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Glossary of Acronyms and Terms

Glossary of Acronyms

ADAMHA —Alcohol, Drug Abuse, and Mental Health Administration (PHS)
AHA —American Hospital Association
ALOS —average length of stay
APACHE —Acute Physiology and Chronic Health Evaluation
ARF –Area Resource File (HRSA)
ASPE —Assistant Secretary for Planning and Evaluation (DHHS)
CBO –Congressional Budget Office (U.S. Congress)
CDC –Centers for Disease Control (PHS)
CHAS —Center for Health Administration Studies (University of Chicago)
CON —certificate of need
CPHA —Commission on Professional and Hospital Activities
CPT-4 —Current Procedural Terminology, 4th Edition
CRS —Congressional Research Service (U.S. Congress)
DHHS –U.S. Department of Health and Human Services
DRG —diagnosis-related group
ECOG —Eastern Cooperative Oncology Group
ESRD —end-stage renal disease
ESWL —extracorporeal shock wave lithotripsy
FDA —Food and Drug Administration (PHS)
FTE —full-time equivalent
GAO –General Accounting Office (U.S. Congress)
GCRC —general clinical research center
HANES —Health and Nutrition Examination Survey (NCHS)
HCFA —Health Care Financing Administration (DHHS)
HCRIS —Hospital Cost Report Information System (HCFA)
HCUP —Hospital Cost and Utilization Project (NCHSR&HCTA)
NDS –Hospital Discharge Survey (NCHS)
HES –Health Examination Survey (NCHS)
HIM —Health Insurance Master Enrollment Record (HCFA)
HIS –Health Interview Survey (NCHS)
HRSA —Health Resources and Services Administration (PHS)
HSQB —Health Standards and Quality Bureau (HCFA)
ICD-9-CM —International Classification of Diseases, 9th Revision, Clinical Modification
ICF —intermediate care facility
ICU —intensive care unit
IOLS —intraocular lenses
IRS —Internal Revenue Service
JCAH –Joint Commission on the Accreditation of Hospitals
LOS —length of stay
MADRS —Medicare Automated Data Retrieval System (HCFA)
MEDISGRPS—Medical Illness Severity Grouping System
MEDPAR —Medicare Provider Analysis and Review (HCFA)
MFI —Master Facility Inventory of Hospitals and Institutions (NCHS)
MHS —Medicare History Sample
MMACS —Medicare/Medicaid Automated Certification System (HCFA)
NAFAC –National Association for Ambulatory Care Centers
NAMCS —National Ambulatory Medical Care Survey (NCHS)
NCHS —National Center for Health Statistics (PHS)
NCHSR —National Center for Health Services Research (PHS)
NCHSR& HCTA —National Center for Health Services Research and Health Care Technology Assessment (PHS)
NCI –National Cancer Institute (NIH)
NIH –National Institutes of Health (PHS)
NLTCS —National Long-Term Care Survey (ASPE, HCFA)
NMCES —National Medical Care Expenditure Survey (NCHSR)
NMCUES —National Medical Care Utilization and Expenditure Survey (NCHS, HCFA)
NNHS —National Nursing Home Survey (NCHS)
NSF —National Science Foundation
NSPHPC –National Survey of Personal Health Practices and Consequences (NCHS)
ODE —Office of Demonstrations and Evaluation (ORD)

OHPE	—Office of Health Planning and Evaluation (PHS)
OHTA	–Office of Health Technology Assessment (NCHSR)
OR	–Office of Research (ORD)
ORD	—Office of Research and Demonstrations (HCFA)
OTA	—Office of Technology Assessment (U.S. Congress)
PATBILL	—Medicare's inpatient bills file
PHDDS	—PRO Hospital Discharge Data Set
PHS	–Public Health Service (DHHS)
PMAA	—premarket approval application
POS	–Provider of Services (MMACS)
PPO	—preferred provider organization
PPS	—prospective payment system (Medicare)
PRO	—utilization and quality control peer review organization
ProPAC	—Prospective Payment Assessment Commission
PSRO	—professional standards review organization
PTCA	—percutaneous transluminal coronary angioplasty
R&D	—research and development
SDW	–Survey of Disability and Work (SSA)
SIC	—Standard Industrial Classification
SIP	—Survey of Institutionalized Persons (Bureau of the Census)
SMSA	—Standard Metropolitan Statistical Area
SNF	—skilled nursing facility
SSA	—Social Security Administration (DHHS)
TDM	—therapeutic drug monitoring
TEFRA	—Tax Equity and Fiscal Responsibility Act of 1982
UHDDS	—Uniform Hospital Discharge Data Set
VA	—U.S. Veterans Administration
WHO	—World Health Organization

Glossary of Terms

Access: Potential and actual entry of a population into the health care delivery system.

Ambulatory care: Medical care provided to patients in physician offices, clinics, or outpatient facilities.

Ancillary services: Medical technologies used directly to support clinical care, such as diagnostic radiology, radiation therapy, clinical laboratory, and other special services.

Average length of stay (ALOS): The average length of hospital stay experienced by a group of patients.

Bad debt: Unpaid patient hospital bills.

Budget neutrality: A term used in the Social Security Amendments of 1983 (Public Law 98-21) to mean that the aggregate payments by Medicare for the operating costs of inpatient hospital services in fiscal years 1984 and 1985 will be neither more nor less than such payments would have been 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 payment system (PPS) for hospitals, 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 passthroughs (i.e., are not subject to the new system's controls).

Carriers: Organizations authorized by the Health Care Financing Administration to help administer the Part B benefits under Medicare. Carriers determine coverage and benefit amounts payable and make Part B payments to providers or beneficiaries.

Case mix: The relative frequency of admissions of various types of patients, reflecting different needs for hospital resources.

Clinical trial: A scientific research activity undertaken to define prospectively the effect and value of medical devices, agents, regimens, procedures, etc., applied to human subjects.

Conditions of participation (Medicare): Requirements that health care providers (including hospitals, skilled nursing homes, home health agencies, etc.) must meet in order to be eligible 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-based reimbursement: See *retrospective cost-based reimbursement.*

Current Procedure Terminology, 4th Edition (CPT-4): A coding system for procedures performed by physicians that is used in Medicare Part B billing.

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,

Diagnosis-related groups (DRGs): Groupings of diagnostic categories that are the case-mix measure mandated by the Social Security Amendments of 1983 (Public Law 98-21) for Medicare's prospective payment system (PPS) for hospitals. DRG categories were drawn from the International Classification of Diseases, 9th Revision, Clinical Modification, and modified by the presence of a surgical procedure, patient age, presence or absence of significant

comorbidities or complications, and other relevant criteria.

Discharge abstract: A shortened version of a discharged patient's medical record including items extracted from the medical record.

Discretionary adjustment factor: The component of the DRG update factor that accounts for cost increases or decreases that are not necessarily captured by inflation measures, e.g., quality of care. The discretionary adjustment factor was originally set at 1 percent per year but was later limited by Congress to 0.25 percent for fiscal years 1985 and 1986.

DRG weight: A weight assigned to a DRG that represents its assumed resource use relative to other DRGs. The higher the weight, the larger the Medicare payment.

Freestanding facilities: Health care facilities that are not physically, administratively, or financially connected to a hospital. An example is a freestanding ambulatory surgery center.

Full-time equivalent (FTE) employees: The number of full-time employees it would take to work the total number of hours worked by part-time, full-time, and over-time employees.

Hemodialysis: A process by which blood is pumped from a patient's body into a dialyzer and then returned to the body in a continuous extracorporeal blood loop. While in the dialyzer, the blood flows next to but separate from another fluid, a dialysate. The blood and the dialysate are separated from each other by a semipermeable membrane. Waste products and other molecules pass through the semipermeable membrane, and the blood takes on its appropriate properties.

Home health agency: An organization that is primarily engaged in providing skilled nursing services and other therapeutic services (e. g., physical, occupational, or speech therapy) in the patient's home.

Iatrogenic events: Infections, drug reactions, or other mishaps due to treatment in a hospital or by a physician.

Inpatient care: Medical care that includes an overnight stay in a medical facility. In this report, the term generally refers to overnight treatment in a hospital.

Intermediaries: Organizations authorized by the Health Care Financing Administration to make Medicare Part A payments to hospitals. Intermediaries also make payments for home health and outpatient hospital services covered under Part B.

International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM): A two-part system of coding patient medical information used in abstracting systems and for classifying patients into DRGs for Medicare. The first part is a comprehensive list of diseases with corresponding codes compatible with the World Health Organization's list of disease codes. The second part contains procedure codes, independent of the disease codes.

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 most 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—Part A (Hospital Insurance) and Part B (Supplementary Medical Insurance). Health insurance protection is available to Medicare beneficiaries without regard to income.

Medicare cost reports: Annual reports submitted by individual hospitals to Medicare intermediaries and used to calculate the amount of Medicare's obligation to the hospital under cost-based reimbursement.

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: Medical 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 hospital inpatient services, posthospital 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 those not automatically eligible for Part A may enroll in the program by paying a monthly premium, The beneficiary is responsible for an initial deductible and / or copayment for some services.

Part B (Medicare): Medicare's Supplementary Medical Insurance program which covers physician services, hospital outpatient services, outpatient physical therapy and speech pathology services, and various other limited ambulatory services and supplies such as prosthetic devices and durable medical equipment. This program also covers home health services for Medicare beneficiaries who have Part B coverage only. Enrollment in 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.

Passthroughs: Elements of hospital cost that are not covered by Medicare's prospective payment system (PPS) established by the Social Security Amendments of 1983 and continue to be paid for on the basis of cost-based reimbursement. Under Medicare's PPS, capital costs, direct teaching, and outpatient service expenses are passthroughs.

Per-case payment: A type of prospective payment for health care services in which the hospital (or other provider) 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 DRG-based prospective payment system (PPS) for inpatient services is a per-case payment system.

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 action of physicians, nurses, and support staff.

Professional standards review organizations (PSROs): Community-based, physician-directed, nonprofit agencies established under the Social Security Amendments of **1972** (Public Law **92-603)** to review the quality and appropriateness of institutional health care provided to Medicare and Medicaid beneficiaries. PSROs have been replaced by utilization and quality control peer review organizations (PROS).

Prospective payment: A method of payment for health care services in which the amount of payment for services is set prior to the delivery of those services and the hospital (or other provider) 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.

Prospective Payment Assessment Commission (ProPAC): An independent commission established by the Social Security Amendments of 1983 (Public Law 98-21), the law that created Medicare's DRG-based prospective payment system (PPS), to advise the Secretary of Health and Human Services on the annual update factor and on adjustments of DRG classifications and weights.

Quality assessment: Measurement and evaluation of quality of care for individuals, groups, or populations.

Quality assurance: A term that refers to integrated programs that attempt to protect or raise quality of care by conducting assessments, taking action to correct problems found, and following up corrective interventions.

Quality of care: A term used in this report to refer to the kind of care that maximizes an inclusive measure of patient welfare after one has taken account of the balance of expected gains and losses that attend the process of care in all its parts.

Ratesetting: A method of payment for health care services in which a State (or other) regulatory body decides what prices a hospital, for example, may charge in a given year.

Recalibration: The periodic process of adjusting the prices of DRGs relative to each other, through changes in DRG weights.

Retrospective cost-based reimbursement: A method of payment for health care services in which hospitals (or other providers) are paid their incurred costs of treating patients after the treatment has occurred,

Reweighing: The adjustment of certain DRG weights to reflect changes in relative resource costs.

Short-stay hospitals: Hospitals in which the average length of stay is less than **30** days.

Skilled nursing facility (SNF): A specially qualified institution that has the staff and equipment to provide skilled nursing care or rehabilitation services and other related health services and that also meets specified regulatory certification requirements.

Standard Industrial Classification (SIC) codes: A categorization of data on products and companies that is used by the U.S. Department of Commerce. Establishments (plants) are assigned to SIC "industries" on the basis of their primary line of business. However, SIC data on shipments of a specific product include all shipments of the relevant product, regardless of the "industry" in which the producing establishment is classified.

Substantially equivalent device: A device first marketed after the **1976 Medical** Device Amendments that the Food and Drug Administration has found to be similar to a device already being marketed. To be found substantially equivalent, a postamendments device need not be identical to a preamendments device, but must not differ markedly in materials, design, or energy source.

Technology diffusion: The diffusion or spread of a medical technology into the health care system. It is generally thought to be in two phases: the initial phase in which decisions are made to adopt or reject the technology, and a subsequent phase in which decisions are made to use the technology,

Updating: The annual process of increasing (or decreasing) all DRG prices by an "update factor" that determines the overall generosity of Medicare's prospective payment system for hospitals. The update factor used in this process has two components: 1) an inflation factor that reflects inflation in the hospital sector; and 2) a "discretionary adjustment factor" that reflects cost increases (or decreases) not captured by inflation measures,

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 (PSROs). Hospitals are mandated by the Social Security Amendments of 1983 (Public Law 98-21) to contract with PROS to review quality of care and appropriateness of admissions and readmission.

Waivered States: States holding waivers from the Health Care Financing Administration that allow them to participate in experimental payment programs as alternatives to Medicare's prospective payment system (PPS). Currently, they are Maryland, Massachusetts, New Jersey, and New York (New York will not have a waiver after Dec. 31, 1985). These States are required by their special contracts with the Federal Government to keep their aggregate Medicare expenditures below what they would be under the national PPS.