

HJR 20: Health Care Price Transparency
Topic Terminology: Reimbursement and Pricing
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- **Ambulatory Surgery Centers (ASC).** Ambulatory surgery centers, also known as outpatient surgery centers or same day surgery centers, are health care facilities where surgical procedures not requiring an overnight hospital stay are performed. Such surgery is commonly less complicated than that requiring hospitalization. (Wikipedia)
- **Care Managers.** Care managers are employees of insurance companies who review and approve or disapprove procedures or surgeries before they occur. Decisions of the care managers are meant to control costs for the insurance company and alert consumers that a particular procedure will or will not be covered by their health insurance plans.
- **Centers for Medicare and Medicaid Services (CMS).** The Centers for Medicare & Medicaid Services (CMS) is part of the federal Department of Health and Human Services (HHS). CMS oversees the following programs: Medicare, Medicaid, the Children’s Health Insurance Program (CHIP), and the Health Insurance Marketplace. Part of this agency’s responsibilities includes monitoring health outcomes and cost control in health insurance funded by the federal government (CMS.gov).
- **Certificate of Need.** In the health care realm, states may require a certificate of need (CON) before hospitals or health facilities acquire property, make plans to expand, or decide to build new facilities. The purpose of a CON is to ensure that the building or expansion plans will not create surplus capacity or duplicative facilities. In 2015, the FTC issued a statement opposing state CON laws (hfma.org).
- **Chargemaster.** Chargemaster, or charge description master (CDM), is a comprehensive listing of items billable to a hospital patient or a patient's health insurance provider. The chargemaster typically serves as the starting point for negotiations with patients and health insurance providers to specify what amount of money will actually be paid to the hospital.
- **Charity Care, Uncompensated Care, Community Benefit.** Nonprofit hospitals are exempt from most federal, state, and local taxes. This favored tax status is intended to be an acknowledgement of the “*community benefit*” provided by these institutions. In addition to tax exemptions, nonprofit status allows hospitals to benefit from tax-exempt bond financing and to receive charitable contributions that are tax- deductible to the donors. Since 1913, the IRS code has included tax exemptions for nonprofit hospitals. Prior to 1969, to qualify for tax-exempt status a hospital had to provide, “to the extent of its financial ability, free or reduced-cost care to patients unable to pay for it.” *Charity care* assumes that the patient has asked for help and has received care for free or a reduced cost. *Uncompensated care* is a broader term that includes both charity care and patients who don’t pay their bills.

In 1969, the charitable care IRS standard was replaced with a more general requirement that compelled hospitals to engage in activities that benefit the communities they serve. Under the “community benefit” standard, spending that promotes community health, in addition to charity care, counts toward meeting the requirements for tax exemption. The Internal Revenue Service (IRS) allows hospitals broad latitude in determining what activities and services constituted community benefit. The community benefit standard remained basically unchanged until 2008, when the IRS added a requirement that hospitals submit additional information regarding community benefits on the new Schedule H worksheet attached to their Form 990, which must be filed annually with the IRS by nonprofit organizations. Schedule H categories of community benefit activities include the net, unreimbursed costs of charity care (providing free or discounted services to patients who qualify under the hospital’s financial assistance policy); participation in means-tested government programs, such as Medicaid; health professions education; health services research; subsidized health services; community health improvement activities; and cash or in-kind contributions to other community groups (such as donating funds to a community health screening event or hosting a blood drive).

Hospitals can also claim what the IRS terms *community building activities*, such as investments in housing or environmental improvements, if they separately submit evidence documenting the relationship between such investments and health improvement. Schedule H also requires the reporting of bad debt (amounts uncollected from patients who did not qualify for or ask for charity care) and shortfalls associated with Medicare payments, but the IRS does not count these amounts as community benefits. (healthaffairs.org)

- **Coding.** Medical coding is the process of translating information from patient records – treatments, tests, procedures, and diagnoses – into the standardized codes used to bill patients and third-party payers such as insurance companies, Medicaid, and Medicare. The rating scale is from 1 to 5 with 5 indicating a significant and complex treatment. Reimbursement for service increases according to the code level from 1 to 5.

Diagnosis codes track diseases and other health conditions, inclusive of chronic diseases such as diabetes and heart disease, and infectious diseases such as norovirus and the flu. Procedure codes track interventions performed. These diagnosis and procedure codes are used by health care providers, government health programs, private health insurance companies, workers' compensation carriers, software developers, and others for a variety of applications in medicine, public health and medical statistics, including:

- statistical analysis of diseases and therapeutic actions;
- reimbursement (e.g., to process claims in medical billing based on diagnosis-related groups);
- knowledge-based and decision support systems; and
- direct surveillance of epidemic or pandemic outbreaks. (Wikipedia.org)

- **Cost-to-Charge Ratio.** The cost-to-charge ratio is the ratio of a hospital's costs for a service to what they charge for the service. This term is most commonly used in relation to Medicare. Medicare has assigned to every hospital a specific overall cost-to-charge ratio that it deems reasonable to participate in government-sponsored insurance. Cost-to-charge ratio requires that hospitals keep the ratio constant. In other words, if a hospital raises the price on one procedure, that would require lowering the price of some other service.
- **Diagnosis Related Group (DRG).** When Medicare began, the program initially paid hospitals their "usual and customary charges," but in the mid-1980s Medicare began paying according to a diagnosis related group (DRG). According to CMS, DRGs are "a patient classification scheme which provides a means of relating the type of patients a hospital treats (i.e., its case mix) to the costs incurred by the hospital.... In 1983 Congress amended the Social Security Act to include a national DRG-based hospital prospective payment system for all Medicare patients." For example, the payment for a hospital stay for an appendectomy or for pneumonia would be a fixed amount depending almost entirely on the diagnosis. (CMS.gov)
- **Employer-Sponsored Health Insurance.** Employer-sponsored health insurance is paid for by businesses on behalf of their employees as part of an employee benefit package. Most private (non-government) health coverage in the United States is employment-based. Nearly all large employers in America offer group health insurance to their employees. The cost of providing health insurance to employees is tax deductible for the employer.
- **Executive Compensation.** IRS rules require that nonprofit CEOs receive "reasonable compensation;" however, this can vary widely depending on a variety of factors.
- **Facility Fees.** Facility fees allow a health care organization to bill patients a service charge for the patient's use of hospital facilities and equipment. In some cases, a patient may be responsible for the service bill if their insurance declines to pay or if the patient has a high-deductible health plan. Hospitals can charge patients facility fees if they see physicians who work in an office that is owned by the hospital. (beckershospitalreview.com)
- **Fee for Service.** "A method in which doctors and other health care providers are paid for each service performed. Examples of services include tests and office visits." (healthcare.gov)
- **Health Maintenance Organizations (HMOs).** A type of health insurance plan that usually limits coverage to care from doctors who work for or on contract with the HMO. It generally won't cover out-of-network care except in an emergency. An HMO may require a patient to live or work in its service area to be eligible for coverage. HMOs often provide integrated care and focus on prevention and wellness. (healthcare.gov)
- **Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS).** In 2012, CMS began value-based purchasing for fee-for-service Medicare. A portion of hospital performance is assessed with the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey, a measure of patient and caregiver experience.

- **Independent Contractors.** In the 1990s, some hospitals turned emergency room and outpatient clinic physicians into independent contractors instead of salaried employees. A contracted physician is often paid a flat fee or on a time and materials basis.
- **No Patient Contact (NPC).** NPC refers to instances when a health care provider is listed on a medical bill as providing service, but has not had actual contact with the patient.
- **Observation Status or Hospital Status.** When patients are admitted to a hospital, their status is identified as inpatient or outpatient. For example, if a patient is in the hospital for observation to determine if the patient has a concussion, that patient is considered to be an outpatient. Medicare pays a bundled rate for inpatient care, but has no similar limits for outpatient services. (medicare.gov)
- **Operating Surplus.** Because hospitals are usually nonprofits, they cannot make a profit, but they can have an operating surplus or margin. A surplus occurs when revenue exceeds expenses in a given year. Operating at an exact break-even level is probably impossible, so hospital boards budget for a surplus of 2% to 3%. Having this slight margin creates a financial cushion going into the next fiscal year that can help mitigate surprises, such as a sudden drop in number of patients or lower reimbursements from government or private sources. All surpluses must be invested back into the organization – they cannot be used to pay staff or board members.
- **Outpatient Services.** Because of advances in medical treatments, some medical procedures can now be safely performed outside of a hospital without the necessity to stay overnight. Many hospitals and independent physician groups developed outpatient programs that provided single-focused services such as endoscopy, infusions, dialysis, psychiatric and behavioral health, and minor surgeries. Instead of performing any or all procedures in doctor’s offices or in hospitals, patients are sent to separate outpatient departments or centers.
- **Physician Extender.** “Physician extenders (PE) is a health care provider who is not a physician but who performs medical activities typically performed by a physician. It is most commonly a nurse practitioner or physician assistant.” (ent.ufl.edu)
- **Profit Lines or Service Lines.** “Hospitals and physicians have used a service line approach for decades to provide efficient, high-quality care to well-defined, patient populations:
 - Patients with related diseases or conditions (e.g., cardiovascular, orthopedic)
 - Patients in specific life stages (e.g., senior health, pregnancy)
 - Patients receiving treatments for related conditions (e.g., transplant)
 Adapted from the product line approach used by other industries, service lines organize all the care that particular patient populations need. For example, an orthopedic service line would provide the various services that joint replacement patients need, beginning 30 days before surgery to 90 days after (i.e., preadmission testing, surgery, and rehabilitation).” (hfma.org)

- **Quality Assurance.** Quality assurance is an effort in health care to identify the components of quality health care and to improve the quality and safety of care. “The concept includes the assessment or evaluation of the quality of care; identification of problems or shortcomings in the delivery of care; designing activities to overcome these deficiencies; and follow-up monitoring to ensure effectiveness of corrective steps.” (ncbi.nlm.nih.gov)
- **Relative Value Units.** “This measurement attempts to standardize clinician work into numerical units that can be added together to create a simple measure of volume, divided per clinician in aggregate to examine productivity per provider, multiplied by conversion factors to compare work effort across surgical or medical disciplines (work RVU), and used in any number of other calculations and manipulations. The RVU was created with the intent of converting numerous factors into a single measurable unit. These factors include the time it takes to perform a given service, the technical skill that service requires, the mental effort and judgment required of the providers, and the liability risk associated with that service.” (Pickard 2014)
- **Surplus Capacity.** During the 1980s and 1990s, researchers and policymakers generally agreed that hospitals had substantial excess inpatient capacity. Between 1980 and 1995, hospital inpatient admissions declined by approximately 15 percent, and occupancy rates nationwide fell from about 76 to 63 percent (Bazzoli et al 2006). In general, hospitals are not expected to be completely full all the time because they must maintain a reserve or standby capacity to deal with unanticipated health needs. Furthermore, some excess hospital capacity is desirable because it provides leverage to third-party payers in their rate negotiations with hospitals. In the late 1990s, however, the general perception was that the U.S. health system had several thousand unneeded hospital beds that, if closed, could reduce the nation's health expenditures on hospital care (Madden 1999).