

# Glossary

**Accreditation** - Certification by a recognized organization that an individual, service or facility has met a set of standardized criteria typically determined by a process set by the certifying organization.

**Acute Care Hospital** - A facility that provides services designed to meet the needs of patients who require short-term care for a period of less than 30 days.

**Allied Health Professional** - Persons who are not nurses or physicians but have special training and are licensed when necessary. They work under the supervision of a health professional and provide direct patient care. They include respiratory, physical and occupational therapists; radiology technologists and technicians; medical laboratory technologists and technicians; and surgical technologists.

**Ambulatory Care** - Health care services provided on an outpatient basis, where no overnight stay in a health care facility is required.

**American College of Radiology (ACR)** - The recognized organization for imaging (radiology) accreditation.

**American Hospital Association** - The nation's principal trade association for hospitals, with offices in Washington, D.C., and Chicago.

**Ancillary Care Services** - Diagnostic or therapeutic services, such as laboratory, radiology, pharmacy and physical therapy, performed by non-nursing departments.

**Any Willing Provider** - Terminology relating to legislation that would require managed care plans to allow any individual physician or other provider to participate on the provider panels he or she does business with.

**Authorization** - A process by which a managed care plan determines that care is medically necessary.

**Bad Debt** - The costs absorbed by hospitals or physicians for care provided to patients from whom payment was expected but no payment was received. Bad debt differs from charity care.

**Balance Billing** - A practice typically prohibited by managed care plan contracts in which the provider bills the patient for the amount of the billed charge that exceeds the payment by the insurer plus the member cost share.

**Captive** - A licensed insurance company owned by a parent company that underwrites the insurance risks of that parent company's operations.

**Certificate of Need (CON)** - A method of confirming the need for, and ensuring access to, health care facilities, services and technology in which the approval of a government agency or other empowered entity is required for a health care organization to engage in a construction or remodeling project, make a significant capital expenditure or provide a new service. CON helps control costs by requiring all applicants to demonstrate the need for services and facilities in order to prevent overutilization and unnecessary duplication of services, while also discouraging unfair competition from facilities that serve few, if any, Medicaid and uninsured patients.

**Charge** - The dollar amount that a health care provider assigns to a specific unit of service to a patient. A “charge” may not be totally reflective of the actual cost involved in providing that service.

**Charity Care** - Charity care presents that portion of health care services that are provided by a hospital under a hospital’s charitable care program and where payment is not expected because the patient has a demonstrated inability to pay for some or all of the services.

**Clinical Laboratory Improvement Amendments (CLIA)** - The recognized organization for laboratory accreditation.

**Coinsurance** - The percentage of either billed charges or the plan’s contract rate that a member is required to pay for covered services.

**College of American Pathologists (CAP)** - CAP is an internationally recognized program designed to help laboratories achieve the highest standards of excellence to impact patient care positively.

**Community Benefit** - Programs or services that address community health needs, particularly those of the poor, minorities and other underserved groups, and provide measurable improvement in health access, health status and use of health care resources.

**Community-Building Activities** - Activities that are proactive, strategic investments in prevention, and that will reduce the burden of preventable illness. These activities address what is often referred to as social and economic determinants of health such as education, employment, income, housing, and social supports.

**Conditions of Participation** - Conditions health care organizations must meet in order to begin and continue participating in the Medicare and Medicaid programs. These health and safety standards are the foundation for improving quality and protecting the health and safety of beneficiaries.

**Copayment or Copay** - A defined amount of payment per visit that a member must pay for health care services under an insurance plan.

**Cost Share** - The portion of the fee for health care services that an insurer requires the plan member to pay, including copayments, coinsurance and deductible.

**Cost Shifting** - A phenomenon occurring in the U.S. health care system in which providers are inadequately reimbursed for their costs by some payers and subsequently raise their prices for other payers in an effort to recoup costs.

**Covered Services** - Those health care services for which a member is entitled to benefits under the terms of their insurance policy.

**Credentialing** - Generally used as the basis for appointing health care professionals to a hospital's staff, it is the process used to analyze the qualifications of a licensed practitioner's education, training, experience, competence and judgment. A credentialed staff member is permitted to perform clinical duties at the hospital.

**Critical Access Hospital (CAH)** - Established under the Balanced Budget Act of 1997, CAHs are limited-service hospitals located in rural areas with no more than 25 acute-care beds. They receive cost-based payment for Medicare patients and are relieved from some Medicare regulations.

**CSR Orion** - A joint effort between the Joint Commission Resources (JCR) and GHA to structure and implement a program by which hospitals can receive education, consulting and feedback on an ongoing basis for standard requirements for accreditation.

**Deductible** - The amount that a member must pay for covered services during a specified period (usually a policy year) before benefits will be paid by the insurer.

**Delegated Credentialing** - A formal process by which an organization, such as a managed care plan, gives another entity the authority to perform credentialing functions on its behalf.

**Diagnosis Related Group (DRG)** - A method of classifying inpatients into groupings based on common characteristics, each of which can be expected to require similar services. Used as the basis of the Medicare and Medicaid inpatient payment system.

**Disproportionate Share Hospital (DSH)** - A hospital with a disproportionately large share of low-income or uninsured patients. Under Medicaid, states augment payment to these hospitals. Medicare inpatient hospital payments are also adjusted for this added burden.

**DNV Healthcare (DNV)** - DNV is a voluntary accreditation agency that surveys enrolled hospitals regarding many aspects of quality.

**EMTALA** - Emergency Medical Treatment and Active Labor Act, a federal law passed in 1986, ensures hospitals provide care to anyone needing emergency treatment, regardless of citizenship, legal status or ability to pay.

**ERISA** - Employee Retirement Income Security Act of 1974, a federal law that sets minimum standards for most voluntarily established pension and health plans in private industry.

**EOB, Explanation of Benefits, EOMB, Explanation of Medical Benefits or Remittance Advice** - A document that summarizes how reimbursement was determined in the payment of a health plan claim.

**Health Information Technology for Economic and Clinical Health Act (HITECH)** - Part of the American Recovery and Reinvestment Act of 2009 (ARRA), the HITECH Act contains incentives related to health care information technology in general (e.g. creation of a national health care infrastructure) and contains specific incentives designed to accelerate the adoption of electronic health record (EHR) systems among providers.

**Health Insurance Portability and Accountability Act (HIPAA)** - Title I of HIPAA protects health insurance coverage for workers and their families when they change or lose their jobs. Title II of HIPAA requires the establishment of national standards for electronic health care transactions and national identifiers for providers, health insurance plans and employers and also addresses the security and privacy of health data.

**Hospital-Acquired Condition** - A condition that develops while a patient is in the hospital, such as an infection, a pressure ulcer or some type of injury.

**Hospital Authority** - A statutorily created public corporation in a county or municipality that is authorized to exercise certain specified public and essential governmental functions, including the acquisition, construction and equipping of hospitals and other health care facilities to promote the public health needs of the community.

**Hospital Authority (Restructured)** - A hospital that is owned by a hospital authority that has delegated its management authority and responsibilities to a nonprofit corporation via a restructuring process whereby the authority maintains ownership of the lands, buildings, facilities and other assets that constitute the hospital and the nonprofit corporation is responsible for operating the hospital. Georgia law requires that at least one member of the hospital authority serve on the governing body of the nonprofit entity and that the nonprofit entity provides the hospital authority with an annual financial statement.

**Hospital Provider Payment Program** - Implemented in FY 2011 and reauthorized in FY 2014, and again in FY 2017, to create an additional funding source for the state's share of Medicaid costs and to fund a rate increase for hospitals serving Medicaid recipients. This program is scheduled to end on June 30, 2020.

**Hospital Medicaid Financing Program** - Created in March 2013 to provide additional Medicaid payments to hospitals participating in the Hospital Provider Payment Program.

**Indigent Care** - Unpaid charges for services to patients whose family income is less than or equal to 125 percent of the Federal Poverty Level.

**Indigent Care Trust Fund (ICTF)** - Established in 1990 to expand Medicaid eligibility and services; support rural and other health care providers, primarily hospitals, which serve the medically indigent; and fund primary health care programs for medically indigent Georgians. The ICTF is an umbrella program that contains the Disproportionate Share Hospital (DSH) program, nursing home and hospital provider fees, breast cancer tag fees, ambulance rates and other uninsured/indigent initiatives.

**Intergovernmental Transfer (IGT)** - Local governmental funds transferred to the state on behalf of a public provider to provide the state matching funds for supplemental payments made to that public provider.

**The Joint Commission (TJC)** - TJC is a voluntary accreditation agency that surveys enrolled hospitals regarding many aspects of quality.

**Licensed Beds** - The maximum number of beds authorized by a government agency for a health care organization to admit patients.

**Long-Term Acute Care Hospital (LTAC)** - A hospital providing specialized care to medically complex patients who usually require an extended hospital stay.

**Long-Term Care Facility (LTCF)** - Any residential health care facility that administers health, rehabilitative or personal services for a prolonged period of time.

**Managed Care** - A mechanism for financing and/or delivery of health care that is intended to control cost, utilization and quality of care.

**Medicaid Integrity Contractor (MIC)** - An auditor hired by the Centers for Medicare and Medicaid Services (CMS) to review Medicaid claims for mispayment.

**Member or Covered Person** - Someone that has insurance coverage through a health plan. May also be referred to as an Enrollee or Beneficiary.

**National Committee for Quality Assurance (NCQA)** - A non-profit organization that sets quality standards, evaluates and accredits managed care plans and other healthcare organization.

**Out-of-Network care** - Health care services provided to a health plan member by a provider who does not participate in that plans' contracted provider network.

**Outpatient Prospective Payment System (OPPS)** - A determined payment methodology for a Medicare outpatient procedure.

**Other Free Care** - Other uncompensated care provided as a result of employee discounts, administrative adjustments, courtesy discounts, small bill write-offs, or other similar write-offs not based on a patient's inability to pay.

**Payer** - An organization (such as the federal government for Medicare or a commercial insurance company) or person who directly reimburses health care providers for their services.

**Present On Admission (POA)** - Whether or not a patient has a certain condition at the time of being admitted to a hospital. These conditions include different types of infections and pressure ulcers.

**Prospective Payment System (PPS)** - A system in which payment for services is determined before the services are actually provided and that amount is reimbursed to the provider regardless of the actual cost of services.

**Provider Network or Network** - A group of providers that have contracted with a managed care plan under which they agree to accept reduced rates and abide by other plan rules in exchange for either increased volume of patients or the ability to receive payment for care provided to insurance plan members.

**Quality Measure** - A tool that helps measure or quantify health care processes, outcomes, patient perceptions, and organizational structure and/or systems that are associated with the ability to provide high-quality health care and/or that relate to one or more quality goals for health care.

**Recovery Audit Contractor (RAC)** - An auditor hired by the Centers for Medicare and Medicaid Services (CMS) to review Medicare claims for mispayment.

**Serious Adverse Event** - An unexpected event that happens during a hospital admission that results in harm or injury to a patient.

**Specialty Hospital** - A limited-service hospital designed to provide one medical specialty such as orthopedic or cardiac care.

**Surveillance and Utilization Review (SUR)** - A Georgia Department of Community Health program designed to identify aberrant Medicaid claiming behavior of providers and identify and recover Medicaid overpayments.

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

**Tobacco Master Settlement Agreement** - In 1998, Georgia was one of 46 states to participate in a Master Settlement Agreement (MSA) with the four largest tobacco companies in the U.S. The MSA was a result of multiple state lawsuits against the tobacco companies that sought recovery for Medicaid and other public health expenses incurred in the treatment of smoking-induced illnesses.

**Trauma** - An injury or injuries caused by external force or violence. Trauma injuries may range from minor to severe, from obvious to non-apparent, and may include single or multiple injuries.

**Trauma System** - An organized approach to facilitating and coordinating a multidisciplinary system response to severely injured patients.

**TRICARE** - TRICARE is the Department of Defense's worldwide health care program available to eligible beneficiaries from any of the seven uniformed services—the U.S. Army, U.S. Navy, U.S. Air Force, U.S. Marine Corps, U.S. Coast Guard, Commissioned Corps of the U.S. Public Health Service, and the National Oceanic and Atmospheric Administration.

**Uncompensated Care** - Care given for which payment is not received, or for which only a portion of the cost is reimbursed. Includes charity care and indigent care, Medicaid underpayments, legislated care underpayments and bad debt.

**Utilization Review** - The process by which a managed care company controls the provision of health care services through determination of medical necessity of care, including pre-certification, prior authorization, concurrent review and retrospective review.