	medical economic index
MERIC	Missouri Economic Research & Information Center
MERS-CoV	Middle East respiratory syndrome coronavirus
MFA	medical facilities appendix
MFN	most-favored-nation clause
MFS	Medicare fee schedule
MGCRB	Medicare Geographic Classification Review Board
MHA	Missouri Hospital Association
MHAPS	Metropolitan Hospital Associations Purchasing Service
MHC	Missouri Health Connections
MHCA	Missouri Health Care Association
MHD	MO HealthNet Division
MHEFA	Missouri Health and Educational Facilities Authority
MHFRC	Missouri Health Facilities Review Committee
MHIO	Missouri Health Information Organization

MHIP Missouri Health Insurance Pool

MHN MO HealthNet

MHO Missouri Hospice Organization

MLN Missouri League for Nursing

MLP midlevel practitioner

MLR medical loss ratio

MMRS Metropolitan Medical Response System

MNC Missouri Nursing Coalition

MoAHA Missouri Association of Homes for the Aging

MoAHQ Missouri Association for Healthcare Quality

MoAMSS Missouri Association of Medical Staff Services

MoANA Missouri Association of Nurse Anesthetists

MONA Missouri Nurses Association

MONL Missouri Organization of Nurse Leaders

MOSALPN Missouri State Association of LPNs Inc.

MOSHE Missouri Society for Healthcare Engineers

MOSHP Missouri Society of Health-System Pharmacists

MPLIA Missouri Professional Liability Insurance Association

MRI magnetic resonance imaging

MRSA methicillin-resistant staphylococcus aureus

MSA medical savings account

MSA metropolitan statistical area

MSAE Missouri Society of Association Executives

MSBN Missouri State Board of Nursing

MSC MHA Management Services Corporation

MS-DRG Medicare diagnosis-related drug

MSHA	Missouri Society of Hospital Attorneys
MSHCA	Missouri Society of Health Care Attorneys
MSHHRA	Missouri Society for Healthcare Human Resources Administration
MSHP	Missouri State Highway Patrol
MSMA	Missouri State Medical Association
MSN	master of science in nursing
MSP	Medicare Secondary Payer
MSSP	Medicare Shared Savings Program
MTN	Midwest Transplant Network
MTS	Mid-America Transplant Services
MUA	medically underserved area
MUP	medically underserved population
MUR	monthly utilization report
MVPS	Medicare volume performance standard

N

NACH	National Association of Children's Hospitals
NACHRI	National Association of Children's Hospitals & Related Institutions
NAEHCA	National Association of Employers on Health Care Action
NAHMOR	National Association of HMO Regulators
NAHQ	National Association for Healthcare Quality
NAIC	National Association of Insurance Commissioners
NAMSS	National Association of Medical Staff Service Professionals
NAPH	National Association of Public Hospitals
NARP	National Association of Retired Persons
NBME	National Board of Medical Examiners

NBRC	National Board for Respiratory Care
NCCI	National Correct Coding Initiative
NCCMERP	National Coordinating Council for Medication Error Reporting and Prevention
NCD	National Coverage Determinations
NCHPD	National Council on Health Planning and Development
NCHS	National Center for Health Statistics
NCHSR	National Center for Health Services Research
NCN	National Commission on Nursing
NCQA	National Committee for Quality Assurance
NCSL	National Conference for State Legislators
NFPA	National Fire Protection Association
NFRA	nursing facility federal reimbursement allowance
NGA	National Governors' Association
NHI	National Health Insurance
NHQI	Nursing Home Quality Initiative
NHSN	National Healthcare Safety Network
NICU	neonatal intensive care unit
NIH	National Institutes of Health
NIOSH	National Institute for Occupational Safety and Health
NLN	National League for Nursing
NLRB	National Labor Relations Board
N.P.	nurse practitioner
NPA	National Purchasing Alliance
NPI	national provider identifier
NPRM	notice of proposed rule-making
NPSF	National Patient Safety Foundation

NPSP	National Patient Safety Partnership
NQF	National Quality Forum
NQS	National Quality Strategy
NRC	Nuclear Regulatory Commission
NUBC	National Uniform Billing Committee

O

OASIS	outcome and assessment information set
OB-GYN	obstetrics and gynecology
OBRA	Omnibus Budget Reconciliation Act
OIG	Office of Inspector General
OMB	Office of Management and Budget
ONC	Office of the National Coordinator
OP	outpatient
OPHP	Office of Public Health Preparedness
OPO	organ procurement organization
OPPS	outpatient prospective payment system
OQR	Outpatient Quality Reporting
O.R.	operating room
OSHA	Occupational Safety and Health Administration
O.T.	occupational therapy/therapist
OTC	over-the-counter

P

P.A.	physician assistant
PAC	political action committee

PAC of MHA	Political Action Committee of the Missouri Hospital Association
PACU	post anesthesia care unit
PAI	patient assessment instrument
PAT	pre-admission testing
PCCM	primary care case management
PCN	primary care network
PCP	primary care physician
PCT	patient care technician
PDR	physician's desk reference
PEPPER	Program for Evaluating Payment Patterns Electronic Report
PET	positron emission tomography
PFS	physician fee schedule (Medicare)
PHI	protected health information
PHN	public health nurse
PHO	physician-hospital organization
PHP	prepaid health plan
PHS	Public Health Service
PHSA	Public Health Service Act
P.I.	performance improvement
PIP	periodic interim payment (Medicare)
PMG	personal membership group
PMPM	per member per month
PNP	pediatric nurse practitioner
POA	present on admission
POS	point-of-service
PPACA	Patient Protection and Accountable Care Act

PPO	preferred provider organization
PPRC	Physician Payment Review Commission
PPS	prospective payment system
PRIMO	Primary Care Resource Initiative for Missouri
PRO	peer review organization
ProCON	Providers Insurance Consultants
ProPAC	Prospective Payment Assessment Commission
PRRB	Provider Reimbursement Review Board
PSDA	Patient Self-Determination Act
PSN	provider-sponsored network
PSO	provider-sponsored organization
PSRO	Professional Standards Review Organization
Pt	patient
P.T.	physical therapy/therapist

Q

Q.A.	quality assurance
QAP	quality assurance program
QAPI	Quality Assessment and Performance Improvement
QHP	qualified health plans
Q.I.	quality improvement
QIO	quality improvement organization
Q.M.	quality management
QMB	qualified Medicare beneficiary

R

RAB	regional advisory board
RAC	recovery audit contractor
RBRVS	resource-based relative value scale
RCA	root cause analysis
RDRG	refined diagnosis related group
REC	restoration environmental contractor
RFA	Regulatory Flexibility Act
RFP	request for proposal
RHC	rural health clinic
RHIA	registered health information administrator (AHIMA)
RHIT	registered health information technician (AHIMA)
R.N.	registered nurse
ROE	return on equity
ROI	return on investment
RPB	Regional Policy Board (AHA)
RPCH	rural primary care hospital
RRA	registered record administrator
RUG	resource utilization group

S

S.	Senate resolution (federal legislation only. *See* **S.B.** for state legislation.)
SARS	severe acute respiratory syndrome
S.B.	Senate bill (state legislation only. *See* **S.** for federal legislation.)
SBH	swing-bed hospital
SCH	sole community hospital

SFY	state fiscal year
SGR	Sustainable Growth Rate
SHARE	Shared Hospital Activities and Regional Efforts
SHEA	Society for Healthcare Epidemiology of America
SHOP	small business health options program
SHSMD	Society for Healthcare Strategy and Market Development (AHA)
SICU	surgical intensive care unit
SIDS	sudden infant death syndrome
SLABHC	St. Louis Area Business Health Coalition
SLAOPS	St. Louis Association of Osteopathic Physicians and Surgeons
SLMHC	St. Louis Metropolitan Hospital Council
SLMMS	St. Louis Metropolitan Medical Society
SNF	skilled nursing facility
SNS	Strategic National Stockpile (formerly National Pharmaceutical Stockpile)
SNU	skilled nursing unit
SSA	Social Security Administration
SSI	Social Security Income
STEMI	ST elevation myocardial infarction

T

TANF	Temporary Assistance for Needy Families
TAVR	transcatheter aortic valve replacement
TCD	Time Critical Diagnosis System
TEFRA	Tax Equity and Fiscal Responsibility Act of 1982
The Alliance	The Health Alliance of MidAmerica LLC
TPA	third-party administrator

TPL	third-party liability
TQI	total quality improvement
TQM	total quality management

U

UAP	Unlicensed Assistive Personnel
UAN	United American Nurses
UB-92	Uniform Billing Code of 1992
UCR	usual, customary and reasonable charges
UNOS	United Network for Organ Sharing
U.R.	utilization review
URAC	Utilization Review Accreditation Commission
USP	United States Pharmacopeia

V

VA	Department of Veterans Affairs (previously Veterans' Administration)
VAP	ventilator associated pneumonia
VBP	value-based purchasing
VHA	Voluntary Hospitals of America
VNA	Visiting Nurse Association
VRDC	Virtual Research Data Center

W

WHO	World Health Organization
WIC	Women and Infant Children Program

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