Advanced Certificate in Health Care Systems Engineering

Healthcare Policy and Regulation

Healthcare Policy and Regulation Glossary

Accountable Care Organization (ACO)
A type of healthcare organization where a group of healthcare providers work together to coordinate care for patients, with the goal of improving quality of care and reducing costs. ACOs are held accountable for the quality and cost of care they provide to patients.

Adverse Event
An event that results in harm to a patient due to healthcare management rather than the underlying disease process. Adverse events can be caused by medical errors, system failures, or other factors.

Alternative Payment Models (APMs)
Payment models that incentivize healthcare providers to deliver high-quality care at lower costs. APMs include models such as bundled payments, shared savings, and pay-for-performance.

Antitrust Laws
Laws that promote fair competition in the marketplace and prevent companies from engaging in anti-competitive behavior. In healthcare, antitrust laws aim to prevent monopolies and promote competition among providers.

Beneficiary
An individual who is eligible to receive benefits from a healthcare program, such as Medicare or Medicaid. Beneficiaries may be patients, providers, or other stakeholders.

Bundled Payments
A payment model where a single payment is made to cover all services related to a specific episode of care, rather than paying for each service separately. Bundled payments are designed to promote coordination among providers and reduce costs.

Certificate of Need (CON)
A regulatory process used in some states to control the construction or expansion of healthcare facilities and services. CON laws aim to prevent overbuilding of healthcare infrastructure and promote access to affordable, high-quality care.

Clinical Practice Guidelines
Evidence-based recommendations for healthcare providers on the best ways to diagnose, treat, and manage various medical conditions. Clinical practice guidelines are developed by expert panels and are intended to improve the quality of care and patient outcomes.

CMS Innovation Center

The Center for Medicare and Medicaid Innovation (CMMI) within the Centers for Medicare and Medicaid Services (CMS) that tests innovative payment and service delivery models to improve quality of care and reduce costs. The CMS Innovation Center is responsible for developing and implementing new payment models, such as accountable care organizations and bundled payments.

Credentialing
The process by which healthcare providers are evaluated and approved to participate in a health plan or healthcare organization. Credentialing involves verifying a provider's qualifications, training, and licensure to ensure they meet the standards for quality and safety.

Electronic Health Record (EHR)
A digital version of a patient's paper chart that contains the patient's medical history, diagnoses, medications, treatment plans, and other health information. EHRs are used by healthcare providers to store, manage, and share patient information electronically.

Emergency Medical Treatment and Labor Act (EMTALA)
A federal law that requires hospitals to provide emergency medical treatment to anyone who seeks care in the emergency department, regardless of their ability to pay. EMTALA aims to ensure that individuals have access to emergency care when needed.

Health Information Exchange (HIE)
A system that allows healthcare providers to electronically share patient information, such as medical records, test results, and treatment plans. HIEs facilitate communication and coordination among providers to improve patient care and outcomes.

Health Insurance Portability and Accountability Act (HIPAA)
A federal law that protects the privacy and security of individuals' health information. HIPAA sets standards for the use and disclosure of protected health information by healthcare providers, health plans, and other entities.

Health Maintenance Organization (HMO)
A type of managed care organization that provides healthcare services to members for a fixed fee. HMOs typically require members to choose a primary care physician and obtain referrals for specialist care. HMOs focus on preventive care and care coordination to improve quality and reduce costs.

Medicaid
A joint federal and state program that provides health insurance to low-income individuals and families. Medicaid covers a wide range of healthcare services, including hospital care, physician visits, prescription drugs, and long-term care.

Medicare
A federal health insurance program for individuals aged 65 and older, as well as certain younger individuals with disabilities. Medicare has several parts that cover different services, such as hospital care (Part A), medical services (Part B), and prescription drugs (Part D).

Patient-Centered Medical Home (PCMH)
A model of primary care that focuses on providing comprehensive, coordinated, and patient-centered care. PCMHs aim to improve access to care, enhance communication between patients and providers, and promote better health outcomes.

Pay-for-Performance (P4P)
A payment model that incentivizes healthcare providers to meet specific performance targets or quality measures. Providers are rewarded financially for achieving these targets, such as improving patient outcomes or reducing hospital readmissions.

Quality Improvement Organization (QIO)
An organization that works to improve the quality of care provided to Medicare beneficiaries by healthcare providers. QIOs review medical records, monitor patient outcomes, and provide technical assistance to help providers deliver high-quality care.

Readmission
The act of a patient returning to the hospital shortly after being discharged, often due to complications or incomplete treatment. Hospital readmissions are a key focus of healthcare policy and regulation, as they can lead to increased costs and lower quality of care.

Shared Savings Program (MSSP)
A program established by the Centers for Medicare and Medicaid Services (CMS) that promotes accountable care organizations (ACOs) to improve quality of care and reduce costs. ACOs that meet specific quality and savings targets are eligible to share in the savings generated.

Telemedicine
The use of technology, such as video conferencing and remote monitoring, to deliver healthcare services to patients at a distance. Telemedicine allows patients to access care from providers without having to travel to a healthcare facility, improving access and convenience.

Value-Based Payment
A payment model that ties reimbursement to the quality and outcomes of care provided, rather than the volume of services delivered. Value-based payment models aim to reward providers for delivering high-quality, cost-effective care and improving patient outcomes.