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Glossary of Acronyms

AAMC —Association of American Medical Colleges
AAPCC —average adjusted per capita cost
ACC —American College of Cardiology
ACP —American College of Physicians
ACR —American College of Radiology
ACS —American College of Surgeons
ADAMHA —Alcohol, Drug Abuse and Mental Health Administration (Public Health Service)
AHA —American Hospital Association
AMA —American Medical Association
BC/BS –Blue Cross and Blue Shield Association
CABG —coronary artery bypass graft surgery
CAPD —continuous ambulatory peritoneal dialysis
CBA —cost-benefit analysis
CBO –Congressional Budget Office (U.S. Congress)
CDC –Centers for Disease Control (Public Health Service)
CEA —cost-effectiveness analysis
CEA/CBA —cost-effectiveness analysis/cost-benefit analysis
CEAP —Clinical Efficacy Assessment Project (ACP)
CHAMPUS —Civilian Health and Medical Program of the Uniformed Services
CFA —capital facilities allowance (U.S. Department of Defense)
CMSS –Council of Medical Specialty Societies
CON —certificate of need
CPI —Consumer Price Index
CT —computed tomography scanner
DATTA —Diagnostic and Therapeutic Technology Assessment (AMA)
DHHS —Department of Health and Human Services
DRG —Diagnosis Related Group
ECRI —formerly the Emergency Care Research Institute
ESP —economic stabilization program
ESRD —end-stage renal disease
FDA —Food and Drug Administration (U.S. Department of Health and Human Services)
GAO –General Accounting Office (U.S. Congress)
GPPP —group practice prepayment plans
HCFA —Health Care Financing Administration (U.S. Department of Health and Human Services)
HCPCS —HCFA Common Procedure Coding System
HI —Hospital Insurance (Part A) program
HIAA —Health Insurance Association of America
HIMA —Health Industry Manufacturers Association
HMO —health maintenance organization
ICF —intermediate care facility
ICU —intensive care unit
IOM —Institute of Medicine (National Academy of Sciences)
IPA —independent practice association
JCAH –Joint Commission for the Accreditation of Hospitals
KPMCP —Kaiser-Permanente Medical Care Program
LOS –length of stay
MCR —Medicare cost report
MDC —Major Diagnostic Category
NAFEC —National Association of Freestanding Emergency Centers
NCHCT —National Center for Health Care Technology (Public Health Service)
NCHS —National Center for Health Statistics (Public Health Service)
NCHSR —National Center for Health Services Research (Public Health Service)
NIH —National Institutes of Health (Public Health Service)
NMCES —National Medical Care Expenditures Survey
NMR —nuclear magnetic resonance
OASH —Office of the Assistant Secretary for Health (Public Health Service)
OCP –Office of Coverage Policy (Health Care Financing Administration)
ODR —Office of Direct Reimbursement (Health Care Financing Administration)
OHTA –Office of Health Technology Assessment (National Center for Health Services Research)
OTA —Office of Technology Assessment (U.S. Congress)
PHS –Public Health Service (U.S. Department of Health and Human Services)
PMC —patient management category
Pro —preferred provider organization
PRO —utilization and quality control peer review organization
ProPAC —Prospective Payment Assessment Commission

PSRO —Professional Standards Review Organization
PTCA —percutaneous transluminal coronary angioplast y
QALY —quality-adjusted life-year
RAHC —Rochester Area Hospitals' Corporation
SLE —systemic lupus erythymatosis
SMI —Supplementary Medical Insurance (Part B) program
SNF —skilled nursing facility
SSOP —second surgical opinion program
TEAM —Technology Evaluation and Acquisition Methods for Hospitals (AHA)
TEFRA —Tax Equity and Fiscal Responsibility Act of 1982 (Public Law *97-248)*
TPN —total parenteral nutrition

Glossary of Terms

Allowable costs: Hospital costs that are reimbursable under the Medicare program.

Ancillary technology: Medical technology used directly to support clinical services, including diagnostic radiology, radiation therapy, clinical laboratory, and other special services.

Assignment: An agreement by a physician to bill the Medicare program directly and to accept Medicare's reasonable charge as full payment for his or her services. If the physician does not accept assignment, the patient is billed by the physician and is responsible for the difference between what Medicare will pay and what the doctor charges for a particular service.

Beneficiary cost-sharing: The general set of financing arrangements whereby the consumer must pay some out-of-pocket cost to receive care. (Also see coinsurance, copayment, deductible, and premium.)

Budget neutrality: Specified by the Social Security Amendments of 1983 (Public Law 98-21) to mean that the aggregate payments for the operating costs of inpatient hospital services in fiscal years 1984 and 1985 will be neither more nor less than would have been paid under the Tax Equity and Fiscal Responsibility Act (Public Law *97-248)* for the costs of the same services.

Capital costs: Expenditures for capital plant and equipment used in providing a service. Under Medicare's prospective hospital payment system established by the Social Security Amendments of 1983 (Public Law 98-21), hospitals' capital costs (depreciation, interest, and return on equity to for-profit institutions) are treated as pass-throughs (i. e., are not subject to the new system's controls).

Cavitation: A method of paying for medical care on a fixed, periodic prepayment basis per individual. Payment by "cavitation" implies that the amount paid by the individual is independent of the number of services that individual has received.

Case mix: The relative frequency of admissions of various types of patients, reflecting different needs for hospital resources. There are many ways of measuring case mix, some based on patients' diagnoses or the severity of their illnesses, some on the utilization of services, and some on the characteristics of the hospital or area in which it is located.

Certificate of need (CON): A regulatory planning mechanism required by the National Health Planning Resources Development Act of 1974 to control large health care capital expenditures. Each State is required to enact a CON law. CON applications by institutions are reviewed by local health systems agencies, which recommend approval or disapproval; they are denied or approved by State health planning and development agencies.

Coinsurance: A form of beneficiary cost-sharing whereby the insured pays a percentage of the total cost of health services.

Conditions of participation: Requirements that a provider must meet in order to be allowed to receive payments for Medicare patients. An example is the requirement that hospitals conduct utilization review.

Copayment: A form of beneficiary cost-sharing whereby the insured pays a specific amount at the point of consumption of health services, e.g., *$10* per visit.

Cost-benefit analysis (CBA): An analytical technique that compares the costs of a project or technological application to the resultant benefits, with both costs and benefits expressed by the same measure. This measure is nearly always monetary.

Cost-effectiveness analysis **(CEA):** An analytical technique that compares the costs of a project or of alternative projects to the resultant benefits, with costs and benefits/effectiveness expressed by different measures. Costs are usually expressed in dollars, but benefits/effectiveness are ordinarily expressed in terms such as "lives saved, " "disability avoided, " "quality-adjusted life years saved, " or any other relevant objectives. Also, when benefits/effectiveness are difficult to express in a common

metric, they may be presented as an "array."

CEA/CBA: A composite term referring to a family of analytical techniques that are employed to compare costs and benefits of programs or technologies. Literally, the term as used in this assessment means "cost-effectiveness analysis/cost-benefit analysis."

Coverage: In the Medicare program, coverage refers to the benefits available to eligible beneficiaries, distinguished from payment which refers to the amount and met hods of payment for covered services.

Deductible: A form of beneficiary cost-sharing in which the insured incurs an initial expense of a specified amount within a given time period (e. g., *$250* per year) before the insurer assumes liability for any additional costs of covered services.

Depreciation: An estimate of the value of consumption of a fixed asset during a specific period of time.

Diagnosis Related Groups (DRGs): Groupings of diagnostic categories drawn from the International Classification of Diseases and modified by the presence of a surgical procedure, patient age, presence or absence of significant comorbidities or complications, and other relevant criteria. DRGs are the case-mix measure mandated for Medicare's prospective hospital payment system by the Social Security Amendments of 1983 (Public Law 98-21).

DRG payment: The system of prospective payment for inpatient services by Medicare which was mandated by the Social Security Amendments of 1983.

Effectiveness: Same as efficacy (see below) except that it refers to ". . . average or actual conditions of use."

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

End-stage renal disease: Chronic renal failure that occurs when an individual irreversibly loses a sufficient amount of kidney function so that life cannot be sustained without treatment intervention. Hemodialysis and kidney transplant surgery are two forms of therapy.

Fee-for-service: A method of paying for medical care on a retrospective basis by which each service actually received by an individual bears a related charge.

Fee schedules: Set amounts of payment to physicians for particular services, generally established by a regulatory body.

Global budgeting: A method of hospital cost containment in which participating hospitals must share a prospectively set budget. Methods for allocating funds among hospitals may vary.

Health maintenance organization (HMO): A health care organization that acts as both insurer and provider of comprehensive but specified medical services by a defined set of physicians to a voluntarily enrolled population paying a prospective per capita fee (i. e., paying by "cavitation").

Historical cost depreciation: An estimate of depreciation (see definition) based on the original cost of the fixed asset.

Inpatient care: Care that includes an overnight stay in a medical facility.

Length of stay (LOS): The number of days a patient remains in the hospital from admission to discharge.

Medical technology: The drugs, devices, and medical and surgical procedures used in medical care, and the organizational and supportive systems within which such care is provided.

Medicare: A nationwide, federally administered health insurance program authorized in *1965* to cover the cost of hospitalization, medical care, and some related services for eligible persons over age *65,* persons receiving Social Security Disability Insurance payments for 2 years, and persons with end-stage renal disease. Medicare consists of two separate but coordinated programs-Hospital Insurance (Part A) program and the Supplementary Medical Insurance (Part B) program. Health insurance protection is available to insured persons without regard to income.

Medicare carriers: Medicare contractors that compute reasonable charges and make Medicare Part B payments, determine whether claims are for covered services, deny claims for noncovered services, and deny claims for unnecessary use of services.

Medicare contractors: Blue Cross/Blue Shield plans or commercial insurers that perform the Medicare program's claims processing and payment functions at the local level under the policy and operational guidance of the Health Care Financing Administration. (Also see *Medicare carriers, Medicare intermediaries.)*

Medicare Economic Index: The index that the Medicare program uses to determine physicians' prevailing charges, as specified by the Social Security Amendments of *1972* (Public Law *92-603).* Specifically, the prevailing charges are calculated by multiplying the 1973 prevailing charges by the current index, which is promulgated annually for the 12-month period beginning July 1.

Medicare intermediaries: Medicare contractors that determine reasonable costs for covered items and services, make payment and guard against unnecessary use of covered services for Medicare Part A payments. Intermediaries also make payments for home health and outpatient hospital services covered under Part B.

Medicare vouchers: A proposed administrative change in the Medicare program in which each eligible person would be allowed a set amount of money to purchase medical care and/or health insurance.

Medigap insurance: Private supplementary medical insurance covering Medicare deductibles and co-

insurance.

Outliers: Cases with unusually high or low resource use. DRG outliers are defined by the Social Security Amendments of 1983 (Public Law 98-21) as atypical cases that have either an extremely long length of stay or extraordinarily high costs when compared to most discharges classified in the same DRG.

Outpatient care: Care that does not include an overnight stay in the facility in which care is provided.

Part A **(Medicare):** Medicare's Hospital Insurance program which covers specified inpatient services in hospitals, post-hospital extended care, and home health care services. Part A, which is an entitlement program for those who are eligible, is available without payment of a premium, although the beneficiary is responsible for an initial deductible and or copayment for some services. Those not automatically eligible for Part A may enroll in the program by paying a monthly premium.

Part B (Medicare): Medicare's Supplementary Medical Insurance program which covers medically necessary physician services, hospital outpatient services, outpatient physical therapy and speech pathology services, and various other limited ambulator-y services and supplies such as prosthetic devices and durable medical equipment. Part B also cow ers home health services for those Medicare beneficiaries who have Part B coverage only. Part B is (optional and requires payment of a monthly premium. The beneficiary is also responsible for a deductible and a coinsurance payment for most covered services.

Pass-throughs: In a prospective per case payment system, pass-throughs are elements of hospital cost that are paid on the basis of cost-based reimbursement. For example, under Medicare's new DRG payment system, capital costs, direct teaching, and outpatient services expenses are pass-throughs.

Per **case** payment: A type of prospective hospital payment system in which the hospital is paid a specific amount for each patient treated, regardless of the number and types of services or number of days of care provided. Medicare's DRC, payment system forinpatient servicrs is a per case payment system.

Preferred provider organization (PPO):A contract agreement between providers (physicians or hospitals or both), patients, and insurers that medical care will be delivered at a discounted price as long as the patients use the "preferred providers, " i.e., those who are among the contractors.

Premium: A form of beneficiary cost-sharing in which the insured pays a specified amount within a specific time period (e. g., $14.60 per month) as the consideration paid for a contract of insurance.

Prevalence: In epidemiology, the number of cases of disease, infected persons, or persons with disabilities or some other condition, present at a particular time and in relation to the size of the population. It is a measure of morbidity at a point in time.

Price level depreciation: An estimate of depreciation (see definition) based on the current replacement value of the fixed asset.

Procedure (medical or surgical): A medical technology involving any combination of drugs, devices, and provider skills and abilities. Appendectomy, for example, may involve at least drugs (for anesthesia), monitoring devices, surgical devices, and the skilled actions of physicians, nurses, and support staffs.

Professional Standards Review Organizations (PSROs): Community-based, physician-directed, nonprofit agencies established under the Social Security Amendments of 1972 (Public Law 92-603) to monitor the quality and appropriateness of institutional health care provided to Medicare and Medicaid beneficiaries.

Prospective hospital payment: A hospital payment method in which the amount that a hospital is paid tor services is set prior to the delivery of those services and the hospital is at least partially at risk for losses or stands to gain from surpluses that accrue in the payment period. Prospective payment rates may be per service, per capita, per diem, or per case rates. Medicare's DRG payment system for inpatient hospital services is a particular form of prospective payment.

"Reasonable and necessary": Criteria used by the Health Care Financing Administration or Medicare contractors to determine what services are eligible for Medicare coverage.

Reasonable charge: The amount (subject to a patient deductible and coinsurance) Medicare will pay for a physician's service. The reasonable charge is the lowest of: 1) the physician's actual charge; 2) the physician's *customary charge (the* median of charges filed by a physician during the previous year for the service); and 3) the prevailing charge (calculated by multiplying the Medicare Economic Index by the 1973 prevailing charge which is the 7.5th percentile of the distribution of customary charges of all area physicians in 1972, weighted by the number of times each physician billed for the service).

Recalibration: Periodic changes in relative DRG prices, including assignment of prices to new DRCs.

Retrospective cost-based reimbursement: A payment method in which hospitals are paid their incurred costs of treating patients after the treatment has occurred.

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

especially the evaluation of efficacy and safety. The comprehensive form of technology assessment is then termed “comprehensive technology assessment .“

Utilization and quality control peer review organizations (PROS): Physician organizations established by the Tax Equity and Fiscal Responsibility Act of 1982 (Public Law 97-248) to replace Professional Standards Review Organizations. Hospitals are mandated to contract with PROS to review quality of care and appropriateness of admissions and readmission.