GLOSSARY

Average daily census: Total patient days for a year divided by 365.

Bad debt expense: The provision for actual or expected uncollectible expenses resulting from the extension of credit. Because bad debts are reported as an expense and not a deduction from revenue, the gross charges that result in bad debts will remain in net revenue.

Capitation: An at-risk payment arrangement in which a health care organization receives a fixed, prearranged payment and in turn guarantees to deliver or arrange all medically necessary care required by enrollees in the capitated plan. Specified by contractual agreements between the payer and the organization, the amount of the fixed payment reflects an actuarial assessment of the services required by enrollees and the costs of providing these services.

Charges: Revenue from services rendered to inpatients and outpatients at full established rates (also known as "gross patient revenue").

Charity Care: Health services that were never expected to result in cash inflows. Charity care results from a provider's policy to provide health care services free of charge to individuals who meet certain financial criteria. For purposes of the AHA Annual Survey of Hospitals, charity care is measured on the basis of revenue foregone, at established rates.

Cost Shifting: Charging one group of patients more in order to make up for underpayment by others. Most commonly, charging some privately insured patients more in order to make up for underpayment by Medicaid or Medicare.

Discounted Fee-for-Service: A financial reimbursement system whereby a provider agrees to supply services on a Fee-for-Service basis, but with the fees discounted by a certain percentage from the physician's usual and customary charges. An agreed upon rate for service between the provider and payer that is usually less than the provider's full fee. This may be a fixed amount per service, or a percentage discount. Providers generally accept such contracts because they represent a means to increase their volume or reduce their chances of losing volume.

Exclusive Provider Organization (EPO): A plan that limits coverage of non-emergency care to contracted health care providers. Operates similar to an HMO plan but is usually offered as an insured or self-funded product. Sometimes looks like a managed care organization that is organized similarly to a PPO in that physicians do not receive capitated payments, but the plan allows patients to choose medical care only from network providers. If a patient elects to seek care outside of the network, then he or she will usually not be reimbursed for the cost of the treatment. Uses a small network of providers and has primary care physicians serving as care coordinators (or gatekeepers). Typically, an EPO has financial incentives for physicians to practice cost-effective medicine by using either a prepaid per-capita rate or a discounted fee schedule, plus a bonus if cost targets are met. Most EPOs are forms of POS plans because they pay for some out-of-network care.

Gross Patient Revenue: Revenue from services rendered to inpatients and outpatients at full established rates (also known as "charges").

Health Maintenance Organization (HMO) HMOs offer prepaid, comprehensive

health coverage for both hospital and physician services. The HMO is paid monthly premiums or capitated rates by the payers, which include employers, insurance companies, government agencies, and other groups representing covered lives. The HMO must meet the specifications of the federal HMO act as well as many rules and regulations required at the state level. There are four basic models: group model, individual practice association, network model and staff model. An HMO contracts with health care providers, e.g., physicians, hospitals, and other health pro- fessionals. The members of an HMO are required to use participating or approved providers for all health services and generally all services will need to meet further approval by the HMO through its utilization program. Members are enrolled for a specified period of time. HMOs may sub-capitate to other groups. For example, it may carve out certain benefit categories, such as mental health, and sub-capitate these to a mental health HMO. Or the HMO may sub-capitate to a provider, provider group or provider network. HMOs are the most restrictive form of managed care benefit plans because they restrict the procedures, providers and benefits.

Indemnity fee for service: The traditional type of health insurance, in which the insured is reimbursed for covered expenses without regard to choice of provider. Payment up to a stated limit may be made either to the individual incurring and claiming the expense, or directly to providers.

Indemnity Plan (Indemnity Health Insurance): A plan that reimburses physicians for services performed, or beneficiaries for medical expenses incurred. Such plans are contrasted with group health plans, which provide service benefits through group medical practice.

Integrated Delivery Systems (IDS): Many different, but similar, definitions exist for IDS. An IDS can be a financial or contractual arrangement between health providers (usually hospitals and doctors) to offer a comprehensive range of health care services through a separate legal entity operating as a single health care delivery system. IDS can be a network of organizations usually including hospitals and physician groups, that provides or arranges to provide a coordinated continuum of services to a defined population and is held both clinically and fiscally accountable for the outcomes of the populations served. IDS can also be a health care provider organization which vertically integrates physician, hospital, and, usually, also health plan businesses in some manner in order to establish a full continuum of care, seamless delivery of services and the ability to manage care under new reimbursement arrangements.

Managed Care: A term covering a broad spectrum of arrangements for health care delivery and financing, including managed indemnity plans (MIP), health maintenance organizations (HMO), preferred provider organizations (PPO), point-of-service plans (POS), and direct contracting arrangements between employers and providers.

Medicaid (Title XIX): Medicaid is an entitlement program financed by both the state and federal government (through the Social Security Administration) and managed by the states. Medicaid provides health care insurance to eligible persons younger than 65 years of age who cannot afford to pay private health insurance. The federal government matches the states' contribution on a certain minimal level of available coverage. The states may institute additional services, but at their own expense.

Medicare (Title XVIII): A federal program for the elderly and disabled, regardless of financial status. It is not necessary, as with Medicaid, for Medicare recipients to be poor. A U.S. health insurance program for people aged 65 and over, for persons eligible for social security disability payments for two years or longer, and for certain workers and their dependents who need kidney transplantation or dialysis. Monies from payroll taxes and premiums from beneficiaries are deposited in special trust funds for use in meeting the expenses incurred by the insured. It consists of two separate but coordinated programs: hospital insurance (Part A) and supplementary medical insurance (Part B).

Net Patient Revenue: The estimated net realizable amounts from patients, third-party payers, and others for services rendered. The number includes estimated retroactive adjustments called for by agreements with third-party payers; retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and then adjusted later as final settlements are determined.

Physician-Hospital Organization (PHO) An organization representing hospitals and physicians as an agent. A legal entity formed by a hospital and a group of physicians to further mutual interests and to achieve market objectives. A PHO generally combines physicians and a hospital into a single organization for the purpose of obtaining payer contracts. A contracted arrangement among physicians and hospital(s) wherein a single entity, the PHO, agrees to provide services to insurers' subscribers. The PHO serves as a collective negotiating and contracting unit. A PHO may be structured to share the risk of contracting between hospital(s) and doctors. PHOs may also own, operate or subcontract MSOs, health plans or providers. A PHO can manage risk. It is typically owned and governed jointly by a hospital and shareholder physicians.

Point-of-Service Plan (POS): Managed care plan which specifies that those patients who go outside of the plan for services may pay more out-of-pocket expenses. A health insurance benefits program in which subscribers can select between different delivery systems (i.e., HMO, PPO and fee-for-service) when in need of health care services and at the time of accessing the services, rather than making the selection between delivery systems at time of open enrollment at place of employment. Typically, the costs associated with receiving care from the "in network" or approved providers are less than when care is rendered by non-contracting providers. Costs are also less if provided by approved providers in either the HMO or PPO rather than "out of network" or "out of plan" providers. This is a method of influencing patients to use certain providers without restricting their freedom of choice too severely.

Preferred Provider Organization (PPO) Some combination of hospitals and physicians that agrees to render particular services to a group of people, perhaps under contract with a private insurer. The services may be furnished at discounted rates and the insured population may incur out-of-pocket expenses for covered services received outside the PPO if the outside charge exceeds the PPO payment rate. A PPO can also be a legal entity or it may be a function of an already formed health plan, HMO or PHO. The entity may have a health benefit plan that is also referred to as a PPO. PPOs are a common method of managing care while still paying for services through an indemnity plan. Most PPO plans are point of service plans, in that they will pay a higher

percentage for care provided by providers in the network. Many insurers will offer PPOs as well as HMOs. Generally PPOs will offer more choice for the patient and will provide higher reimbursement to the providers. See also Point-of-Service.

Prospective Payment System (PPS): A payment method that establishes rates, prices or budgets before services are rendered and costs are incurred. Providers retain or absorb at least a portion of the difference between established revenues and actual costs. (1) The Medicare system used to pay hospitals for inpatient hospital services; based on the DRG classification system. (2) Medicare's acute care hospital payment method for inpatient care. Prospective per-case payment rates are set at a level intended to cover operating costs in an efficient hospital for treating a typical inpatient in a given diagnosis-related group. Payments for each hospital are adjusted for differences in area wages, teaching activity, care to the poor, and other factors. Hospitals may also receive additional payments to cover extra costs associated with atypical patients (outliers) in each DRG. Capital costs, originally excluded from PPS, are being phased into the system. By 2001, capital payments will be made on a fully prospective, per-case basis.

Uncompensated Care: Service provided by physicians and hospitals for which no payment is received from the patient or from third-party payers. Some costs for these services may be covered through cost shifting. Not all uncompensated care results from charity care. It also includes bad debts from persons who are not classified as charity cases but who are unable or unwilling to pay their bill. See Cost Shifting

Utilization Review (UR), Utilization Management (UM): Evaluation of the necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities. In a hospital, this includes review of the appropriateness of admissions, services ordered and provided, length of stay, and discharge practices, both on a concurrent and retrospective basis. Utilization review can be done by a peer review group, or a public agency. UR is a method of tracking, reviewing and rendering opinions regarding care provided to patients. Usually UR involves the use of protocols, benchmarks or data with which to compare specific cases to an aggregate set of cases. Those cases falling outside the protocols or range of data are reviewed individually. Managed care organizations will sometimes refuse to reimburse or pay for services that do not meet their own sets of UR standards. UR involves the review of patient records and patient bills primarily but may also include telephone conversations with providers. The practices of pre-certification, re-certification, retrospective review and concurrent review all describe UR methods. UR is one of the primary tools utilized by IDS, MCO and health plans to control over-utilization, reduce costs and manage care.

These definitions are drawn from glossaries located at the following URLs:

http://www.healthforum.com/HFStats/asp/Glossary.asp

http://www.pohly.com/terms.shtml

http://statecoverage.net/glossary.htm