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THE ROLE OF A PATIENT CARE OMBUDSMAN AND THE CONSUMER PRIVACY OF OMBUDSMAN IN HEALTHCARE BANKRUPTCY CASES

By

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The Bankruptcy Abuse Prevention and Consumer Protection Act of 2005 ("BAPCPA") introduced two new participants in the bankruptcy process -- the Patient Care Ombudsman and the Consumer Privacy Ombudsman. Although it has been 10 years since the enactment of BAPCPA, the role of the Patient Care Ombudsman and the Consumer Privacy Ombudsman continues to evolve.

THE PATIENT CARE OMBUDSMAN

- 11 U.S.C. §333 of the Bankruptcy Code provides that if a debtor in a case under Chapter 11 is a healthcare business, the court shall order, not later than 30 days after the commencement of the case, the appointment of an ombudsman to monitor the quality of patient care and to represent the interests of patients of the healthcare business unless the court finds that the appointment of such ombudsman is not necessary for the protection of patients under the specific facts of the case. 11 U.S.C. § 333(a)(1).

- Patient Care Ombudsmen are appointed in Healthcare Bankruptcies filed in Chapter 7, 9 or 11 of the Bankruptcy Code.

- There is a logical basis for the appointment of a Patient Care Ombudsman in a Chapter 9 or 11 case that involves a restructure, sale or other liquidation, given that patient care issues may be impacted. Logic would also follow that it would be a rare circumstance that there would be a role for a Patient Care Ombudsman in a Chapter 7, although at least one court has appointed a Patient Care Ombudsman in a Chapter 7 case. In re Dari Ann Ungaretti, Case No. 06-16094(MB) (Bankr. N.D. Ill. 2006).

The Definition Of A Healthcare Business

- A "healthcare business" as defined in 11 U.S.C. §101(27A) means any public or private entity (without regard to whether that entity is organized for profit or not-for-profit) that is primarily engaged in offering to the general public facilities and services for - (i) diagnosis or treatment of injury, deformity or disease; and (ii) surgical, drug treatment, psychiatric, or obstetric care and includes:

I. General or Specialized Hospital;
II. Ancillary, Ambulatory, Emergency or Surgical Treatment Facility;
III. Hospice;
IV. Home Health Agency; and
V. Other Healthcare Institution that is Similar to an Entity Referred to in Subclauses I, II, III or IV.

- This includes bankruptcies filed by companies primarily engaged in offering public facilities and services to the general public for diagnosis or treatment of injury and disease, or surgical, drug, psychiatric or obstetric care. This also includes hospitals, ambulatory and surgical care facilities, long-term facilities, assisted living facilities, home health agencies, Hospice and related businesses. Healthcare companies that do not operate facilities, commonly do not constitute a healthcare bankruptcy.

- However, there is some inconsistency in the statute. The statutory definition includes home health care companies even though home health care companies do not usually operate facilities.

The Appointment Process

- Rule 2007.2 of the Federal Rules of Bankruptcy Procedure implements Section 333 and mandates that the court "shall order the appointment of a patient care ombudsman under Section 333 of the Code, unless the court, on motion of the United States Trustee or a party in interest, filed not later than 21 days after the commencement of the case or within another time fixed by the court, finds that the appointment of a patient care ombudsman is not necessary for the protection of patients under specific circumstances of the case." Fed.R. Bankr.P. 2007.2

- If the Court orders an appointment of an ombudsman under Section §333(a)(1), the United States Trustee is directed to appoint one disinterested person (other than the United States Trustee) to serve as such ombudsman. 11 U.S.C. §333(2)(A).

- If the Debtor is a healthcare business that provides long-term care, then the United States Trustee may appoint the State Long-Term Care Ombudsman appointed under the Older Americans Act of 1965 for the state in which the case is pending, to serve as the ombudsman. 11 U.S.C. §333(2)(B).

- If the United States Trustee does not appoint a State Long-Term Care Ombudsman, the Court shall notify the State Long-Term Care Ombudsman appointed under the Older Americans Act of 1965 for the State in which the case is pending, of the name and address of the person who is appointed to serve as ombudsman. 11 U.S.C. §333(2)(C).

- Under the Bankruptcy Code, the Patient Care Ombudsman can be an individual or a firm, though generally the U.S. Trustee's Office prefers to appoint individuals rather than firms as a matter of policy.

The Presumption for a Patient Care Ombudsman

- The "shall order the appointment . . . unless the court . . . finds" language of Section 333(a)(1) suggests that patient care ombudsman should be the rule.

- However, some recent decisions appear to place the burden on the proponent of the appointment to show that an ombudsman is needed because of specific problems at the facility. See In re Alternative Healthcare, 377 B.R. 754 (Bankr. S.D. Florida 2007) (finding that there was sufficient oversight from the state and in-house procedural safeguards, that the patients and debtor shared a substantial interest in a successful reorganization and that it would be a waste of scarce financial resources to appoint an ombudsman). See also In re Valley Health Systems, 381 B.R. 756 (Bankr. C.D. Calif. 2008) (placing the evidentiary burden on the trustee to demonstrate the need for a patient care ombudsman).

Role of the Patient Ombudsman Role

- An ombudsman appointed under Section 333 of the Bankruptcy Code must "(1) monitor the quality of patient care provided by the debtor to the extent necessary including interviewing patients and physicians; (2) report to the court orally or in writing in not more than 60 day intervals concerning the quality of patient care provided, and (3) if the ombudsman determines that the quality of patient care is declining significantly or is otherwise being materially compromised, file a motion or report with the court immediately upon making such determination. 11 U.S.C. §333(b).

- The Ombudsman position was created to help protect the interests of patients in a healthcare bankruptcy.

- The Ombudsman functions as a friend, advocate and mediator.

Privacy Issues

- Section 333(c)(1) of the Bankruptcy Code provides that an ombudsman appointed pursuant to this Code Section shall "maintain any information obtained by such ombudsman under this Section that relates to patients (including information relating to patient records) as confidential information. Such ombudsman may not review confidential patient records unless the Court approves its review in advance and imposes restrictions on such ombudsman to protect the confidentiality of such records." 11 U.S.C. §333(c)(1).

- Rule 2015(b) of the Federal Rules of Bankruptcy Procedure provides that a motion to review confidential documents is to be served on the patient and any patient's family member or other contact person.

- Despite the Bankruptcy Code's restriction to an ombudsman access to confidential information without court order, it is not unlikely that an ombudsman will come into possession of certain confidential medical information as a result of patient interviews or

otherwise. The Patient Care Ombudsman needs to careful to maintain all patient confidentiality, perhaps in some instances necessitating the ombudsman's reports being filed under seal.

Costs

- The U.S. Trustee whenever possible appoints the State Long-Term Care Ombudsman in Healthcare Cases resulting in a cost savings to the estate.

- The appointment of a patient care ombudsman has been attacked as an additional and unnecessary cost. See Valley Healthcare System, 381 BR 756) (Bankr. C.D. Calif. 2008)

Retention of Lawyers and Accountants

- Neither Section 333 nor any other bankruptcy code provision specifies that a patient care ombudsman may appoint legal counsel at the estate's expense.

- Generally, courts have authorized patient care ombudsman to appoint legal counsel. See Synergy Hematology-Oncology Medical Associates, Inc., 433 BR 316, 318 (Bankr. C.D. Cal. 2010) and Renaissance Hospital-Grand Prairie, Inc. 2008 WL 5746904 (Bankr. N.D. Tex. 2008).

- The Synergy court analogized the patient care ombudsman to the appointment of an examiner and found that notwithstanding the lack of statutory authority for an examiner to hire legal counsel, the courts have frequently authorized such employment pursuant to Section 105(a). Synergy, 433 B.R. at 318.

- On the other hand, the Renaissance court disagreed that a patient care ombudsman should be analogized to an examiner, the Renaissance court analogized that an examiner, like a trustee, debtor-in-possession or committee, has a common interest in preserving the value of the estate while a patient care ombudsman is concerned with a constituency. Renaissance, 2008 WL 5746904, at *3. The Renaissance court nevertheless granted the patient care ombudsman's applications to retain professionals, on the basis that Congress must have anticipated that an ombudsman would on occasion have to have the assistance of counsel and other professionals. Id.

- But also see In re Haven Eldercare, LLC, 382 B.R. 180 (Bkrtcy. Ct. 2008). Although the motion before the court was the debtor's request for an order approving monthly compensation scheme for professionals, in its discussion regarding same, the court noted that the Bankruptcy Code did not appear to provide for direct estate compensation for attorneys and/or others employed by the patient care ombudsman and suggested that the code seemed to contemplate that compensation of such entities should be the responsibility of the ombudsman who could then seek to have the expenses reimbursed under Section 330(a)(1)(B).

Case Law Developments

Not surprisingly, other than the cases previously discussed, most of the reported decisions primarily involve cases where an appointment of a healthcare ombudsman was opposed by the debtor. The decision by a court not to appoint an Ombudsman can be broken down into two categories – either the court decided or found that the debtor was not a health care business within the definition of the Code, or that the specific circumstances of the case warranted that no patient healthcare ombudsman be appointed. See for example:

- **In re North Shore, 400 B.R. 7 (Bankr. E.D.N.Y. 2008).**

  Court held that the appointment of an ombudsman was unnecessary because of the existing oversight by local and internal authorities and several provisions executed during the Chapter 11 to ensure that there would be no interruptions in access to medications. Of particular importance to the court was the fact that the debtor did not provide any in-patient services at its facilities and, therefore, patients were not dependent on the debtor's facilities to accommodate lengthy treatment. This court also found it "very significant" that while the debtor served more than 30,000 critically ill patients in the proceeding fourteen months, it received only five complaints, equating to a complaint rate was far less than 1%.

- **In re Vartanian, 2007 WL 4418163 (Bankr. D. Vt. 2007).**

  A *pro se* debtor filed a Chapter 7 case and listed his occupation as "Chiropractor (sole proprietorship)" and checked boxes identifying the nature of his business as "Health Care Business." At an evidentiary hearing to determine whether an ombudsman was necessary, the U.S. Trustee argued against appointing an ombudsman using the nine factors from In re Alternative Family Care. While the court did not address any of these factors specifically, the brief opinion noted the due diligence of the U.S. Trustee and the fact that the Chapter 7 Trustee testified that there were no funds available in the estate from which to pay any ombudsman. Additionally, the debtor may have not fully understood the definition of a "Health Care Business" and may not have actually qualified as such.

THE CONSUMER PRIVACY OMBUDSMAN

- BAPCPA amended the Code to add provisions designed to protect the sale or lease of the personal information to parties not affiliated with the debtor of personal information that the debtor obtained pursuant to a privacy notice. See 11 U.S.C. §363(b)(1)(B) 11 U.S.C. §332 and 11 U.S.C. §101(41A).

- 11 U.S.C. § 332 provides that if a hearing is required under §363(b)(1)(B) of the Code, the court shall order the United States Trustee to appoint, not later than 7 days before the commencement of the hearing, one disinterested person (other than the United States Trustee) to serve as a Consumer Privacy Ombudsman. It further provides that notice of such sale hearing be timely given to such ombudsman.

- So, if the debtor has a privacy notice that prohibits transfers of personally identifiable information to parties not affiliated with the debtor, then a Consumer Privacy Ombudsman must be appointed to oversee the sale. 11 U.S.C. §363(b)(1)(B).

- On the other hand, a debtor whose privacy notice anticipates asset sales involving personally identifiable information that are consistent with the debtor's privacy notice may transfer the information through a sale or lease without the appointment of a Consumer Privacy Ombudsman.

Role of the Consumer Privacy Ombudsman

- The Consumer Privacy Ombudsman may appear and be heard at the hearing required under Section 363(b)(1)(B) and shall provide to the court information to assist the court in its consideration of facts, circumstances and conditions of the proposed sale or lease of personally identifiable information.

- Such information may include presentation of:

    - The Debtor's privacy policy;

    - The potential losses or gains of privacy to consumers if such sale or lease is approved by the court;

    - The potential costs or benefits to consumers if such sale or lease is approved by the court; and

    - The potential alternatives that would mitigate potential privacy losses or potential costs to consumers.

- In at least one instance, a Consumer Privacy Ombudsman was appointed in a healthcare bankruptcy where no sale was contemplated. In the high profile case of Dr. Robert W. Hunt, the doctor who implanted 12 embryos in Nadya Suleman, who as a result gave birth to eight children, a consumer privacy ombudsman was appointed because the United States Trustee saw significant privacy and accessibility issues regarding patient

and consumer confidentiality issues. In re Robert W. Hunt, A Medical Corporation, Case No. 11-58228(ER) (Bankr. C.D. CA. 2011).

- A Consumer Privacy Ombudsman shall not disclose any personally identifiable information obtained by the ombudsman under this Title.

- The services of a Consumer Privacy Ombudsman is not limited to healthcare cases.

The Definition of Personally Identifiable Information

- 11 U.S.C. 101(41A) defines the term "personally identifiable information" as any of the following relating to a customer:

    - Name, including, first name or initial and last name;

    - Address;

    - E-Mail Address;

    - Telephone Number;

    - Social Security Number;

    - Credit Card Number; or

    - The definition also applies to birth dates, birth certificate numbers or places of birth, and other information that, combined with a name or other item from the bulleted list, would allow someone to identify or contact a consumer, either in person on through the internet.

Identifying When a Consumer Privacy Ombudsman is Warranted

- The debtor must provide services or sale products to consumers.

- A published privacy policy must exist and must have existed on the date of the filing.

- The debtor must collect personally identifiable information in connection with consumer transactions.

- If one of the above three factors is missing, then the Consumer Privacy provisions do not apply.

Reimbursement of Costs and Expenses

- Section 330(a)(1) of the Bankruptcy Code provides that a Consumer Privacy Ombudsman is entitled to reasonable compensation for actual, necessary services rendered and to reimbursement of actual, necessary expenses, all of which is allowable as an administrative expense priority claim.

- Though it is not specifically authorized by the Code, bankruptcy courts have approved the retention of professionals by Consumer Privacy Ombudsman. See for example In re Stone and Barry's Manhattan, LLC, et al., Case No. 08-12579(ALG) (Bankr. S.D.N.Y. 2008).

Selected statutory and regulatory law relevant to nonprofit healthcare organizations

Your panelists have compiled the following information about selected statutes and regulations applicable to healthcare entities and nonprofits in New York and New England.

Relevant Connecticut Statutes

Requirement of Certificate of Need for Health Care Facilities other than Nursing Home Facilities

Connecticut requires certain types of health care providers to obtain state approval prior to making substantial investments in new equipment for facilities, adding or discontinuing health care service, selling or merging. *See* C.G.S.A. §19a-638. A health care facility is defined as including hospitals, freestanding emergency departments, outpatient surgical facilities, mental health facilities and substance abuse treatment facilities. *See* C.G.S.A. §19a-630(11).

The CONS are submitted to the Office of Health Care Assess (OHCA) for review and approval. An applicant must publish notice at least 20 days in advance of filing on application for not less than three consecutive days in a newspaper having a substantial circulation in the area where the project is to be located. *See* C.G.S.A. §19a-639a. The notice must contain a brief description of the nature of the project as well as the address of the project. Five days after the receipt of the application OHCA will post notice of the application on its website and with the Secretary of State. Not later than thirty days after the filing of the application OHCA may request any additional information it deems necessary to complete the application. The applicant has up to sixty days after OHCA's request to submit the requested information. If the information is not timely submitted, OHCA will deem the application to have been withdrawn.

Once the application is deemed to be complete, OHCA will provide notice of same to the applicant and to the public by posting such notice on its website. The review period begins on the date the notice is placed on the website. The review period for a competed application is up to 90 days from the date upon which OHCA posts the notice on its website. However the review period can be extended for good cause on upon consent of the parties. OHCA may decide on its own or upon request to hold a hearing on the application. If OHCA holds a public hearing on the application, OHCA shall issue a decision not later than 60 days after the date OHCA closes the public hearing record.

OHCA will take into consideration (1) whether the proposed project is consistent with the policies and standards of the Department of Health (DPH); (2) the relationship of the proposed project to the Statewide Healthcare Facilities and Services Plan; (3) whether there is a clear public need; (4) whether the proposal is financially feasible; (5) whether the proposal will

improve quality, accessibility and cost effectiveness of healthcare delivery in the region; (6) whether the applicant's past and proposed provision of healthcare services; (7) whether the applicant has satisfactorily identified the population to be served and satisfactorily demonstrated the need for such proposed services; (8) the utilization of existing healthcare facilities, healthcare services in the proposed service area; (9) whether the proposed project will result in an unnecessarily duplication of healthcare services; (10) if the application fails to provide or reduces access to services by Medicaid recipients or indigent persons, whether the applicant has demonstrated good cause for doing so; (11) whether the applicant has satisfactorily demonstrated that the proposal will not negatively impact the diversity of healthcare providers and patient choice in a geographic region; and (12) whether the applicant has satisfactorily demonstrated that any consolidation resulting from the proposal will not adversely affect healthcare costs or accessibility to care. *See* C.G.S.A. §19a-639.

Requirement of Certificate of Need for Nursing Home Facilities

Section 17b-352 of the Connecticut General Statutes governs the CON requirements for nursing home facilities seeking to transfer ownership or control, introduce an additional function or service, or terminate or decrease service. For the purposes of this section, facility means a residential facility for persons with intellectual disabilities licensed pursuant to C.G.S.A. §17a-277 and certified to participate in the Title XIX Medicaid Program as an intermediate care facility for individuals with intellectual disabilities; or a nursing home, rest home or residential care home as defined in C.G.S.A. §19a-490. Pursuant to Section 19a-490, residential care home, nursing care home, or rest home means an establishment which furnishes food, shelter and services, in single or multiple facilities, to two or more persons unrelated to the proprietor, which meet a need beyond the basic provisions of food, shelter and laundry.

Facilities governed by Section 17b-352 must submit requests and obtain approval from the Department of Social Services ("DSS"). Prior to submitting a CON application, the applicant must submit a letter of intent requesting application forms and instructions from DSS. The letter of intent must include the name of the applicant, a statement indicating whether the application is for new, additional, expanded or replacement facilities, services or functions, a termination or reduction in presently authorized service bed capacity or any new additional or terminated beds and their type, the estimated capital cost, the town where the project will be located and a brief description of the proposed project. A CON application will not be accepted unless the letter of intent has been on file with the DSS for not less than ten days. The Office of the Long-Term Ombudsman must be notified by the Facility at the same time a letter of intent is submitted to the DSS.

At the same time, an applicant submits its letter of intent it must provide notice, in writing, to all patients, guardians and conservators, if any, or any legally liable relatives or other responsible parties, if known, and shall post such notice in a conspicuous location at the facility. The notice shall state the following: (1) the projected date the facility will be submitting its certificate of need application, (2) only the department has the authority to either grant, modify or deny the application, (3) the department has up to ninety days to grant, modify or deny the certificate of need application, (4) a brief description of the reason or reasons for submitting a

request for permission, (5) that no patient shall be involuntarily transferred or discharged pursuant to state and federal law because of the filing of the certificate of need application, (6) that all patients have a right to appeal any proposed transfer or discharge, and (7) the name, mailing address and telephone number of the Office of the Long-Term Care Ombudsman and local legal aid office.

DSS shall review the request made for a CON to the extent it deems necessary. In the case of a proposed transfer of ownership or control, DSS will consider the financial responsibility and business interests of the transferee and ability of the facility to continue to provide needed services. DSS will grant, modify or deny the request within 90 days of receipt of the letter of intent. However, the review period may be extended for an additional fifteen days if the DSS has requested additional information subsequent to the commencement of the DSS's review period. Additionally, the period may be extended for a maximum of 30 days if the applicant has not timely filed information deemed necessary by DSS. The applicant is entitled to request a hearing if aggrieved by the decision of the DSS.

Enactment of Public Act 14-168

Effective October 1, 2014, an act concerning notice of acquisitions, joint ventures, affiliations of group medical practices and hospital admissions, medical foundations and CONs, was enacted by the Connecticut Legislature (the "Act"). Pursuant to the Act, the Attorney General ("AG") must be notified 30 days prior to the effective date of any transaction that results in a material change to the business or corporate structure of a Group Practice. A "Group Practice" is defined as two or more physicians in which each physician provides substantially the full range of services that the physician members routinely provide. Material changes include:

(1) mergers, consolidations, or other affiliation with:

(a) another group practice that results in a group practice of more than eight physicians;

(b) hospital, hospital system, captive professional entity, medical foundation or other entity organized by or controlled by such hospital or hospital system;

(2) the acquisition of substantially all of:

(a) the properties and assets of a group practice; or

(b) a hospital, hospital system, captive professional entity, medical foundation or other entity organized by or controlled by such hospital or hospital system;

(3) the employment of all or substantially all of the physicians of a group practice by:

(a) another group practice that results in a group practice comprised of eight or more physicians; or

(b) a hospital, hospital system, captive professional entity, medical foundation or other entity organized by or controlled by such hospital or hospital system; and

(4) the acquisition of one or more insolvent practices by:

(a) another practice group that results in a group practice comprised of eight or more physicians; or

(b) a hospital, hospital system, captive professional entity, medical foundation or other entity organized by or controlled by such hospital or hospital system.

The notice to the AG must identify the parties to the transaction, describe the proposed transaction, state the names of the physicians and their specialties subject to the transaction, provide the names and entities that will perform services following any approval of the proposed transaction, give addresses for each location and describe the service area to be served and services to be provided at each location.

No later than December 31, 2014 and annually thereafter, each hospital and hospital system and each group practice comprised of more than thirty physicians shall file with the AG and DPH a written report for each group practice that includes:

(a) a description of the nature of the relationship between the hospital or hospital system and the group practice;

(b) the names and specialties of each physician practicing medicine with the group practice;

(c) the names of the business entities that provides services to the group practice and the addresses for each location where services are provided;

(d) the primary service area served by such location; and

(e) a description of the services provided.

The Act also made some amendments to the C.G.S.A. §19a-638 to require a CON when there is a transfer of ownership or group practice to any entity other than a physician or a group of physicians. "Group Practice" is defined as a practice that has eight or more full time equivalent physicians, legally organized in a partnership, professional corporation, limited liability company and was formed to render professional services, medical foundation, not for profit corporation, faculty practice plan or similar entity in which each physician provides substantially the full range of services that the physician routinely provides. *See* C.G.S.A. §19a-630(10). OHCA will consider the proposed transaction to determine: (1) whether the application has satisfactorily demonstrated that the proposal will not negatively impact diversity of health care providers and patient choice in the geographic region; (2) whether the application has satisfactorily demonstrated that any consolidation resulting from the proposed transaction will not affect the health care costs or accessibility to care; and (3) there is a presumption in favor of the transaction when there was an offer made in response to the request for proposal or similarly voluntary offer for sale.

Sale of Non-Profit Hospitals

Section 19a-486 to 19a-486h covers the criteria for the sale of non-profit hospitals. Pursuant to Section 19a-486, "Non-Profit Hospital" means a non-profit entity licensed as a hospital pursuant to this chapter and any entity affiliated with such hospital through governance or membership, including, but not limited to, a holding company or subsidiary. Section19a-486a provides that no hospital shall enter into an agreement to transfer a material amount of assets or operations or a change in control of operations to a person that is organized or operating for-profit without first having received approval of the agreement by DPH and the AG.

The non-profit hospital and the purchaser must concurrently submit a letter of intent to the DPH and the AG by certified mail, return receipt requested, or delivering it by hand to each office. Such letter must contain the name and address of the non-profit hospital, the name and address of the purchaser, a brief description of the terms of the proposed agreement and the estimated capital expenditures, cost or value associated with the proposed amendment. DPH and the AG will review the letter to determine whether what is being proposed requires approval pursuant to this Chapter. If approval is required, the DPH and AG will send to the purchaser and the non-profit hospital an application form. The DPH may refuse the proposal and not send an application form.

The application must include the following information: (1) the name and address of the non-profit hospital, (2) the name and address of the purchaser, (3) description of the terms of the proposed agreement, (4) copies of all contracts, agreements and memoranda of understanding relating to the proposed agreement, (5) a fairness evaluation, (6) documentation that the non-

profit hospital exercised the due diligence, and (7) such other information as the DPH or the AG shall deem necessary.

No later than sixty days after the date of the mailing of the application form, the non-profit hospital and purchaser must concurrently file the application with the DPH and the AG. DPH and the AG shall review the application and determine whether it is complete. The Commissioner and the AG shall have no later than twenty days after the date of the receipt of the application to provide written notice to the non-profit hospital and the purchaser of any deficiencies found in the application, and the application shall not be deemed complete until such deficiencies are corrected. No later than twenty-five days after the date of the receipt of the completed application, DPH and the AG will jointly publish a summary of such agreement in a newspaper of general circulation where the non-profit hospital is located. DPH and the AG have one hundred and twenty days after the date of the receipt of the completed application to approve the application with or without modification, or deny the application.

If DPH and the AG require more than one hundred and twenty days to review the application, then the AG must either obtain an extension by consent or initiate a proceeding to enforce a subpoena. If the AG fails to act within that one hundred and twenty day time period, the application will be deemed approved.

Grounds for denial of the application by the AG include such reasons as: the transaction is prohibited by Connecticut statutory or common law, failure to exercise due diligence, failure to disclose any conflicts of interests, a fair market value is not being paid, the fair market value was manipulated or unfeasible financing.

DPH will not approve an application if (1) the affected community is not assured of continued access to affordable health; (2) if the purchaser has not made a commitment to continue to provide health care services to the uninsured and underinsured; (3) safeguard procedures are not in place to avoid a conflict of interest with respect to patient referral, and (4) a CON is not justified.

Prior to making any decision on the application, the DPH and AG will jointly conduct one or more public hearings, one of which will be in the primary service area of the non-profit hospital. At least fourteen days before conducting such hearing, the DPH and the AG will provide notice of the time and place of the hearing through publication in one or more general circulation newspapers in the affected community. If an application is denied, the applicants may appeal such decision to the Superior Court.

Cy Pres

Bankruptcy proceedings involving non-profit health care facilities are often faced with addressing charitable bequests that could be at risk of being distributed to a non-charitable organization or in a manner that is not consistent with the settlor's charitable purposes, as a result of a section 363 sale or closure. C.G.S.A. § 45a-535e protects against such a result and provides that if the charitable purpose or restriction contained in the bequest becomes unlawful and impractical, impossible to achieve or wasteful, a Court, upon application of the institution, may modify the purpose of the fund or the restriction on the use of the fund in a manner consistent

with the charitable purposes expressed in the bequest. The institution must notify the AG, who will be given an opportunity to be heard.

Relevant New York Statutes

Overview of the New York Certificate of Need Program

New York has an extensive CON program in place for healthcare services and facilities. New York' CON program is generally governed by Title 28 of the Public Health Act, but involves the interplay of numerous other state statutes and regulations, including the recently amended 10 NYCRR §710.1[1], as well as Titles 36 and 40 of the Public Health Act. New York's CON process governs the establishment, construction, renovation and major medical acquisitions of healthcare facilities and agencies such as hospitals, nursing homes, homecare agencies, hospice and diagnostic and treatment centers.

CON applications are required for any healthcare facility that wishes to establish a new healthcare facility, homecare agency or hospice, a change in ownership, the addition of certain specialized services or major capital projects. CON applications are reviewed by the Public Health and Health Planning Council ("PHHPC"). The CON Program and PHHPC are administered by the New York State Department of Health. CONs are generally reviewed using the following criteria: (1) public need, (2) financial feasibility, (3) character and competence and (4) compliance with the constructions requirements of 10 NYCRR §710.1 et. seq.

The New York CON Program has a three tiered review process, a full review, an administrative review and a limited review. A full review is required, for example, for any changes in ownership or consolidation of article 28 providers with include hospitals, nursing home, and diagnostic and treatment centers and will be reviewed and decided by PHHPC. Administrative and limited reviews apply to lower cost, less intrusive projects, such as the acquisition of equipment, and do not require a recommendation from PHHPC. The New York Department of Health website contains detailed explanations of the CON review types and requirements, as well as all of the forms and schedules required for the submission of a CON.

Cy Pres

New York law also protects against the misappropriation of charitable funds in sale of dissolution of a non-profit debtor. Pursuant to NPCL § 555, a court, upon application of an institution, may modify the bequest if the restriction has become impracticable or wasteful or will otherwise not further the purpose of the bequest. Notice must be given to the donor, if available, and the AG of the application, and they will have an opportunity to be heard. To the extent practicable, any modification must be made in accordance with the donor's probable intention

[1] The amendments to §710.1 streamlined the CON process by exempting certain projects from the process regardless of the cost and expanding the list of projects eligible for limited review.

Relevant Vermont Statutes

Requirement of Certificate of Need

Vermont law restricts a health care facility's development of a new health care project without first obtaining a CON from the Green Mountain Care Board ("GMCB"). *See* 18 V.S.A. §9434. A new health care project is defined, for the purposes of this Section, as including the transfer or conveyance of more than fifty percent ownership in a health care facility, other than a hospital. *See* 18 V.S.A. §9420(a).

18 V.S.A. §9434(b) provides that a hospital shall not develop or have developed on its behalf a new healthcare project without issuance of a CON by GMCB. The Statute is silent as to whether a CON is required for the sale or merger of a hospital. *See* 18 V.S.A. §9434(b).

The criteria that an applicant must demonstrate in order to obtain a CON can be found in 18 V.S.A. §9437 and includes demonstrating (1) that the application is consistent with the state's health care allocation plan, (2) the cost of the project is reasonable, (3) there is an identifiable, existing, or reasonably anticipated need, (4) the project will improve the quality of health care in the state, (5) the project will not have an undue adverse impact on other services provided by the applicant, (6) the project will serve the public good, (7) the applicant has adequately considered the availability of affordable accessible patient transportation services to the facility and (8) if the application is for the purchase of new healthcare information technology, it conforms with the Health Care Information Technology Plan established under 18 V.S.A. §9351.

The procedures for completing and submitting a CON include submitting an application that contains the information established by the Board which may include: (1) institutional utilization data, (2) financial statements, (3) third party reimbursement data, (4) feasibility studies, surveys, designs, plans, working drawings, or specifications developed in relation to the proposed project, (5) annual reports and (6) leases and contracts. *See* 18 V.S.A. §9440.

Prior to filing an application for a CON, an applicant must file a letter of intent with GMCB. An application can be filed no earlier than thirty days after the submission of the letter of intent. If an application is not filed within six months of the date that the letter of intent is submitted to GMCB, then the letter of intent becomes invalid. Public notice of such letters of intent must be provided in newspapers having general circulation in the region of Vermont affected by the letter of intent. The notice must identify the applicant, the proposed project and the deadline by which a competing application or petition to intervene must be filed. In addition, a copy of the public notice must be sent to the clerk of the municipality in which the health care facility is located.

GMCB will review the letter of intent, and within thirty days, determine whether the project described in the letter requires a CON. If a CON is required, the application for a CON must be filed before development of the project begins. Within ninety days of receipt of the application, GMCB will notify the applicant that the application is complete. The Board may extend the ninety day review period for an additional sixty days or for a period of time or longer with the consent of the applicant. If the Board has requested additional information time during

which the applicant is responding to the request, it shall not be included in the maximum review period.

Once an application is deemed to be complete, public notice of the application shall be provided in a newspapers having general circulation in the region of Vermont affected by the application. The notice must identify the applicant, the proposed project and the deadline by which a competing application or petition to intervene must be filed.

GMCB has one hundred and twenty days from the date the applicant was notified that the application was complete to determine whether to approve or deny the application. GMCB may extend the review period up to an additional thirty days or a further time period if consented to by the applicant.

If the Board denies an application in whole or in part, the parties will be given an opportunity to file exceptions; and present briefs and oral argument to GMCB.

Conversion of Non-Profit Hospitals

A non-profit hospital may only be converted to for-profit if there is compliance with the provisions of V.S.A. §9420. A party or parties seeking to convert a qualifying amount of the hospital's assets to for-profit must obtain the approval of the Commissioner of Financial Regulation (the "Commissioner") and the AG.

A qualifying amount is defined as at least One Million Dollars and represents at least forty percent of the value of the assets of the non-profit hospital.

The application must include: (1) a detailed summary of the proposed conversion, (2) contain the names and addressed of all parties to the conversion, (3) copies of all organizational documents, (4) copies of all contracts and agreements related to the conversion, (5) copies of the most recent audited financial reports of the parties, (6), a detailed description of the assets of the non-profit hospital, (7) a detailed description of the process by which the decision to undertake the conversion was made, (8) the amount, source and nature of any consideration to be paid to the non-profit hospital and related parties, (9) a detailed description of the disposition of any charitable bequests, (10) a certified board resolution, (11) certifications, signed by members of the governing body and (12) a description of how the charitable obligations of the non-profit hospital will be fulfilled.

The AG has thirty days after the receipt of the application or within ten days of the receipt of any amendment thereto, whichever is longer, to determine whether the application is complete. The Commissioner must agree that the application is complete. If the application is incomplete, the parties will be notified of same, and its deficiencies.

The AG and the Commissioner will hold one or more public hearings on the application. The hearing will be held within thirty days of the determination by the AG that the application is complete. The hearing or hearings must be completed within sixty days of the AG's

determination that the application is complete. The AG is required to provide reasonable notice of any hearing to the parties, the Commissioner, and the public.

The Commissioner will review and approve or deny the application within fifty days following the last public hearing. However, the Commission may extend the time period by an additional sixty days. A denial by the Commissioner may be appealed to the Supreme Court.

Notice of the approval or disapproval by the AG of the application will be provided no later than either sixty days following the date of the last hearing, or ten days following approval of the conversion by the Commissioner, whichever is later. However, the AG, may, for good cause, extend this period an additional sixty days.

If the AG does not approve the conversion, the parties may commence an action in the Superior Court within sixty days of the AG's notice of disapproval. Within forty-five days of the commencement of such an action, the Court shall hold a hearing to determine whether the conversion satisfied the statutory standards. The Court will determine the matter within forty-five days of the conclusion of the hearing. However, the Court, for good cause, may extend each of the time for an additional thirty days or for a longer period, if agreed to by the parties and the AG.

If the Court finds that the parties have shown that the conversion meets the standards of Subsection (j) of Section 9420, the Court shall set aside the determination of the AG and the parties may proceed under this Section as if the AG had approved the conversion. However, if the AG prevails in the action, the Court may order the parties to reimburse the State for the reasonable value of the AG's services and expenses in defending the action.

Cy Pres

Like the other states in the Second Circuit, Vermont has a Statute to prevent the distribution of a charitable bequest in a situation where a bankruptcy non-profit could result in the bequest being distributed to a non-charitable organization or in a manner that is not consistent with the settlor's charitable purposes. Section 413 of Title 14A of the Vermont Statutes provides for a mechanism by which the Probate Court of the Superior Court on the motion any trustee or interested person, or the AG, may apply *cy pres* to modify or terminate the trust by directing the trust property to be applied or distributed in whole or in part in a manner consistent with the settlor's purposes, if a particular charitable purpose becomes unlawful, impractical, wasteful or impossible to achieve.

Relevant First Circuit Provisions

Certification of Need for Health Care Facilities

Maine

The Health Care Oversight division of the Department of Health and Human Services conducts Certificate of Need review. DHHS has authority to approve or deny the acquisition, expansion or development of health care services or facilities. 22 M.R.S.A. c. 103, 103-A.

Massachusetts

Massachusetts Department of Public Health oversees the Determination of Need ("DoN") regulations. The key regulations and statutes:

- M.G.L. c. 111, §§ 25B - 25G
- M.G.L. c. 111, §§ 51 - 53, 51A
- 105 CMR 100.000 et seq.

New Hampshire

New Hampshire requires a Certificate of Need (CON) for the following project types, if they are above annually-indexed cost thresholds:

- construct or modify health care facilities,
- acquire new medical equipment, or
- offer new inpatient care beds and services.

The current thresholds are:

- $3,050,117 for any acute care facility project
- $2,033,411 for any other licensed health care facility project (nursing home, ambulatory surgical center, rehabilitation hospital, psychiatric hospital, specialty hospital, outpatient clinics); and

- $400,000 for equipment

The program is overseen by an appointed board, the Health Services Planning and Review Board, assisted by the Office of Health Services Planning and Review, an administrative unit of the Department of Health and Human Services. The program is established by R.S.A. ch. 151-c.

Rhode Island

The Rhode Island Certificate of Need Program is overseen by the Office of Health Systems Development, a division of the Rhode Island Department of Health. The review is set forth in R.I.G.L. ch. 23-15. Acquisitions, mergers, and new healthcare facility constriction are subject to the determination of need process, as are equipment or building renovations over statutory thresholds.

Sale, Transfer, Merger or Acquisition

Maine

A nonprofit corporation may sell or transfer all or substantially all of its assets, authorized by at least a majority of the corporation's members, or if there are no members entitled to vote, by a majority of the corporation's directors. 13-B MSA §10.

Massachusetts

The Attorney General's Non-Profit Organizations/Public Charities Division has regulatory authority over transactions involving nonprofits. Mergers and consolidations must comply with the statutory requirements, set forth at M.G.L. c. 180, § 10.

If a Massachusetts public charity merges or consolidates then the surviving corporation must also be a public charity governed under M.G.L. c. 180, § 10A(a).

A sale of all or substantially all of the assets of a public charity requires compliance with M.G.L. c. 180, § 8A, including advance notice to the AGO.

New Hampshire

Acquisition transactions involving health care charitable trusts are governed by R.S.A. 7:19 and Department of Health and Human Services regulations at He-Hea 1200 et seq. Prohibitions on monopolies, which may be applicable to hospital mergers, are set forth in R.S.A. 356:2 and 356:3.

Rhode Island

Transfer of 20% or more of ownership, control or assets requires approval of both the Rhode Island Department of Health and the RI Department of the Attorney General as set forth in the Hospital Conversions Act, R.I. Gen. L. § 23-17.14. Merger and consolidation of two nonprofits are governed by R.I. Gen. L. §§ 7-6-43 through 7-6-48.

Conversion

Maine

The Attorney General has jurisdiction to review and approve the conversion of a nonprofit corporation to a for-profit corporation or to an out of state nonprofit. 5 MSA §194. The transaction must comply with 5 MSA §§ 194-C through 194-H. As defined, conversion includes transfer or change in control over the assets of the nonprofit, but excludes " a transaction that supports or continues the charitable activities of the public charity." 5 MSA § 194-B Conversions of assets with fair market value less than $50,000 require notice to the Attorney General, and are deemed approved absent a rejection by the AG within 20 days. The attorney General has authority to approve a conversion of assets with FMV between $50,000 and $500,000. A conversion in excess of $500,000 must be approved by the Superior Court.

Massachusetts

The transfer of a non-profit, acute care hospital to a for-profit entity is subject to review by the Attorney General's Office under M.G.L. c. 180, §8A(d) and approval by a single justice of the Supreme Judicial Court. A transfer of 20% or more of the hospital's operations or assets triggers 8A(d) review. At least 90 days advance notice to the AGO is required.

New Hampshire

Conversion of a nonprofit corporation to for profit status is governed by RSA ch. 151-c.

Rhode Island

Transfer of 20% or more of ownership, control or assets requires approval of both the Rhode Island Department of Health and the RI Department of the Attorney General as set forth in the Hospital Conversions Act, R.I. Gen. L. § 23-17.14. Review of a transfer of ownership or control of a healthcare facility from nonprofit to for profit ownership is covered under this statute.

Dissolution

Maine

A nonprofit corporation may voluntarily dissolve, authorized by at least a majority of the corporation's members, or if there are no members entitled to vote, by a majority of the corporation's directors. 13-B MSA §1101. Creditors may bring a dissolution complaint against an insolvent nonprofit. 13-B MSA § 1105.

A nonprofit corporation may sell or transfer all or substantially all of its assets, authorized by at least a majority of the corporation's members, or if there are no members entitled to vote, by a majority of the corporation's directors. 13-B MSA §10.

If the authorized asset sale constitutes a conversion transaction, approval by the Attorney General, and if applicable, the Superior Court, is required. Id. *See* 5 MSA §§ 194-C through 194-H.

Massachusetts

The Attorney General's Non-Profit Organizations/Public Charities Division has regulatory authority over dissolution of public charities. M.G.L. c. 180, § 11A.

A nonprofit with no remaining net assets conducts its dissolution through an administrative dissolution petition filed with the Attorney General's Office. A nonprofit that has remaining net assets at the time it seeks to dissolve must obtain the approval of the Supreme Judicial Court. That approval starts with a complaint filed, nominally, against the Attorney General, followed by AGO review. In most cases, the Attorney General review will result in consent to the requested relief, dissolution. The dissolution complaint is heard by a single justice of the SJC.

New Hampshire

Dissolution is governed by statute, R.S.A. 292:9 through 292:10-a. Form NP-5 must be filed with Secretary of State Corporations Division. The form calls for a detailed plan for the disposition of assets and satisfaction of debts.

Rhode Island

A nonprofit corporation may voluntarily dissolve. R.I. Gen. Laws §§ 7-6-50 through 7-6-55. Creditors may bring a dissolution complaint against an insolvent nonprofit. R.I. Gen. Laws. § 7-6-60(a)(2). The Superior Court, in the county where the registered or principal office is located, has jurisdiction to determine dissolution complaints brought by the corporation, a director or member, or a creditor. R.I. Gen. Laws. § 7-6-60.

Procedures for liquidating the assets of a nonprofit, including the power to appoint a receiver and determination of the order of priorities of distributions, are specified in R.I. Gen. Laws. § 7-6-61.

Cy pres

Maine

When the particular charitable purpose of a trust becomes unlawful, impracticable, impossible to achieve, or wasteful, the court may modify or terminate the trust in a manner consistent with the settlor's charitable purposes. 18-B M.R.S. §413.

Massachusetts

Notice to the Office of the Attorney General required. The AGO may determine that judicial approval required. If so, the nonprofit seeks that approval via a complaint to the Single Justice of the Supreme Judicial Court. M.G.L. c. 180, § 8A(c).

Under the Uniform Prudent Management of Institutional Funds Act, codified at M.G.L. ch. 180A, § 5(d) and Supreme Judicial Court Rule 1:23, an institution seeking to modify certain restrictions of an institutional fund that has been in existence for 20 years or longer and has a total value of $75,000 or less as of the end of its last fiscal year may do so without petitioning the court for relief if the institution obtains the consent of the Attorney General.

New Hampshire

Cy pres standards are set forth at RSA 498:4-a through 498:4-e and RSA 547:3-c Jurisdiction to determine cy pres issues is in the probate court, unless related to an already pending superior court case. RSA 498:4-a.

Rhode Island

The Superior Court, in the county where the registered or principal office is located, has jurisdiction to determine distribution of assets of a nonprofit corporation in liquidation. R.I. Gen.

L. §§ 7-6-60, 7-6-61. Determination is made by complaint filed with Superior Court. R.I. Gen. L. § 18-4-1.

Health Care Reform Acronym Sheet

Health Reform Acronym	What it Stands For	Definition
ACA (or PPACA)	Patient Protection and Affordable Care Act	The comprehensive health care reform bill passed in March, 2010 that seeks to achieve a triple aim of better population health, lower per capita costs, and elevated patient experience.
ACO	Accountable Care Organization	Comprised of one or more providers (physician groups, hospitals) and a payer (Medicare, private insurers), ACOs receive shared savings bonuses—along with traditional fee-for-service payments—for lowering costs and increasing quality of care for their assigned patients.
ARRA	American Recovery and Reinvestment Act of 2009 ("Stimulus Bill")	The health care aspects of the bill focus on extending money to states for Medicaid and to the uninsured for private insurance.
BPCI	Bundled Payments for Care Improvement Initiative	Program in which Medicare issues one sum, or a “bundled” payment, to the physicians, hospitals, and post-acute care providers involved in delivering an episode of care during a specific time period.
CHIP	Children’s Health Insurance Program, enacted 1997	Program of the Health and Human Services department to offer health care financing to families with children.
CI	Clinical Integration	Clinical integration (CI) is a legal arrangement that allows hospitals and physicians to collaborate to improve quality and efficiency while remaining independent entities.
CMS	Centers for Medicare & Medicaid Services	Government organization within the Department of Health and Human Services that manages Medicare, Medicaid, and CHIP.
EHB	Essential Health Benefits	A list of benefits that must be covered by all new health care plans beginning on January 1, 2014.
EHR	Electronic Health Record	Digital medical record designed to be shared among locations.
EMR	Electronic Medical Record	Digital medical record designed to serve on system or entity.
EBP	Evidence-based practice	Evidence-based practice is the explicit use of the best available medical evidence in making clinical decisions.
ESI	Employer Sponsored Insurance	Insurance paid by businesses on behalf of their employees.
FFS	Fee-For-Service	System of payment to providers where providers receive reimbursement for each service they perform.
FPL	Federal Poverty Level	Income level set by the federal government. Key in determining eligibility and corresponding subsidies for ACA programs.
FQHC	Federally Qualified Health Center	Clinics offering comprehensive health care to an underserved population and receive Medicare and Medicaid payment.
FTE	Full Time Equivalent	For purposes of the ACA, this is 30 hours/wk or more.

GF	Grandfathered Health Plan	Established health plans that need not include EHBs.
HAC	Hospital-Acquired Conditions	Illnesses or complications that patients contract during their hospital stay and are considered to be highly avoidable.
HCAHPS	Hospital Consumer Assessment of Health Care Providers and Systems	The HCAHPS survey measures patient experience.
HCR	Health Care Reform	Ongoing legislative and regulatory movement.
HHS	U.S. Department of Health and Human Services	Overarching department responsible for providing Americans with health care services and improving overall health.
HIE, HIM or HIX	Health Insurance Exchange (or Marketplace)	Several names are used to describe the ACA's online portals to register for private or government insurance.
HIPAA	Health Insurance Portability and Accountability Act of 1996	Law designed to ensure patient health care privacy.
HITECH	Health Information Technology for Economic and Clinical Health Act	Enacted through the 2009 ARRA, this act offers regulations and funding for hospitals and physicians to implement health IT.
HRP	High Risk Pools	ACA-established insurance for those with preexisting conditions.
ICD-10	International Statistical Classification of Diseases and Related Health Problems	10th version of the codes to classify disease in provider settings. Used heavily be CMS and insurance firms to allot payments.
IDN	Integrated Delivery Network	A formal system of providers and sites of care that provides both complete health services and a health coverage plan to patients in a particular geographic area.
TJC (formerly JCAHO)	The Joint Commission	The Joint Commission (TJC) is an independent, not-for-profit organization that accredits and certifies hospitals and other types of health care organizations and providers.
MA	Medicare Advantage	A Medicare plan offered by a private company that works with Medicare to deliver care and receive payments.
MCO	Managed Care Organization	Health care delivery method managed by a private company where patients agree to visit only certain doctors and hospitals.
MEC	Minimum Essential Coverage	A level of basic medical care individuals are mandated to maintain under the ACA.
MedPAC	Medicare Payment Advisory Commission	Group which advises Congress on the Medicare program.
MSSP	Medicare Shared Savings Program	Shared savings is a payment model where providers are paid for each procedure they perform and may receive bonus income for reducing spending below a spending target. The MSSP is CMS's program to establish the ACOs that receive these payments.
MU	Meaningful Use	Series of guidelines from the HITECH Act to encourage providers to achieve high-level electronic record competency.
PCMH	Patient-centered Medical Home	A team-based care model for physician groups centered on the effective provision of primary and preventive care.
QHP	Qualified Health Plan	An insurance plan providing essential health benefits and approved to be sold on a health insurance marketplace.
RRP	Readmissions Reduction Program	This Medicare program, implemented under the ACA, will significantly penalize hospitals for having a high rate of patients readmitted to a hospital within 30 days of a prior acute care stay.

SHOP	Small Business Health Options Program	Specific health insurance exchanges for small business owners to purchase employer-sponsored insurance for workers.
VBP	Value-Based Purchasing	A CMS initiative that positively or negatively adjusts Medicare reimbursement based on performance on quality metrics.

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Glossary of terms used in medical practice management

OR: Medical practice management glossary

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| R | S| T | U | W | X | Sources]

A

Accounts Receivable: The amounts due to a practice from patients, insurance companies, and other customers for services provided.

Accreditation Association for Ambulatory Healthcare (AAAHC): This organization offers voluntary accreditation for ambulatory care organizations.

Accrual accounting: A system of accounting where revenues are recorded as earned when services are performed, rather than when cash is exchanged. Cost is recorded in the period during which it is incurred, that is, when the asset or service is used, regardless of when cash is paid. Costs for goods and services that will be used to produce revenues in the future are reported as assets and recorded as costs in future periods.

ACMPE Body of Knowledge for Medical Practice Management: Defined by ACMPE, this document contains a comprehensive description of the knowledge, skills and abilities requisite for success in the medical practice profession.

Actuary: Using probability and statistics, performs financial forecasts as to policy rates, reserves and dividends.

Adjusted Average Per Capita Cost (AAPCC): An estimate developed by Centers for Medicare & Medicaid Services (CMS) equivalent to the cost of care for Medicare beneficiaries in a given area based on historical fee-for-service payments.

Adjusted Community Rate (ACR): The premium the managed care organization would charge to provide the Medicare-covered benefits to a group account adjusted for the expected increased utilization by Medicare beneficiaries. It can also be used for other industry classes.

Adjustments to fee-for-service charges: The difference between the fee-for-service charges based on the practice's fee schedule and the amount expected to be paid by patients or third-party payers. This represents the value of services performed for which payment is not expected due to contractual agreements or other reasons.

Administrative Code Sets: Code sets that characterize a general business situation, rather than a medical condition or service. Under HIPAA, these are sometimes referred to as non-clinical or non-medical code sets. See also Code Sets and Medical Code Sets.

Administrative Services Organization (ASO): An insurance company that provides only administrative services such as claims processing, stop-loss coverage, network development, etc. The plan purchaser (i.e. employer) assumes all risks associated with the provision of payments or services to beneficiaries.

Administrative Simplification: Title II, Subtitle F, of HIPAA which authorizes HHS to: (1) adopt standards for transactions and code sets that are used to exchange health data; (2) adopt standard identifiers for health plans, health care providers, employers, and individuals for use on standard transactions; and (3) adopt standards to protect the security and privacy of personally identifiable health information.

Admissions/1000: The number of hospital admissions per thousand plan enrollees per year.

Advanced Beneficiary Notice (ABN): A document to inform a Medicare beneficiary before a service is provided that Medicare will probably not pay for the service. The notice enables the beneficiary to decide whether or not to receive the service and pay for the service out of pocket or through another insurance company.

Adverse Drug Event (ADE): The harmful result of a medication, whether or not it is a result of a medication error.

Adverse Selection: Describes a plan with a disproportionate percentage of enrollees who are more likely to file claims and use services because of existing higher health risk conditions, such as AIDS and substance abuse populations.

Agency for Health Care Policy and Research (AHCPR): See Agency for Healthcare Research and Quality

Age Discrimination in Employment Act of 1967 (ADEA): The act protecting individuals age 40 and older from discrimination in the workforce. It is unlawful to discriminate against a person because of his/her age with respect to any term, condition, or privilege of employment -- including, but not limited to, hiring, firing, promotion, layoff, compensation, benefits, job assignments, and training.

Age/Sex Rating: A method of structuring capitation payments based on enrollee/membership age and sex.

Agency for Healthcare Research and Quality (AHRQ): agency in the U.S. Department of Health and Human Services that funds research and demonstration

projects relating to health care quality. Formerly the Agency for Health Care Policy and Research (AHCPR).

Allowable Charge: The maximum amount a third-party will reimburse for a given service.

All Patient Diagnosis Related Groups (APDRG): Expands DRGs beyond Medicare beneficiaries to include pediatric, maternity and HIV-related groupings.

All-Payer System: All payments for health care services are the same regardless if the payer is a self-insured employer plan, private insurer, individual, or Federal or State government.

Alternative Delivery System (ADS): A method of providing health care benefits that departs from traditional indemnity methods. An HMO, for example, can be said to be an alternative delivery system.

Alternative Medicine: Also referred to as integrated or complementary medicine. Includes non-allopathic therapies such as homeopathy, massage, acupuncture, chiropractic care, etc.

Ambulatory Encounter: A documented, face-to-face contact between a patient and a provider who exercises independent judgment in the provision of services to the individual in an ambulatory setting. Ambulatory settings include: provider's office, patient's home, outpatient hospital, emergency room, ambulatory surgery center, nursing facility, public health clinics, mental health facility, etc. See also Encounter and Hospital Encounter.

Ambulatory Patient Groups (APGs): Similar to DRGs, assigns ambulatory patients into case types to provide a pricing mechanism for outpatient services.

Ambulatory Surgery Center (ASC): A freestanding entity that is specifically licensed to provide surgery services that are performed on a same-day outpatient basis. To qualify for ASC certification under Medicare a facility must be (1) a distinct entity that operates exclusively to furnish outpatient surgical services, (2) either an independent freestanding facility, or under the common ownership, licensure or control of a hospital and (3) surveyed and approved by CMS.

Ambulatory Visit Group (AVG): Similar to the DRG classification, but refers to ambulatory rather than hospital care.

American College of Medical Practice Executives (ACMPE): ACMPE is the standard-setting and certification body of the Medical Group Management Association (MGMA), offering board certification and Fellowship in medical practice management.

Americans with Disabilities Act of 1990 (ADA): The act prohibiting discrimination against people with disabilities in employment, transportation, public accommodation, communications, and governmental activities. It requires that reasonable accommodations for accessibility and employment must be made in public places and businesses, including medical practices.

Ancillary Services: Services other than physician and nursing services, including clinical laboratory, radiology and imaging and other medical support services.

Anniversary: The beginning of a subscriber group's benefit year. A subscriber group with a year coinciding with the calendar year would be said to have a January 1st anniversary.

Antikickback Statute: This statute (42 U.S.C. §13201-7(b)) prohibits anyone from paying or accepting a payment in exchange for services that might be covered by the federal health programs (i.e., Medicare and Medicaid).

Any Willing Provider (AWP): State laws requiring a managed care network to accept any physician or non-physician provider who meets the network's usual selection criteria, is willing to be reimbursed at the managed care organization's rates, and agrees to the managed care organization's utilization guidelines.

Application Service Provider (ASP): A third-party entity that manages and distributes software-based services and solutions to customers across a wide area network from a central data center. ASPs enable practices to outsource some or almost all aspects of their information technology needs and to manage the financing of new systems.

ASA Units: The American Society of Anesthesiologists (ASA) nonmonetary, relative units of measure that indicate the value of anesthesia services. Each unit consists of three components for each procedure: base unit, time in 15-minute increments and risk factors. See also Relative Value Units (RVUs)

Attrition Rate: Disenrollment expressed as a percentage of total membership. An HMO with 50,000 members experiencing a two percent monthly attrition rate would need to gain 1,000 members per month in order to retain its 50,000-member level.

Auto Managed Care: Auto insurance companies contract with provider networks for healthcare services for injured motorists on a capitation basis. Originally developed in Colorado in 1991, auto managed care is designed to reduce costs associated with motor accidents. Unlike traditional managed care, there is no preventative care and focuses on soft-tissue damage utilizing chiropractors, physical therapists, massage therapists, acupuncturists, etc.

Average Length of Stay (ALOS): Refers to the number of hospital days per admissions (total days/total admissions). May also be called length of stay (LOS) and estimated length of stay (ELOS).

Average Payment Rate (APR): The maximum amount CMS will pay to an HMO or competitive medical plan for Medicare services provided under a risk contract and weighted by age, sex, geographic locator and acuity.

Average Sales Price: For CMS' purposes, a manufacturer's average sales price is calculated by National Drug Code for each calendar quarter by dividing a manufacturer's total sales by the total number of units sold in that quarter.

Average Wholesale Price: For CMS' purposes, the average wholesale price intended to represent the average price used by wholesalers to sell drugs to their customers. It has been based on prices reported by drug manufacturers that are published in industry reference publications or drug price compendia.

B

Bad Debt: Accounts receivables that are declared to be uncollectible and are usually written off. A medical practice may choose to outsource the collection of these accounts to a collection agency.

The Balanced Budget Act of 1997 (BBA):– The Act (Public Law 105-33) which contained 335 provisions related to the Medicare program that required the development of new regulations and policies for providers. Most notably, this legislation reduced Medicare provider payments and restructured the formula used to set Medicare reimbursement rates.

Basic Health Services: Benefits that all federally qualified HMOs must offer as defined under Subpart A, 110.102 of the Federal HMO Regulations.

Benchmarking: The process of comparing performance to a preestablished standard or performance of another facility or group with the goal of determining best practices and achieving superior performance.

Benefit Package: A collection of specific services or benefits that the HMO is obligated to provide under terms of its contracts with subscriber groups or individuals.

Benefit Year: A 12-month period that a group uses to administer its employee benefits program. A majority of subscribers use a January through December benefit year. A benefit year, however, may not match the fiscal year used by a group, for example, mental health benefits may coincide with the member's anniversary date.

Block scheduling: Appointment scheduling system that schedules several patients to arrive at the same time, for example on the hour and half-hour. See also Modified Wave Scheduling and Open Access Scheduling.

Bonus Pool: An amount of money set aside to be given to providers for meeting certain performance standards. See also Withhold.

Break-Even Point: The HMO membership level at which total revenues and total costs are equal and therefore produces neither a net gain nor loss from operations.

Bundling: The setting of an inclusive package price or global fee for all the medical services required for a specific procedure (usually includes both professional and institutional services), for example, maternity care or coronary artery bypass graft. May also be known as package pricing.

Business Associate: Under HIPAA, a person or organization that performs a function or activity on behalf of a covered entity, but is not part of the covered entity's workforce. A business associate can also be a covered entity in its own right.

Business Coalition: Several employers in a community form a cooperative with the intent to purchase health care at a lower cost for their employees.

Business Corporation: A for-profit organization recognized by law as a business entity separate and distinct from its shareholders. Shareholders need not be licensed in the profession practiced by the corporation.

Buy-in agreement: The legal agreement between an individual physician and a medical practice that specifies the requirements and process for the physician to become a shareholder of the practice.

C

C-Corporation: A corporate structure that may issue two types of stock (common and preferred) with different voting and distribution rights. Physicians my easily buy in and out of the corporations stock. Income of the corporation is taxed twice: as the corporation's income and as the dividends distributed to stock holders. See also S-corporation.

Cafeteria Employee Benefit Plan: Employer provides a set amount of money to each plan which employees use to pay for the benefits they select from a range of options. Options include: health, dental or life insurance; vision care; child and dependent care; and retirement plans. The plans may also be funded by employee contributions. Also known as Flexible Benefit Plans. See also Section 125 Plans.

Capital Expenditure: Expenses that will be deducted over a number of years representing the asset's useful life as the purchase price is depreciated over the years. Capital expenditures are defined by the Internal Revenue Service but typically include: office buildings, building improvements, major medical or office equipment, information technology, and office furniture.

Capitation: The per capita payment for providing a specific menu of health services to a defined population over a set period of time. The provider usually receives, in advance, a negotiated monthly payment from the HMO. This payment is the same regardless of the amount of service rendered by the medical practice. See also Global Capitation and Contact Capitation.

Carve-Out: Services separately designed and contracted to an exclusive, independent provider by a managed care plan. For example, psychiatry is often a carved-out service.

Case Management: Patients with a specific diagnosis or who require extensive services are identified and a plan developed to systematically coordinate patient care

to insure appropriate care with the best outcome and to reduce the costs of providing service.

Case Mix: Set of categories of patients (type and volume) treated by a healthcare organization and representing the complexity of the organization's case load.

Case Rate: The rate for an established medical procedure or diagnosis to include all services and charges that relate to that procedure or diagnosis. It is best used for procedures or diagnoses with quantifiable services and a specific length of service. An example would be transplants.

Cash Accounting: A system of accounting where revenues are recorded when cash is received and costs are recorded when cash is paid out. See also Accrual Accounting and Modified Cash Accounting.

Cash Indemnity Benefits: Sums that are paid to insure for covered services and that require submission of a filed claim. Insurers may assign such payments directly to providers of services (hospitals, physicians, etc.). Payments may or may not fully reimburse enrollees for costs incurred. See also Indemnity Insurance.

Catchment Area: The geographic area from which a managed care organization draws its patients.

Census: A statistical listing of enrollees by age, sex, number of dependents, etc. (also called on eligibility list).

Centers for Medicare & Medicaid Services (CMS): The agency, part of the U.S. Department of Health and Human Services, which manages the Medicare and Medicaid programs and oversees the State Children's Health Insurance Program (SCHIP) with the Health Resources and Services Administration. Formerly the Health Care Financing Administration.

Channeling: Designing the plan's incentives to encourage plan members to use network providers.

Charge: Price assigned to a unit of medical or health service, such as a visit to a physician or a day in a hospital. The charge for a service may be unrelated to the actual cost of providing the service. See also Allowable Charge.

Charge Capture: The process of collecting all services, procedures, and supplies provided during patient care.

Charity Care: Fee-for-service gross charges, at the practice's undiscounted rates, for all services provided to charity patients. Charity patients are patients who do not have the resources to pay for services. See also Professional Courtesy.

Cherry Picking: Refers to insurance plan practice of enrolling only healthy individuals while not accepting individuals with existing health problems.

Chronic Care Network (CCN): An integrated health care network to serve patients with chronic conditions. CCNs can follow a patient population across time, place and provider and have a key prevention role.

Churning: From the insurance perspective, churning is continually replacing lost customers with new customers. From the provider perspective, churning is constantly seeing a patient for services that may not be appropriate.

Civil Rights Act, 1964: The act prohibiting discrimination based on race, color, religion, sex, national origin, physical and mental handicaps and age. The Civil Rights Act of 1991 expanded individual protections to include sexual harassment.

Civilian Health and Medical Program of the Uniformed Services (CHAMPUS): The federal program providing health care coverage to families of military personnel, military retirees, certain spouses and dependents of such personnel. Currently provided under the TRICARE program. A medical benefits program established to cost-share charges for medically necessary civilian services and supplies required in the diagnosis and treatment of illness or injury when the required services are not available from the direct care system of Department of Defense treatment facilities or designated uniformed services treatment facilities (USTFs). See also TRICARE.

Clayton Antitrust Act, 1914: Prohibits mergers, acquisitions and certain joint ventures where the likely effect may be to substantially lessen competition or tend to create a monopoly.

Clinical Service Line Co-Management (CSLCM): This is a contractual management services agreement between a hospital or health system and a group of specialists to share responsibility for the outcomes of hospital-based clinical service lines. It is an alternative to gain sharing which has been questioned by the OIG.

Clinic Without Walls: A business entity legally combining independent physicians or medical practices in order to create centralized management and decision-making structures and to share administrative, billing, and purchasing costs. The result is an organization with multiple sites. The physicians and medical practices retain their independence by maintaining their private offices and practice styles. Assets are not merged. To qualify for a medical group exemption, a clinic without walls must bill as a single tax ID. Also known as group practice without walls.

Clinical Laboratory Improvement Amendments (CLIA), 1988: The law requiring certification of all laboratories, including physician offices, in accordance with federal regulations to ensure accuracy of laboratory testing.

Clinical Service Organization (CSO): Created by academic medical centers to integrate the activities of the medical school, faculty practice plan and hospital to negotiate with managed care plans.

Closed Panel: Medical services are delivered in the HMO-owned health center or satellite clinic by physicians who belong to a specially formed but legally separate medical group that only serves the HMO. This term usually refers to group and staff HMO models. Can also be a network.

Code Set: Under HIPAA, any set of codes used to encode data elements, such as tables of terms, medical concepts, medical diagnostic codes, or medical procedure codes. This includes both the codes and their descriptions. See also Administrative

Code Sets and Medical Code Sets.

Coinsurance: The portion of the cost for care received and for which an individual is financially responsible. Usually this is determined by a fixed percentage, as in major medical coverage. Often coinsurance applies after a specified deductible has been met.

Collections: The sum of fee-for-service collections, capitation payments and other medical activity revenues. Also called total medical revenue.

Community Health Information Network (CHIN): Information network linking providers, insurers, patients and suppliers throughout a community.

Community Mental Health Center: An institutional facility certified by Medicare, which provides outpatient services to the chronically mental ill.

Community Rating: A method for determining health insurance premiums based on actual or anticipated costs in a specific geographic location as opposed to an experience rating that looks at individual characteristics of the insured.

Compensation Plan: Plan specifying the amount of compensation a physician or other individual will receive from the medical practice or other. The compensation may be a specific amount (a salary) or based on the physician's productivity or other incentive system.

Complementary Medicine: See Alternative Medicine

Coordinated care organization: Organization developed to provide all the medical care, services and supplies for comprehensive care based on medical diagnosis or injury. Often developed to provider workers' compensation services.

Compliance Plans/Programs: Policies and procedures to ensure internal controls for compliance with applicable laws and regulations. Medical practices frequently develop compliance plans specific to fraud and abuse regulations, HIPAA and OSHA requirements.

Composite Rate: A uniform (weighted average) premium applicable to all eligible in a subscriber group regardless of number of claimed dependents. This rate is common among labor unions and large employer groups and usually does not require any contribution by the union member or employee.

Computer-Based Patient Record (CPR): See Electronic Health Record.

Computerized Provider Order Entry (CPOE): A computerized system typically deployed in hospitals or large practices wherein the provider directly enters orders for distribution to various operational systems or departments for their action. CPOE systems are most effective when coupled with clinical decision support to ensure complete, accurate and legible orders.

Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985: Federal employment insurance law that requires employers to provide a time limited health insurance plan to any employee that leaves the organization. The employee usually

pays the premium for the time period.

Consumer Assessment of Health Plans Survey (CAHPS®): A Medicare beneficiary satisfaction survey required by CMS. The survey is based on a database using a HEDIS subset and 33 Medicare-related measures.

Consumer-Directed Health Plan: Health plan characterized by influencing patients and clients to select cost-efficient healthcare through the provision of information about health benefit packages and through financial incentives. See also Self-Directed Health Plans.

Contact Capitation: A form of capitation most often applied to specialty physicians that takes different forms. Usually, patients select the specialist they choose to see and the managed care organization counts that patient as a single contact over a set period of time (a year, a quarter, or half year). The MCO pays that specialist the percentage of total capitation dollars that their contacts represented of the total specialty visits over the time period.

Continuity of Care Record (CCR): A content specification that provides a standard set of data for referrals to share with other healthcare providers. The set of basic patient information in the record includes patient and provider information, insurance information, patient's health status, recent care provided, as well as recommendations for future care, and the reason for referral or transfer. It was developed by the standards organization, ASTM International, and several medical societies.

Continuum of Care: Health care services provided either during inpatient hospitalization or for multiple diagnoses over a lifetime to give a basis for evaluating effectiveness, quality and cost of care.

Contract: An HMO agreement executed by a subscriber group (see group contract). The term may be used in place of subscriber when referring to penetration within a given subscriber group. Also used to designate an enrollee's coverage.

Contract Capitation (or case rate capitation): Reimbursement to participating specialists based on a referral or an episode of care.

Contract Mix: The distribution of enrollees according to contracts classified by dependency categories, for example, the number or percentage of singles, doubles, or families. Contract mix is used to determine average contract size.

Conversion Factor: A component of the Resource Based Relative Value Scale which sets reimbursement rates for services paid for by Medicare. The conversion factor captures fluctuations in physicians' fees, the number of Medicare beneficiaries, growth in the economy and costs to the Medicare program due to changes in law or regulation. The conversion factor also limits the growth of the Medicare program.

Conversion Privilege: This gives individuals under a group plan the right to convert from a group health policy to an individual policy in the event the individual leaves the group.

Coordination of Benefits: Establishes procedures to be followed in the event of

duplicate insurance coverage thus assuring that no more than 100 percent of the costs of care are reimbursed to the patient. Reimbursement is coordinated between the primary and secondary insurance carriers by the medical group.

Copayment: A payment made by an HMO enrollee at the time that selected services are rendered. Some employer benefit packages require a copayment between $2.00 and $20.00 for each doctor's office visit. Some impose a fixed dollar amount for inpatient hospitalization. Copayments are subject to limitation as defined in Subpart A, 110.105 of the Federal HMO Regulations. Copayments are deducted from the providers' reimbursement rate.

Corporate practice of medicine: Regulations enacted at the state level affecting physicians ability to provide medical services on the behalf of, or in concert with, any organization other than a professional services corporation for the practice of medicine. The regulations were enacted to prevent commercial exploitation of medical practice and prevent any conflict in physicians' loyalty between their patients and their employers.

Covered Entity: Defined by HIPAA as 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 Service: Specific service for which a healthcare insurance company will pay.

Credentialing: Obtaining, reviewing and verifying documentation of training, experience and board certification for physicians and other providers. This is done by an insurer or a third party or full risk medical groups if delegated.

Critical Path: A pathway or protocol specifying the best procedures and treatment based on the specific disease or medical event that the patient has been diagnosed with. Also called clinical pathways or protocols.

Current Procedural Terminology® (CPT®): A standard system of codes and descriptive terms, developed by the American Medical Association, for the reporting of medical procedures and services provided by physicians and other healthcare providers.

D

Data Content: Under HIPAA, this is all the data elements and code sets inherent to a transaction and not related to the format of the transaction.

Data Mining: The process used to query and analyze a data warehouse for trends.

Data Warehouse: Integrates separate databases within a health care system for the interchange of data to allow the MIS system to handle data from several sources as if from one source.

Days per Thousand: Utilization measure of hospital days incurred annually for each thousand covered lives per year.

Decision Support Software: Designed to make relevant information accessible to decision makers.

Deductible: The part of an individual's health care expenses that the patient must pay before coverage from the insurer begins. The annual deductible coincides with the subscriber's contract anniversary.

Deferred Compensation: Pretax compensation that an employee chooses to direct into a retirement account. There are three types of accounts: qualified retirement accounts (including defined contribution, define benefit and 401(k) plans); tax-deferred annuities as described in the Internal Revenue Code Section 403(b); and unfunded deferred compensation plans for tax-exempt organizations as specified by Internal Revenue Code Section 457.

Defined Benefit Pension Plan: Employees receive a fixed or determinable retirement benefit at normal retirement age based on a formula specified in the plan.

Defined Care: Term applied to defined contribution and self-directed health plans.

Defined Contribution Pension Plan: Employer contributes a specific amount to the plan for each employee each year. The value of an employees' account will vary upon retirement depending on value of the individual accounts' investments, length of service and time of termination.

Defined Contribution Insurance Plan: Employers make a specific dollar contribution towards the cost of insurance coverage for employees without defining or guaranteeing the nature or amount of services provided. Employees may pay up to the deductible until catastrophic insurance coverage takes effect. Because employees choose how to spend the defined contribution amount, the employer doesn't have to be responsible for the cost differences between any of the available plans. See also Health Reimbursement Accounts.

Demand Management: Use of decision and behavior support systems, such as self-care interventions, health promotion and education tools, to encourage patients to use medical services appropriately.

Designated Code Set: A medical code set or an administrative code set that is required to be used by the adopted implementation specification for a standard transaction.

Designated Health Services: The services determined by the Stark Law that a physician cannot refer a Medicare or Medicaid patient to if the physician has an ownership or investment interest in the facility providing the service. The services include medical laboratory, physical therapy, radiology and imaging, occupational therapy, radiation therapy, DME, prosthetics and orthotics, home health, outpatient prescription drugs, and inpatient and outpatient hospital services.

Diagnosis Related Groups (DRGs): Classification system developed at Yale University using 383 major diagnostic categories based on the ICD-9 codes. This

procedure assigns patients into case types. DRGs were originally designed to facilitate the utilization review process but they are also used to analyze patient case mix in hospitals and determine hospital reimbursement policy.

Digital Imaging and Communications in Medicine (DICOM): Standard protocol for exchanging medical images among computer systems.

Digital Signature: A means to guarantee the authenticity of a set of input data in the same way that a written signature verifies the authenticity of a paper document; a cryptographic transformation of data that allows a recipient of the data to prove their source and integrity and protect against forgery.

Direct Compensation: See Total Compensation. See also Indirect Compensation.

Direct Contracting: Individual employers or business coalitions contract directly with providers for health care services with no HMO/PPO intermediary. This enables the employer to include in the plan the specific services preferred by their employees and is usually done under ERISA guidelines.

Discounted Fee-For-Service: Physician services provided as fee-for-service but at a negotiated rate less than the usual charge.

Disease Management: The integrated monitoring of a patient, particularly with a chronic illness, to focus on prevention of recurrence, improved quality of life, and cost-effective care. Also refers to the systematic study of a diagnosis or intervention to focus on the outcomes for a population, rather than an individual patient.

Disenrollment: Procedure for deleting individuals or groups from a provider or plan.

Doctor's Office Quality Information Technology Project (DOQ-IT): A CMS initiative to promote the use of electronic health records (EHRs) in medical practices.

Drug Formulary: List of medications covered by a plan and dispensed through participating pharmacies.

Dual Choice: A health benefit offered by an employment group permitting eligibles of the group a voluntary choice of health plans; usually the employer's primary insurer and an HMO.

Due Diligence: Level of prudence to be expected from a reasonable person under specific circumstances.

Due Process (DP): A type of managed care law which imposes requirements on health care related to provider participation. Typically these laws impose certain fairness requirements on the manner in which providers are selected and/or terminated from health plans (e.g., by requiring notice of the formation of networks, disclosure of selection criteria, etc.). Due process provisions are often included in any willing provider statutes.

Dumping: This refers to denying or limiting medical care when patients are transferred to another facility because of inability to pay for treatment. This is legally prohibited unless the transfer is medically necessary.

Durable Medical Equipment (DME): Equipment with a primary medical purpose and continually reused, such as wheelchairs, etc.

E

E-Health: A broad term describing the many information technology applications in the healthcare industry including e-mail communication between patients and providers, telemedicine, and Internet-based tools such as online scheduling, patient education resources, etc.

Economic Credentialing: The selection process of using economic criteria (number of referrals, number of tests, etc.) in addition to quality of care and professional competency to determine a provider's qualifications to be added to hospital medical staff or to continue to have staff privileges.

Electronic Data Interchange (EDI): Exchange of information between two or more organizations using electronic transmission. EDI uses network transaction standards from the ANSI Accredited Standards Committee (ASC) X12.

Electronic Health Record (EHR): A computer-based medical record system that provides for the capture of data from multiple sources and is used as the primary source of information to support clinical decision making at the point of care.

Electronic Medical Record (EMR): A term that is often used in physician practices to refer to EHRs. In hospitals, EMR often refers to a document imaging system.

Electronic Remittance Advice: Any of several electronic formats for explaining the payments of health care claims. See also Explanation of Benefits.

Electronic Signature: Any representation of a signature in digital form, including an image of a handwritten signature. It is not as secure as a digital signature.

Emerging Healthcare Organizations (EHO): Hospitals, physicians and/or payers that are merging, integrating or affiliating in response to changes in the health care environment.

Employee Assistance Program (EAP): A program provided by an employer to assist employees dealing with emotional or personal issues that may impact employee performance.

Employee Mandate: A state law requiring an employer to provide health coverage or pay a share of employee's health insurance. Sometimes referred to as benefit mandate.

Employee Retirement Income Security Act (**ERISA) of 1974:** This act sets federal requirements for pension and employee benefit plans to include employer health plans. It addresses plan design issues and discrimination within a benefit plan. Employers are allowed to determine the medical costs of their own group and to self-

fund the risk of employee medical costs. In addition, the act provides that the employer is not subject to premium tax or mandated benefits.

Employer Identifier Number: A standard adopted by the Secretary of HHS to identify employers in standard transactions. The IRS' Employer Identification Number (EIN) is the adopted standard.

Employment agreement: Formal agreement or contract between an employee and the employing organization (i.e. group practice) specifying the individual's and organization's responsibilities, compensation and benefits for work performed, and terms under which agreement will be terminated.

Encounter: A documented, face-to-face contact between a patient and a provider who exercises independent judgment in the provision of services to the individual in an ambulatory or hospital setting. If a patient with the same diagnosis sees two different providers on the same day, it is one encounter. If a patient sees two different providers on the same day for two different diagnoses, then it is considered two encounters. See also Ambulatory Encounters.

Endorsement: Official change in the provisions of coverage issued by the insurer and attached to the policy or certificate.

Enrollment: The process of converting subscriber group potential enrollees into HMO members or the aggregate count of HMO enrollees as of a given time.

Episode of Care: All the care and services provided for a specific diagnosis for a specific time frame.

Evaluation and Management Coding (E/M or E&M Coding): CPT® codes for services where physicians spend face-to-face time with a patient. The key elements involved in an E&M service are (1) obtaining a medical history, (2) performing a physical examination and (3) making medical decisions. The medical decisions may involve varying levels of medical involvement ranging from low to high. Codes used for E&M services delineate this involvement into five levels.

Evergreen Contracts: Refers to managed care contracts that renew automatically after the initial term has been completed.

Evidence-Based Medicine: The practice of medicine base on clinical decision support using evidence of best practices rather than an arbitrary set of rules.

Evidence of Insurability: Statement or proof of a health status necessary to obtain healthcare insurance, especially private healthcare insurance.

Exclusion: Situation, instance, condition, injury or treatment that the health plan states will not be covered and for which the health plan will not pay any benefits.

Exclusive Provider Organization (EPO): While similar to a PPO in that an EPO allows the patient to go outside the network for care, if he/she does so in an EPO, they are required to pay the entire cost of care. An EPO differs from an HMO in that EPO physicians do not receive capitation but instead are reimbursed only for actual services provided.

Exempt employees: Employees exempt from the minimum wage and overtime requirements of the Fair Labor Standards Act, provided they meet certain tests regarding job duties and responsibilities and are compensated on a salary basis at not less than stated amounts. Executive, administrative, professional, and outside sales personnel are included in the definition.

Experience Rating: A method to determine an HMO premium structure based on the actual utilization of individual subscriber groups. This is not a permissible rating method under federal qualification requirements. Age, sex, and utilization experience are the principal determinants in rate setting using this method. Outside the HMO setting, experience rating is the most prevalent method used.

Explanation of Benefits (EOB): Information returned to a provider and patient describing the payments a health plan will make based on a patient's benefits and the payer's policies. Also called remittance advice.

F

Faculty Practice Plan: A form of group practice organized around medical school faculty or physicians. The faculty associated with the plan provides patient care as part of the teaching and research responsibilities of the medical school. The practice plan is responsible for billing, collections, contract negotiation and redistribution of income.

Fair Labor Standards Act of 1938 (FLSA): The act establishing minimum wage, overtime pay, recordkeeping, and child labor standards affecting full-time and part-time workers in the private sector and in federal, state, and local governments and defining which employees are exempt from minimum wage and overtime restrictions.

False Claims Act: This statute prohibits the presenting of a claim to the United State that the claimant knows to be "false, fictitious, or fraudulent," including billing for services that weren't rendered or weren't medically necessary and filing claims at inflated rates.

Family and Medical Leave Act of 1993 (FMLA): The act allowing employees up to 12 weeks of unpaid leave within a 12-month period for a serious health condition, the birth or adoption of a child, or caring for a relative with a serious illness. Employees are eligible if they have worked for the company or practice for more than one year, for 1,250 hours over the previous 12 months, and if there are at least 50 employees within the organization.

Federal Insurance Contributions Act (FICA): Federal law that requires a paycheck deduction and employer contribution with the income contributed to the Social Security and Medicare program.

Federal Qualification: The Health Maintenance Organization Act of 1973 encouraged the development of HMOs. Under this act, HMOs that voluntarily chose to comply with regulatory requirements more stringent than state law are eligible to receive federal grants and loans. The act also requires large employers to make HMO

plans available to their employees if requested to do so by an HMO in the employer's location.

Fee-for-Service (FFS): The patient or payer is charged according to a fee schedule set for each service and/or procedure to be provided and the patient's total bill will vary by the number of services/procedures actually provided.

Fee Schedule: Specific charges or allowances for procedures and services.

Fiscal Intermediary (FI): See Medicare Part A Fiscal Intermediary

Formulary: Listing of all drugs covered by a health plan.

Foundation: May be created by a hospital or delivery system as a nonprofit corporation to provide medical services. May be used to acquire the assets of a medical group for a fair market price and then contract for physician services. The foundation has the management responsibility and employs the nonphysician staff. The medical group remains self-governing and retains physician autonomy.

Fraud and abuse: A broad term covering a variety of illegal and unethical practices, usually applied to improper billing processes, making false claims, and receiving kickbacks. Several federal laws exist related to fraud and abuse for Medicare services, including the False Claims Act, Medicare and Medicaid Patient Protection Act of 1987, and the Antikickback Statute.

Freedom of Choice (FOC): These laws require health plans to allow plan members to go to non-participating providers, and in some cases, prohibit the use of financial incentives to encourage the use of participating providers.

Full-Risk Capitation: A delivery system agrees to provide all services, to include patient care, hospitalization, home care, preventive care, dental care and mental health services, to an entire geographic population.

Full-Time Equivalent (FTE): An employee or physician who regularly works the number of hours the practice considers to be the minimum number of hours for a normal work week. This could be 36, 40 or 50 hours or some other standard.

G

Gainsharing: A compensation plan that relates compensation to organizational goals and objectives, including reducing overhead, increasing revenue or improving patient satisfaction. Often used to describe a contractual arrangement involving a hospital and a group of physicians directed at the promotion of hospital cost savings. See also Profit Sharing and Clinical Service Line Co-Management.

Gatekeeper: A primary care physician in a managed care organization who manages the overall care of patients and makes referrals. His/her function is to assure appropriate health care utilization and control costs. May also be called a care manager.

Geographic Practice Cost Index (GPCI): A component of the Resource Based Relative Value Scale which sets reimbursement rates for services paid for by Medicare. The GPCI adjusts inputs reflecting the cost differences of delivering medical services between regions in the physician fee schedule. The Medicare Physician Fee Schedule defines the GPCI for each year.

Goodwill: The premium paid in excess of the value of the tangible assets when a practice is purchased. It is based on the assumption that a percentage of the practice's patients will continue as patients of the practice after the purchase.

Global Capitation: A delivery system agrees to provide all services, to include patient care, hospitalization, home care, preventive care, dental care and mental health services, to an entire geographic population.

Gross charges: The full dollar value, at the practice's established undiscounted rates, of services provided to all patients before reduction by charitable adjustments, professional courtesy adjustments, contractual adjustments, employee discounts and bad debts. For both Medicare participating and nonparticipating providers, gross charges should include the practice's full, undiscounted charge and not the Medicare limiting charge.

Group Contract: An agreement between the HMO and a subscribing group specifying rates, performance covenants, relationships among parties, schedule of benefits, and other conditions. The term is generally limited to a 12-month period and may be renewed after that.

Group Health Plan: A health plan contracted by an employer or employee organization to provide health coverage to employees, former employees, and their families.

Group Model HMO: There are two kinds of group model HMOs. In the closed panel model, medical services are delivered in the HMO-owned health center or satellite clinic by physicians who belong to a specially formed but legally separate medical group that only serves the HMO. The group is paid a negotiated monthly capitation fee by the HMO, and the physicians in turn are salaried and generally prohibited from carrying on any fee-for-service practice. In the second type of group model, the HMO contracts with an existing, independent group of physicians to deliver medical care. Usually, an existing multispecialty group practice adds a prepaid component to its fee-for-service mode and affiliates with or forms an HMO. The group may contract with more than one HMO and serve non-HMO patients.

Group Practice: See Medical Group Practice.

Group Practice Improvement Network (GPIN): A national network of multispecialty practices dedicated to achieving and sustaining performance excellence by sharing knowledge of best practices.

Group Purchasing Organization (GPO): An organization that unites healthcare providers in order to contract for the purchase of equipment, supplies and services at discounted prices based on high volume. The members must often agree to make a minimum amount of purchases through the GPO.

H

Health Care Clearinghouse: A public or private entity that does either of the following: 1) Processes information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction; or 2) Receives a standard transaction from another entity and processes information into nonstandard format or nonstandard data content for a receiving entity. Entities may include but aren't limited to billing services, repricing companies, community health management information systems or community health information systems, and "value-added" networks and switches.

Health Care Consumerism: Patient use of the Internet to obtain information on specific medical conditions.

Health Care Quality Improvement Act (HCQIA): This federal act, passed in 1996, provides liability protection for physicians and hospitals that participate in peer review and it established a national clearinghouse to collect physician disciplinary and malpractice information.

Health Information Technology (HIT): The concept of using electronic devices and media in all forms in health care to achieve quality, cost efficiency and effectiveness benefits.

Health Insurance Portability and Accountability Act of 1996 (HIPAA): Law passed by Congress to provide continuous insurance coverage and reduce insurance fraud and abuse. The Administrative Simplification section requires adoption of standards for claims and other financial and administrative transactions, code sets, identifiers, privacy, and security.

Health Level Seven (HL7): An ANSI-accredited group that defines standards for the cross-platform exchange of information within a healthcare organization.

Health Maintenance Organization (HMO): An insurance company that provides a comprehensive range of health services to an enrolled population for a fixed sum of money paid in advance for a specified period of time. These health services include a wide variety of medical treatments and consults, inpatient and outpatient hospitalization, home health service, ambulance service, and sometimes dental and pharmacy services.

Health Plan: An insurance entity that provides or pays the cost of medical care. Types include group health plans, indemnity insurance companies, health maintenance organizations, or any welfare benefit plan such as Medicare, Medicaid, CHAMPUS, and Indian Health Services. Often also called "payer."

Health Plan Employer Data and Information Set (HEDIS®): Evaluation indicators established in 1991 by the National Committee on Quality Assurance to standardize health plan performance measures of quality, access, patient satisfaction, utilization and finance.

Health Professional Shortage Area (HPSA): Federal designation for areas with

shortages of health care providers. Facilities located in a HPSA receive a 10 percent bonus payment for Medicare services. This bonus is based on the amount actually paid (80 percent of the fee schedule rate) and not the Medicare allowed amount.

Health Reimbursement Account (HRA): An employer-funded form of defined contribution or self-directed health plan similar to health savings accounts.

Health Risk Appraisal (HRA): Tool to conduct overall assessment of a new patient's medical condition and risk factors. Managed care organizations may conduct HRAs to identify issues that will need to be addressed to preserve the patient's health and lower the overall costs.

Health Savings Account (HSA): Health insurance that combines a low-cost, high-deductible insurance policy with a tax-free savings account to pay for qualified medical expenses. An individually-funded plan shifting more responsibility to individuals for health care management. Any funds in a HSA at the end of the year can be withdrawn or carried forward.

Healthcare Common Procedure Coding System (HCPCS): Identifiers in a standardized coding system that are used primarily to identify products, supplies and services not included in the Current Procedural Terminology (CPT®). The development and use of the HCPCS began in the 1980's and the codes are maintained jointly by the America's Health Insurance Plans, the Blue Cross and Blue Shield Association and the Centers for Medicare & Medicaid Services.

Healthcare Integrity and Protection Data Bank (HIPDB): This web site is integrated with the National Practitioner Database and is available to federal and state government agencies to combat fraud and abuse in health insurance and health care delivery. The HIPDB is primarily a flagging system that serves to alert users that a comprehensive review of a practitioner's, provider's, or supplier's past actions may be prudent. Access to the site is limited.

Healthcare Provider Taxonomy Codes: An administrative code set that classifies health care providers by type and area of specialization. The code set will be used in certain adopted transactions. (Note: A given provider may have more than one Healthcare Provider Taxonomy Code.)

HMO Regulatory Agency: A state agency empowered to grant or rescind an HMO's authority to transact business, to license its solicitors, and to regulate its affairs in the best interest of the consuming public. In nearly all states, these powers are vested in insurance departments.

Hold Harmless: Clause in managed care contracts stating if either the HMO or physician is held liable for malpractice or corporate malfeasance, the other party is not.

Home Care: Medical care, ordinarily provided in a hospital or ambulatory setting, but instead administered in the patient's home because he/she is unable to make frequent office visits. Home care is more cost-effective than hospitalization.

Hospital Encounter: A documented face-to-face contact between a patient and a provider who exercises independent judgment in the provision of services to the individual. Hospital encounters occur in inpatient hospitals, birthing centers, military treatment facilities, inpatient psychiatric facilities, and comprehensive inpatient rehabilitation facilities. See also Ambulatory Encounter and Encounter.

Hospitalist: A physician who spends at least 25 percent of his/her professional time in the hospital to handle all admissions from a specific practice or group of physicians. These doctors are the physicians of record for inpatients until they are returned to their primary care provider at the time of discharge. Hospitalists manage the practice's inpatients across specialities from pediatrics to geriatrics. Also, health plans and hospitals may employ hospitalists to provide cover for non-business hours.

Hospitalizing Physician: A patient care arrangement in which the group designates a physician to admit a patient to the hospital and this physician is responsible for coordinating all diagnostic treatments and processes as needed during that patient's hospital stay.

I

Immigration Reform and Control Act of 1986 (IRCA): This act makes it illegal to hire, recruit or employ an individual who doesn't have authorization to work within the United States. Requires employers to examine evidence of the individual's work authorization (e.g., proof of U.S. citizenship) and record the evidence that was examined on From I-9.

Impairment: The condition under which alcohol, drugs, mental illness or another affliction interfere with an individual's ability to exercise prudent medical judgment or the ability to practice medicine with reasonable skill and safety. Includes physician impairment.

Incurred But Not Reported (IBNR): An amount of money to be accrued as an accounts payable for medical expenses incurred (or) for which the plan or provider is responsible but has not yet been billed. These are often referrals from a medical group. The patient has received the service, but it has not been reported to the plan.

Incurred But Not Reported (IBNR) Account: Special liability accounts used by medical practices with capitation contracts to keep track of amounts owed to providers outside the practice for services provided to the practice's capitated patients.

Indemnity Insurance/Carrier: An insurance organization that pays health care providers for services delivered to its enrollees through a flat or discounted fee-for-service system or reimburses enrolled individuals directly for health care expenses.

Independent Practice Association/Organizations (IPA/IPO): An association or network of licensed providers and/or medical practices. An IPA is usually a unique legal entity, most often operating on a for-profit basis. Typically, the primary purpose of the IPA is to secure and maintain contractual relationships between providers and health plans.

Indirect Compensation: The benefits provided by an organization to its employees. Includes benefits required by law (i.e., Social Security, Medicare, unemployment insurance, etc.) as well as voluntary benefits (health insurance, paid vacation time, vision, life and dental insurance, professional memberships, professional development, etc.

Informatics: A field of study that focuses on the use of technology for improving access to, and utilization of, information. Health informatics is the broadest view of information technology in health care.

Informed Consent: After being fully informed by the physician as to the risks, benefits and alternatives to a procedure or treatment, the patient makes the decision whether or not to proceed with the procedure or treatment. Informed consent is a legal requirement prior to surgery or treatment. Emergencies are an exception to this requirement.

Insurance Company: An organization that indemnifies an insured party against a specified loss in return for premiums paid as stipulated by a contract. See also Health Plan.

Integrated Healthcare System (IHS): A network of organizations that provide or coordinate and arrange for the provision of a continuum of health care services to consumers and are willing to be held clinically and fiscally responsible for the outcomes and the health status of the populations served. Generally consisting of hospitals, physician groups, health plans, home health agencies, hospices, skilled nursing facilities or other provider entities. The networks may be built through virtual integration processes encompassing contractual arrangements and strategic alliances as well as through direct ownership. May also be called an Integrated Healthcare Organization (IHO) or an Integrated Delivery System (IDS).

Intensivist: A physician who has specialized in critical care.

International Classification of Diseases, Ninth Revision (ICD-9): Medical practices currently use the International Statistical Classification of Diseases and Related Health Problems, Ninth Edition Clinical Modification (ICD-9-CM), volumes 1, 2, and 3 for diagnosis and inpatient procedure classification. The ICD-9-CM was developed in the 1970s and is owned and administered by the World Health Organization.

Inurement: Section 501 (c) (3) of the Internal Revenue Code requires that tax exempt organizations must be operated exclusively for charitable, educational or other exempt purposes, and no part of the net income will be used to the benefit of any private shareholder or individual. Inurement takes place when unreasonable benefit is conferred on private individuals or other insiders of an exempt organization. Examples are excessive compensation paid to a physician who is employed by a hospital, unreasonable compensation paid to a medical director, or the hospital's provision of free or below market office space to a physician or group.

J

J-Codes: A subset of the HCPCS Level II code set with a high-order value of "J" that has been used to identify certain drugs and other items. Under HIPAA, these codes will be replaced by NDC codes.

Joint Commission on Accreditation of Healthcare Organizations (JCAHO): This not-for-profit organization accredits hospitals, outpatient facilities and other institutions.

Joint Venture: A legal entity where two or more parties work together, sharing profits and losses. The joint venture may be limited to a single project.

K

Knowledge-Based System: A computerized system that not only collects data but also uses logic rules to assist providers in making clinical decisions.

L

Leapfrog Group: A coalition of employers and organizations who purchase health care whose goals are reducing preventable medical mistakes and improving the quality and affordability of health care. They also encourage the reporting of health care quality and outcomes so consumers and purchasing organizations can make more informed health care choices.

Limited Liability Company (LLC): A legal entity that is a hybrid between a corporation and a partnership because it provides limited liability to owners like a corporation while passing profits and losses through to owners like a partnership.

M

Malpractice Insurance: Insurance against the risk of incurring financial loss due to professional misconduct or lack of ordinary skill.

Managed Care (or Coordinated Care): A system in which the provider of care is incentivized to establish mechanisms to contain costs, control utilization, and deliver services in the most appropriate settings. There are three key factors in managed care: 1) controlling the utilization of medical services; 2) shifting financial risk to the provider; and 3) reducing the use of resources in rendering treatments to patients.

Managed Care Organization (MCO): Any organization that contracts with physicians and other providers for the delivery of medical care and exercises control over the care provided. Features often include contracts with a limited number of providers, limitations on the benefits provided to beneficiaries, and control over the costs of providing the services. The models range from closed panel HMOs with all

physicians as employees to loosely structured PPOs, hospital-owned physician practices or managed indemnity plans.

Management Services Organization (MSO): An entity organized to provide various forms of practice management and administrative support services to health care providers. These services may include centralized billing and collections services, management information services and other components of the managed care infrastructure. MSOs do not actually deliver health care services. They may be jointly or solely owned and sponsored by physicians, hospitals or other parties or they may expand their ownership base by involving outside investors. Some MSOs also purchase assets of affiliated physicians and enter into long-term management service arrangements.

Mandated Benefits: Benefits that a health plan must provide by state or federal law.

Market Area: The targeted geographic area or areas in which the principal market potential is located; it may be the same as an HMO's defined service area, but not necessarily. Frequently, market areas overlap service areas. (See service area.)

Market Share: That part of the market potential that an HMO or a medical group has captured; usually market share is expressed as a percentage of the market potential.

Market Share Model for Capitation: Capitation payments are distributed to specialists in accordance with the physician's (or group's) market share of the total number of patients cared for by that specialty for a specified period of time. In this model, the number of patients and not the number of care episodes determines market share.

Master Person Index (MPI): A file of basic demographic data about the patients in a health care organization or the persons enrolled in a health plan and the identifiers assigned to those patients or persons to link them with their health records. An enterprise-wide master patient index (EMPI) integrates all master person indexes in an enterprise so as to achieve a common index in order to identify and link all the records for a given patient.

Maximum Allowable Charge: The amount set by an insurance company as the highest amount that can be charged for a particular medical service.

Maximum Defined Data Set: Under HIPAA, this is all of the required data elements for a particular standard based on an implementation specification. An entity creating a transaction is free to include whatever data any receiver might want or need. The recipient is free to ignore any portion of the data that is not needed to conduct their part of the associated business transaction, unless the inessential data is needed for coordination of benefits.

Medicaid: A federal health program, established by Title XIX amendment of the Social Security Act, available only to certain low-income individuals and families. It is a state administered program and each state sets its own guidelines regarding eligibility and services.

Medicaid Risk Contract: A health plan accepts a pre-determined fixed fee for delivery of care to Medicaid beneficiaries.

Medical Code Sets: Codes that characterize a medical condition or treatment. These code sets are usually maintained by professional societies and public health organizations. See also Administrative Code Sets.

Medical Cost Ratio (MCR): Compares the cost of providing service to the amount paid for the service.

Medical Division Employment: Physicians are employed by the hospital or hospital subsidiary and are incorporated as employees into the integrated delivery system.

Medical Foundation: See Foundation

Medical Group Management Association (MGMA): The nation's principal voice for medical group practice. MGMA leads the profession and assists members through information, education, networking and advocacy.

Medical Group Practice: A single legal entity or collection of legal entities consisting of at least three physicians who deliver health care services.

Medical IRAs: A variation of the individual retirement account that would establish a tax deferred savings account for an individual to cover the cost of health care services. See Health Savings Accounts.

Medical Loss Ratio: Cost of care provided as a ratio between the cost to deliver medical care and the premiums paid to the plan. This ratio does not include costs for quality-related activities, such as CQI. Also known as the medical cost ratio.

Medical Malpractice: Professional negligence committed by a physician or other health care provider resulting in an injured patient.

Medical Necessity: Healthcare services and supplies that are proven or acknowledged to be effective in the diagnosis, treatment or cure of a health condition, illness, injury or disease and are consistent with the medical community's accepted standard of care.

Medical Protocols: Specifies the specific treatment options for a defined set of clinical symptoms or laboratory results. Accumulated outcomes databases are used to design these protocols.

Medical Record: The compilation of all documentation concerning a person's health care in a given health care organization. Also called a patient record, a health record, or a chart.

Medical Risk Contract: A health plan accepts a predetermined fixed fee for delivery of care to Medicare beneficiaries.

Medical Savings Account (MSA): See Health Savings Account.

Medicare: The federal health insurance program for: people 65 years of age or older, certain younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure with dialysis or a transplant, sometimes called ESRD). Established in 1966 by an amendment of the Social Security Act, Title XVIII.

Medicare Advantage (MA): The Medicare Prescription Drug, Improvement and Modernization Act (MMA) replaced the Medicare+Choice program with Medicare Advantage, allowing Medicare beneficiaries to enroll in a managed care plan. Also known as Medicare Part C.

Medicare Carrier: A Medicare contractor that administers the Medicare Part B (Professional) benefits and handles inquiries from patients and providers for a given region.

Medicare Economic Index (MEI): A measure used the Resource Based Relative Value Scale (RBRVS), which limits annual increases in recognized fees. This figure captures inflation in selected expenses that are relevant to the practice of medicine in the office setting.

Medicare Part A: Medicare coverage for inpatient care in hospitals, including critical access hospitals, and skilled nursing facilities (not custodial or long-term care). It also helps cover hospice care and some home health care. Beneficiaries must meet certain conditions to get these benefits.

Medicare Part A Fiscal Intermediary (FI): A Medicare contractor that administers the Medicare Part A (institutional) benefits for a given region.

Medicare Part B: Medicare coverage for doctors' services and outpatient care. It also covers some other medical services that Part A doesn't cover, such as physical and occupational therapy and some home health care. Part B helps pay for these covered services and supplies when they are medically necessary.

Medicare Part D: Medicare's prescription drug plan. Beneficiaries choose the drug plan and pay a monthly premium.

Medicare Payment Advisory Commission (MedPAC): This commission was created in 1997 with the merger of the Physician Payment Review Commission and the Prospective Payment Assessment Committee and is charged to advise Congress on Medicare payment issues.

Medicare + Choice (M+C): Medicare Part C program created by the Balanced Budget Act in which the Medicare program contracts with health plans, provider sponsored organizations, private PPS plans, and medical savings accounts to provide beneficiary health care. Replaced by the Medicare Advantage (MA) program

Medicare Physician Fee Schedule (MPFS): Payment system for physician and certain other services based on a relative value scale that includes components for work, practice expense, and malpractice expense. Established by the Omnibus Budget Reconciliation Act of 1989

Medicare Prescription Drug, Improvement, and Modernization Act of 2003

(MMA): Legislation that provides seniors and people with disabilities with a prescription drug benefit, more choices of coverage under Medicare, and other reforms intended to control Medicare costs and ensure coverage.

Member Month: A unit of volume measurement. A member month is equal to one member enrolled in an HMO for one month, whether or not the member actually receives any services during the period. Two member months are equal to one member enrolled for two months or two members enrolled for one month. Many internal operating statistics for HMOs are expressed in terms of member months.

Mental Health Parity: Mental health diagnoses are covered in the same manner as physical diagnoses.

Midwives or Certified Nurse Midwives (CNMs): advance practice nurses with post-bachelor's degree education and clinical training who specialize in pregnancy and births.

Mixed model: HMOs may use a combination of the staff, group, network or IPA models.

Modified Cash Accounting: A system of accounting that is primarily a cash-based system, but allows the cost of long-lived (fixed) assets to be expensed through depreciation. The modified cash system recognizes inventories of goods intended for resale as assets. Under a modified cash system, purchases of buildings and equipment, leasehold improvements and payments of insurance premiums applicable to more than one accounting period are normally recorded as assets. Costs for these assets are allocated to accounting periods in a systematic manner over the length of time the practice benefits from the assets.

Modified Wave Scheduling: Scheduling system that clusters patients at the beginning of each hour or block of time, followed by individual appointments every ten, fifteen or twenty minutes during the rest of the hour or block. Specific types of appointments may be scheduled at certain time periods depending on length of time of those appointments. For example, two sick patient appointments followed by a physical exam.

Modifier: A factor that causes an increase or decrease to RVU values such as modifiers 21, 22, 51 and 70 for additional complexity or multiple procedures.

Morbidity: Actuarial term indicating the incidence and severity of illness in a specific population.

Mortality Rate: Actuarial term for the expected number of deaths per defined population.

Multispecialty Practice: A medical group practice that consists of physicians practicing in different specialties. The physicians may be in several primary care specialties, specialty care only, or a mixture of primary and specialty care.

Multitiered Plan: Under this arrangement, patients are given three options for coverage: full coverage in an HMO with a limited number of providers, access to a preferred- provider organization usually accompanied by slightly higher co-

payments, and the opportunity to go to out-of-network providers, which requires paying the highest co-payments.

N

National Committee for Quality Assurance (NCQA): A not-for-profit organization performing accreditation review of managed care plans, often the payers require the medical groups to meet the same criteria.

National Correct Coding Initiative (NCCI): A set of coding regulations to prevent fraud and abuse in physician and hospital outpatient coding; specifically addresses unbundling and mutually exclusive procedures.

National Drug Code (NDC): A medical code set maintained by the Food and Drug Administration that contains codes for drugs that are FDA-approved. The Secretary of HHS adopted this code set as the standard for reporting drugs and biologics on standard transactions.

National Health Information Infrastructure (NHII): A national initiative to improve the effectiveness, efficiency and overall quality of health care by adopting a comprehensive network of interoperable systems of clinical, public health, and personal health information that would improve decision-making by making health information available when and where it is needed. This is not a centralized database of medical records or a government regulation.

National Labor Relations Act of 1935 (NLRA): Defines unjust labor practices for both employers and employees; provides mechanism for complaint hearings; and defines mechanisms through which employees can select a union. Also set up the National Labor Relations Board for enforcing the Act's provisions.

National Patient Identifier: A system for uniquely identifying all recipients of health care services. This is sometimes referred to as the National Individual Identifier (NII) or as the Healthcare ID.

National Payer Identifier: A system for uniquely identifying all organizations that pay for health care services. Also known as the Health Plan ID or Plan ID.

National Practitioner Data Bank (NPDB): Created in 1986 as a national central clearinghouse for malpractice actions taken against providers. Also maintains records of any actions concerning competence or conduct such as suspensions, censures and license revocations. Hospitals are required to request reports from the NPDB when a physician or dentist applies for staff privileges.

National Provider Identifier (NPI): A system for uniquely identifying all providers of health care services, supplies, and equipment, primarily for billing services under Medicare. Provided for under HIPAA, it will replace the Unique Physician Identifier Number (UPIN).

Net Loss Ratio: Total claims liability and total expenses divided by premiums.

Network Model: An organizational form in which the HMO contracts for medical services with several separate and distinct medical groups or systems to serve a geographic area allowing members to select which group or system will manage their care. For federal qualification purposes, such models are designated as IPAs.

Noncompete clause: Clause in employment agreements which prohibit the individual from practicing within the same region after leaving the business (e.g. medical practice). The agreement usually specifies the length of time and geographic area for which the clause is in effect. Also known as restrictive covenant.

Non-exempt employees: Employees protected by the Fair Labor Standards Act regulations regarding minimum wage and overtime rules. This includes all employees other than those defined by the Fair Labor Standards Act as being exempt from the act's requirements. See also Exempt Employees.

Nonphysician Provider (NPP): Specially trained and licensed providers other than physicians who can provide medical care and billable services. Examples include audiologists, Certified Registered Nurse Anesthetists (CRNAs), midwives, nurse practitioners, occupational therapists, optometrists, physical therapists, physician assistants, psychologists, social workers and surgeon's assistants.

Not-for-Profit Corporation: An organization that has obtained special exemption under Section 501(c) of the Internal Revenue Code that qualifies the organization to be exempt from federal income taxes. To qualify as a tax-exempt organization, a practice or faculty practice plan would have to provide evidence of a charitable, educational or research purpose.

Nurse Anesthetist or Certified Registered Nurse Anesthestist (CRNA): advanced practice nurses with extensive education and training for providing anesthesia services in conjunction with other health care professionals, usually anesthesiologists.

Nurse Practitioner (NP): Nurses with advanced education and intensive clinical experience who take a more independent role in diagnosis and management of patients care. Scope of practice and ability to write prescriptions depend on state regulations.

O

Occupational Safety and Health Administration (OSHA): The federal agency responsible for assuring the safety and health of workers by setting and enforcing standards and encouraging continual improvement in workplace safety and health.

Office of Inspector General: A division of the U.S. Department of Health and Human Services (HHS) that investigates issues of noncompliance in the Medicare and Medicaid programs such as fraud and abuse.

Omnibus Reconciliation Acts: Federal tax and budget conciliation acts affecting Medicare reimbursement and other areas.

Open Access: Plan members can see participating specialists without referral from the primary care physician.

Open access scheduling: The scheduling system with open periods throughout the day so that a patient can be seen in the practice the same day as she or he calls.

Open-Ended HMO: Enrollees are allowed to receive services outside the HMO provider network without referral authorization, but are usually required to pay an additional copay and/or deductible.

Open Enrollment Period: The period of time stipulated in a group contract in which those eligible in the group can choose a health plan alternative for the coming benefit year. There is also an open enrollment period as defined in the Federal HMO Regulations requiring HMOs who meet certain criteria to conduct annual open enrollments for periods of not less than 30 days (refer to 110.107 of the Federal HMO Regulations). This federally required open enrollment of individuals should not be confused with enrollment of individuals many HMOs pursue as a normal part of their marketing strategies.

Open Panel: Private physicians contract with a plan to provide care in their own offices.

Operating Expenses/Operating Cost: The nonprovider expenses related to operating and managing the practice. Includes, but is not limited to, personnel salaries and benefits (other than physicians and nonphysician providers), information technology, building operating expenses, supplies, insurance premiums, and marketing expenses.

Outliers: A patient who varies significantly from other patients in the same DRG (such as a longer or shorter length of stay, death, leaving against medical advice, etc.). Also used to describe healthcare providers whose services include unusually long lengths of stay, high number of diagnostic tests or other sources of high or low costs or utlization.

Outcome: The qualitative and/or quantitative result of medical treatment.

Outcomes Measurement: Formal process for measuring the effectiveness of medical treatment, the cost of treatment and patient satisfaction with treatment results.

Out-of-Area Benefits: The scope of emergency benefits (and related limitations) available to HMO members while temporarily outside their defined service areas. Some HMOs offer unlimited out-of-area emergency coverage. Others impose a stated maximum annual dollar benefit. Emergency coverage is usually the only HMO benefit in the total benefit package for which members may need to file claims forms for reimbursement of their out-of-pocket expenditures for care.

Out-of-Area Services: Services received by HMO enrollees when the member is outside the plan's established geographic area of service as defined in the contract and service agreement. Usually these services are not covered unless a delay would

adversely affect the individual's health status.

P

Paid Time Off (PTO): The number of days or hours provided to employees, per year or other period, for time off needed for vacation, illness, or other personal issues. A days off program rather than separating vacation and sick leave.

Partnership: An organization where two or more individuals have agreed that they will share profits, losses, assets and liabilities, although not necessarily on an equal basis. The partnership agreement may or may not be formalized in writing.

Patient Flow: The process related to managing the patient's visit to a medical facility from the patient's arrival and check in, the time spent with medical assistants, physicians and other medical personnel, and check out.

Patient Panel: The population of subscribers assigned to a provider.

Patient Portal: A secure entry point from the Internet to a practice's Web page, designed especially for patient use.

Patient Safety: The prevention of harm to patients caused by errors of commission and omission in health care.

Pay for Performance (P4P): An incentive system offered by some payers to healthcare providers based on their quality outcomes or other factors. There are a variety of forms of P4P based on the payer. Some programs give financial incentives to providers who can meet evidence-based standards of care for particular conditions, such as heart disease, asthma and breast cancer screening. See also Performance-Based Incentive.

Payer: In healthcare, an entity that assumes the risk of paying for medical services. This is usually a health plan, an HMO, or a self-insured employer but can also be a uninsured patient.

Payer mix: The relative percentages of a practice's patients that are covered by government, self-pay, managed care and other third-party health care insurance organizations.

Peer Review: Evaluation of a physician's performance by a panel of other physicians, usually within the same geographic area and medical specialty.

Performance-Based Incentive: Some fee-for-service contracts stipulate that the payer will reward the provider with additional payments beyond those guaranteed in the fee-for-service contract if the provider meets certain performance specifications. Since no funds are withheld by the payer up front, this type of contract is not typically viewed as an at-risk contract. Also known as value-based system. See also Pay for Performance.

Penetration: The percentage of business that an HMO is able to capture in a particular subscriber group or in the market area as a whole. For example, signing up 10 enrollees or members out of 100 eligibles yields a 10 percent penetration.

Per Contract/Per Month (PC/PM): Amount of dollars for each contract (single or family) for each month.

Per Diem: Total payment rate per day regardless of actual charges. Per diems may be broken down into categories such as medical/surgical, maternity or pediatrics.

Per Member/Per Month (PMPM): Capitated payments made by a health plan to a provider for a specified set of services rendered to a beneficiary per month of care.

Per Thousand Members Per Year (PTMPY): A common indicator of hospital utilization.

Personal Health Record (PHR): The maintenance of a health record by a patient, integrating information from various providers and self-reported information. PHRs come in many forms, some electronic. Some are originated by a provider, others by the patient. See also Electronic Health Record.

Pharmacoeconomics: Studies the cost effectiveness of interventions such as drugs or surgical procedures.

Pharmacy Benefit Management Company (PBM): A company that provides services such as claims processing, formulary management, and drug utilization review.

Pharmacy Risk: An agreement between parties (particularly a health plan and providers) related to managing pharmaceutical expenses. It may take the form of a capitated pharmacy budget or a bonus agreement.

Physician: Any doctor of medicine (MD) or doctor of osteopathy (DO) who is duly licensed and qualified under the law of jurisdiction in which treatment is received.

Physician assistants (PAs): Health care professionals licensed to practice medicine with physician supervision. As part of their comprehensive responsibilities, PAs conduct physical exams, diagnose and treat illnesses, order and interpret tests, counsel on preventive health care, assist in surgery, and in virtually all states can write prescriptions. Within the physician-PA relationship, physician assistants exercise autonomy in medical decision making and provide a broad range of diagnostic and therapeutic services.

Physician/Hospital Organization (PHO): An organizational entity that is formed between hospitals and physicians that allows for cooperative activity while giving a level of independence to the participating parties. This organizational structure is usually formed to pursue managed care contracts.

Physician impairment: See Impairment.

Physician Incentive Plan (PIP): Compensation system within a medical group practice or other healthcare organization to encourage and reward physicians for

meeting the organization's goals and objectives. Defined by CMS as "any compensation arrangement between a MCO and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services furnished to Medicare beneficiaries or Medicaid recipients enrolled in the MCO." This regulation includes all compensation arrangements negotiated between the MCO and other contracting tiers such as IPAs and PHOs. The physician incentive rule applies to compensation plans based on the use or cost of referral services. This rule only applies to Medicare risk contracts, Medicaid HMOs and health insuring organizations contracting under Medicare that are subject to the Social Security Act. See also: Pay for Performance

Physician Payment Review Commission (PPRC): Created by Congress in 1986 to recommend changes in current reimbursement procedures and policies for physicians receiving payments from Medicare. The PPRC and the Prospective Payment Assessment Committee were merged into the Medicare Payment Advisory Commission in 1997.

Physician Organization (PO): Network of physicians that contracts with managed care organizations.

Physician Patient Panel: The number of patients, regardless of payer, assigned to a physician.

Physician Practice Management Company (PPMC): Publicly held or entrepreneurial directed enterprises that acquire total or partial ownership interests in physician organizations and provide management services for the practices. PPMCs are a type of MSO, however, the motivations and strategies related to development of growth and profits for their investors differentiate them from other MSO models.

Physician Voluntary Reporting Program: CMS program to record clinical information on 36 different performance measures from physician offices that choose to participate. In turn, CMS plans to provide these practices with confidential profiles based on the reported data.

Physician Work RVUs: The physician work component of the total RVU for all procedures performed by the medical practice, for both fee-for-service and capitation patients and for all payers. See also Relative Value Units (RVUs)

Picture Archiving and Communication System (PACS): Integrated computer system that obtains, stores, retrieves and displays digital images; including radiologic images.

Point of Care: computer system that captures data at the location where the health care service is performed; for example, at the bedside, in the examination room, or in a home.

Point-of-Service: This product may also be called an open-ended HMO and offers a transition product incorporating features of both HMOs and PPOs. Beneficiaries are enrolled in an HMO but have the option to go outside the network for an additional cost (additional co-insurance and deductibles).

Population-Based Care: Physicians use an assessment of experience across a population to build their knowledge to treat the individual patient. Education for both physicians and patients characterizes population-based care.

Population Per HMO: The ratio of a metropolitan area market population divided by the number of HMOs in that market area.

Portability: Continuous coverage is provided with no required waiting periods for individuals changing to new plans.

Practice Expenses: Element of the relative value unit that covers the physician's overhead costs, such as employee wages, office rent supplies, and equipment; divided into facility and nonfacility expenses.

Practice Expense Advisory Committee (PEAC): Established by the American Medical Association in 1998, the Committee is charged with reviewing direct expense inputs (e.g., clinical time, supplies and equipment) for individual CPT codes. The PEAC then forwards their recommendations to CMS for review in determining the Medicare physician fee schedule.

Practice Guidelines: Written descriptions of appropriate treatment for a specific diagnosis or medical condition. The Institute of Medicine defines practice guidelines as "systematically developed statements to assist practitioner and patient decisions about appropriate health care services for specific clinical circumstances."

Practice Management System (PMS): Software that automates a medical practice's patient appointment scheduling, registration, billing and payroll functions. Many products also provide electronic data interchange (EDI) for filing claims and electronic funds transfer (EFT).

Precertification: Evaluation by the payer or financial intermediary to determine if specific medical services, such as hospitalization, are appropriate treatment for a patient. Also called prior authorization.

Preexisting Condition: A current or previous health condition that may limit an individual from obtaining health insurance or is excluded from specific services.

Preferred Provider Organization (PPO): A group of physicians and/or hospitals who contract with an employer to provide services to their employees at a discounted fee. In a PPO, the patient may go to the physician of his/her choice, even if that physician does not participate in the PPO, but the patient receives care at a lower benefit level.

Prescription Benefit Manager (PBM): Monitors prescription claims for an HMO and tracks what drugs and the volume prescribed by the plan's participating physicians. See also Pharmacy Benefit Management Company.

Pricer/Repricer: A person, an organization, or a software package that reviews procedures, diagnoses, fee schedules, and other data and determines the eligible amount for a given health care service or supply. Additional criteria can then be applied to determine the actual allowance, or payment, amount.

Primary Care: The Institute of Medicine defines primary care as "the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community." MGMA includes the following in primary care: family practice, geriatrics, internal medicine and pediatrics.

Primary Care Physician (PCP): Provides treatment of routine injuries and illnesses and focuses on preventative care. Serves as gate keeper under managed care. The American Academy of Family Physicians defines primary care as "care from doctors trained to handle health concerns not limited by problem origin, organ systems, gender or diagnosis." Usually includes physicians who practice internal medicine, pediatrics or family practice and sometimes obstetrics/gynecology.

Primary Care Network: The structure for these networks will vary considerably depending on the specific network. It may range from a loose association of physicians in a geographic area with a limited sharing of overhead, patient referral, call, etc. to a more structured association with commonly owned satellite clinics, etc.

Prior Authorization: Procedure used in managed care to control utilization of services by prospective reviewing and approval.

Professional component (PC): The physician's professional services used to evaluate the results of a diagnostic test. Within the Medicare physician fee schedule, a professional component is denoted with the status "26" to indicate that the professional services may be separately billed.

Professional Corporation: A for-profit organization recognized by law as a business entity separate and distinct from its shareholders. Shareholders must be licensed members of the same profession. It includes limited liability for stockholders and allows corporate ownership of tangible and intangible assets.

Professional Courtesy: Fee-for-service gross charges, at the practice's undiscounted rates, for all services provided to patients who are not expected to pay full rates for the services. These patients my include employees, physicians' or employees' family members, and other medical professionals. See also Charity Care.

Professional Employer Organizations (PEO): An organization that provides integrated services to effectively manage critical human resource responsibilities and employer risks for clients by establishing and maintaining an employer relationship with the employees at the client's worksite and by contractually assuming certain employer rights, responsibilities, and risk. As the employer, the PEO then manages the human resources, employee benefits, payroll and workers' compensation issues for the client.

Professional Liability: The risk of an injury related to a failure to provide an expected standard of care in an established physician-patient relationship.

Professional Review Organization (PRO): State-sponsored or independent organizations or committees that review the practice and records of a provider, practice or institution. Best known examples are the Medicare utilization and quality

control peer review organizations now known as Quality Improvement Organizations (QIO).

Profiling: Use of statistics to identify physicians who either over or under utilize services. This information is used as feedback to change utilization patterns.

Profit Sharing: A system where the employees of a medical practice receive a predetermined share of the organization's profits. See also Gainsharing.

Progressive Rates: A method employed by some HMOs in which they implement new rates either monthly, quarterly, or semiannually. Any new or renewal subscriber groups with anniversaries falling within such periods would automatically be subject to prevailing rates in effect during those periods, and these rates are generally guaranteed for the full 12-month benefit year. This method is said to offer greater rate parity than a fixed rate throughout the HMO's fiscal year. Consequently, it has the effect of containing rate changes on a group-to-group basis each benefit year.

Prospective Payment Assessment Commission (ProPAC): Advised Congress on hospital payment policy. This commission was combined with the PPRC in 1997 to form Medicare Payment Advisory Commission.

Prospective Payment System: Medicare implemented a standardized payment system in 1983 giving hospitals a fixed reimbursement based on the diagnosis of the patient.

Protected Health Information (PHI): The term used in HIPAA to refer to individually identifiable health information to be protected by an entity that must adhere to HIPAA regulations (i.e., a covered entity).

Provider Sponsored Health Plan (PSHP): The health plan is owned, operated or sponsored by one or more health care providers. This may be a hospital, health system or medical group. See also Provider Sponsored Organization.

Provider Sponsored Organization (PSO): The Balanced Budget Act of 1997 defines PSOs as public or private entities that are owned and operated by a health care provider or a group of affiliated providers that bear substantial risk for the care provided. The PSO arrangement facilitates contracting directly for Medicare risk patients.

Providers: Those institutions and individuals who are licensed to provide health care services (for example, hospitals, skilled nursing facilities, physicians, pharmacists, etc.).

Q

Quality Assurance Program: An internal peer review process that audits the quality of care delivered. The program should include an educational mechanism to identify and prevent discrepancies in care.

Quality Compass: A product developed by NCQA, based on HEDIS data, to rate

health plans according to a set of performance measures such as the plan's preventative care program, etc.

Quality Improvement Organization: Medicare contractor charged with ensuring quality improvement throughout the healthcare system. QIOs shall accomplish this by working with providers, practitioners, Medicare Advantage organizations, beneficiaries and other stakeholders and by seeking to promote improvements in organizational culture, systems adoption and use, and redesign of care processes.

Quality of Care: The degree of excellence of health care services; may be determined by outcomes, lack of medical errors, and/or patient satisfaction.

R

Rate Band: State regulation determines the variation allowed in insurance premiums. The variation is based on age, gender, occupation, etc.

Re-aged Accounts Receivable: When aging of an account is reset to zero days when charges are sent to a second payer or patient for payment of the remaining portion.

Records Retention: Plan or protocol for maintaining medical, personnel and business records based on requirements and recommendations from the IRS, state regulating agencies, and malpractice insurance carriers. Should also include standard policy for proper destruction of records after the retention period has passed.

Reengineering: Making changes in procedures and processes in order to improve efficiency and quality of output.

Regional Health Information Organization (RHIO): Groups of hospitals, physician practices, and other health-related organizations in a geographic location or region of the country that are interconnected and would form a regional health information network (RHIN).

Reinsurance: A type of protection purchased by HMOs from insurance companies specializing in underwriting specific risks for a stipulated premium. This becomes a cost of doing business for HMOs. Typical reinsurance risk coverages are: 1) individual stop-loss, 2) aggregate stop-loss, 3) out-of-area and 4) insolvency protection. As HMOs grow in membership, they usually reduce their reinsurance coverage (and related direct costs) as they reach a financial position to assume such risks themselves.

Relative Value Units (RVUs): Nonmonetary, relative units of measure that indicate the value of health care services and resources consumed when providing different procedures and services. RVUs assign relative values or weights to medical procedures primarily for the purpose of the reimbursement of services performed. They are used as a standardized method of analyzing resources involved in the

provision of services or procedures. See also Resource-Based Relative Value Scale (RBRVS).

Relative Value Update Committee (RUC): An American Medical Association specialty committee formed in 1991 to make recommendations to CMS on the relative values to be assigned to new or revised CPT codes.

Report Cards: Performance reports that evaluate the operation, services or processes of a business or organization. May be used for internal purposes or released publicly. Health care report cards evaluate the care provided to patients by a provider.

Reported But Not Incurred (RBNI): A benefit under a health plan which is planned, has been reported to the plan, but has not taken place. An example would be a scheduled surgery.

Reserves: Restricted cash investments or highly liquid investments intended to protect the HMO (or provider entity assuming the insurance risk) against insolvency or bankruptcy. Regulatory agencies may mandate reserve requirements; also, some HMOs establish voluntary reserves by systematically setting aside a small portion of each month's realized revenues.

Resource-Based Relative Value Scale (RBRVS): This relative value scale was developed for CMS for Medicare reimbursement. Relative values are assigned to CPT codes on the basis of the resources needed to perform the service.

Reverse Capitation: Refers to capitating specialist care while paying primary care physicians on a fee-for service basis.

Rightsizing: The systematic process of reviewing employee numbers, tasks and work processes to determine the appropriate number and mix of staff needed to meet medical practice goals.

Risk: The chance or possibility of loss. For example, physicians may be held at risk if hospitalization rates exceed agreed-upon thresholds. The sharing of risk is often employed as a utilization control mechanism within the HMO setting. Risk is also defined in insurance terms as the probability of loss associated with a given population.

Risk-Based Capital Analysis (RBC): A method to evaluate the financial status of insurers and indicate an insurer's ability to cover losses. Previously not used in healthcare, but in 1998 the National Association of Insurance Commissioners began applying RBC to HMOs.

Risk Contract: A provider agrees to furnish specific services for a predetermined fee and assumes the risk that the contract fee will cover the costs involved in providing care.

Risk Management: Processes and procedures to identify and limit exposure to risk including professional liability, personnel injuries and human resource issues; property-related risk (natural disasters, general liability and safety); compliance with

federal and state regulations; and financial risk, including insurance contractual arrangements.

Risk Pool: Funds set aside (withheld) by a managed care organization to cover over-utilization or to encourage limits on utilization. Distribution of funds to contributing providers is based on the MCOs formula. More commonly seen in primary care than with specialists. See also Withhold.

Risk Sharing: An arrangement between health plans and healthcare providers determining who is responsible for financial gain and loss based on the costs of providing medical care for the health plan's enrollees for a specific period. The arrangement varies depending on the initial amount of risk transferred, the services for which the provider is at risk, and whether the health plan offers stop-loss protection.

S

S-Corporation: Corporate structure with more stock restrictions than C-corporations, including not more than 75 stockholders; only individual, no corporate, stockholders; and having only one class of stock. However, the income is only taxed once, when the dividends are distributed to the shareholders.

Safe Harbor: A set of federal regulations providing criminal and civil protection for certain health care business practices entered into by hospitals and physicians when specific requirements are met.

Safe Medical Device Act of 1990 (SMDA): Act requiring that health care facilities report serious or potentially serious device-related injuries or illness of patients and/or employees to the manufacturer of the device, and if death is involved, to the federal Food and Drug Administration ("FDA").

Safety Zone: Under certain and specifically defined circumstances, competing healthcare providers can share fee-related information without fear of antitrust violations.

Satellite clinic: A smaller, separate clinical facility for which the practice incurs occupancy costs such as lease, depreciation and utilities. Merely having physicians practice in another location does not qualify that location as a branch or satellite clinic.

Saturation: A condition that occurs when an HMO achieves its maximum penetration either in a subscriber group or in the marketplace itself. When this condition becomes evident, an HMO's first goal is to retain its saturation level while assessing how to achieve an increase in market share or how to expand its service or market area.

Savings Incentive Match Plan for Employees (SIMPLE) IRA: Employer-sponsored IRA for employers with 100 or fewer employees and no qualified pension

plans. Employees contribute to the plan through salary deferment. SIMPLE IRA's are not tax qualified plans.

Section 125 Plans: Employee funded, pre-tax accounts that are used for certain expenses such as non-covered medical expenses, copayments, deductibles, and child care. Internal Revenue Code Section 125 defines the plans' requirements.

Self-Directed Health Plans (SDHPs): Uses episode allowances, instead of capitation or other traditional managed care strategies, to market bundled services. Physicians accept a risk-adjusted payment to provide whatever treatment is necessary to give the patient a reasonable expected health status. The patient and physician determine how insurance funds are spent. This approach manages acute and chronic conditions within an allowance for an "episode" of care. The term is also being applied to defined contribution or defined care health plans.

Self-Insurance: An entity itself assumes the risk of coverage and makes appropriate financial arrangements rather than purchasing insurance from a third party and paying a premium for this coverage. (Also called self-funding.)

Self-Pay: Fee-for-service gross charges at the practice's undiscounted rates for all services provided to patients who pay the medical practice directly. These patients may or may not have insurance.

Service Area: The territory within certain boundaries that an HMO designates for providing service to members. Some HMOs establish a mileage radius from their delivery sites; some rely on zip codes; others use county boundaries in defining service areas.

Severance Pay: A predetermined amount of money usually based on length of service within an organization that an employee would receive if his/her position is terminated.

Sherman Antitrust Act of 1890: The act that prohibits monopolization and any contracts, combinations or conspiracies that unreasonably restrain trade.

Simplified Employee Pensions (SEP): An employer-funded individual retirement account. SEP's are a type of employer-sponsored IRA's and aren't tax qualified plans.

Single-Payer System: Financing mechanism in which government acts as the only insurer and sets reimbursement rates for providers.

Single-Specialty Practice: A medical group practice that provides services related to only one specialty. This classification is based on the clinical work of the practice and not necessarily on the specialties of the physicians in the practice. For example, a single-specialty neurosurgery practice may include a neurologist and a radiologist.

Skilled Nursing Facility (SNF): A health facility that is licensed by an individual state to provide continuous skilled nursing care and supportive care to patients whose primary need is for the availability of skilled nursing care or supportive care on an extended basis. A SNF provides 24 hour inpatient care and as a minimum, includes physician, skilled nursing, dietary, pharmaceutical services and an activity program. May also be referred to as an extended care facility (ECF).

Small Subscriber Group Aggregate: A combination of small businesses, professional associations, or other entities formed for the purpose of being considered a single, large subscriber group.

Social HMO (SHMO): A demonstration program to integrate acute and long-term care for enrolled Medicare beneficiaries over age 65. A 2002 evaluation of the program recommended that the Social HMO programs be converted to Medicare+Choice plans which are now under Medicare Advantage.

Sole Proprietorship: An organization with a single owner who is responsible for all profit, losses, assets and liabilities.

Specialty Case Rate: Fixed amount of money paid to a specialist for all professional care for a specific procedure or diagnosis. Can include technical and/or facility charges.

Speech recognition: Technology that uses voice patterns to allow computers to record voice and automatically translate it into narrative text in real time. Previously known as voice recognition.

Staff Model HMO: The staff model consists of a group of physicians who are either salaried employees of a specially formed professional group practice which is an integral part of the HMO plan or salaried employees of the HMO. Medical services in staff models are delivered at HMO-owned health centers and, generally, only to HMO members. The physicians in either form of staff model are usually limited in their fee-for-service activities.

Standard Class Rate: Used to calculate monthly premium rates using a base revenue requirement per member or per employee multiplied by group demographic information.

Stark Law: Also known as federal physician self-referral laws, the law prohibits a physician from referring a Medicare or Medicaid patient for “designated health services” in which the physician or physician’s immediate family members have an ownership or investment interest.

Stop-Loss: The purchase of insurance coverage from a third party in the event of unexpected financial loss to the health plan or provider, may be individual or aggregate and usually both. In the event of a catastrophic claim, stop-loss limits the exposure for both the insurer and the purchaser.

Subacute Care: A step-down unit for patients that don’t need the intensive services of an acute hospital setting, but are not ready to be released to independent care at home.

Subrogation: Requires the insured individual to assign any rights to recover damages to the insurer (not allowed by law in some states).

Subscriber: An employer, union, or association that contracts with an HMO for health care for its eligible enrollees.

Supplemental Health Services: The benefits an HMO offers that exceed their basic health service requirements, as defined in Subpart A, 110.101(c) and 110.102 of the Federal HMO Regulations.

Sustainable Growth Rate (SGR): The update formula used to establish a target rates for growth of the Medicare program. The SGR takes into account estimates of the percentage change in physicians' fees, the average number of Medicare beneficiaries, growth in the gross domestic product (GDP) and costs to the Medicare program due to changes in law or regulation. These four estimates are used to create a percentage by which the previous year's conversion factor is modified.

Systematized Nomenclature of Medicine Clinical Terms (SNOMED CT®): A comprehensive clinical vocabulary used in many EHR systems to encode clinical terms for use in clinical decision support systems. It was developed by the College of American Pathologists and is freely distributed through SNOMED International under special license from the U.S. National Library of Medicine.

T

Tail coverage: Malpractice insurance to cover claims made after a physician leaves a practice.

Tax Equity and Fiscal Responsibility Act (TEFRA): One of its provisions of this act prohibits employers and health plans from requiring workers 65-69 to use Medicare instead of the employer's health plan.

Technical component (TC): The technical component represents the labor costs for administering diagnostic tests and the overhead costs for equipment, etc. CMS has established supervision levels, which apply to administration of many diagnostic tests. The technical component is determined by subtracting the professional component from the global fee.

Telemedicine: Telecommunication system that links health care organizations, providers and patients from diverse geographic locations and transmits text and images for medical consultation and treatment.

Third Party Payers: Organizations that pay health care providers for services provided to individuals enrolled in their plans. Such organizations include managed care companies, indemnity insurance companies, employers, and others.

Third Party Administrator (TPA): An administrative organization other than the employee benefit plan or health care provider that collects premiums, pays claims and/or provides administrative services.

Triage (Nurse Triage): A system for categorizing patients needs as life-threatening, urgent, important or routine, and the correct response and action from medical providers. In medical practices, the system usually involves responding to patients' phone calls with the appropriate direction for care. Managed care organizations use triaging to direct care and efficiently use resources as well as a

central point for communication with patients and providers and for utilization review.

TRICARE: The Department of Defense's worldwide health care program for active duty and retired uniformed services members and their families which implements a comprehensive managed health care delivery system composed of military medical treatment facilities and CHAMPUS.

Total Compensation: The amount reported as direct compensation on a W2, 1099, or K1 (for partnerships) plus all voluntary salary reductions such as 401(k), 403(b), Section 125 Tax Savings Plan and Medical Savings Plan. The amount should include salary, bonus and/or incentive payments, research stipends, honoraria and distribution of profits. However, it does not include the dollar value of expense reimbursements, fringe benefits pay by the practice, or any employer contributions to employee's voluntary savings plans. See also Indirect Compensation.

Total Quality Management (TQM): Also called continuous quality improvement. Uses the concepts originally developed by W. Edward Deming to study a practice's systems to identify and improve sources of error, waste or redundancy. Input and feedback from all levels of staff and patients are used to understand and improve current processes. Also called Continuous Quality Improvement (CQI).

Trading Partner: Under HIPAA, an external entity with whom business is conducted, i.e. customer. This relationship can be formalized via a trading partner agreement. (Note: a trading partner of an entity for some purposes, may be a business associate of that same entity for other purposes.)

U

Unbundling: Billing separately for the components of a service previously included in a single fee.

Unified Medical Language System ® (UMLS®): A system of databases and software tools developed by the National Library of Medicine to facilitate the development of computer systems that behave as if they "understand" the meaning of the language of biomedicine and health.

Unique Physician Identification Number (UPIN): An identification number assigned to physicians who bill Medicare. HIPAA legislation requires that the UPIN be replaced by the National Provider Identifier by 2007.

Usual, customary and reasonable (UCR): Typical fees charged for specific health care services in a particular area based on the provider's usual charge or the amount charged by other providers in the area.

Utilization: The frequency with which a benefit is used, for example, 3,200 physician office visits per 1,000 HMO members per year. Utilization experience multiplied by the average cost per unit of service delivered equals capitated costs.

Utilization Management Review: A process that monitors the use of available resources (including professional staff, facilities, and services) to determine medical necessity, cost effectiveness, and conformity to criteria for optimal use.

W

Withhold: A percentage of payment to the provider held back by the payer as means of funding a risk pool. The funds in the risk pool (the withhold) may be returned to the provider by the payer, in whole or in part, based on the goals related to financial performance and/or utilization of outpatient and/or inpatient services. The amount of withhold returned depends on individual utilization by the gatekeeper; referral patterns through the year by the gatekeeper, groups of physicians or the overall plan pool; and financial indicators for the overall capitated plan.

Workers' Compensation: An employer funded, state regulated program providing insurance coverage for work-related injuries and disabilities.

X

X12: An ANSI-accredited group that defines EDI standards for several American industries, including health insurance. Most of the electronic transaction standards in HIPAA are X12 standards.

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