Glossary of Healthcare Terminology

AAPCC	Adjusted Average Per Capita Cost
ACA	Affordable Care Act
ACL	Administration for Community Living (formerly Administration on Aging)
ACO	Accountable Care Organization: A collection of doctors, medical groups, hospitals, and other healthcare professionals who work together to deliver high-quality, coordinated care to the patients they serve.
AMI	Acute Myocardial Infarction
BBA	Balanced Budget Act
BPCI	Bundled Payments for Care Improvement Initiative
Break-Even Point	The point at which costs or expenses and revenue are equal
CABG	Coronary Artery Bypass Graft Surgery
CBO	Congressional Budget Office
CHF	Chronic Heart Failure
CHNA	Community Health Needs Assessment: Required of all 501(c)(3) Hospitals under the Affordable Care Act, the initial CHNA was due by March 2012 and must be completed every 3 years (next one due March 2015); publicly reported, it requires community engagement and assessment of needs and implementation strategy to address the identified needs.
CMS	Centers for Medicare Services
DSMT	Diabetes Self-Management Training
Dual Eligibles	People qualifying for both Medicare and Medicaid benefits
EB	Evidence-Based
EMTALA	Emergency Medical Treatment and Labor Act
ESRD	End-Stage Renal Disease: People with permanent kidney failure requiring dialysis or a kidney transplant

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FFS	Fee for Service
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center: A reimbursement designation from the Bureau of Primary Health Care and the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services.
HAC	Hospital Acquired Conditions
HEDIS	Healthcare Effectiveness Data and Information Set
HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems: (Pronounced "H-caps"), also known as the CAHPS Hospital Survey, is a survey instrument and data collection methodology for measuring patients' perceptions of their hospital experience.
HCC	Hierarchical Condition Category
HHS	Department of Health and Human Services
HI Trust Fund	Hospital Insurance Trust Fund
HMO	Health Maintenance Organization: An organization that provides or arranges managed care for health insurance, self – funded health care benefit plans, individuals, and other entities in the United States and acts as a liaison with health care providers (hospitals, doctors, etc.) on a prepaid basis.
Innovation Center	The Center for Medicare and Medicaid Innovation; Division of CMS that supports development and testing of innovative healthcare payment and service delivery models.
ISP	Individual Service Plan
JCOHA	Joint Commission on Accreditation of Healthcare Organizations: An independent, not-for-profit organization that accredits and certifies nearly 21,000 health care organizations and programs in the United States
LTSS	Long Term Services and Supports
Mandatory Populations	Must select a MCO plan or accept an auto-assignment if they do not select within a defined time period
MCO	Managed Care Organization: A group of health industry companies and professionals that work together to provide health care at affordable rates, and to control the costs of providing these services.
Medical Loss Ratio (MLR)	The percent of premium an insurer spends on claims and expenses that improve health care quality
Medicare Advantage Plans	Offered by a private company that contracts with Medicare to provide you all your Part A and Part B benefits.

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Medicare Special Needs Plans (SNPs)	A type of Medicare Advantage Plan (like an HMO or PPO) that limits membership to people with specific diseases or characteristics, and tailors their benefits, provider choices, and drug Formularies to best meet the specific needs of the groups they serve.
Medigap	Health Insurance sold by private insurance companies as a supplemental policy to cover the 20% coinsurance requirements
MI	Acute Myocardial Infarction
MLTSS	Managed Long Term Care Services and Supports: An arrangement between State Medicaid programs and contractors through which the contractors receive capitated payments for LTSS and are accountable for the delivery of services and supports that meet quality and other standards set in the contract.
MLR	Medical Loss Ratio
MMA	Medicare Modernization Act
MRSA	Medicaid Rural Service Area
MSSP	Medicare Shared Savings Program
PACE	Program of All-inclusive Care for the Elderly
PCMH	Patient-Centered Medical Home: a care delivery model whereby patient treatment is coordinated through their primary care physician to ensure they receive the necessary care when and where they need it, in a manner they can understand.
PMPM	Per Member Per Month: the rate the MCO receives for each enrolled beneficiary
QRA	Quality Improvement Activity
ROI	Return On Investment
RFP	Request for Proposal
RRB Benefits	Railroad Retirement Board Benefits
SCHIP	State Children's Health Insurance Program
SNF	Skilled Nursing Facility
SPA	State Plan Amendment
SSI	Federal Supplemental Security Income Program
SMI	Supplementary Medical Insurance Trust Fund
STAR ratings	A rating system used to measure how well Medicare Advantage and prescription drug (Part D) plans perform
SWOT Analysis	Analysis of an organization's Strengths, Weaknesses, Opportunities and Threats

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TEFRA	Tax Equity and Fiscal Responsibility Act
Title XIX	Of the Social Security Act; enacted on July 30, 1965, established regulations for the Medicaid Program to provide healthcare services to low-income children deprived of parental support, their caretaker relatives, the elderly, the blind and individuals with disabilities.
Tricare	Formerly known as the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), Tricare is a health care program of the United States Department of Defense Military Health System.
Voluntary Populations	Are not required to participate and have the option of not participating in MLTSS
VPB	Value-Based Purchasing

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