Selected Healthcare Buzz Terms

Center for Medicare and Medicaid Services (CMS): An agency with the Department of Health and Human Services that administers the Medicare program and jointly administers the Medicaid program with the individual states. CMS will also have a role in running many major initiatives in the Health Care Reform legislation including Medicaid expansion and several of the changes to Medicare.

Health and Human Services Office of the Inspector General (OIG): The duty of the OIG is to protect the integrity of Department of Health and Human Services (HHS) programs, as well as the health and welfare of the beneficiaries of those programs. The OIG has a responsibility to report both to the Secretary and to the Congress program and management problems and recommendations to correct them. The OIG's duties are carried out through a nationwide network of audits, investigations, inspections and other mission-related functions performed by OIG components. The OIG conducts frequent audits of provider billing practices to CMS and will receive a greater oversight authority as health care reform is implemented.

Children’s Health Insurance Program (CHIP formally known as SCHIP the State Children’s Health Insurance Program): CHIP is a program created in 1997 and covers about six million children that allows states to cover children beyond Medicaid (133% of federal poverty starting in 2014) eligibility levels through CHIP. States set premiums and cost sharing on a sliding scale based on income and can provide a more limited set of benefits than Medicaid. States and the federal government jointly fund both programs, although the Federal government pays a higher proportion of CHIP costs up to a capped total amount for each state. Some states offer a vision and hardware benefit but it is not mandated by the Federal government.

Patient Protection and Affordable Act (PPACA or ACA): this is the name of the healthcare reform legislation signed into law on March 23, 2010. It also applies to a companion piece of legislation called the Health Care and Education Reconciliation Act of 2010. The law includes numerous health-related provisions to take effect over a four-year period, including expanding Medicaid eligibility, subsidizing insurance premiums, providing incentives for businesses to provide health care benefits, prohibiting denial of coverage/claims based on pre-existing conditions, establishing health insurance exchanges, and support for medical research. It also has a nondiscrimination provision (aka Harkin Amendment) that is described below.

Healthcare Reform Market Based Terms
**Accountable Care Organization (ACO):** A network of health care providers that bands together to provide the full continuum of health care services for patients. The network would receive a payment for all care provided to a patient, and would be held accountable for the quality and cost of care. New pilot programs in Medicare and Medicaid included in the health reform law would provide financial incentives for these organizations to improve quality and reduce costs by allowing them to share in any savings achieved as a result of these efforts. ACO’s will generally be associated with large integrated health networks like Kaiser Permanente, Mayo Clinic or the Cleveland Clinic or possibly a large hospital system but the goal of the pilot programs is to bring the concept to smaller healthcare entities.

**Current Procedural Terminology (CPT):** The CPT code set accurately describes medical, surgical, and diagnostic services and is designed to communicate uniform information about medical services and procedures among physicians, coders, patients, accreditation organizations, and payers for administrative, financial, and analytical purposes.

**Employer Pay or Play:** This is a provision in the PPACA that requires employers to provide health insurance for their workers or pay a fee or penalty to the government. Also known as an employer mandate, it would exempt small businesses with fewer than 50 employees.

**Employee Retirement Income Security Act of 1974 (ERISA):** Legislation enacted in 1974 to protect workers from the loss of benefits provided through the workplace. ERISA does not require employers to establish any type of employee benefit plan, but contains requirements applicable to the administration of the plan when a plan is established. The requirements of ERISA apply to most private employee benefit plans established or maintained by an employer, an employee organization, or both.

**Essential benefits:** The PPACA requires all health-insurance plans sold after 2014 to include a basic package of benefits, including hospitalization, outpatient services, maternity care, prescription drugs, emergency care and preventive services, among other benefits. It also restricts the amount of cost-sharing that patients must pay for these services.

**Grandfathered plan:** A health plan that an individual was enrolled in prior to March 23, when the act was signed. Grandfathered plans are exempted from most changes required by the PPACA. New employees may be added to group plans that are grandfathered, and new family members may be added to all grandfathered plans. Group health insurance: Health insurance that is offered to a group of people, such as employees of a company. The majority of Americans have group health insurance through their employer or their spouse's employer.
The Healthcare Common Procedure Coding System (HCPCS): HCPCS are a set of health care procedure codes based on CPT codes and used in filing Medicare and Medicaid claims. HCPCS was established to provide a standardized coding system for describing the specific items and services provided in the delivery of health care and can include services that are not assigned a CPT code. HCPCS allows CMS to reimburse new medical services that may not have a CPT assigned to it yet. HCPCS includes CPT but CPT may not necessarily include HCPCS.

Health Insurance Exchanges: A purchasing arrangement through which insurers offer and smaller employers and individuals purchase health insurance. The PPACA creates new "American Health Benefit Exchanges" in each state to assist individuals and small businesses in comparing and purchasing qualified health-insurance plans. Exchanges also will determine who qualifies for subsidies and make subsidy payments to insurers on behalf of individuals receiving them. They also will accept applications for other health-coverage programs such as Medicaid and CHIP. An example of this arrangement is the Commonwealth Connector, created in Massachusetts in 2006.

The International Statistical Classification of Diseases and Related Health Problems 10th Revision (ICD-10): Created by the World Health Organization (WHO) and will be used in the United States starting in 2013 for medical coding and reporting to CMS and the National Center for Health Statistics (NCHS). There are two types of ICD-10 codes that will be used in the US. The ICD-10-CM (clinical modification) is a morbidity classification for classifying diagnoses and reason for visits in all health care settings. The other type is ICD-10-PCS, PCS stands for “procedural coding system,” and will replace Volume 3 of ICD-9-CM as the inpatient procedural coding system. ICD-10 will not replace CPT as the coding system for physician services.

Medical Loss Ratio (MLR): A requirement under the PPACA that mandate what percentage of premium dollars an insurance company must spend on medical care, as opposed to administrative costs or profits. Specifically, the PPACA requires insurers in the large group market to have an MLR of 85% and insurers in the small group and individual markets to have an MLR of 80%.

Patient Centered Medical Home (PCMH): A healthcare setting where patients receive comprehensive primary care services; have an ongoing relationship with a primary care provider who directs and coordinates their care; have enhanced access to non-emergent primary, secondary, and tertiary care; and have access to linguistically and culturally appropriate care. Optometry has an opportunity to be involved in this concept because primary care physicians are looking for professionals to work with and can actively participate in the continuum of care.

Pay for Performance (P4P): A payment system in which providers receive incentives for meeting or exceeding quality and cost benchmarks. Some systems also penalize providers who
do not meet established benchmarks. The goal of pay for performance programs is to improve the quality of care over time.

**Qualified health plan (QHP):** A health-insurance policy that is sold through an exchange. The PPACA requires exchanges to certify that qualified health plans meet minimum standards contained in the law.

**The Harkin Amendment:** sponsored by Sen. Tom Harkin (D-Iowa) is language in the PPACA that creates the first-ever federal standard of provider non-discrimination and will bar health insurers, ERISA plans and the Federal Employees Health Benefit Program (FEHBP) from discriminating in plan coverage and participation against ODs and other providers. It also states that it does not prevent the group health plan, health insurer or the Secretary from establishing varying reimbursement rates based on quality or performance measures. Beginning in 2014, the Harkin Amendment would prevent public and private health plans from discriminating against licensed and certified health professionals with regard to health plan participation or coverage. Health insurance plans – including a number of large employer-sponsored programs organized under the Federal Employee Retirement Income Security Act (ERISA) – in many instances have made it policy to summarily deny coverage for the services of qualified health care providers as a cost containment measure, the AOA Advocacy Group says.
Healthcare Reform Health Information Technology Terms

**Electronic health record (EHR)**: A computer-accessible, interoperable resource of clinical and administrative information pertinent to the health of an individual. Information is drawn from multiple clinical and administrative sources and is used primarily by a broad spectrum of clinical personnel involved in the individual’s care, enabling them to deliver and coordinate care and promote wellness.

**Health information exchange (HIE)**: The electronic movement of any and all health-related data according to an agreed-upon set of interoperability standards, processes, and activities across nonaffiliated organizations in a manner that protects the privacy and security of that data and the entity that organizes and takes responsibility for the process. HIEs must be self-sufficient by 2015 through some type of funding mechanism (dues, fees or government financing).

**Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH Act)**: The HITECH Act was signed into law on February 17, 2009 as part of the American Recovery and Reinvestment Act of 2009 (ARRA). The HITECH Act stipulates that, beginning in 2011, healthcare providers will be offered financial incentives for demonstrating meaningful use of electronic health records (EHR). Incentives will be offered until 2015, after which time penalties may be levied for failing to demonstrate such use. The Act also establishes grants for training centers for the personnel required to support HIT infrastructure so it offers opportunity to office support staff to be trained in HIT.

**Meaningful Use**: Meaningful use refers to measures that healthcare providers are using HIT at a level that the Federal government deems necessary to obtain the financial incentives under the HITECH Act and starting in 2015 used to determine that provider will not have their Medicare payments penalized.

**Office of the National Coordinator for Health Information Technology (ONC)**: A Federal office within the Department of Health and Human Services (HHS) and is the principal Federal entity charged with coordination of nationwide efforts to implement and use the most advanced health information technology and the electronic exchange of health information.

**Regional health information organization (RHIO)**: A multi-stakeholder governance entity that brings together nonaffiliated health and healthcare-related providers and the beneficiaries they serve for the purpose of improving healthcare for the communities in which it operates. It takes
responsibility for the processes that enable the electronic exchange of interoperable health information within a defined contiguous geographic area.