



# COMMON HEALTH CARE ABBREVIATIONS & TERMINOLOGY



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# Table of Contents

Forward .....	2
Abbreviations—Health Care .....	3-14
Abbreviations—Medical .....	15-19
Abbreviations—Disaster Preparedness .....	20-22
Definitions—Health Care Terminology .....	23-54
Sources .....	55

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## Sources

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The sources both direct and indirect for the information compiled in this glossary are many and we acknowledge the following:

- ⇒ A brief glossary of medical and surgical terms by Johnson & Johnson.
- ⇒ *The Trustee Guide* published by the Wisconsin Hospital Association.
- ⇒ *A Trustee Glossary* published by the South Dakota Association of Health Care Organizations.
- ⇒ *A Primer for Hospital Trustees* published by the American Hospital Association.
- ⇒ *Health Reform: The Terms* published by the Tennessee Assembly of Hospital Governing Boards.
- ⇒ *The Columbia Journalism Review May/June 1993 "Focus on Health Care: A Handbook for Journalists"* by Trudy Liebermann.
- ⇒ *The Washington Post July 13, 1993, "Framework of Health Reform Plan is Set"* by Dana Priest.
- ⇒ *Handbook of Managed Care Terminology*, published by Healthcare Association of New York State.
- ⇒ *Patient Financial Services Resource Guide*, published by the American Association of Healthcare Administrative Management.
- ⇒ FEMA Acronyms, Abbreviations and Terms, August 2003

*The Iowa Hospital Association (IHA) is a voluntary nonprofit corporation composed of institutional memberships of city, county, state, church-related, and other community health facilities and health systems all bonded by a common goal—the delivery of services and programs for the betterment of the health and well being of the statewide community.*

*The bylaws of IHA state its purpose shall be to promote the health of communities by supporting hospitals and health systems in providing high quality and comprehensive patient care services.*

*IHA has prepared this glossary to help hospital board members keep current with constantly changing health care terms and new technology definitions.*



**URGENT CARE**—Care for injury, illness, or another type of condition (usually not life threatening) which should be treated within 24 hours. Also refers to after-hours care, and to a health plan’s classification of hospital admissions as urgent, semi-urgent, or elective.

**USUAL, CUSTOMARY, AND REASONABLE (UCR)**—Amounts charged by health care providers that are consistent with charges from similar providers for the same or nearly the same services in a given area.

**UTILIZATION**—Patterns of usage for a particular medical service such as hospital care or physician visits.

**UTILIZATION REVIEW**—An evaluation of the care and services that patients receive which is based on pre-established criteria and standards.

**WRAPAROUND PLAN**—Refers to insurance or health plan coverage for copays or deductibles that are not covered under a member’s base plan. This is often used for Medicare.

**WRITE-OFFS**—Accounts that are partially or fully uncollectable and must be written off as bad debts, charity care, etc.

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## Abbreviations

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### Health Care

AAHAM	American Association of Healthcare Administrative Management
AAHP	American Association of Health Plans
AAPCC	Average Adjusted Per Capita Cost
AARP	American Association of Retired Persons
ABN	Advance Beneficiary Notice
ACHE	American College of Healthcare Executives
ACR	Adjusted Community Rating
ACS	American Cancer Society ... also American College of Surgeons
ACU	Ambulatory Care Unit
ADA	Americans with Disabilities Act ... also American Diabetes Association
ADC	Average Daily Census
ADS	Alternative Delivery System
AG	Attorney General
AGPA	American Group Practice Association
AHA	American Hospital Association ... or American Heart Association
AHRQ	Agency for Health Care Research and Quality
AIDS	Acquired Immune Deficiency Syndrome
ALJ	Administrative Law Judge
ALOS	Average Length of Stay
AMA	American Medical Association

AMCRA	American Medical Care and Review Association
ANA	American Nurses Association
AONE	American Organization of Nurse Executives
APC	Ambulatory Payment Classification
APG	Ambulatory Patient Group
APR-DRG	All Payer Refined Diagnostic Related Group
ARC	American Red Cross
ASC	Ambulatory Surgery Center
ASO	Administrative Services Only contract
BBA	Balanced Budget Act of 1997
BBRA	Balanced Budget Relief Act of 1999
BCAA	Blue Cross Association of America
BCBSI	Blue Cross/Blue Shield of Iowa now known as Wellmark Blue Cross Blue Shield of Iowa
BCLS	Basic Cardiac Life Support
BHAI	Behavioral Health Affiliate of Iowa
BIA	Bureau of Indian Affairs
BIPA	Benefits Improvement & Protection Act of 2000
BLS	Bureau of Labor Statistics
CAH	Critical Access Hospital
Cahaba GBA	Cahaba Government Benefit Administrators, LLC (administers Medicare health insurance for the Centers for Medicare & Medicaid Services (CMS))
CAM	Complementary and Alternative Medicine
CARF	Commission on Accreditation of Rehabilitation Facilities
CAT	Computerized Axial Tomography

**TOTAL QUALITY MANAGEMENT (TQM)**—A philosophy and system for achieving constant performance improvement at every level. Key elements of TQM include company wide continuous quality improvement (CQI) efforts (sometimes called a quality improvement program), self-directing work teams, employee involvement programs, flexible service delivery processes, quick change over and adaptability, customer focus, supplier integration, and production cycle time reduction. Many health care organizations implement TQM programs as a competitive strategy.

**TRANSFER**—(1) A change in medical care unit, medical staff unit or responsible physician for a patient during hospitalization. ... or ... (2) A situation in which the patient is transferred to another acute care hospital for related care.

**TRIAGE**—Evaluation of patient conditions for urgency and seriousness and the establishment of a priority list in order to direct care and ensure the efficient use of medical and nursing staff and facilities. Triageing patients occurs in situations with multiple victims.

**UB-92**—The institutional uniform billing claim form maintained by the National Uniform Billing Committee is used by hospitals across the nation to bill for services.

**ULTRASOUND**—Refers to sound that has different velocities in tissues which differ in density and elasticity from others; this property permits the use of ultrasound in outlining the shape of various tissues and organs in the body.

**UNCOMPENSATED CARE**—Sum of bad debts and charity care absorbed by a hospital in providing medical care for patients who are uninsured or are unable to pay.

**UNDERWRITING**—The process of identifying, evaluating, and classifying the potential level of risk represented by a group seeking insurance coverage, in order to determine appropriate pricing, risk involved, and administrative feasibility. The chief purpose of underwriting is to make sure the potential for loss is within the range for which the premiums were established. Underwriting can also refer to the acceptance of risk.

**UNIVERSAL ACCESS**—The provision of coverage for health care services to all citizens.

hour nursing coverage and availability of physical, occupational, and speech therapies.

**SURGICENTER**—A health care facility that is physically separate from a hospital and provides pre-scheduled surgical services on an outpatient basis, generally at a lower cost than inpatient hospital care ... also called a Free-Standing Outpatient Surgery Center.

**SWING BEDS**—Acute care hospital beds that can also be used for long-term care, depending on the needs of the patient and the community; only those hospitals with fewer than 100 beds and located in a rural community, where long-term care may be inaccessible, are eligible to have swing beds.

**TEACHING HOSPITALS**—Hospitals that have an accredited medical residency training program and are typically affiliated with a medical school.

**TELEMEDICINE**—The use of medical information exchanged from one site to another using electronic communications for the health and education of patients or providers and to improve patient care.

**TERMINAL CONDITION**—An incurable condition in which death is imminent, a persistent vegetative state, or a permanent coma when death is not imminent.

**TERTIARY CARE**—Refers to highly technical services for the patient who is in imminent danger of major disability or death.

**THIRD PARTY ADMINISTRATOR (TPA)**—A firm outside the insuring organization, which handles the administrative duties such as collecting premiums, claims processing, claims payment, membership services, utilization review, for employee health benefit plans and managed care plans. Third party administrators are used by organizations that actually fund the health benefits but find it not cost effective to administer the plan themselves. If claims payment is one of the services, the TPA is considered a third party payer. Unlike insurance carriers, TPAs do not underwrite the insurance risk.

**THIRD-PARTY ADMINISTRATION (TPA)**—Administration of a group insurance plan by some person or firm other than the insurer or the policyholder.

**TOMOGRAPHY**—A diagnostic technique using x-ray photographs which do not show the shadows of structures before and behind the section under scrutiny.

CBSA	Core Based Statistical Area
CCI	Correct Coding Initiative
CCR	Cost-to-Charge Ratio
CCU	Cardiac Care Unit
CDC	Centers for Disease Control and Prevention
CHA	Catholic Health Association
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CHAMPVA	Civilian Health and Medical Program of the Veterans Administration
CICU	Cardiac Intensive Care Unit
CIPI	Capital Input Price Index
CISM	Critical Incident Stress Management
CLIA	Clinical Laboratory Improvement Act (1967) ... also Clinical Laboratory Improvement Amendments (1988)
CMHC	Community Mental Health Center
CMI	Case Mix Index
CMP	Competitive Medical Plan ... also Civil Monetary Penalty
CMS	Centers for Medicare and Medicaid Services
COB	Coordination of Benefits
COBRA	Consolidated Omnibus Budget Reconciliation Act of 1985
COI	Certificate of Insurance
CON	Certificate of Need
COP	Condition of Participation
CORF	Comprehensive Outpatient Rehabilitative Facility

CPI	Consumer Price Index
CPR	Customary, Prevailing, and Reasonable (charges) ... also Cardiac Pulmonary Resuscitation
CPT	Current Procedural Terminology
CQI	Continuous Quality Improvement
DEA	Drug Enforcement Administration
DHS	Department of Human Services (Iowa)
DMAT	Disaster Medical Assistance Team
DME	Durable Medical Equipment ... also Direct Medical Education
DNR	Department of Natural Resources ... also Do Not Resuscitate ... also Do Not Report
DRA	Deficit Reduction Act of 2005
DRG	Diagnosis Related Group
DSA	Disproportionate Share Adjustment
DSH	Disproportionate Share Hospital
EBP	Evidence Based Practice
ECF	Extended Care Facility
EEOC	Equal Employment Opportunity Commission
EHR	Electronic Health Record
EMR	Electronic Medical Record
EMS	Emergency Medical Services
EMTALA	Emergency Medical Transfer Active Labor Act
EOB	Explanation of Benefits
EOC	Episode of Care ... also Emergency Operations Center
EOMB	Explanation of Medicare Benefits

includes 2,700 codes, covering 95 percent of Medicare allowed charges.

**RESPIRE CARE**—Short-term care to allow a parent to get relieve or give temporary relief to the person who regularly assists with home care ... not reimbursable through Medicare or Medicaid.

**RESTRICTED FUNDS**—Includes all hospital resources that are restricted to particular purposes by donors and other external authorities; the resources of these funds are not currently available for the financing of general operating activities but may be so used in the future when certain conditions and requirements are met; there are three types of restricted funds: (1) specific purpose, (2) plant replacement and expansion, and (3) endowment (see definitions).

**RISK POOLS**—Arrangements by states to provide health insurance to the unhealthy uninsured who have been rejected for coverage by insurance carriers.

**SEAMLESS CARE**—The experience by patients of smooth and easy movement from one aspect of comprehensive health care to another, notable for the absence of red tape.

**SELF-INSURED PLAN**—A health plan where the risk for medical cost is assumed by an employer rather than an insurance company or managed care plan. Self-insured plans sometimes contract with insurance companies or third-party administrators to administer benefits. Also referred to as Self-Funded Plan.

**SELF-PAY**—That portion of the bill that is to be paid in part of in full by a patient from his/her own resources, as it is not payable by a third party.

**SEMI-PRIVATE ROOM**—An accommodation of not less than two or more than four beds.

**SINGLE PAYER SYSTEM**—A financing system, such as Canada's in which a single entity—usually the government—pays for all covered health care services.

**SKILLED NURSING FACILITY (SNF)**—A facility, either freestanding or part of a hospital, that accepts patients in need of rehabilitation and medical care. To qualify for Medicare coverage, SNFs must be certified by Medicare and meet specific qualifications, including 24-

services are necessary and payment should be made for care provided under the Medicare and Medicaid programs.

**QUALITY OF CARE**—A desired degree of excellence in the provision of health care. The health care delivery processes which are thought to be determinants of quality include: structural adequacy, access and availability, technical abilities of practitioners, practitioner communication skills and attitudes, documentation of services provided, coordination and follow-up, patient commitment and adherence to a therapeutic regimen, patient satisfaction, and clinical outcome.

**RATIONING**—The allocation of medical care by price or availability of services.

**REASONABLE AND CUSTOMARY CHARGE**—Charge for health care which is consistent with the going rate or charge in a certain geographical area for identical or similar services; also referred to as “customary, prevailing, and reasonable.”

**REINSURANCE**—A type of insurance purchased by providers and health plans to protect themselves from extraordinary losses. Types of reinsurance coverage include: individual stop loss, aggregate stop loss, out-of-area protection, and insolvency protection. Reinsurance is a transaction between and among insurers for the assumption of risk in exchange for a premium. Usually, a primary insurer will cede only a portion of its total risk and premium payments to a reinsurer, either as a percentage of total premiums or only for losses above a particular threshold.

**RELATIVE VALUE SCALE (RVS)**—A pricing system for physicians’ services which assigns relative values to procedures based on a defined standard unit of measure, as defined in the current procedural terminology (CPT). RVS units are based on median charges by physicians. Physicians often use the RVS system as a guide in establishing fee schedules. This system is rapidly being replaced by RBRVS-based payment systems.

**REMITTANCE**—The actual sum of money due.

**RESOURCE BASED RELATIVE VALUE SCALE (RBRVS)**—A fee schedule used as the basis of the physician reimbursement system by Medicare. The RBRVS assigns relative values to each CPT code for services on the basis of the resources related to the procedure rather than simply on the basis of historical trends. RBRVS

EPA	Environmental Protection Agency
EPO	Exclusive Provider Organization
EPSDT	Early Periodic Screening Diagnosis and Treatment Program
ER/ED	Emergency Room/Emergency Department
ERISA	Employee Retirement Income Security Act
FAQ	Frequently Asked Questions
FDA	Food and Drug Administration
FEC	Freestanding Emergency Center
FEHBP	Federal Employees Health Benefits Plan
FFS	Fee For Service
FI	Fiscal Intermediary
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
FSA	Flexible Spending Accounts
FTC	Federal Trade Commission
FTE	Full-Time Equivalent
GAF	Geographic Adjustment Factor
GAO	U.S. General Accountability Office
GHAA	Group Health Association of America
GME	Graduate Medical Education
GPCI	Geographic Practice Cost Index
HANYS	Healthcare Association of New York State
HAWK-I	Healthy and Well Kids in Iowa
HCPCS	Healthcare Common Procedure Coding System
HEDIS	Health Plan Employer Data and Information Set

HEICS	Hospital Emergency Incident Command System
HFMA	Healthcare Financial Management Association
HHA	Home Health Agency
HHS	Health and Human Services (Federal)
HHSC	Health and Human Services Commission
HIAA	Health Insurance Association of America
HIM	Health Information Management
HIPAA	Health Insurance Portability and Accountability Act
HIPCs	Health Insurance Purchasing Cooperatives
HMO	Health Maintenance Organization
HPB	Historic Payment Basis
HPCI	Health Policy Corporation of Iowa
HPSA	Health Professional Shortage Area
HQRM	Healthcare Quality and Resource Management
HSR	Hospital Specific Rate
IAHSA	Iowa Association of Homes and Services for the Aging
ICD-9-CM	International Classification of Diseases, 9th revision
ICF/MR	Intermediate Care Facility for the Mentally Retarded
ICN	Iowa Communications Network
ICS	Incident Command System
ICU	Intensive Care Unit
IDIA	Iowa Department of Inspections and Appeals
IDPH	Iowa Department of Public Health

Patients usually have free choice to select other providers but are given strong financial incentives to select one of the designated preferred providers. Unlike an HMO, a PPO is not a prepaid plan but does use some utilization management techniques. PPO arrangements can be either insured or self-funded. An insurer-sponsored PPO combines a large network of providers, utilization management programs, administrative services, and health care insurance. A self-funded PPO generally excludes administrative and insurance services from the plan package. However, employers can purchase these services separately.

**PRIMARY CARE**—Basic care including initial diagnosis and treatment, preventive services, maintenance of chronic conditions, and referral to specialists.

**PRIMARY CARE NETWORK (PCN)**—A group of primary care physicians (PCP) who share the risk of providing care to members of a managed care plan. The PCP in a primary care network is accountable for the total health care services of a plan member, including referrals to specialists, supervision of the specialists' care, and hospitalization. Participating PCPs' services are covered by a monthly capitation payment to the PCN.

**PRIMARY CARE PHYSICIAN**—Physician in a managed care network who supervises medical care for members and makes referrals to specialists if needed.

**PROSPECTIVE PAYMENT SYSTEM (PPS)**—Also called prospective pricing; a payment method in which the payment a hospital will receive for patient treatment is set up in advance; hospitals keep the difference if they incur costs less than the fixed price in treating the patient and they absorb any loss if their costs exceed the fixed price.

**PROVIDER SPONSORED ORGANIZATION (PSO)**—Public or private entities established or organized and operated by a health provider or a group of affiliated health care providers that provide a substantial proportion of services under the Medicare+Choice contract and share substantial financial risk.

**QUALITY ASSURANCE**—Term that describes attempts by managed care organizations to measure and monitor the quality of care delivered.

**QUALITY IMPROVEMENT ORGANIZATION (QIO)**—Federally funded physician organizations, under contract to the Department of Health and Human Services, that review quality of care, determine whether

**POINT-OF-SERVICE**—Members in a point of service HMO or PPO can go outside the network for care, but their co-pay and deductible will be more than if they had used providers who are part of the HMO, PPO, or health plan.

**POINT-OF-SERVICE PLAN (POS)**—A type of managed care plan that allows patients to choose how to receive services at the point when the services are needed. They may use “out of network providers” for an additional fee. Also called open-ended HMO, swing-out HMO, self-referral option, or multiple option plan.

**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 which tracks metabolism and responses to therapy. Used in cardiology, neurology, and oncology; particularly effective in evaluating brain and nervous system disorders.

**PRACTICE GUIDELINES**—Formal procedures and techniques for the treatment of specific medical conditions that assist physicians in achieving optimal results. Practice guidelines are developed by medical societies and medical research organizations, such as the American Medical Association (AMA) and the Agency for Health Care Policy and Research (AHCPR), as well as many HMOs, insurers, and business coalitions. Practice guidelines serve as educational support for physicians and as quality assurance and accountability measures for managed care plans.

**PREADMISSION CERTIFICATION**—Process in which a health care professional evaluates an attending physician’s request for a patient’s admission to a hospital by using established medical criteria.

**PREEXISTING CONDITION**—A physical or mental condition that an insured has prior to the effective date of coverage. Policies may exclude coverage for such conditions for a specified period of time.

**PREFERENTIAL DISCOUNTS**—Reimbursements to health care providers from insurance companies and other payers based on negotiated discounts off providers’ regular charges.

**PREFERRED PROVIDER ORGANIZATION (PPO)**—A plan that contracts with independent providers at a discount for services. Generally, the PPO’s network of providers is limited in size.

IDS	Integrated Delivery System
IFMC	Iowa Foundation for Medical Care
IHA	Iowa Hospital Association
IHC	Iowa Healthcare Collaborative
IHHCC	Iowa Hospital Home Care Council
IHERF	Iowa Hospital Education & Research Foundation
IHI	Institute for Healthcare Improvement
IHO	Iowa Hospice Organization
IHS	Indian Health Services
IME	Indirect Medical Education ... also Iowa Medicaid Enterprise
IMGMA	Iowa Medical Group Management Association
IMS	Iowa Medical Society
INA	Iowa Nurses Association
IOM	Institute of Medicine
IOMA	Iowa Osteopathic Medical Association
IONL	Iowa Organization of Nurse Leaders
IPA	Independent Practice Association
IPF	Inpatient Psychiatric Facility
IRB	Institutional Review Board
IRF	Inpatient Rehabilitation Facility
ISMP	Institute for Safe Medication Practices
ITC	Iowa Trauma Coordinators
LAMA	Left Against Medical Advice
LCD	Local Coverage Determinations
LOS	Length of Stay

LSA	Legislative Service Agency
LTC	Long-Term Care
MA	Medicare Advantage
MAC	Medicare Administrative Contractor
MB	Market Basket
MBI	Market Basket Index
MCO	Managed Care Organization
MDA	Muscular Dystrophy Association
MDC	Major Diagnostic Category
MDH	Medicare Dependent Hospital
MDS	Minimum Data Set
MedPAC	Medicare Payment Advisory Commission
MEI	Medical Economic Index
MFS	Medicare Fee Schedule
MGCRB	Medicare Geographic Classification Review Board
MMA	Medicare Modernization Act of 2003
MOB	Medical Office Building
MRI	Magnetic Resonance Imaging
MSA	Metropolitan Statistical Area
MSO	Management Service Organization
MUA	Medically Underserved Area
MUP	Medically Underserved Population
MVPS	Medicare volume performance standard
NB	Newborn
NBC	Nuclear/Biological/Chemical

**PATIENT DAYS**—Refers to each calendar day of care provided to a hospital inpatient under the terms of the patient’s health plan, excluding the day of discharge. “Patient days” is a measure of institutional use and is usually stated as the accumulated total number of inpatients (excluding newborns) each day for a given reporting period, tallied at a specified time (like midnight) per 1,000 use rate, or patient days/1,000. Patient days are calculated by multiplying admissions by average length of stay (ALOS).

**PATIENT SATISFACTION SURVEY**—Questionnaire used to solicit the perceptions of plan enrollees/patients regarding how a health plan meets their medical needs and how the delivery of care is handled (e.g., waiting time, access to treatments).

**PEER REVIEW**—An evaluation of the appropriateness, effectiveness, and efficiency of medical services ordered or performed by practicing physicians or professionals by other practicing physicians or clinical professionals. A peer review focuses on the quality of services that are performed by all health personnel involved in the delivery of the care under review and how appropriate the services are to meet the patients’ needs.

**PERINATAL**—The care of a woman before conception, of the woman and her fetus through pregnancy, and of the mother and her neonate until 28 days after childbirth.

**PHYSICIAN HOSPITAL ORGANIZATION (PHO)**—A type of integrated delivery system that links hospitals and a group of physicians for the purpose of contracting directly with employers and managed care organizations. A PHO is a legal entity which allows physicians to continue to own their own practices and to see patients under the terms of a professional services agreement. This type of arrangement offers the opportunity to better market the services of both physicians and hospitals as a unified response to managed care.

**PICTURE ARCHIVING AND COMMUNICATION SYSTEM (PACS)**- are computers or networks dedicated to the storage, retrieval, distribution and presentation of images.

**PHYSICIAN’S ASSISTANT (PA)**—A specially trained and licensed allied health professional, who performs certain medical procedures previously reserved to the physician. PAs practice under the supervision of a physician.

contract, that a plan member must pay out of his/her own pocket toward eligible expenses for himself/herself and/or dependents.

**OUT-OF-POCKET PAYMENTS (OPP)**—Cash payments made by a plan member or insured person to the provider in the form of deductibles, coinsurance, or copayments during a defined period (usually a calendar year) before the out-of-pocket limit is reached.

**OUTCOMES**—The end result of medical care, as indicated by recovery, disability, functional status, mortality, morbidity, or patient satisfaction.

**OUTCOMES MEASUREMENT**—The process of systematically tracking a patient’s clinical treatment and responses to that treatment using generally accepted outcomes measures or quality indicators, such as mortality, morbidity, disability, functional status, recovery, and patient satisfaction. Such measures are considered by many health care researchers as the only valid way to determine the effectiveness of medical care.

**OUTPATIENT CARE**—Treatment provided to a patient who is not confined in a health care facility. Outpatient care includes services that do not require an overnight stay, such as emergency treatment, same-day surgery, outpatient diagnostic tests, and physician office visits. Also referred to as ambulatory care.

**OUTPATIENT OBSERVATION**—Services furnished by a hospital, including the use of a bed and periodic monitoring by the hospital’s professional staff, to evaluate a patient’s condition and to determine the need for possible admission to the facility as an inpatient, not to exceed 24-48 hours.

**OVER-THE-COUNTER (OTC)**—Drugs that may be obtained without a written prescription from a physician.

**PATIENT ADVOCATE**—A person whose job is to speak on a patient’s behalf and help patients get any information or services they need.

**PATIENT ASSESSMENT**—The review of a patient’s needs and expectations for services to be provided, which includes a clinical and financial focus and discussion of alternative options for care and after care planning.

**PATIENT BILL OF RIGHTS**—Outlines the basic rights of each patient in a healthcare facility.

NCD	National Coverage Determination
NCQA	National Committee for Quality Assurance
NDMS	National Disaster Medical System
NF	Nursing Facility
NIC	Neonatal Intensive Care
NICU	Neonatal Intensive Care Unit
NIH	National Institute for Health
NIMS	National Incident Management System
NLRB	National Labor Relations Board
NP	Nurse Practitioner
NPI	National Provider Identifier
NQF	National Quality Forum
OASIS	Outcome and Assessment Information Set
OBRA	Omnibus Budget Reconciliation Act
ODS	Organized Delivery System
OIG	Office of Inspector General
OMB	Office of Management and Budget
OPO	Organ Procurement Organization
OPP	Out-of-Pocket Payments
OR	Operating Room
OSHA	Occupational Safety and Health Administration
OT	Occupational Therapy
OTC	Over-the-Counter
PA	Physician’s Assistant
PACS	Picture Archiving and Communication System

PCN	Primary Care Network
PCP	Primary Care Provider/Physician
PDL	Prescription Drug List
PDP	Prescription Drug Plan
PET	Positron Emission Tomography
PFFS	Private Fee-for-Service
PHN	Public Health Nurse
PHO	Physician Hospital Organization
PHS	Public Health Services
POS	Point of Service
PPE	Personal Protective Equipment
PPI	Producer Price Index
PPO	Preferred Provider Organization
PPRC	Physician Payment Review Commission
PPS	Prospective Payment System
PRO	Peer Review Organization
PRRB	Provider Reimbursement Review Board
PSO	Provider Sponsored Organization
PT	Physical Therapy
QA	Quality Assurance
QI	Quality Improvement
QIO	Quality Improvement Organization
RBRVS	Resource-Based Relative Value Scale
RHC	Rural Health Clinic
RPB 6	Regional Policy Board 6 (AHA)

both SNFs (*skilled nursing facilities*) and intermediate care facilities participating in the Medicaid program are referred to as NFs (*nursing facilities*).

**NURSING LEVELS OF EDUCATION**—The levels of education established for nursing are:

- **Vocational/LPN** requires one year of formal nursing training at a vocational or technical school;
- **Diploma/RN** requires two-to-three years of education at a hospital school for nursing;
- **Associate Degree/ASN or ADN** requires two years of education at a college or university;
- **Baccalaureate Degree/BSN** requires four academic years of education at a college or university.
- **Masters Degree/MSN** requires completion of at least one year of prescribed study beyond the baccalaureate degree.

**OPEN ENROLLMENT PERIOD**—The period when an employee may change health plans; usually occurs once a year.

**OPEN PANEL**—Allows for any willing provider to contract with an HMO providing the provider meets all the requirements set forth by the HMO.

**OPERATING MARGIN**—Margin of net patient care revenues in excess of operating expenses.

**OUT-OF-AREA BENEFITS**—Benefits, usually limited to emergency services, that an HMO provides to its members when they are outside the HMO's service area.

**OUT-OF-AREA SERVICES**—Medical services provided to HMO members when plan members are outside the service area of the HMO.

**OUT-OF-NETWORK SERVICES**—Health care services received by a plan member from a non-contracted provider. Reimbursement is usually lower when a member goes out of network. Other financial penalties may apply for out-of-network services.

**OUT-OF-POCKET LIMIT**—The total amount of money, including deductibles, copayments, and coinsurance, as defined in the

**NETWORK**—Self-contained, fully integrated system of providers.

**NODE**— An existing healthcare organization serving as a local field office for IHI’s 5 Million Lives Campaign. Each node offers support to anywhere from 50 to a few hundred hospitals grouped by geography, system or membership. Core functions of each node include communicating information between the network and IHI, and providing educational opportunities for the network to learn and work together. The Iowa Healthcare Collaborative is the Iowa Node for the 5M Campaign.

**NON-COVERED SERVICE**—The service does not meet the requirements of a Medicare benefit category, is statutorily excluded from coverage on grounds other than 1862(a)(1), or is not reasonable and necessary under 1862 (a)(1).

**NOSOCOMIAL INFECTION**—Infection acquired in a hospital.

**NOT-FOR-PROFIT HOSPITAL**—A hospital that operates on a not-for-profit basis under the ownership of a private corporation; typically, such a hospital is run by a board of trustees, is exempt from federal and state taxes, and uses its profits to cover capital expenses and future operating costs; the initial source of funding is usually philanthropy.

**NUCLEAR MEDICINE**—The use of radioisotopes to study and treat disease, especially in the diagnostic area.

**NURSE PRACTITIONER (NP)**—A licensed nurse who has completed a nurse practitioner program at the master’s or certificate level and is trained in providing primary care services. NPs are qualified to conduct expanded health care evaluations and decision-making regarding patient care, including diagnosis, treatment, and prescriptions, usually under a physician’s supervision and, generally, they provide services at a lower cost than PCPs. NPs may also be trained in medical specialties, such as pediatrics, geriatrics, and midwifery. Legal regulations in some states prevent NPs from qualifying for direct Medicare and Medicaid reimbursement, writing prescriptions, and admitting patients to hospitals. Also called advance practice nurse (APN).

**NURSING FACILITY**—A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled or sick persons, or on a regular basis, health-related care services above the level of custodial care to other than mentally retarded individuals. NOTE: Effective October 1, 1990,

RUGs	Resource Utilization Groups
RVS	Relative Value Scale
RVU	Relative Value Unit
SCH	Sole Community Hospital
SCHIP	State Children’s Health Insurance Program
SEIU	Service Employees International Union
SMDA	Safe Medical Devices Act (1990)
SNF	Skilled Nursing Facility
SNS	Strategic National Stockpile
SPECT	Single Photon Emission Computerized Tomography
SSA	Social Security Administration
SSI	Supplemental Security Income ... also ServiShare
Stark (#)	Physician referral laws—part of OBRA ’89 (“Stark I”) and ’93 (“Stark II”)
TPA	Third-Party Administrator or Third-Party Administration
TQI	Total Quality Improvement
TQM	Total Quality Management
TRHCA	Tax Relief and Health Care Act of 2006
UB-04	Uniform Billing Form, modified in 2004
UB-92	Uniform Billing Form, modified in 1992
UC	Urgi Center
UCR	Usual, Customary and Reasonable (charges)
UR	Utilization Review
USPHS	United States Public Health Service
VA	Veterans Administration

VHA	Voluntary Hospitals of America
WHO	World Health Organization
WIC	Women and Infant Children Program
WMD	Weapons of Mass Destruction

the plans regardless of the extent, expense, or intensity of services provided. Enrollees gain contracts which have lower deductibles and copayments and usually have an expanded set of health benefits than through a traditional fee-for-service Medicare arrangement. Risk contracts may be group-sponsored such as for a member of a group retirement program, or may be set up for individuals.

**MEDICARE-SUPPLEMENT POLICY**—A type of health insurance policy that provides benefits for services Medicare does not cover.

**MEDIGAP INSURANCE**—A supplemental health insurance policy in which a Medicare beneficiary pays a monthly premium to cover the cost of health benefits that Medicare does not cover.

**MedPAC**—Medicare Payment Advisory Commission created by Congress in 1997 for the purpose of making recommendations regarding the Medicare program to Congress. This commission replaces the Physician Payment Review Commission (PPRC) and the Prospective Payment Assessment Commission (ProPAC).

**MERGER**—Union of two or more organizations by the transfer of all assets to one organization that continues to exist while the other(s) is (are) dissolved.

**MORBIDITY**—Incidence and severity of illness and accidents in a well-defined class or classes of individuals.

**MORTALITY**—Incidence of death in a well-defined class or classes of individuals.

**MULTI-HOSPITAL SYSTEM**—Two or more hospitals owned, leased, contract managed, or sponsored by a central organization; they can be either not-for-profit or investor-owned.

**NATIONAL COVERAGE DETERMINATION**—The national coverage determination (NCD) is the formal instruction to Medicare claims processing contractors regarding how to process claims (*when to pay, when not to pay, pay only when certain clinical conditions are met*). The NCD is issued as a manual instruction or other document such as a program memorandum, ruling or Federal Register notice and is posted to our coverage database.

**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.

**MEDICALLY NECESSARY**—A term used to describe the supplies and services provided to diagnose and treat a medical condition in accordance with the standards of good medical practice and the medical community.

**MEDICARE**—A federally administered health insurance program for persons aged 65 and older and certain disabled people under 65 years old. Created in 1965 under Title XVIII of the Social Security Act, Medicare covers the cost of hospitalization, medical care, and some related services for eligible persons without regard to income. Medicare has four parts. Medicare Part A: Hospital Insurance (HI) Program is compulsory and covers inpatient hospitalization costs. Medicare Part B: Supplementary Medical Insurance Program is voluntary and covers medically necessary physicians' services, outpatient hospital services, and a number of other medical services and supplies not covered by Part A. Part A is funded by a mandatory payroll tax. Part B is supported by premiums paid by enrollees. Medicare Part C offers beneficiary's choices for participating in private sector health care plans to receive health care coverage financed by the Medicare program. Medicare Part D, is the voluntary prescription drug benefit, established by the MMA, and slated for implementation in 2006.

**MEDICARE ADVANTAGE**—The name given to the Medicare managed care program by MMA, to replace Medicare+ Choice. MA is designed to maintain many of the same eligibility enrollment, grievance and appeals provisions but changes payment methodology and brings PPOs into the program to introduce more health plan choices to Medicare beneficiaries, particularly in rural areas.

**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 reclassification is being requested.

**MEDICARE RISK CONTRACT**—Type of agreement in which HCFA contracts with HMOs and competitive medical plans (CMP) to provide services to Medicare beneficiaries for a monthly fixed payment, which is based on a percentage of the adjusted average per capita cost (AAPCC). HMOs and CMPs are at risk or financially liable for the care and treatment of those beneficiaries who enroll in

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## Abbreviations

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### Medical

Abd.	Abdominal
ACLS	Advanced Cardiac Life Support
AED	Automated External Defibrillator
AF	Atrial Fibrillation
AI	Aortic Insufficiency
AIDS	Acquired Immune Deficiency Syndrome
ALS	Advanced Life Support
AMA	Against Medical Advice
ANP	Advanced Nurse Practitioner
ART	Accredited Record Technician
AS	Aortic Stenosis
ATLS	Advanced Trauma Life Support
BE	Barium Enema
BLS	Basic Life Support
BMR	Basal Metabolism Rate
BP	Blood Pressure
BTLS	Basic Trauma Life Support
BUN	Blood Urea Nitrogen
Ca	Carcinoma
CADAC	Certified Alcohol and Drug Abuse Counselor
CBC	Complete Blood Count
CC	Chief Complaint

CISM	Critical Incident Stress Management
CNM	Certified Nurse-Mid Wife
CNS	Central Nervous System
CPR	Cardiopulmonary Resuscitation
CRNA	Certified Registered Nurse Anesthetist
CVA	Cerebrovascular Accident, a stroke
CVI	Cerebrovascular Insufficiency
DC	Doctor of Chiropractic
DD	Differential Diagnosis
DDS	Doctor of Dental Surgery
DIFF.	Differential Blood Count
DO	Doctor of Osteopathy
DNR	Do Not Resuscitate ... also Do Not Report
DPM	Doctor of Podiatric Medicine
DPT	Diphtheria, Pertussis, Tetanus
D&C	Dilatation and Curettage
D&E	Dilatation and Evacuation
DSC	Doctor of Surgical Chiropody
DVM	Doctor of Veterinary Medicine
ECU	Environmental Control Unit
EEG	Electroencephalogram
EENT	Eye, Ear, Nose and Throat
EKG, ECG	Electrocardiogram
EMG	Electromyogram
EMS	Emergency Medical Service

among privately owned health plans to drive down the cost of health care.

**MANAGEMENT SERVICE ORGANIZATION (MSO)**—An entity that provides practice management and other operational services to physicians, which can include facilitating managed care contracting.

**MANDATED BENEFITS**—Certain services or benefits, such as prenatal care, mammographic screening, and care for newborns that states require insurers to include in health insurance policies. Sometimes called state mandates.

**MARKET BASKET**—Components of the overall cost of hospital care.

**MARKET BASKET INDEX (MBI)**—An inflationary measure of the cost of goods and services purchased by hospitals.

**MEDICAID**—A federal public assistance program enacted into law on January 1, 1966, under Title XIX of the Social Security Act, to provide medical benefits to eligible low income persons needing health care regardless of age. The program is administered and operated by the states which receive federal matching funds to cover the costs of the program. States are required to include certain minimal services as mandated by the federal government but may include any additional services at their own expense.

**MEDICAL HOME:** The focal point through which all individuals regardless of age, sex, race, or socioeconomic status receive their acute, chronic and preventive medical care services that are accessible, accountable, comprehensive, compassionate, coordinated, integrated, patient/family-centered, safe, scientifically valid and satisfying to both patients and physicians.

**MEDICAL LOSS RATIO**—The ratio between the cost to deliver medical care and the amount of money that a plan receives. Insurance companies often have a medical loss ratio of 92 percent or more; tightly managed HMOs may have medical loss ratios of 75-85 percent, although the overhead (or administrative cost ratio) is concomitantly higher. The medical loss ratio is dependent on the amount of money brought in, as well as the cost of delivering care; thus, if the rates are too low, the ratio may be high, even though the actual cost of delivering care is not out of line.

**LIFETIME RESERVE DAYS**—Under Medicare, each beneficiary has a lifetime reserve of 60 additional days of inpatient hospital services after using 90 days of inpatient hospital days during a benefit period. Lifetime reserve days, once used, are not renewed, unlike the initial benefit days and co-insurance days. The patient must sign an agreement to use their lifetime reserve days before a provider may use lifetime reserve days during a hospital stay.

**LIVING WILL**—Document generated by a person for the purpose of providing guidance about the medical care to be provided if the person is unable to articulate those decisions (see Advance Directive).

**LONG-TERM CARE**—A continuum of maintenance, custodial, and health services to the chronically ill, disabled, or mentally handicapped.

**MAGNETIC RESONANCE IMAGING (MRI)**—A non-invasive diagnostic technique used to create images of body tissue and monitor body chemistry; uses radio and magnetic waves instead of radiation.

**MANAGED CARE**—A term that applies to the integration of health care delivery and financing. It includes arrangements with providers to supply health care services to members, criteria for the selection of health care providers, significant financial incentives for members to use providers in the plan, and formal programs to monitor the amount of care and quality of services.

A health care organization, such as a health maintenance organization, that “manages” or controls what it spends on health care by closely monitoring how doctors and other medical professionals treat patients.

**MANAGED COLLABORATION**—Distinct from managed competition, the planned cooperation of multiple providers for the benefit of the community; a cornerstone of the American Hospital Association’s national reform proposal.

**MANAGED COMPETITION**—A method for controlling health care costs by organizing employers, individuals, and other buyers of health care into large cooperatives that will purchase coverage for their members. Insurance companies and managed care organizations will compete to supply coverage for the lowest cost. It requires most employers and individuals to purchase health coverage through a health alliance and counts on competition

EMT	Emergency Medical Technician
ENT	Ear, Nose and Throat
FACHE	Fellow of the American College of Healthcare Executives
FBS	Fasting Blood Sugar
FMG	Foreign Medical Graduate
FSH	Follicle Stimulating Hormone
GB viz.	Gall Bladder Visualization
GC	Gonococcal, Gonorrhea
GI	Gastrointestinal
GP	General Practitioner
GU	Genitourinary
Hgb.	Hemoglobin
ICN	Intermediate Care Nursery
IM	Intramuscular
IP	Intraperitoneal
IV	Intravenous
IVP	Intravenous Pyelogram (urogram)
LPC	Licensed Professional Counselor
LPN	Licensed Practical Nurse
LPT	Licensed Physical Therapist
LVN	Licensed Vocational Nurse
MD	Medical Doctor
mEq.	Milliequivalent
MHA	Master of Hospital (Health) Administration

MHSA	Master of Health Services Administration
MI	Myocardial Infarction ... also Mitral Insufficiency ... also Mental Institution
MOM	Milk of Magnesia
Mono	Mononucleosis
MPA	Master of Public Administration
MPH	Master of Public Health
MS	Mitral Stenosis ... also Master of Science or Medical Scientist
MSN	Master of Science in Nursing
MSW	Master of Social Work
N	Normal
NB	Newborn
ND	Doctor of Naturopathic Medicine
OB-GYN	Obstetrics and Gynecology
OD	Doctor of Optometry
O.D.	Right Eye
O.S.	Left Eye
PA	Physician Assistant ... also Posterior-Anterior
P&A	Percussion and Auscultation
PALS	Pediatric Advanced Life Support
PAT	Paroxysmal Atrial Tachycardia
PBI	Protein-Bound Iodine
Ped.	Pediatrics ... also Pediatrician
pH	Expression of acidity or alkalinity. pH 7 is neutral; above 7 alkalinity increases; below 7 acidity decreases.

some degree of flexibility for each provider ... also referred to as independent physician association.

**INTEGRATED CARE**—A comprehensive spectrum of health services, from prevention through long-term care, provided via a single administrative entity and coordinated by a primary care “gatekeeper.”

**INTEGRATED DELIVERY NETWORKS OR SYSTEM (IDN OR IDS)**—An entity (corporation, partnership, association, or other legal entity) that enters into arrangements with managed care organizations; employs or has contracts with providers; and agrees to provide or arrange for the provision of health care services to members covered by the managed care plan.

**INTERNATIONAL CLASSIFICATION OF DISEASES, 9TH REVISION, (ICD-9-CM)**—The classification of disease by diagnostic codification into six-digit numbers. ICD-10, is under development and will use alphanumeric codes.

**THE JOINT COMMISSION**—(formerly called JCAHO ... *Joint Commission on Accreditation of Healthcare Organizations*) An organization that accredits healthcare organizations. The national commission with the mission to improve the quality of health care provided to the public. The Joint Commission develops standards of quality in collaboration with health professionals and others and stimulates health care organizations to meet or exceed the standards through accreditation and the teaching of quality improvement concepts.

**JOINT VENTURE**—An organization formed for a single purpose or undertaking which makes its membership liable for the organization’s debts.

**LENGTH OF STAY (LOS)**—The period of hospitalization as measured in days billed; average length of stay is determined by discharge days divided by discharges.

**LIABILITY INSURANCE**—Insurance covering risks or losses arising from injury or damage to another person or property.

**LIEN**—Recorded claim against real or personal property (*minimum dollar limits*). Over 1/3 of the states have hospital lien statutes which permit a hospital to obtain a lien on the money a patient receives for damages.

individually. Holding companies usually form a separate parent organization that is controlled by a single governing board. This second model of horizontal integration provides less organizational autonomy than an alliance but enables organizations to share information, reduce duplication, streamline decision making, and allocate capital resources more effectively.

**HOSPICE**—An organization that provides medical care and support services (such as pain and symptom management, counseling, and bereavement services) to terminally ill patients and their families; may be a freestanding facility, a unit of a hospital or other institution, or a separate program of a hospital, agency, or institution.

**HOSPITAL PREAUTHORIZATION**—A managed care technique in which the insured obtains permission from a managed care organization before entering the hospital for non-emergency care.

**HOSPITALISTS**—A physician whose practice is caring for patients while in the hospital. A primary care physician (PCP) turns their patients over to a hospitalist, who becomes the physician of record and provides and directs the care of the patient while the patient is hospitalized and returns the patient to the PCP at the time of hospital discharge.

**INCIDENT TO SERVICES**—Incident to the physician’s professional service refers to the services or supplies that are furnished as an integral, although incidental, part of a physician’s personal professional services in the course of diagnosis or treatment.

**INDEMNITY INSURANCE**—Insurance that provides selected coverage within a framework of fee schedules, limitations, and exclusions to coverage as negotiated with subscriber groups whereby beneficiaries are reimbursed after carrier review and filed claims are processed. It pays a certain percentage of the charges billed by the provider of services and the patient is responsible for the balance.

**INDEPENDENT PRACTICE ASSOCIATION (IPA)**—A group of independent physicians who have formed an association as a separate legal entity for contracting purposes. IPA physician providers retain their individual practices, work in separate offices, continue to see their non-managed care patients, and have the option to contract directly with managed care plans. A key advantage of the IPA arrangement is that it helps its members achieve some of the negotiating leverage of a large physician group practice with

Preemy	Premature Infant
PSA	Prostate Specific Antigen
RAD	Radiation Absorbed Dose
RBC	Red Blood Count
SC	Subcutaneous
SCIC	Significant Change in Condition
SICU	Surgical Intensive Care Unit
SIDS	Sudden Infant Death Syndrome
SOB	Short of Breath
START	Simple Triage and Rapid Transport
Stat.	Immediately
STD	Sexually Transmitted Disease
T&A	Tonsillectomy and Adenoidectomy
TB	Tuberculosis
Temp.	Temperature
VD	Venereal Disease
VDRL	Serology
WBC	White Blood Count

## Abbreviations

### Disaster Preparedness

ACIP	Advisory Committee on Immunization Practices
ADPER	Acute Disease Prevention and Emergency Response
AIIR	Airborne Infection Isolation Room
APHL	Association of Public Health Laboratories
CADE	Center for Acute Disease Epidemiology
CBRNE	Chemical, Biological, Radiological, Nuclear and Explosive
CDOR	Center for Disaster Operations and Response
CIO	Chief Information Officer
COG	Continuity of Government
COOP	Continuity of Operations
CIP	Critical Infrastructure Protection
DOT	Department of Transportation
DMAT	Disaster Medical Assistance Team
DMORT	Disaster Mortuary Operational Response Team
DPI	Bureau of Disease Prevention and Immunization
DPS	Department of Public Safety
ECC	Emergency Coordination Center
EMAC	Emergency Management Assistance Compact
EOC	Emergency Operations Center
EPI-X	Epidemic Information Exchange (national list serve)

Committee for Quality Assurance (NCQA) is responsible for coordinating HEDIS and making changes each year.

**HEALTH REIMBURSEMENT ACCOUNT**—An employee medical expense option in which an employer retains an employee fund from which payments for an employee’s medical expenses are paid. The employee loses any remaining dollars after leaving the company. If there are not enough funds in the employee fund to pay the patient responsibility amounts, then the employee is liable for the remaining balance.

**HEALTHCARE COMMON PROCEDURAL CODING SYSTEM (HCPCS)**—A set of codes used within the Medicare system that describes and defines health care services and procedures. HCPCS include CPT-4 (Current Procedural Terminology, 4th Revision) codes in addition to codes for non-procedures such as durable medical equipment and ambulance transportation.

**HEALTHCARE SPENDING ACCOUNTS**—An employee medical expense option which includes a high deductible with a low premium that are used to accumulate tax free dollars in a savings account to be used for deductibles and copays. Money remaining in the account at year end can be rolled over to the next year.

**HOLD HARMLESS CLAUSE**—A clause that prohibits the provider from billing the patient for any amount, except for co-pays and deductibles, regardless of the payer’s failure to pay on the bill for any reason. (The hold harmless clause is typically associated with denied days, denied charges as a result of failure to meet pre-authorization or pre-certification requirements, late admission notifications, delayed discharges, delayed procedures, etc.)

**HOME HEALTH CARE**—Health care services are provided in a patient’s home instead of a hospital or other institutional setting; services provided may include nursing care, social services, and physical, speech, or occupational therapy.

**HORIZONTAL INTEGRATION**—A competitive strategy used by some hospitals (or other organizations) to control the geographical distribution of health care services by integrating the services of two or more similar (i.e., “horizontal”) health care facilities. Two common horizontal integration approaches are hospital alliances and holding companies. In an alliance, two or more hospitals form a coalition to contract as a single entity, develop joint clinical services, or pursue business opportunities that cannot be supported

**GUARANTEED RENEWABLE**—An insurance contract that an insurer cannot terminate, providing an insured pays the required premiums in a timely manner. With these contracts, insurers have the right to raise premiums but only for an entire class of policyholders.

**GUARANTOR**—A person who accepts the responsibility of paying another party’s debt.

**HEALTH ALLIANCE**—Large purchasing group that will collect premiums from employers and contract with health care plans to provide care to enrollees. Also known as a health insurance purchasing cooperative (HIPC).

**HEALTH INSURANCE PURCHASING COOPERATIVE (HIPC)**—A large group of employers and individuals functioning as an insurance broker to purchase health coverage, certify health plans, manage premiums and enrollment, and provide consumers with buying information. Also called health insurance purchasing group, health plan purchasing cooperative, and health insurance purchasing corporation.

**HEALTH MAINTENANCE ORGANIZATION (HMO)**—A health care payment and delivery system involving networks of doctors and hospitals. Members must receive all their care from providers within the network.

- **Staff Model HMO.** Physicians are on the staff of the HMO and are usually paid a salary.
- **Group Model HMO.** The HMO rents the services of the physicians in a separate group practice and pays the group a per patient rate.
- **Network Model HMO.** The HMO contracts with two or more independent physician group practices to provide services and pays a fixed monthly fee per patient.

**HEALTH PLAN EMPLOYER DATA AND INFORMATION SET (HEDIS)**—A standard data reporting system developed in 1991 to measure the quality and performance of health plans. A main goal of HEDIS is to standardize health plan performance measures for consumers and payers. HEDIS concentrates on four aspects of health care: (1) quality, (2) access and patient satisfaction, (3) membership and utilization, and (4) finance. Within each focus area is a specific set of HEDIS data measures (e.g., number of immunizations for pediatric enrollees, etc.). The National

ER	Emergency Room
ESF	Emergency Support Function(s)
ESF06	Mass Care Emergency Support Function
ESF08	Health and Medical Services Support Function
FEMA	Federal Emergency Management Agency
HAN	Health Alert Network
HAZMAT	Hazardous Material(s)
HEPA	High-Efficiency Particulate Air
HHS	U.S. Department of Health and Human Services
HERT	Hospital Emergency Response Team
HICPAC	Hospital Infection Control Practices Advisory Committee
HICS	Hospital Incident Command System
HLSEM	Homeland Security and Emergency Management
HPAI	Highly Pathogenic Avian Influenza
IAC	Iowa Administrative Code
IC	Incident Commander
ICC	Incident Command Center
ICP	Infection Control Professional
ICS	Incident Command System
IDAC	Infectious Disease Advisory Committee
IDALS	Iowa Department of Agriculture and Land Stewardship
IISN	Iowa Influenza Surveillance Network
JIC	Joint Information Center
LMS	Learning Management System

LPHA	Local Public Health Agency
LRN	Laboratory Response Network
ME	Medical Examiner
MMRS	Metropolitan Medical Response System
NIMS	National Incident Management System
NIPP	National Infrastructure Protection Plan
NNDSS	Nationally Notifiable Disease Surveillance System
NRP	National Response Plan
PAPR	Personal Air-Purifying Respirator
PPE	Personal Protective Equipment
SARS	Severe Acute Respiratory Syndrome
SEOC	State Emergency Operations Center
SME	State Medical Examiner
SNS	Strategic National Stockpile
TSA	Transportation Security Administration
UHL	University (of Iowa) Hygienic Laboratory
VAERS	Vaccine Adverse Events Reporting System
VFC	Vaccines for Children
VMBIP	Vaccine Management Business Improvement Project
WMD	Wepon(s) of Mass Destruction

**FLEXIBLE SPENDING ACCOUNTS (FSA)**—A employee medical expenses option which employees use to pay medical expenses. Money remaining in the account at the end of the year is forfeited.

**FOR-PROFIT HOSPITAL**—A hospital operated for the purpose of making a profit for its owner(s); the initial source of funding is typically through the sale of stock; profits are paid to stockholders in dividends (also referred to as a proprietary or an investor-owned hospital).

**FORMULARY**—The list of prescription medications that may be dispensed by participating pharmacies without health plan authorization. The formulary is selected based on effectiveness of the drug, as well as its cost. The physician is requested or required to use only formulary drugs unless there is a valid medical reason to use a non-formulary drug. Formularies may be open or closed. Closed formularies are restricted by the number and type of drugs included in the list.

**FREESTANDING AMBULATORY SURGERY CENTER**—A medical facility which provides surgical treatment on an outpatient basis only.

**FULL-TIME EQUIVALENT PERSONNEL (FTES)**—Refers to hospital employees; total FTE personnel is calculated by dividing the hospital's total number of paid hours by 2080, the number of annual paid hours for one full-time employee.

**GATEKEEPER**—Term used to describe the coordination role of the primary care provider (PCP) who manages various components of a member's medical treatment, including all referrals for specialty care, ancillary services, durable medical equipment, and hospital services. The gatekeeper model is a popular cost-control component of many managed care plans because it requires a subscriber to first see their PCP and receive the PCP's approval before going to a specialist about a given medical condition (except for emergencies).

**GATEKEEPER PPO**—A health care payment and delivery system consisting of networks of doctors and hospitals. Members must choose a primary care physician, use doctors in the network, or face higher out-of-pocket costs.

**GOOD SAMARITAN LAW**—A legal doctrine that protects a person from penalty for aiding another person(s) in emergency situations.

**EXCESS CAPACITY**—The difference between the number of hospital beds being used for patient care and the number of beds available.

**EXCLUSIONS**—Medical conditions specified in a policy for which the insurer will provide no benefits.

**EXCLUSIVE PROVIDER ORGANIZATION (EPO)**—A health care payment and delivery arrangement in which members must obtain all their care from doctors and hospitals within an established network. If members go outside, benefits are not payable.

**EXPERIENCE RATING**—A method of calculating health insurance premiums for a group based on the risks the group presents. An employer whose employees are unhealthy will pay higher rates than another whose employees are healthier.

**EXPLANATION OF BENEFITS (EOB)**—A statement to the payee and/or beneficiary reflecting charges submitted, charges allowed, amount for which the beneficiary is responsible and the amount that was paid to the provider or beneficiary. EOBs may specify deductible, coinsurance amounts, catastrophic caps, and other out-of-pocket amounts.

**EXPLANATION OF MEDICARE BENEFITS (EOMB)**—A notice that is sent to you after the doctor files a claim for Part B services under the Original Medicare Plan. This notice explains what the provider billed for, the Medicare-approved amount, how much Medicare paid, and what you must pay.

**FEE SCHEDULE**—Maximum dollar amounts that are payable to health care providers for the services they provide. Medicare and insurance companies have a fee schedule for doctors who treat patients.

**FEE-FOR-SERVICE**—A reimbursement mechanism that pays providers for each service or procedure they perform; opposite of capitation.

**FIRST-DOLLAR COVERAGE**—A health insurance policy with no required deductible.

**FISCAL INTERMEDIARY (FI)**—An organization that contracts with the federal government to administer portions of the Medicare program. The Iowa fiscal intermediary is Cahaba Government Benefit Administrators (GBA).

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## Definitions

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### Health Care Terms

**ACCOUNTS PAYABLE**—Liabilities arising from credit purchases of goods or services.

**ACCOUNTS RECEIVABLE**—Uncollected revenue; an asset account comprised of individual subsidiary accounts owed to a business entity.

**ACCREDITATION**—An evaluative process in which a healthcare organization undergoes an examination of its policies, procedures and performance by an external organization (“accrediting body”) to ensure that its meeting predetermined criteria. It usually involves both on and off-site surveys.

**ACCREDITATION FOR DEEMING**—Some states use the findings of private accreditation organizations, in part or in whole, to supplement or substitute for State oversight of some quality related standards. This is referred to as “deemed compliance” with a standard.

**ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS)**—Fatal, incurable disease caused by a virus that can destroy the body’s ability to fight off illness resulting in recurrent opportunistic infections or secondary diseases afflicting multiple body systems.

**ACUITY**—Degree or severity of illness.

**ACUTE CARE HOSPITAL**—Typically a community hospital which has services designed to meet the needs of patients who require short-term care for a period of less than 30 days.

**ADMINISTRATIVE SERVICES ONLY (ASO)**—A term that applies to large employers who self-insure health coverage and contract with a third party to provide various administrative services, such as claims processing and employee communications.

**ADVANCE BENEFICIARY NOTICE (ABN)**—A notice that a doctor or supplier should give a Medicare beneficiary to sign in the following cases:

- Your doctor gives you a service that he or she believes that Medicare does not consider medically necessary.
- Your doctor gives you a service that he or she believes that Medicare will not pay for.

If you do not get an ABN to sign before you receive the service from your doctor and Medicare does not pay for it, then you do not have to pay for it. If the doctor does give you an ABN that you sign before you get the service and Medicare does not pay for it, then you will have to pay your doctor for it. ABN only applies if you are in the Original Medicare Plan. It does not apply if you are in a Medicare Managed Care Plan or Private Fee-for-Service Plan.

**ADVANCE DIRECTIVE**—Written instructions recognized under law relating to the provision of health care when an individual is incapacitated. An advance directive takes two forms: living wills and durable power of attorney for health care.

**ADVERSE SELECTION**—The tendency of people who are in poorer than average health to apply for insurance coverage.

**AFFILIATION**—One organization effectively controlled by another or associated with others under common ownership or control.

**AGENCY FOR HEALTH CARE RESEARCH AND QUALITY (AHRQ)**—A component of the Public Health Services (PHS) responsible for research on quality, appropriateness, effectiveness, and cost of health care.

**ALL-PAYER SYSTEM**—Payment set by the government for payers of health care bills, including the government, private insurers, large companies or individuals.

**ALLIED HEALTH PROFESSIONAL**—A specially trained non-physician health care provider. Allied health professionals include: paramedics, physician assistants (PA), certified nurse midwives (CNM), phlebotomists, social workers, nurse practitioners (NP), and other caregivers who perform tasks that supplement physician services.

**ALLOWABLE CHARGE**—The maximum fee that a third party will reimburse a provider for a given service.

**ALLOWABLE COST**—Items or elements of an organization’s costs that are reimbursable under a payment formula. Allowable costs

**DRG CREEP**—(Also known as Code Creep or Upcoding). Practice of coding at a level higher than justified to generate a higher level of reimbursement.

**DUAL ELIGIBLE**—An individual who is entitled to Medicare Part A and/or Part B and is also eligible for some form of Medicaid benefit.

**DURABLE POWER OF ATTORNEY FOR HEALTH CARE**—Allows an individual to designate in advance another person to act on his/her behalf if he/she is unable to make a decision to accept, maintain, discontinue, or refuse any health care services.

**EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA)**— Federal law that establishes uniform standards for employer-sponsored benefit plans. The law effectively prohibits states from experimenting with alternative health-financing arrangements without waivers from Congress and prohibits states from regulating employers which “self-insure” their employee health plans.

**ENDOWMENT FUND**—A type of restricted fund which includes all resources that, by donor restriction, must be held intact as endowments to produce investment income; the use of which may be restricted by donors.

**ETHICS COMMITTEE**—Multi-disciplinary group which convenes for the purpose of staff education and policy development in areas related to the use and limitation of aggressive medical technology; acts as a resource to patients, family staff, physicians, and clergy regarding health care options surrounding terminal illness and assisting with living wills.

**EVIDENCE BASED PRACTICE (EBP)**—Evidence-based practice (EBP) is an approach to health care wherein health professionals use the best evidence possible, i.e., the most appropriate information available, to make clinical decisions for individual patients. EBP values, enhances and builds on clinical expertise, knowledge of disease mechanisms, and pathophysiology. It involves complex and conscientious decision-making based not only on the available evidence but also on patient characteristics, situations, and preferences. It recognizes that health care is individualized and ever changing and involves uncertainties and probabilities. Ultimately, EBP is the formalization of the care process that the best clinicians have practiced for generations.

**CRITICAL ACCESS HOSPITAL (CAH)**—Part of the Medicare Rural Hospital Flexibility Program created by BBA 97. A critical access hospital is a small rural hospital (limited to 25 acute care beds and an annual aggregate average length of stay of 96 hours) that receives cost based reimbursement for inpatient, outpatient and skilled care.

**DEDUCTIBLE**—Type of cost sharing that requires a beneficiary to pay a specified amount of covered medical services before the health plan or insurer assumes liability for all or part of the remaining costs.

**DIAGNOSIS-RELATED GROUP (DRG)**—A resource classification system that serves as the basis of the method for reimbursing hospitals based on the medical diagnosis for each patient. Hospitals receive a set payment amount determined in advance based on the length of time patients with a given diagnosis are likely to stay in the hospital.

**DIRECT CONTRACTING**—Refers to a direct contractual arrangement between an employer and a provider or provider organization, for the provision of health care services. The two parties may negotiate rates for services in a variety of ways, such as discounted charges, per diem rates, or DRGs. Direct contracts may include use of third party administrators for claims processing, utilization management, or other administrative functions. Direct contracting is often used as a cost containment strategy since fewer costs are incurred by a “middleman” insurance company.

**DISCHARGE PLANNING**—A process used to decide what a patient needs for a smooth move from one level of care to another. This is done by a social worker or other health care professional. It includes moves from a hospital to a nursing home or to a home care. Discharge planning may also include the services of home health agencies to help with the patient’s home care.

**DISPROPORTIONATE SHARE HOSPITAL**—A hospital with a disproportionately large share of low-income patients. Under Medicaid, states augment payment to these hospitals. Medicare inpatient hospital payments are also adjusted for this added burden.

**DOWNCODE**—Reduce the value and code of a claim when the documentation does not support the level of services billed by a provider.

may exclude uncovered services, luxury items or accommodations, unreasonable or unnecessary costs and/or expenditures.

**ALTERNATE DELIVERY SYSTEMS**—Health services provided in other than an inpatient, acute care hospital, such as skilled and nursing facilities, hospice programs, and home health care.

**ALTERNATIVE TREATMENT PLAN**—Provision in managed care arrangements for treatment usually outside of a hospital.

**AMBULATORY**—Not confined to a bed—capable of moving.

**AMBULATORY CARE**—Medical care provided on an outpatient basis.

**AMBULATORY PATIENT GROUP (APG)**—A system used to classify patients into nearly 300 pathology groups rather than 14,000 of the International Classification of Diseases. It is similar to DRGs, but applied to urgencies.

**AMBULATORY PAYMENT CLASSIFICATION (APC)**—A method used to classify outpatient services and procedures that are comparable clinically and in terms of resource use.

**AMBULATORY SURGICAL CENTER**—A free-standing facility, other than a physician’s office, where surgical and diagnostic services are provided on an ambulatory basis.

**ANCILLARY**—a term used to describe services that relate to a patient’s care such as lab work, x-ray, and anesthesia.

**ANY WILLING PROVIDER**—Legislation compelling insurers to sign a participation agreement with any provider (such as a pharmacy or physician) that agrees to abide by the same terms of the contract and to accept the same payment level as other providers. An underlying purpose of the law is to preserve the patient’s freedom of choice. This regulation directly impacts HMOs and preferred provider organizations, which attempt to control health care costs, and quality by selectively contracting with providers, monitoring their performance, and rewarding the most efficient providers.

**APR-DRG**—*All Patient Refined – Diagnosis Related Group* (developed by 3M Corporation). The software is a patient classification system that uses hospital patient discharge data and computer-based logic to assign patients to severity of illness and

risk of mortality classes so they can be accurately compared in terms of length of stay, resource consumption and outcomes.

**ASSIGNMENT OF BENEFITS**—A written authorization, signed by the patient or policyholder, to pay benefits directly to the hospital. It is usually acquired at the time of admission and imperative to be obtained prior to discharge. An assignment of benefits does not guarantee payment.

**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.

**AVERAGE ADJUSTED PER CAPITA COST (AAPCC)**—The methodology used to develop the premium rate paid to HMOs by the federal government for Medicare recipients in a given geographic region based on historical service costs.

**AVERAGE DAILY CENSUS (ADC)**—The average number of hospital inpatients per day. The ADC is calculated by dividing the total number of patient days during a given period by the number of calendar days in that period.

**AVERAGE LENGTH OF STAY (ALOS)**—The average number of days in a given time period that each patient remains in the hospital. ALOS varies by type of admission, age, and sex. To calculate ALOS, divide the total number of bed days by the number of discharges for a specified period.

**BAD DEBTS**—Uncollectable revenue after discounts, allowances, or write-offs. The write-off of such an account creates a decrease in the accounts receivable asset and an increase to the bad debt expense.

**BENCHMARKING**—A process which identifies best practices and performance standards, to create normative or comparative standards (benchmark) as a measurement tool. By comparing an organization against a national or regional benchmark, providers are able to establish measurable goals as part of the strategic planning and Total Quality Management (TQM) processes.

**COPAYMENT OR COPAY**—A type of cost-sharing that requires a health plan enrollee to pay a fixed dollar amount due at the time of service for certain medical services (a covered service), referred to as the patient’s out-of-pocket expense for health care treatment.

**COST BENEFIT ANALYSIS**—A method comparing the costs of a project to the resulting benefits, usually expressed in monetary value.

**COST CONTAINMENT**—Control or reduction of inefficiencies in the consumption, allocation, or production of health care services.

**COST REPORT**—The report required from providers on an annual basis in order to make a proper determination of amounts payable under the Medicare program.

**COST SHARING**—Method of reimbursement for health care services that holds the patient responsible for a portion or percentage of the charge as a strategy to reduce utilization (i.e., coinsurance, copayments, deductibles, and premiums).

**COST-SHIFTING**—Practice whereby a health care provider charges certain patients or third party payers more for services in order to subsidize service provided below cost or free to the poor or uninsured, such as increasing commercial pay patient fees to cover indigent care losses.

**COVERED BENEFIT**—A health service or item that is included in your health plan, and is partially or fully paid.

**COVERED ENTITY**—Under HIPAA, this is a health plan, a health care clearinghouse, or a health care provider who transmits any health information in electronic form in connection with a HIPAA transaction.

**COVERED LIVES**—Number of persons who are enrolled in a particular health plan or enrolled for coverage by a provider network.

**CREDENTIALING AND PRIVILEGING**—Process by which hospitals determine the scope of practice of practitioners providing services in the hospital; criteria for granting privileges or credentialing are determined by the hospital and include individual character, competence, training, experience, and judgment.

**CONCURRENT REVIEW**—A routine review by an internal or external utilization reviewer during the course of a patient’s treatment to determine if continued treatment is medically necessary. This is sometimes called “continued stay review”.

**CONDITION REPORT**—As related to patients, generally includes: (1) treated and released, (2) good, (3) fair, (4) serious, (5) critical.

**CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)**—Federal law that requires employers with more than 20 employees to extend group health insurance coverage for at least 18 months after employees leave their jobs. Employees must pay 100 percent of the premium.

**CONSOLIDATION**—Unification of two or more corporations by dissolution of existing ones and creation of a single new corporation.

**CONSUMER PRICE INDEX (CPI)**—An inflationary measure encompassing the cost of all consumer goods and services.

**CONSUMER PRICE INDEX, MEDICAL CARE COMPONENT**—An inflationary measure encompassing the cost of all purchased health care services.

**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.

**CONTRACTUAL ALLOWANCE**—Difference between rates billed to third party payers and the amount that will actually be paid by the third party payer.

**COORDINATION OF BENEFITS (COB)**—A method of integrating benefits payable under more than one group health insurance plan so that the insured’s benefits from all sources do not exceed 100 percent of the allowable medical expenses. Also referred to as the policy guidelines established by the National Association of Insurance Commissioners to prevent double payment for services when an enrollee has coverage from two or more sources and determine what organization has primary responsibility for payment.

**BOARD CERTIFIED**—Describes a physician who is certified as a specialist in his/her area of practice. To achieve board certification, a physician must meet specific standards of knowledge and clinical skills within a specific field or specialty. Usually, this means completion of a supervised program of certified clinical residency and the physician passing both an oral and written examination given by a medical specialty group.

**BOARD ELIGIBLE**—Describes a physician who has graduated from a board-approved medical school, completed an accredited training program, practiced for a specified length of time, and is eligible to take a specialty board examination within a specific amount of time.

**BRAIN DEATH**—Total irreversible cessation of cerebral function, as well as spontaneous function of the respiratory and the circulatory systems.

**BUNDLING**—Practice of billing certain procedures together whereby hospital is paid for only one of the services, not both. Typically, bundling of services reduces reimbursement as it is more than likely that billing the services separately would result in a larger payment. Bundling of services is applicable to inpatient, outpatient, skilled nursing, and ambulatory care.

**CAFETERIA PLAN**—A corporate benefits plan under which employees are permitted to choose among two or more benefits that consist of cash and certain qualified benefits. It is also referred to as flexible benefit plans or flex plans.

**CAPITAL**—Owners’ equity in a business. Often used to mean the total assets of a business, although sometimes used to describe working capital (i.e., cash) available for investment or acquisition of goods.

**CAPITAL EXPENSE**—An expenditure that benefits more than one accounting period such as the cost to acquire long-term assets. Capital investment decisions typically involve large sums of money for long periods of time and have a major impact on the future services provided by an organization.

**CAPITALIZE**—To record an expenditure that may benefit a future period as an asset rather than as an expense of the period of its occurrence. For example, research and development costs.

**CAPITATION**—Method of payment for health services in which the insurer pays providers a fixed amount for each person served regardless of the type and number of services used.

**CARDIAC CATHETERIZATION**—A procedure used to diagnose disorders of the heart, lungs, and great vessels.

**CASE MANAGEMENT**—A managed care technique in which a patient with a serious medical condition is assigned an individual who arranges for cost-effective treatment, often outside a hospital.

**CASE MIX**—Categories of patients, classified by disease, procedure, method of payment or other characteristics in an institution at a given time usually measured by counting or aggregating groups of patients sharing one or more characteristics.

**CASE MIX INDEX**—The average DRG relative weight for all Medicare admissions, computed by the sum of all DRG relative weights divided by the number of Medicare cases.

**CAT (COMPUTERIZED AXIAL TOMOGRAPHY)**—Diagnostic equipment which produces cross-sectional images of the head and/or body.

**CATASTROPHIC LIMIT**—The highest amount of money you have to pay out of your pocket during a certain period of time for certain covered charges. Setting a maximum amount you will have to pay protects you.

**CENSUS**—The number of inpatients who receive hospital care each day excluding newborns.

**CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)**—The federal agency responsible for administering Medicare, Medicaid and the State Children's Health Insurance Program (CHIP). (*formerly Health Care Financing Administration [HCFA]*).

**CHARITY CARE**—Medical services provided to an individual who is not charged or billed for payment based on established poverty income guidelines. AICPA guidelines state that charity care is a deduction from revenue and is indicated by a footnote on the income statement and must be distinguished separately from bad debts.

**CHEMOTHERAPY**—In the treatment of disease, the application of chemical reagents which have a specific and toxic effect upon the disease-causing microorganism.

**CLAIM**—A bill requesting that Medicare or some other insurance company pay medical services.

**CLAIM ATTACHMENT**—Any of a variety of hardcopy forms or electronic records needed to process a claim in addition to the claim itself.

**CLINICAL LABORATORY IMPROVEMENT AMENDMENT OF 1988 (CLIA)**—Certification standards for laboratories established to consolidate the requirements for Medicare participation with rules for laboratories engaged in interstate testing under the CLIA '67 program; standards contain new quality control and quality assurance, proficiency testing, and personnel requirements.

**CLOSED PANEL**—A managed care plan that contracts with or employs physicians on an exclusive basis for services and does not allow those physicians to see patients from other managed care organizations. Staff model HMOs are examples of closed panel managed care plans.

**CODE BLUE**—Indicates an emergency situation has occurred and mobilizes staff to respond.

**COINSURANCE**—An insurance policy provision under which the insurer and the insured share costs incurred after the deductible is met, according to a specific formula.

**COMMUNITY ACCOUNTABILITY**—The responsibility of providers in a network to document to members (or enrollees) their progress toward specific community health goals and their maintenance of specific clinical standards.

**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 RATING**—The process of determining a group's premium rate in which the rates are based on the average cost of providing care to the plan's enrollees, which is required for federally qualified HMOs.