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Glossary of Acronyms and Terms

Glossary of Acronyms

AHA — American Hospital Association
CPD — cost per discharge
CPHA — Commission on Professional and Hospital Activities
CT — computed tomography
DHHS — Department of Health and Human Services
DRGs — Diagnosis Related Groups
EEG — electroencephalogram
GIR — Guaranteed Inpatient Revenue
HCFA — Health Care Financing Administration
IOM — Institute of Medicine
IPPB — intermittent positive pressure breathing
LOS — length of stay
MDCS — Major Diagnostic Categories
NCHS — National Center for Health Statistics
OTA — Office of Technology Assessment
PAS — Professional Activity Study
PCB — preliminary cost base
PMCS — Patient Management Categories
PROS — Peer Review Organizations
PSROS — Professional Standards Review Organizations
SMSA — Standard Metropolitan Statistical Area
TEFRA — Tax Equity and Fiscal Responsibility Act of 1982

Glossary of Terms

Capital costs: Costs associated with the use of capital facilities and equipment, including depreciation and interest expenses.

Case mix: The relative frequency of admissions of various types of patients, reflecting different needs for hospital resources. There are many ways of measuring case mix, some based on patients' diagnoses or the severity of their illnesses, some on the utilization of services, and some on the characteristics of the hospital or area in which it is located.

Coinurance: A form of cost-sharing whereby the insured pays a percentage of total cost. (Also see *copayment*.)

Copayment: A form of cost-sharing whereby the insured pays a specific amount at the point of consumption, e.g., \$10 per visit. (Also see *coinsurance*.)

Cost-sharing: The general set of financing arrangements whereby the consumer must pay some out-of-pocket cost to receive care, either at the time of initiation of care, or during the time of the provision of health care services, or both.

Deductible: A form of cost-sharing in which the insured incurs an initial expense of a specified amount within a given time period (e.g., \$250 per year) before the insurer assumes liability for any additional costs of covered services.

Diagnosis Related Groups (DRGs): A classification system that groups patients according to principal diagnosis, presence of a surgical procedure, age, presence or absence of significant comorbidities or complications, and other relevant criteria.

DRG inflation: An increase over time in the number of separately identified case-mix classification groups.

DRG payment: Any per-case hospital payment method in which differences in case mix are taken into account using DRGs to classify case types.

Effectiveness: Same as efficacy (see below) except that it refers to "... average or actual conditions of use."

Efficacy: The probability of benefit to individuals in a defined population from a medical technology applied for a given medical problem under ideal conditions of use.

Fee-for-service: A method of paying for medical care on a retrospective basis by which each service actually received by an individual bears a related charge.

Length of stay (LOS): The number of days a patient remains in the hospital from admission to discharge.

Medicaid: A Federal program that is administered and operated individually by each participating State government that provides medical benefits to certain low-income persons in need of health and medical care.

Medical technology: The drugs, devices, and medical and surgical procedures used in medical care, and the organizational and supportive systems within which such care is provided.

Medicare: A nationwide, federally administered health insurance program, authorized in 1965 to cover the cost of hospitalization, medical care, and some related services for eligible persons over age 65, persons receiving Social Security Disability Insurance payments for 2 years, and persons with end-stage renal disease. Medicare consists of two separate but coordinated programs—hospital insurance (part A) and supplementary medical insurance (part B). Health insurance protection is available to insured persons without regard to income.

Pass-throughs: In a per-case payment system, pass-throughs are elements of hospital cost that are paid on the basis of cost-based reimbursement.

Per-case payment: Any prospective hospital payment system with fixed rates of payment based on the hos-

pital admission, not on the number and types of services or number of days of care provided.

Professional Standards Review Organizations (PSROs): Community-based, physician-directed, nonprofit agencies established under the Social Security Amendments of 1972 to monitor the quality and appropriateness of institutional health care provided to Medicare and Medicaid beneficiaries.

Prospective payment: Hospital payment programs where rates are set prior to the period during which they apply and where the hospital incurs at least some financial risk.

Recalibration: Periodic changes in relative DRG prices, including assignment of prices to new DRGs.

Reliability: A measure of the consistency of a method in producing results. A reliable test gives the same results when applied more than once under the same conditions. Also called "precision."

Retrospective cost-based reimbursement: A payment method in which hospitals are paid their incurred costs of treating patients after the treatment has occurred.

Risk: A measure of the probability of an adverse or untoward outcome and the severity of the resultant harm to health of individuals in a defined population associated with use of a medical technology applied for a given medical problem under specified conditions of use.

Safety: A judgment of the acceptability of risk (see above) in a specified situation.

Technology: The application of organized knowledge to practical ends.

Technology assessment: A comprehensive form of policy research that examines the technical, economic, and social consequences of technological applications. It is especially concerned with unintended, indirect, or delayed social impacts. In health policy, the term has also come to mean any form of policy analysis concerned with medical technology, especially the evaluation of efficacy and safety. The comprehensive form of technology assessment is then termed "comprehensive technology assessment."

Utilization and quality control peer review organizations (PROS): Physician organizations established by the Tax Equity and Fiscal Responsibility Act of 1982 (Public Law 97-248) to replace PSROs (see definition). Hospitals are mandated to contract with PROS to review quality of care and appropriateness of admissions and readmissions.

Validity: A measure of the extent to which an observed situation reflects the "true" situation. **Internal validity** is a measure of the extent to which study results reflect the true relationship of a "risk factor" (e.g., treatment or technology) to the outcome of interest in study subjects. **External validity** is a measure of the extent to which study results can be generalized beyond the study sample.