IOWA HOSPITAL ASSOCIATION

Health Care Terms and Abbreviations

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We care about Iowa's health

Academic Medical Center – A group of affiliated institutions, including one or more teaching hospitals, a medical school, and its affiliated faculty practice and other health professional (e.g. nursing, pharmacy, dentistry) schools.

Access to Care – Access to health services means the relative ease of obtaining, and the timely use of, personal health services to achieve the best possible health outcomes. Measures of access include the cost of such care; availability of Medicare, Medicaid, insurance or some other third-party coverage for health services; the location of health facilities and their hours of operation; travel time and distance to health facilities; availability of medical services, including scheduled appointments with health professionals. Access to care often varies based on race, ethnicity, socioeconomic status, age, sex, disability status, sexual orientation, gender identity and residential location.

Accountable Care Organization (ACO) – A network of physicians, hospitals and other health care providers that voluntarily share financial and medical responsibility for providing coordinated high-quality care to Medicare patients. The Patient Protection and Affordable Care Act incentivized the creation of ACOs. When an ACO succeeds in delivering high-quality care and spending health care dollars more wisely, the ACO will share in the savings it achieves for the Medicare program.

Accounts Payable – A current liability account in which a business records the amounts it owes to suppliers or vendors for goods or services. This also sometimes refers to the division or function in a finance department that is responsible for making payments owed by the business to suppliers and other creditors.

Accounting Perspectives (Evaluation) – Perspectives underlying decisions on which categories of goods and services to include as costs or benefits in an analysis.

Accounts Receivable – Amounts owed by customers for goods and services a company allowed the customer to purchase on credit. The amount that the company is owed is recorded in its general ledger account entitled Accounts Receivable. The unpaid balance in this account is reported as part of the current assets listed on the company's balance sheet.

Accreditation – An independent assessment and evaluation process of a health care organization, typically voluntary, to demonstrate the organization's compliance in meeting nationally recognized standards of quality and safety. Accreditation agencies include The Joint Commission, the National Committee for Quality Assurance, DNV GL Health care, Commission on Accreditation of Rehabilitation Facilities, and Healthcare Facilities Accreditation Program, and many smaller accrediting agencies for specialty programs such as home health care. Accreditation needs to be renewed every few years in order to remain in effect.

Accreditation Council for Graduate Medical Education – The Accreditation Council for Graduate Medical Education is the body responsible for accrediting the majority of graduate medical training programs for physicians in the U.S.. It is a nonprofit private council that evaluates and accredits medical residency and internship programs.

Accreditation Survey – The process of evaluation to determine whether a health care organization meets specified standards to achieve external accreditation. Typically this involves an on-site review at the health care organization by external surveyors or evaluators of the individual accrediting body.

Accrual – A technique for determining medical costs for enrollees over a set period, so that money can be set aside in a claims reserve to be used for medical costs incurred during that period. Revenues recognized as services are rendered independent of when payment is received.

Accrual Accounting – Accounting method that recognizes a revenue or expense at the time services are rendered, regardless of when cash is actually exchanged.

Acquisition – The purchase of all, or a majority of, the assets or ownership of a corporation (such as a hospital) by cash, other compensation, asset exchange or gift of majority voting control.

Acquisition Costs – Varied marketing costs within health plans primarily related to the acquisition of subscriber contracts.

Activities of Daily Living (ADL) – A measure of functional ability based on capacity of an individual for self-care, including bathing, dressing, using the toilet, eating, cooking, shopping, and moving across a small room without assistance. This measure is used to evaluate an individual's independent living ability and to assess the need for long-term care or other assistance.

Actuarial Analysis – A means of measuring the statistical probability of the risk of events occurring, such as illness, injury, disability, hospitalization or death.

Actuarial Equivalent – A health benefit plan that offers similar coverage to a standard benefit plan. Actuarially equivalent plans will not necessarily have the same premiums, cost-sharing requirements or even benefits; however, the expected spending by insurers for the different plans will be the same.

Actuarial Value – The percentage of total average costs for covered benefits that a plan will cover. For example, if a plan has an actuarial value of 70%, on average, an individual would be responsible for 30% of the costs of all covered benefits.

Actuary – An accredited insurance professional trained in the science of loss contingencies, investments, insurance accounting, premiums, managed care risks and service utilization. Actuaries calculate predictable health risks and rates and help set health insurance premiums.

Acute Care – Generally refers to inpatient hospital care of a short duration (typically less than 30 days) as compared to ambulatory or long-term care. Acute care is given to treat an individual's physical or mental condition, usually requiring immediate intervention and constant medical attention, equipment and personnel.

Acute Care Hospital – A hospital that provides inpatient medical care and other related services for surgery, acute medical conditions or injuries (usually for a short term illness or condition).

Acute Long-Term Care – Providers that offer specialized acute hospital care to medically complex patients who are critically ill, have multi-system complications or failure, and require hospitalization in a specialized facility offering treatment programs and therapeutic intervention on a 24 hour/7 day a week basis. These patients are typically discharged from intensive care units and require more care than they can receive in a rehabilitation center, skilled nursing facility, or at home.

Adjusted Admissions – An aggregate measure of all patient care activity undertaken in a hospital, both inpatient and outpatient services. The measure reflects the sum of inpatient admissions as well as equivalent admissions attributed to outpatient services. The number of equivalent admissions is derived by multiplying admissions by the ratio of outpatient revenue to inpatient revenue.

Adjusted Average Daily Census – An estimate of the average number of patients (both inpatients and outpatients) receiving care each day during the reporting period, which is usually 12 months. The figure is derived by dividing the number of inpatient day equivalents (also called adjusted inpatient days) by the number of days in the reporting period.

Adjusted Average Per Capita Cost (AAPCC) – Actuarial projections of per capita Medicare spending for enrollees in fee-for-service Medicare. Separate AAPCCs are calculated - usually at the county level - for Part A services and Part B services for the aged, disabled, and people with End Stage Renal Disease. Medicare pays risk plans 95% of the AAPCC, adjusted for the characteristics of the enrollees in each plan. Adjustments are made so that the AAPCC represents the level of spending that would occur if each county contained the same mix of beneficiaries.

Adjusted Community Rate (ACR) – Estimated payment rates that health plans with Medicare-risk contracts would have received if their Medicare enrollees paid their private market premiums, adjusted for differences in benefit packages and service use. Health plans estimate their ACRs annually and adjust subsequent year supplemental benefits or premiums to return any excess Medicare revenue above the ACR to enrollees.

Adjusted Community Rate (ACR) Proposal – A process by which a health plan with a Medicare-risk contract estimates the cost of providing services to its Medicare enrollees based on costs and revenues from its commercial business. Health plans estimate their ACRs annually and adjust the subsequent year's supplemental benefits or premiums offered so that they do not receive a higher rate of return on Medicare enrollees than they do on their commercial business.

Adjusted inpatient days – An accounting method that includes an aggregate measure of workload reflecting the sum of inpatient days and equivalent patient days attributed to outpatient services. The number of equivalent patient days attributed to outpatient services is derived by multiplying inpatient days by the ratio of outpatient revenue to inpatient revenue.

Adjusted Payment Rate (APR) – The Medicare capitated payment to risk-contract HMOs. For a given plan, the APR is determined by adjusting county-level AAPCCs to reflect the relative risks of the plan's enrollees.

Administrative Costs – The costs assumed by a health care organization, insurer or managed care plan for managing health services, including claim processing, billing, marketing, member services, provider relations and other overhead expenses.

Administrative Services Only (ASO) – An arrangement by which typically a large organization funds its own employee health and benefits plan (and assumes the financial risk of such coverage), but hires an outside firm to perform specific administrative services such as claims processing, billing and employee communications.

Admission – Formal acceptance by hospital or other inpatient health care facility of a patient who is to be provided with room, board and health care treatment or services for at least one night or more.

Admission, Discharge, Transfer (ADT) System – Software application used by hospitals and other health care facilities to track patients from the point of arrival to departure by transfer, discharge or death.

Admissions – The number of patients, excluding newborns, accepted for inpatient service during the reporting period. This number includes patients who visit the emergency room and are admitted for inpatient service.

Admitting Privileges – The formal authorization given to a provider (a physician, dentist or podiatrist) by a health care organization's governing board to admit patients into its hospital or health care facility for the provision of diagnostic services or treatment. Privileges are based on the provider's license, education, training and experience.

Adult Cardiac Surgery – A range of cardiac (dealing with the heart) surgical procedures that includes minimally invasive procedures (surgery done with only a small incision or no incision at all, such as through a laparoscope or an endoscope) and more invasive major surgical procedures that include open chest and open heart surgery.

Adult Cardiology Services – An organized clinical service offering diagnostic and interventional procedures to manage the full range of adult heart conditions.

Adult Day Care or Adult Day Health Care – Program providing supervision, medical and psychological care, and social and recreational activities for older adults who live at home or in another family setting, but cannot be alone or prefer to be with others during the day. May include intake assessment, health monitoring, occupational therapy, personal care, noon meal and transportation services.

Adult Diagnostic Catheterization or Coronary Angiography or Coronary Arteriography – Procedure used in diagnosing complex heart conditions. Cardiac angiography involves the insertion of a tiny catheter into the artery in the groin then carefully threading the catheter up into the aorta where the coronary arteries originate. Once the catheter is in place, a dye is injected which allows the cardiologist to see the size, shape and distribution of the coronary arteries. These images are used to diagnose heart disease and to determine, among other things, whether or not surgery is indicated.

Adult Interventional Cardiac Catheterization – Non-surgical procedure that utilizes the same basic principles as diagnostic catheterization, but uses advanced techniques to improve the heart's function. It can be a less invasive alternative to heart surgery.

Advance Beneficiary Notice (ABN) – Written notice given by a health care provider or supplier to a fee-for-service beneficiary before furnishing items or services that are usually covered by Medicare, but are not expected to be paid in a specific instance, such as due to lack of medical necessity.

Advance Directive – A legal document, recognized under individual state law, in which an individual specifies preferences concerning end-of-life care in the event he or she becomes incapacitated or is unable to make decisions. There are different types of advance directives, including a living will, durable power of attorney for health care, and do not resuscitate orders. In the U.S., the laws for advance directives may be different for each state, and each state may allow only certain types of advance directives.

Advanced Practice Registered Nurse (APRN) – A registered clinical nursing professional who has received advanced training and education in his or her field, often a clinical master's degree or doctorate, who may serve as a primary care or specialty health provider. The term includes nurse practitioners, clinical nurse specialists, nurse anesthetists and nurse midwives.

Adverse Drug Reaction (ADR) – A negative physical reaction or complication caused by the use of medication(s) during usual clinical use. An ADR can be caused by a single medication or by a combination of two or more medications that result in an undesirable effect.

Adverse Event – An undesirable medical occurrence resulting in unintended physical or psychological harm to the patient caused by an act of commission or omission, rather than by the underlying disease or condition of the patient. This term is associated with the phrase "never events."

Adverse Selection – Adverse selection occurs when a larger proportion of people with poorer health status enroll in specific plans or insurance options, while a larger proportion of people with better health status enroll in other plans or insurance options. Plans with a subpopulation with higher-than-average costs are adversely selected, while plans with a subpopulation with lower-than-average costs are favorably selected.

Affiliation – An agreement, usually formal, between two or more otherwise independent hospitals, programs or providers describing their relationship to each other. An affiliated hospital allows doctors to practice and admit patients. Doctors can be affiliated with more than one hospital. Affiliation also refers to a hospital and insurance plan contract, wherein the hospital agrees to provide benefits to the plan's members.

Affordable Care Act (ACA) – Formally known as the Patient Protection and Affordable Care Act (or informally known as Obamacare), this federal legislation was signed into law in 2010 and contains new health reform provisions. The ACA refers to two separate pieces of legislation: the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010. Key provisions of the ACA are to increase access to quality, affordable health insurance, lower the uninsured rate, increase industry efficiency and lower health care costs.

Against Medical Advice (AMA) – The self-discharge of a patient who leaves a health care facility against the advice of his or her physician or the medical staff.

Agency for Health care Research and Quality (AHRQ) – Public health service agency in the U.S. Department of Health and Human Services. AHRQ's mission is to support research designed to improve the outcomes and quality of health care, reduce costs, address patient safety and medical errors, and broaden access to effective services.

Aggregate Indemnity – The maximum amount of payment provided by an insurer for each covered service for a group of insured people.

Aggregate Margin – A margin that compares revenues to expenses for a group of hospitals, rather than a single hospital. It is computed by subtracting the sum of expenses for all hospitals in the group from the sum of revenues and dividing by the sum of revenues.

Aggregate PPS Operating Margin or Aggregate Total Margin – A prospective payment system (PPS) operating margin or total margin that compares revenue to expenses for a group of hospitals, rather than for a single hospital. It is computed by subtracting the sum of expenses for all hospitals in the group from the sum of revenues and dividing by the sum of revenues.

Airborne Infection Isolation Room – A single-occupancy room for patient care where environmental factors are controlled in an effort to minimize the transmission of those infectious agents, usually spread person to person by droplet nuclei associated with coughing and inhalation. Such rooms typically have specific ventilation requirements for controlled ventilation, air pressure and filtration.

Alcoholism-drug Abuse or Dependency Inpatient Care – A specialty program that provides diagnosis and therapeutic services to patients with alcoholism or other drug dependencies. Such a program may include inpatient/ residential treatment for patients whose course of treatment involves more intensive care than provided in an outpatient setting or the patient requires supervised withdrawal.

Alcoholism-drug Abuse or Dependency Outpatient Services – Organized hospital services that provide medical care or rehabilitative treatment services to outpatients for whom the primary diagnosis is alcoholism or other chemical or drug dependency.

All-Patient Refined Diagnosis Related Group (APR-DRG) – Classification system that categorizes patients according to their reason for admission, severity of illness, and risk of mortality.

Alliance – A formal organization or association owned by shareholders or controlled by members that works on behalf of the common interests of its individual members in the provision of services and products and in the promotion of activities and ventures.

Allied Health Professional – A non-physician health care professional who provides a range of diagnostic, technical and therapeutic health care services to patients. Allied health professionals include paramedics, physician assistants, certified nurse midwives, nurse practitioners, nurse anesthetists, registered nurses, respiratory therapists physical therapists, and other medical team members. Allied health professionals comprise almost 60% of the health care workforce.

Allowable Costs – The maximum amount covered for a service under health insurance benefits. The contracted allowable amount may not cover the full amount charged by a health care provider in which case the patient or consumer may have to pay the difference.

All-payer System – A system by which all third-party payers of health care bills - the government, private insurers, big companies and people - pay the same rates, set by the government, for the same medical service. This system does not allow for cost shifting.

Alternative Delivery System – Provision of health services in settings that are more cost-effective than an inpatient, acute care hospital, such as skilled and intermediary nursing facilities, hospice programs and in-home services.

Alzheimer's Center – A facility that offers care to people with Alzheimer's disease and their families, through an integrated program of clinical services, research and education.

AMBER Alert – An AMBER Alert is a child abduction alert system, issued to the general public by various media outlets in Canada and the U.S., when police confirm that a child has been abducted. AMBER is the acronym for "America's Missing: Broadcasting Emergency Response" and was named for 9-year-old Amber Hagerman.

Ambulance services – Provision of medical transport services to the ill and injured who require medical attention on a scheduled or unscheduled basis. Ambulances are used to respond to medical emergencies by emergency medical services.

Ambulatory – Describes a patient capable of moving about from place to place, not confined to a bed.

Ambulatory Care – Health services provided on an outpatient basis in a hospital, clinic, physician's office it usually implies that an overnight stay in a health care facility is not necessary.

Ambulatory Patient Classifications (APC) – The federal government's method of paying hospitals for outpatient services for the Medicare program. The APC system classifies some 7,000 services and procedures into about 300 procedure groups. Unlike diagnosis related group reimbursement for inpatient care, where medical events are condensed into one diagnostic related group, an outpatient visit can combine several different APG's. If the patient is admitted from a hospital clinic or emergency department, then there is no APC payment, and Medicare will pay the hospital under inpatient DRG methodology.

Ambulatory Surgery Center (ASC) – A free-standing facility, often certified by Medicare, that provides care to patients requiring surgery and some types of pain management who are admitted and discharged on the same day. Ambulatory surgery centers are distinct from same-day surgical units in hospital outpatient departments for purposes of Medicare payments.

American College of Health care Executives (ACHE) – An international professional society of health care executives who lead hospitals, health care systems and other health care organizations. ACHE provides the Fellow of the American College of Health care Executives (FACHE) designation, signifying certification in health care management, and also offers health care education.

American Hospital Association (AHA) – The American Hospital Association is the national organization that represents and serves all types of hospitals, health care networks, their patients and communities. Nearly 5,000 hospitals, health care systems, networks, other providers of care and 43,000 individual members come together to form the AHA. AHA ensures that members' perspectives and needs are heard and addressed in national health policy development, legislative and regulatory debates and judicial matters. Founded in 1898, the AHA provides education for health care leaders and is a source of information for health care issues and trends.

American Medical Association (AMA) – The largest national professional association for physicians, founded in 1847. The AMA's mission is "to promote the art and science of medicine and the betterment of public health." Publishes the peer-reviewed Journal of the American Medical Association (JAMA).

American Nurses Association (ANA) – The largest professional organization for registered nurses, founded in 1896 (was renamed as the American Nurses Association in 1911) to advance and protect the profession of nursing. The ANA states "nursing is the protection, promotion, and optimization of health and abilities, prevention of illness and injury, alleviation of suffering through the diagnosis and treatment of human response and advocacy in the care of people, families, communities and populations."

American Nurses Credentialing Center (ANCC) – The American Nurses Credentialing Center credentials organizations and people who advance nursing. The ANCC's Magnet Recognition Program designates organizations worldwide where nursing leaders successfully align their nursing strategic goals to improve the organization's patient outcomes.

Ancillary Services – All hospital services for a patient other than room, board and nursing services. Examples include x-ray and other diagnostic imaging, drug and laboratory tests, physical and occupational therapy.

Annual Payment Update – Annual adjustment to Medicare reimbursement rates for hospitals and other health care providers based on inflation. Hospitals can receive their full annual payment update by meeting the requirements of the Reporting Hospital Quality for Annual Payment Update initiative. Under the Hospital Inpatient Quality Reporting Program, CMS collects quality data from hospitals paid under the Inpatient Prospective Payment System, with the goal of driving quality improvement through measurement and transparency by publicly displaying data to help consumers make more informed decisions about their health care.

Anti-kickback Statute – A criminal statute that prohibits offering, paying, soliciting or receiving anything of value to induce or reward referrals or generate federal health care program business.

Antitrust Laws – State and national laws that prohibit health care and other providers from price-fixing or developing monopolies that would prevent consumers from having choices in terms of costs and services.

Any Willing Provider – Any health care provider that complies with an insurer's preferred provider terms and conditions may apply for and shall receive designation as a preferred provider.

Appropriateness Review – A methodology in which individual cases are evaluated for clinical appropriateness and for medical necessity of surgical and diagnostic procedures. The review usually consists of comparing a patient's clinical data to pre-established medical criteria.

Arbitration – The process by which a contractual dispute is submitted to a mutually agreed-on impartial party for resolution. Many managed care plans have provisions for compulsory arbitration (in states where arbitration is allowed) in cases of disputes between providers and plans.

Area Health Education Center (AHEC) – Partnership between health and educational institutions, the purpose of which is to improve the supply, distribution, quality, use and efficiency of health care personnel in specific medically underserved areas. The AHEC program was developed by Congress in 1971 to recruit, train and retain a health professions workforce committed to underserved populations.

Area Wage Index – A component of the Medicare payment calculation intended to account for geographic differences in labor and benefits costs. A labor market area's wage index value is the ratio of the area's average hourly wage to the national average hourly wage.

Arthritis Treatment Center – Specifically equipped and staffed center for the diagnosis and treatment of arthritis and other joint disorders.

Assessment (Community) – The regular collection, analysis and sharing of information about health conditions, risks, and resources in a community. The assessment function is needed to identify trends in illness, injury, and death, the factors which may cause these events, available health resources and their application, unmet needs and community perceptions about health issues.

Assignment – A process under which Medicare pays its share of the allowed charge directly to the physician or supplier. Medicare will do this only if the physician accepts Medicare's allowed charge as payment in full (guarantees not to bill the balance). Medicare provides other incentives to physicians who accept assignment for all patients under the Participating Physician and Supplier Program.

Assignment of Benefits – An agreement or arrangement between a beneficiary and an insurance company by which a beneficiary requests the insurance company to pay the health benefit payment directly to the physician or medical provider.

Assisted Living – A housing alternative that provides a combination of housing, supportive services, personalized assistance and health care designed to respond to the individual needs of those who need help in activities of daily living and instrumental activities of daily living, but do not require intensive medical or nursing care. Supportive services are available 24 hours a day to meet scheduled and unscheduled needs in a way that promotes maximum independence and dignity for each resident. Additional services, such as medication administration, also may be available.

Assistive Technology Center – A program providing access to specialized hardware and software with adaptations allowing people greater independence with mobility, dexterity or increased communication options.

Associate Degree in Nursing (A.D.N.) – A two-year degree in the field of nursing usually earned at a junior or community college that provides opportunities to work in entry-level nursing positions. Nurses with an associate degree are eligible to become registered nurses (RNs) after passing a state licensure exam.

Association Health Plan – Health insurance plans are offered to members of an association. These plans are marketed to individual association members, as well as small businesses members. How these plans are structured, who they sell to and whether they are state-based or national associations determines whether they are subject to state or federal regulation, both, or are largely exempt from regulations.

Attending Physician – A physician who is on the medical staff of a hospital or health care facility and is legally responsible for the care provided to a given patient. A patient's attending physician also is regarded as a person's private physician if that physician cares for the person on an individual or outpatient basis.

Authorization – A utilization management technique used by managed care organizations to grant approval for the provision of specific care or services not performed by the primary care physician. Services requiring authorization vary greatly by health plan.

Auxiliary – A volunteer community organization formed to assist the hospital in carrying out its purpose and to serve as a link between the institution and the community. An auxilian is member of a hospital's auxiliary who may or may not serve as an in-service volunteer at the hospital.

Average Daily Census (ADC) – The average number of people served on an inpatient basis on a single day during the reporting period; the figure is calculated by dividing the number of inpatient days by the number of days in the reporting period.

Average Length of Stay (ALOS) – The average length of stay refers to the average number of days that patients spend in the hospital. It is generally measured by dividing the total number of days stayed by all inpatients during a year by the number of admissions or discharges. Day cases are excluded. The average length of stay in hospitals is often used as an indicator of efficiency. All other things being equal, a shorter stay will reduce the cost per discharge and shift care from inpatient to less expensive post-acute settings.

Baby Doe – A term used in both the law and the media to refer anonymously to infants whose extraordinary treatment has raised ethical questions.

Bachelor of Science in Nursing (B.S.N.) – Four-year degree awarded by an accredited college or university that allows an individual to become a registered nurse (RN) after passing a state licensure examination.

Bad Debt – Debt that is unlikely to be paid or that is not collectible. This might refer to charges for care provided to patients who are financially able to pay but refuse to do so.

Bariatric or weight control services – Bariatrics is the medical practice of weight reduction.

Basic DRG Payment Rate – The payment rate a hospital will receive for a Medicare patient in a particular diagnosis-related group. The payment rate is calculated by adjusting the standardized amount to reflect wage rates in the hospital's geographic area (and cost of living differences unrelated to wages) and the costliness of the DRG.

Basic Health Plan – Beginning in 2015, the health reform law gave states the option of creating a basic health plan to provide coverage to people with incomes between 133% and 200% of poverty, in lieu of having these people enroll in the health insurance exchange and receive premium subsidies. The plan exists outside of the health insurance exchange and includes the essential health benefits as defined by the health reform law. If states choose to offer this plan, the federal government provide states 95% of what it would have paid to subsidize these enrollees in the health insurance exchange. As of 2019, only two states - Minnesota and New York - have opted to institute a basic health plan.

Bed Days – The total number of days of hospital care (excluding the day of discharge) provided to the insured or plan member. Bed days, also called hospital days, discharge days, or patient days, are used to measure hospital utilization and are generally reported in "days per 1,000 plan members per year."

Beds – Number of beds regularly maintained, set up and staffed for use for inpatients at of the close of the reporting period. Excludes newborn bassinets.

Bed-size Category – Hospitals are categorized by the number of beds set up and staffed for use at the end of the reporting period. The eight categories in Hospital Statistics are: 6 to 24 beds; 25 to 49; 50 to 99; 100 to 199; 200 to 299; 300 to 399; 400 to 499; and 500 or more.

Benchmarking – The process of continually measuring products, services and practices against major competitors or industry leaders to create normative or comparative standards (benchmarks).Benchmarking can be used to evaluate quality of care.

Beneficiary – Someone who is eligible for or receiving benefits under an insurance policy or plan. The term is commonly applied to people receiving benefits under the Medicare or Medicaid programs.

Beneficiary Liability – The amount beneficiaries must pay providers for Medicare-covered services. Liabilities include copayments and coinsurance amounts, deductibles and balance billing amounts.

Benefit Levels – The maximum amount a health insurance company agrees to pay for a specific covered benefit.

Benefit Package – Services (such as physician visits, hospitalizations, prescription drugs) covered by an insurer, government agency, or health plan, and the financial terms of such coverage, including cost sharing and limitations on amounts of services.

Best Practices – Health practices, methods, interventions, procedures or techniques based on high-quality evidence in order to obtain improved patient and health outcomes

Billed Charges – A reimbursement method used mostly by traditional indemnity insurance companies, wherein charges for health care services are billed on a fee-for-service basis. Fees are based on what the provider typically charges all patients for the particular service.

Biomedical Ethics – A term used to describe philosophical questions and decision-making involving morals, values, and ethics in the provision of health care. Many ethical issues that arise in health care revolve around end-of-life decision-making, particularly when the patient is not in a position to make decisions for themself. Hospitals typically use a multidisciplinary ethics committee or an ethics consultation service to assist the patient, family and physician(s) in making decisions about the course of care and treatment in an ethically challenging situation.

Birthing Room LDR Room LDRP Room – A single-room type of maternity care with a more homelike setting for families than the traditional three-room unit (labor/delivery/recovery) with a separate postpartum area. A birthing room combines labor and delivery in one room. An LDR room accommodates three stages in the birthing process—labor, delivery, and recovery. An LDRP room accommodates all four stages of the birth process—labor, delivery, recovery, and postpartum.

Birth – Total number of infants born in the hospital during the reporting period. Births do not include infants transferred from other institutions, and are excluded from admission and discharge figures.

Block Grants – A program funding approach wherein the federal government makes lump-sum grants to states, which are then responsible for determining beneficiary eligibility, managing the program, and contributing matching funds.

Blood Donor Center – A facility that performs, or is responsible for the collection, processing, testing or distribution of blood and components.

Blood Stream Infection – A common quality metric, a bloodstream infection occurs when bacteria enter the bloodstream through a wound or other type of infection (e.g. urinary tract infection, respiratory infection), or through a surgical procedure, incision or injection.

Blue Cross/Blue Shield – Nonprofit, tax-exempt insurance service plans that cover hospital care, physician care and related services. Blue Cross and Blue Shield are separate organizations that have different benefits, premiums and policies. These organizations are in all states; The Blue Cross and Blue Shield Association of America is their national organization.

Board Certified – The rigorous process by which a physician demonstrates mastery in a specific area of medical or surgical practice through written, practical or simulation-based testing. The certification is awarded by a medical specialty board.

Board Eligible – The term referring to the period when a physician may take a specialty board examination for certification, after graduating from a board-approved medical school, completing an accredited training program, and practicing for a specified length of time. Although the physician has not yet passed the required examination, he or she meets the pre-requisite requirements and is considerable eligible to take the examination.

Board of Health – The state board of health is comprised of members appointed by the governor. The membership includes people who are experienced in matters of health and sanitation. Local boards of health are governing bodies of at least three people who supervise all matters pertaining to the preservation of the life and health of the people in their jurisdiction. Each local board of health enforces public health statutes and rules, supervises the maintenance of all health and sanitary measures, enacts local rules and regulations, and provides for the control and prevention of any dangerous, contagious or infectious disease.

Bone Marrow Transplant – A procedure in which a patient receives healthy blood-forming cells (stem cells) to replace their own stem cells that have been destroyed by disease, or by the radiation or high doses of anticancer drugs that are given as part of the procedure. The healthy stem cells may come from the bone marrow of the patient or a donor. A bone marrow transplant may be autologous (using a patient's own stem cells that were collected from the marrow and saved before treatment), allogeneic (using stem cells donated by someone who is not an identical twin) or syngeneic (using stem cells donated by an identical twin).

Brain Death – Irreversible loss of brain activity, including involuntary activity necessary to sustain life.

Breast Cancer Screening/Mammograms – Mammography screening – The use of breast X-ray to detect unsuspected breast cancer in asymptomatic women. Diagnostic mammography – The X-ray imaging of breast tissue in symptomatic women who are considered to have a substantial likelihood of having breast cancer already.

Budget Neutrality – For the Medicare program, adjustment of payment rates when policies change so that total spending under the new rules is expected to be the same as it would have been under the previous payment rules.

Bundled Billing – A cost control method that charges a set price for all medical services associated with select procedures, such as a knee replacement or heart attack.

Bundled Payment – Designed to improve quality and control costs, a single payment to providers or health care facilities (or jointly to both) for all services to treat a given condition or provide a given treatment during an "episode of care." Payments are made to the provider on the basis of expected costs for clinically defined episodes that may involve several practitioner types, settings of care, and services or procedures over time.

Burn Care – Provision of care to severely burned patients. Severely burned patients are those with any of the following: (1) second-degree burns of more than 25% total body surface area for adults or 20% total body surface area for children; (2) third-degree burns of more than 10% total body surface area; (3) any severe burns of the hands, face, eyes, ears or feet, or (4) all inhalation injuries, electrical burns, complicated burn injuries involving fractures and other major traumas, and all other poor risk factors.

Business Associate – A person or entity that provides services for a covered entity that involves the use or disclosure of protected health information.

Clostridium Difficile (C. Diff.) – The toxin-producing bacteria Clostridium Difficile (commonly known as C.Diff) that can result from cross-contamination in care settings those most at risk are older adults who take antibiotics and patients who are immunosuppressed.

Cafeteria Plan – This benefit plan gives employees a set amount of funds that they can choose to spend on a different benefit options, such as health insurance or retirement savings.

Capacity – The ability to perform the core public health functions of assessment, policy development and assurance on a continuous, consistent basis, made possible by maintenance of the basic infrastructure of the public health system, including human, capital and technology resources.

Capital – Owners' equity in a business and often used to mean the total assets of a business, although sometimes used to describe working capital (i.e., cash) available for investment or acquisition of goods.

Capital Asset – Property with a life of over one year (e.g. buildings and equipment) that contributes to the functioning of a business and is not intended for sale during the normal course of business.

Capital Costs – Depreciation, interest, leases and rentals, taxes and insurance on tangible assets like physical plant and equipment.

Capital Expenditure Review – An internal or regulatory evaluation of a health care facility's planned capital expenditures (e.g. buildings and equipment) to determine their necessity and appropriateness.

Capital Expense – Expenditure that is spent to acquire or improve a long-term asset.

Capital Structure – The permanent long-term financing of an organization. The relative proportions of short-term debt, long-term debt and owners' equity.

Capital Structure (Leverage) – Measure of the extent to which debt financing is employed by a corporation. The mix of long-term debt and equity employed by a corporation for permanent, long-term financing needs.

Capitalize – To record an expenditure (e.g., research and Development costs) that may benefit a future period as an asset rather than as an expense of the period of its occurrence.

Capitation – Method of payment for health services in which a hospital, physician or provider is paid a fixed amount for each patient regardless of the actual number or nature of the services provided.

Caps – Maximum allowable limits placed on revenue or rates by federal or state government.

Cardiac Electrophysiology – Evaluation and management of patients with complex cardiac rhythm or conduction abnormalities, including diagnostic testing, treatment of arrhythmias by catheter ablation or drug therapy, pacemaker/defibrillator implantation and follow-up.

Cardiac (Coronary) Intensive Care – Provides patient care of a more specialized nature than the usual medical and surgical care on the basis of physicians' orders and approved nursing care plans. The unit is staffed with specially trained nursing personnel and contains monitoring and specialized support or treatment equipment for patients who, because of heart seizure, open-heart surgery, or other life-threatening conditions, require intensive, comprehensive observation and care. May include treatment of patients with myocardial infarction (heart attacks), pulmonary care and heart transplant units.

Cardiac Rehabilitation – A medically supervised program to help heart patients recover quickly and improve their overall physical and mental functioning. The goal is to reduce risk of another cardiac event or to keep an already present heart condition from getting worse. Cardiac rehabilitation programs include counseling to patients, an exercise program, helping patients modify risk factors such as smoking and high blood pressure, providing vocational guidance to enable the patient to return to work, supplying information on physical limitations and lending emotional support.

Care Coordination – The organization of your treatment across several health care providers. Medical homes and accountable care organizations are two common ways to coordinate care.

Care Guidelines – A set of medical treatments for a particular condition or group of patients that has been reviewed and endorsed by a national organization, such as the Agency for Health care Policy Research.

careLearning – careLearning is an online education company operated by state hospital associations and designed to help health care organizations by providing reliable, trusted and easily-accessible talent management solutions.

Carrier – An insurance company or a health plan that has some financial risk or manages health care benefits.

Carve-out Coverage – Carve-out refers to an arrangement where some benefits (e.g., mental health) are removed from coverage provided by an insurance plan, but are provided through a contract with a separate set of providers. Carve-out also may refer to a population subgroup for which separate health care arrangements are made.

Case Management – A system of assessment, treatment planning, referral and follow-up that ensures the provision of comprehensive, and continuous services and the coordination of payment and reimbursement for care. It's often used for patients with specific diagnoses or who require high-cost or extensive health care services.

Case Manager – An experienced health professional (not a physician) who works with patients, providers and insurers to coordinate all services deemed necessary to provide the patient with appropriate health care. It especially is used to assist patients and families with complex needs.

Case Mix – A measure of patient acuity reflecting different patients' needs for hospital resources which is used as a tool for managing and planning health care resources. This measure may be based on patients' diagnoses, the severity of their illnesses and their utilization of services. A high case-mix index refers to a patient population more ill than average.

Case Rate – A reimbursement model that established a flat admission or per service rate for all the services associated with all care immediately before and after diagnosis of a condition. An example in which this form of reimbursement is commonly used is obstetrics.

Case-mix Index (CMI) – The average DRG weight for all cases paid under the prospective payment system (PPS). The CMI is a measure of the relative costliness of the patients treated in each hospital or group of hospitals.

Catastrophic Coverage (Insurance) – An insurance coverage option with limited benefits and a high deductible intended to protect against medical bankruptcy because of an unforeseen illness or injury. These plans are usually geared toward young adults in relatively good health. Catastrophic health plans cover the following benefits, even if the beneficiary hasn't met his or her yearly deductible: three primary care visits every year and free preventive services as required under the Affordable Care Act, including certain screenings and immunizations.

Catastrophic Illness – Any acute or prolonged illness that is usually considered to be life threatening or may produce serious residual disability, entailing substantial expense over an extended period. A catastrophic illness typically requires extensive treatment and hospitalization.

Catchment Area – Geographic area defined and served by a hospital and delineated on the basis of such factors as population distribution, natural geographic boundaries, or transportation accessibility.

Catheter-associated Urinary Tract Infection (CAUTI) – An infection that occurs when bacteria enters the urinary tract through an indwelling urinary catheter. CAUTIs have been associated with increased morbidity, mortality, health care costs and length of stay.

Community Benefit Inventory for Social Accountability (CBISA) – This Lyon Software assists nonprofit hospitals track and report community benefits and features a blend of statistical and narrative information. It also helps hospitals create an annual community benefit report. This software was created based on reporting guidelines developed by the Catholic Health Association and the Voluntary Hospital Association.

Census – Average number of inpatients who receive hospital care each day or over a given period of time (e.g. monthly), including newborns.

Center of Excellence – A specialized service line or program (e.g., neurosciences, cardiac services, diabetes care or orthopedics) developed by a provider to be a recognized high-quality, high-volume, cost-effective clinical program.

Centers for Disease Control and Prevention (CDC) – The federal agency in the U.S. Department of Health and Human Services that serves as the central point for consolidation of disease control and prevention data, health promotion and public health programs. The CDC works 24/7 to protect America from foreign and U.S. health, safety and security threats. Whether diseases start at home or abroad, are chronic or acute, curable or preventable, human error or deliberate attack, the CDC fights disease and supports communities and citizens to do the same.

Centers for Medicare and Medicaid Services (CMS) – The federal agency in the U.S. Department of Health and Human Services that administers the Medicare and Medicaid programs, Children's Health Insurance Program (CHIP), and the federal insurance exchange, it determines provider certification requirements and establishes reimbursement policies and formulas for these programs.

Central Line-associated Bloodstream Infection (CLABSI) – A serious infection that occurs when bacteria enters the bloodstream through a central venous catheter, also known as a central line. Central line-associated bloodstream infections (CLABSIs) result in thousands of deaths each year and billions of dollars in added costs to the U.S. health care system, yet these infections are preventable. The CDC is providing guidelines and tools to the health care community to help end CLABSIs.

Certificate of Coverage – The legal description of listing the benefits, providers and general rules and regulations of the health plan given to employees or beneficiaries.

Certificate of Need (CON) – A document for the purpose of cost control granted by a state to a hospital seeking permission to modify its facility, acquire major medical equipment or offer a new or different health service on the basis of need. Individual states may or may not have specific requirements for CON processes for hospitals. In 2019, approximately 75% of states had some type of CON requirement.

Certified Health Plan – A managed health care plan, certified by the Health Services Commission and the Office of the Insurance Commissioner to provide coverage for the uniform benefits package to state residents.

Chaplaincy or Pastoral Care Services – A service ministering religious or spiritual activities and providing pastoral counseling to patients, their families and staff of a health care organization.

Charge Master – A hospital's comprehensive list of procedures and supplies billable to a patient or health insurance provider.

Charges – The amount billed by a hospital for services provided. A charge usually includes the costs plus an operating margin. Charges are the posted prices of provider services. Many payers pay a discounted rate, negotiated rate, or government-set rate rather than actual charges.

Charity Care – The unreimbursed cost to a hospital for providing, funding or otherwise financially supporting health care services on an inpatient or outpatient basis to a person classified by the hospital as financially or medically indigent.

Chemotherapy – Chemotherapy is the use of drugs to destroy cancer cells. It usually works by keeping the cancer cells from growing, dividing, and making more cells. Because cancer cells usually grow and divide faster than normal cells, chemotherapy has more of an effect on cancer cells.

Cherry Picking – The practice of insurance companies accepting only those businesses, occupations, companies, or people with minimal health risks and avoiding businesses or people that are riskier, and thus, more costly.

Chief Executive Officer (CEO) – The person selected by the governing body to direct overall management of the hospital. The CEO acts on behalf of the governing board and is sometimes called administrator, executive director, president or some similar title.

Chief Financial Officer (CFO) – The senior executive designated by the CEO with the responsibility for the financial operations of the organization, including serving as chief financial spokesperson for the organization. A CFO ensures that a hospital or health system operates in the most cost-effective manner and is responsible for managing all financial risks for the organization.

Chief of Staff – Member of a hospital medical staff who is elected, appointed, or employed by the hospital to be the medical and administrative head of the medical staff. Also sometimes known as president of the medical staff, medical director, or chief medical officer. The chief of staff/CMO must ensure that physicians take steps to decrease variation in practice, leading to compliance with best practice guidelines and to decrease the overall length of stay in hospitals. The CMO promotes coordination of patient care throughout the hospital experience and during the post-discharge phase.

Chief Operating Officer (COO) – Senior executive under the CEO who has responsibility for overall hospital operations. The COO works with the chief financial officer and the chief executive officer to ensure that the hospital has the necessary medical and administrative staff to meet patient demands and budget constraints. A hospital COO is generally considered second in command, under the CEO.

Children's Health Insurance Program (CHIP) – CHIP provides low-cost health coverage to children (up to age 18) in families that earn too much money to qualify for Medicaid. In some states, CHIP covers pregnant women. Each state offers CHIP coverage and works closely with its state Medicaid program. CHIP benefits are different in each state. But all states provide comprehensive coverage, including routine check-ups, immunizations, doctor visits, prescriptions, dental and vision care, inpatient and outpatient hospital care, laboratory and X-ray services and emergency services.

Children's Wellness Program – A program that encourages improved health status and a healthful lifestyle of children through health education, exercise, nutrition and health promotion.

Chiropractic Services – An organized clinical service by a licensed chiropractic professional that typically includes spinal manipulation or adjustment and related diagnostic and therapeutic services. Chiropractic is a licensed health care profession that emphasizes the body's ability to heal itself.

Chronic Care – Both medical care and services that are not directly medical related, such as cooking, giving medications and bathing for those with chronic illnesses.

Chronic Condition or Illness – A health condition or disease that is recurring or has long-lasting effects that may result in long-term care needs. Examples include cancer, diabetes, hypertension (high blood pressure), chronic obstructive pulmonary disease (COPD), arthritis and stroke.

Chronic Disease Management – An integrated care approach to managing illness which includes screenings, check-ups, monitoring and coordinating treatment and patient education. It can improve your quality of life while reducing your health care costs if you have a chronic disease by preventing or minimizing the effects of a disease.

Claim – A formal request, submitted in writing or electronically by providers to an insurer, requesting payment for medical services provided to the beneficiary.

Claims Review – The method by which an enrollee's health care service claims are reviewed before reimbursement is made. Review involves a routine examination of a submitted claim to determine eligibility, coverage of services, and plan liability.

Claims-made Coverage or Policy – A form of liability coverage for claims made (reported or filed) against an insured party (e.g. a hospital or a physician) during the policy period irrespective of when the event occurred that caused the claims to be made. Thus, claims made during a previous period in which the policyholder was insured under a claims-made policy would be covered, provided the coverage is continuous with the insurer.

Clean Claim – A claim submitted by a health care provider for medical care or health care services rendered to an enrollee under a health care plan or to an insured person under a health insurance policy that includes required data elements for timely processing.

Client's Rights – Those rights to which a person is entitled while a patient. In addition to civil and constitutional rights, they include the right to privacy and confidentiality, the right to refuse treatment, and the right of access to the their medical information.

Clinic – An outpatient medical facility. A clinic may be associated with a hospital.

Clinical Department – In departmentalized hospitals, the medical staff organization is subdivided into major divisions such as medicine, surgery, obstetrics-gynecology, pediatrics, family medicine and primary care. Each clinical department has a chief or chair and is responsible for setting and monitoring standards of professional and personal conduct of physicians within those departments.

Clinical Laboratory Improvement Amendments (CLIA) – The Centers for Medicare and Medicaid Services regulates all laboratory testing (except research) performed on humans in the U.S. through the Clinical Laboratory Improvement Amendments. In total, CLIA covers approximately 260,000 laboratories. The objective of the CLIA program is to ensure quality laboratory testing. Although all clinical laboratories must be properly certified to receive Medicare or Medicaid payments, CLIA has no direct Medicare or Medicaid program responsibilities.

Clinical Pathway – A health care management tool based on clinical consensus and the best available evidence regarding the most effective way to treat a disease or post-surgical condition (e.g. total knee replacement). Clinical pathways are designed to reduce variations in health care processes and procedures.

Clinical Privileges – The authorized right to provide medical, surgical, obstetrical or dental care services in the hospital, within well-defined limits, according to an individual's professional license, education, training, experience and current clinical competence. Clinical privileges must be delineated individually for each practitioner by the governing board, based on a medical staff recommendation.

Clinical Quality Measure (CQM) – A metric that helps assess and track the quality and safety of health care services and providers. CQMs evaluate various aspects of patient care, including health outcomes, clinical processes, patient safety, efficient use of health care resources, care coordination, patient engagement, population and public health and clinical guidelines.

Closed Formulary – A list restricting the number and type of drugs covered by a pharmacy benefits management program or managed care plan. A non-formulary drug may be covered if it is determined the drug is medically necessary.

Closed Panel – A managed care plan in which those covered seek care from a primary care provider, contracted to provide services, who also has control over referrals to other physicians in or outside of the managed care plan. Closed panels generally do not reimburse their members for health care services used outside the provider network.

Closed Physician-Hospital Organization (Closed PHO) – A joint venture between the hospital and physicians who have been selected on the basis of cost-effectiveness and quality. The PHO can act as a unified agent in managed care contracting, own a managed care plan, own and operate ambulatory care centers or ancillary services projects or provide administrative services to physician members. The primary difference between a closed PHO and an open one is the proactive decision to limit physician membership in the PHO.

Closed Staff – A hospital's medical staff that accepts no new applicants or a physician or a physician group that exclusively provides under contract all the administrative and clinical services required for operation of a hospital department.

The Consolidated Omnibus Budget Reconciliation Act (COBRA) – Gives workers and their families who lose their health benefits the right to continue group health benefits provided by their group health plan for limited periods of time under certain circumstances such as voluntary or involuntary job loss, reduction in the hours worked, transition between jobs, death, divorce and other life events. Qualified people may be required to pay the entire premium for coverage up to 102% of the cost to the plan.

Code Creep – The practice of billing for more intensive services than were actually provided and for which a higher payment is received. Code creep is also often referred to as upcoding and, in hospital billing, diagnosis-related group (DRG) creep.

Code of Federal Regulations – A codified collection of regulations issued to various departments, bureaus and agencies of the federal government and promulgated in the Federal Register.

Coding – A mechanism for identifying and defining physician or hospital services by specific pre-determined codes.

Co-insurance – Amount a health insurance policy (calculated as a percent age) requires the insured to pay for medical and hospital services, after payment of a deductible.

Commercial Carriers – For-profit, private insurance carriers (e.g. Aetna, Prudential, Blue Cross) offering health and other types of coverage.

Commission on Graduates of Foreign Nursing Schools (CGFNS International) – CGFNS International is an immigration neutral nonprofit organization that helps foreign educated health care professionals live and work in their country of choice by assessing and validating their academic and professional credentials. CGFNS International provides foreign students and health care professionals with a comprehensive assessment of their academic records to facilitate their successful admission to schools in the U.S. and other countries. CGFNS International helps protect migrating health care professionals by advocating for ethical recruitment practices and continuously monitoring the global landscape for developing trends in employment recruitment and workplace norms.

Community Accountability – The responsibility of providers in a network to document to members their progress toward specific community health goals and their maintenance of specific clinical standards.

Community Benefit – The unreimbursed cost to a hospital of providing charity care, government-sponsored indigent health care, donations, education, government-sponsored program services, research and subsidized health services. Community benefits do not include the cost to the hospital of paying taxes or other governmental assessments. Community benefits are evolving standards defined by the Internal Revenue Service to determine the tax-exempt status of nonprofit health care organizations.

Community Health Center – A local, community-based ambulatory health care program, also known as a neighborhood health center, organized and funded by the U.S. Public Health Service to provide primary and preventive health services, particularly in areas with scarce health resources or special-needs populations. Health centers increase access to crucial primary care by reducing barriers such as cost, lack of insurance, distance, and language for their patients. In doing so, health centers provide substantial benefits to the country and its health care system.

Community Health Education – Education that provides health information to people and populations, as well as support for personal, family and community health decisions with the objective of improving health status.

Community Health Improvement Plan (CHIP) – A community health improvement plan is a long-term, systematic effort to address public health problems on the basis of the results of community health assessment activities and the community health improvement process. This plan is used by health and other governmental education and human service agencies, in collaboration with community partners, to set priorities and coordinate and target resources. A community health improvement plan is critical for developing policies and defining actions to target efforts that promote health.

Community Health Information Network (CHIN) – Web-

based network that permits the electronic exchange of clinical, financial and administrative information among unaffiliated health care entities in order to improve the efficiency and delivery of health care in a community. Also known as community health management information system.

Community Health Needs Assessment (CHNA) – Also known as a community health assessment (CHA), refers to a state, tribal, local or territorial health assessment that identifies key health needs and issues through systematic, comprehensive data collection and analysis. Needs assessments identify gaps in health care services identify special targeted populations identify health problems in the community identify barriers to access to health care services and estimate projected future needs. 501(c)3 hospitals are required to conduct a CHNA every three years.

Community Hospitals – Community hospitals are defined as all nonfederal, short-term general and other special hospitals. Other special hospitals include obstetrics and gynecology, eye, ear, nose, and throat, long-term acute-care, rehabilitation, orthopedic; and other individually described specialty services. Community hospitals include academic medical centers or other teaching hospitals if they are nonfederal short-term hospitals. Excluded are hospitals not accessible by the general public, such as prison hospitals or college infirmaries.

Community Outreach – A program that systematically interacts with the community to identify those in need of services, alerting people and their families to the availability of services, locating needed services and enabling people to enter the service delivery system.

Community Rating – A rule that prevents health insurers from varying premiums within a geographic area based on age, gender, health status or other factors.

Comorbidities – One or more pre-existing conditions or diseases (e.g. diabetes) co-occurring with a primary disease or disorder.

Comparative Effectiveness Research (CER) – Comparative effectiveness research identifies what clinical and public health interventions work best for improving health. Interventions include not only the elements of direct clinical care such as diagnosis and treatment protocols, but also innovations in health care delivery, organization and financing and public health interventions in the community, including those intended to modify health awareness, lifestyle, diet or environmental exposures. In a CER study, interventions should, at a minimum, be compared on the basis of some health-related outcome measure.

CompAnalyst – A web-based compensation and benefits survey tool that allows hospitals to compare their data to other hospitals and certain non-health care related companies.

Competitive Bidding – A pricing method that elicits information on costs through a bidding process in order to establish payment rates that reflect the costs of an efficient health plan or health care provider.

Complementary and Alternative Medicine Services (CAM) – Organized hospital services or formal arrangements with providers that offer care or treatment not based solely on traditional western allopathic medical teachings as instructed in most U.S. medical schools. Includes any of the following: acupuncture, chiropractic, homeopathy, osteopathy, diet and lifestyle changes, herbal medicine and massage therapy etc. In the U.S., approximately 38% of adults and approximately 12% of children are using some form of complementary and alternative medicine services.

Compliance – The act of meeting specified standards, policies, procedures, laws or regulations.

Computer-assisted Orthopedic Surgery (CAOS) – Orthopedic surgery using computer technology, enabling three-dimensional graphic models to visualize a patient's anatomy.

Computerized Axial Tomography (CT or CAT) – A diagnostic imaging procedure that uses a computer to make a series of detailed pictures of areas inside the body. The pictures are taken from different angles and are used to create three-dimensional views of tissues and organs. A CT scan may be used to help diagnose disease, plan treatment or find out how well treatment is working. Also called computed tomography scan, computerized tomography.

Computerized Physician Order Entry (CPOE) – Process of electronic entry in which physicians directly enter medication orders or care instructions for a patient into a computer.

Concurrent Review – Managed care technique in which a managed care firm continuously reviews the charts of hospitalized patients for length of stay and appropriate treatment and the progress of discharge plans as they are being provided.

Conditions of Participation (CoPs) – Standards designated by CMS that hospitals, critical access hospitals, and other health care providers such as home health agencies and hospices must comply with in order to participate in the Medicare and Medicaid programs.

Confidentiality – Restriction of access to data and information to people who have a need, reason, and permission for such access.

Conflict of Interest – A conflict of interest is a transaction

or arrangement in which a person has a duty to more than one person or organization, but cannot do justice to the actual or potentially adverse interests of both parties. People other than board members also may be presented with conflicts of interest. Each person is responsible for recognizing a potential conflict of interest and for disclosing it pursuant to the policies of the organization. It is the duty of board members to acknowledge and disclose conflicts of interest as soon as they arise.

Consolidation – Unification of two or more corporations by dissolution of existing ones and creation of a single new corporation.

Consortium – A formal voluntary alliance of two or more institutions for a specific purpose, functioning under a common set of bylaws or rules. Unless otherwise proscribed, each member controls its own assets.

Consumer Price Index (CPI) – Measure of change in prices over time paid by consumers for a market basket of consumer goods and services. Consumers are made up of all urban consumers and urban wage earners. The CPI is used to make changes in the federal income tax structure and cost-of-living wage adjustments.

Consumer Price Index, Medical Care Component – Measure of inflation encompassing the cost of all purchased health care services. The medical care index is one of eight major groups in the Consumer Price Index and is divided into two main components: medical care services and medical care commodities, each containing several item categories. Medical care services, the larger component in terms of weight in the CPI, is organized into three categories: professional services, hospital and related services, and health insurance. Medical care commodities, the other major component, includes medicinal drugs and medical equipment and supplies.

Consumer-directed Health Plans – Consumer-directed health plans seek to increase consumer awareness about health care costs and provide incentives for consumers to consider costs when making health care decisions. These health plans usually have a high deductible accompanied by a consumer-controlled savings account for health care services. There are two types of savings accounts: Health savings accounts (HSAs) and health reimbursement arrangements (HRAs).

Continuing Education (CE) – Education beyond initial professional preparation that is relevant to the type of care delivered. Such education provides current knowledge relevant to an individual's field of practice or service responsibilities and may be related to findings from performance-improvement activities.

Continuing Medical Education (CME) – Continuing education related to the current professional practices of physicians.

Continuous Quality Improvement (CQI) – Approach to quality management that emphasizes the organization and systems rather than the individual. This method empowers employees to continually improve work processes by identifying problems, implementing and monitoring corrective actions and demonstrating or measuring improvement.

Continuum of Care – An integrated system of care providing comprehensive services ranging from preventive and ambulatory services, to acute care, to long-term and rehabilitative services. By providing continuity of care, the continuum focuses on prevention and early intervention for those who have been identified as high risk and provides easy transition from service to service as needs change.

Contract Management – Daily management of an organization under contract by another organization, wherein the managed organization retains legal responsibility and ownership of the facility's assets and liabilities. The managing organization typically reports directly to the managed organization's board or owners.

Contractual Allowance – The negotiated difference between what an insurance company will pay according to its contract and what a hospital or health care provider bills for a service or procedure.

Control – The type of organization responsible for establishing policy concerning the overall operation of hospitals. The three major categories are government (including federal, state and local); nongovernment (nonprofit) and investor-owned (for-profit).

Conversion – The ability, in some states, to switch job-based coverage to an individual policy when one loses eligibility for job-based coverage. Family members not covered under a job-based policy may also be able to convert to an individual policy if they lose dependent status (for example, after a divorce).

Cooperatives/Co-ops – Health management organizations that are managed by the members of the health plan or insurance purchasing arrangements in which businesses or other groups join together to gain the buying power of large employers or groups.

Coordination of Benefits (COB) – Agreement between health plans and insurers to avoid the same services being paid for more than once.

Co-payment (Co-pay) – Cost-sharing arrangement in which an insured person pays a specified charge for a specified service. The insured is usually responsible for payment at the time the health care is rendered. Typical copayments are fixed or variable flat amounts for physician office visits, prescriptions or hospital services.

Core Based Statistical Area (CBSA) – Core based

statistical areas (CBSAs) consist of the county or counties or equivalent entities associated with at least one core (urbanized area or urban cluster) of at least 10,000 people, plus adjacent counties having a high degree of social and economic integration with the core as measured through commuting ties with the counties associated with the core. The U.S. Office of Management and Budget defines CBSAs to provide a nationally consistent set of geographic entities for the U.S. and Puerto Rico for use in tabulating and presenting statistical data.

Core Measures – Standardized quality measures selected to align reporting and improve patient care. The measures were established by CMS, The Joint Commission, payers and health care providers. The guiding principles used by the collaborative in developing the core measure sets are that they be meaningful to patients, consumers, and physicians while reducing variability in measure selection, collection burden and cost. The goal is to establish broadly agreed upon core measure sets that could be harmonized across both commercial and government payers. This is increasingly important as the health care system moves towards value-based reimbursement models.

Corporate Practice of Medicine (CPOM) – The Corporate Practice of Medicine Doctrine (CPOM) refers to the public policy, law in some states, limiting the practice of medicine to licensed physicians by specifically prohibiting businesses or corporations from practicing medicine or employing physicians to practice medicine.

Corporate Restructuring – The formation and use of one or more corporations in addition to the hospital corporation for the purpose of holding assets or carrying out other business activities. Restructuring generally involves either the formation of corporations legally independent of the hospital, or the hospital's becoming a subsidiary of a new parent corporate structure.

Cost Accounting – An accounting system arriving at charges by health care providers based on actual costs for services rendered.

Cost Center – A business or organizational unit of activity or responsibility that incurs expenses.

Cost Containment – A set of strategies aimed at controlling the level or rate of growth of health care costs. These measures encompass a myriad of activities that focus on reducing overutilization of health services, addressing provider reimbursement issues, eliminating waste and increasing efficiency in the health care system.

Cost Finding – Determining how much it actually costs to provide a given service – usually requiring a cost-accounting system or a retrospective cost study.

Cost Sharing – A general term referring to payments made by health insurance enrollees for some portion of their covered services. Examples of cost sharing strategies include deductibles, coinsurance, and copayments.

Cost Shifting – Increasing revenues from some payers to offset losses or lower reimbursement from other payers, such as government payers and the uninsured.

Cost-benefit Analysis – A method comparing the costs of a project to the resulting benefits, usually expressed in monetary value.

Cost-to-charge Ratio (CCR) – A cost-finding measure derived from applying the ratio of third-party payer charges to total charges against the total operating costs in a hospital operating department. Medicare uses CCRs for calculation of outlier payments and DRG cost weighting.

Countercyclical – Medicaid is a countercyclical program in that it expands to meet increasing need when the economy is in decline. During an economic downturn, more people become eligible for and enroll in the Medicaid program when they lose their jobs and their access to health insurance. As enrollment grows, program costs also rise.

Coverage – A person's health care costs are paid by their insurance or by the government.

Covered Entity – Defined by HIPAA as health plans, health care clearinghouses and health care providers who electronically transmit in connection with a transaction for which HHS has adopted a standard.

Covered Lives – The total number of participants and beneficiaries in a health plan or covered by an insurer.

Covered Services – Specific health care services and supplies for which payers provide reimbursement under the terms of the applicable contract (Medicaid, Medicare, group contract or individual subscriber contract).

Credentialing and Privileging – Process by which a hospital obtains, verifies, and assesses the qualifications of a practitioner (e.g. physician, dentists, nurse midwife) and determines the scope of practice for them to provide services in the hospital. Credentials are documented evidence of licensure, education, relevant training, and experience or other qualifications. The criteria for granting privileges is determined by the hospital, is specific to that facility, and is based on credentials, practice history, competence, judgment and performance.

Credentialing Verification Organization (CVO) – An independent organization that confirms the professional credentials of providers for a managed care organization or health care organization rather than requiring the providers to provide this information independently.

Creditable Coverage – Health insurance coverage under

any of the following: a group health plan, individual health insurance, student health insurance, Medicare, Medicaid, CHAMPUS, TRICARE, the Federal Employees Health Benefits Program, Indian Health Service, the Peace Corps, Public Health Plan (any plan established or maintained by a state, the U.S. government, a foreign country), Children's Health Insurance Program (CHIP) or a state health insurance high risk pool. If you have prior creditable coverage, it will reduce the length of a pre-existing condition exclusion period under new job-based coverage.

Crisis Prevention – Services provided in order to promote physical and mental well being and the early identification of disease and ill health prior to the onset and recognition of symptoms, to permit early treatment.

Critical Access Hospital (CAH) – Designated by the Medicare Rural Hospital Flexibility Program as a limited service rural, nonprofit, or public hospital that provides outpatient and short-term inpatient hospital care on an urgent or emergency basis and is a part of a rural health network.

Current Assets – Assets that are expected to be turned into cash in one year (e.g., accounts receivable).

Current Liabilities – Obligations that will become due and payable with cash in one year.

Current Procedural Terminology (CPT) – Coding system for physician services developed by the American Medical Association, the basis of the HCPCS coding system. It is designed to communicate standardized information about services and procedures among physicians, coders, patients, accreditation organizations and payers.

Current Ratio – A financial ratio designed to measure liquidity, based on the relationship or balance between current assets and current liabilities.

Custodial Care – Basic long-term care, also called personal care, for someone with a terminal or chronic illness.

Data Use Agreement (DUA) – A legally binding agreement between entities regarding the transfer or use of personally identifiable data. DUAs serve to outline the terms and use of the data.

Days Per Thousand – A standard unit of hospital utilization measurement that refers to the annualized use (in days) of hospital or other institutional care for each 1,000 covered lives.

Death Rate (Hospital-based) – Number of deaths of inpatients in relation to the total number of inpatients over a given period of time.

Deductible – Amount of expense an insured person must pay for health care services, typically in a calendar year, before the health plan or insurer will pay for covered services.

Deduction from Revenue – The difference between revenue at full established rates (gross) and the payment actually received from payers (net).

Deemed Status – To participate in and receive federal payment from Medicare or Medicaid programs, a health care organization must meet the government requirements for program participation, including a certification of compliance with conditions of participation) or conditions for coverage, which are set forth in federal regulations. The certification is achieved based on either a survey conducted by a state agency on behalf of the federal government, or by a national accrediting organization, such as The Joint Commission or DNV, that has been recognized by CMS.

Defensive Medicine – Health care under which providers order more diagnostic testing than necessary to protect themselves from potential lawsuits by patients. Defensive medicine is said to be a major reason health care costs are so high.

De-identified Data – Health information in which all identifiers have been removed and there is no reasonable basis to believe that the information can be used to identify a specific individual.

Denial – The refusal by a third-party payer to reimburse a provider for services, or a refusal to authorize payment for services prospectively. Denials are generally issued on the basis that a hospital admission, diagnostic test, treatment or continued stay is inappropriate according to a set of guidelines.

Dental Services – An organized dental service or dentists on staff providing dental or oral services to inpatients or outpatients.

Dependent – A child or other person for whom a parent, relative, or other person may claim a personal exemption tax deduction. Under the Affordable Care Act, people may be able to claim a premium tax credit to help cover the cost of coverage for themselves and their dependents.

Dependent Coverage – Insurance coverage for family members of the policyholder, such as spouses, children or partners.

Depreciation – The amortization of the cost of a physical asset (plant, property, and equipment) over its useful life. Annual depreciation is the amount charged each year as expense for such assets as buildings, equipment, and vehicles. Accumulated depreciation is the total amount of depreciation of the hospital's financial books. Funded depreciation refers to setting aside and investing the accumulated depreciation so that monies can be used for replacement and renovation of assets.

Diagnosis-related Groups (DRGs) – Prospective payment rates based on diagnosis related groups have been established as the basis of Medicare's hospital reimbursement system. The 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. Hospitals receive a set amount, determined in advance, based on the length of time patients with a given diagnosis are likely to stay in the hospital.

Diagnostic Radioisotope Facility – The use of radioactive isotopes (Radiopharmaceuticals) as tracers or indicators to detect an abnormal condition or disease.

Direct Access – The ability to see a doctor or receive a medical service without a referral from your primary care physician.

Direct Contracting – Agreement between a hospital and a corporate purchaser for the delivery of health care services at a certain price. A third-party may be included to provide administrative and financial services.

Directors' and Officers' (D&O) Liability Coverage Insurance – Protection for directors and officers of corporations against suits or claims brought by shareholders or others alleging that the directors or officers acted improperly in some manner in the conduct of their duties. This coverage does not extend to dishonest acts.

Disability – A limit in a range of major life activities. This includes activities like seeing, hearing, walking and tasks like thinking and working.

Discharge – Release of a patient from a provider's care, often referring to the date when a patient leaves a hospital, either returning home or transferring to another facility.

Discharge Planning – Evaluation of patients' medical needs in order to arrange for appropriate care after discharge from an inpatient setting.

Discharges – The number of patients who leave an overnight medical care facility (usually a hospital but occasionally an extended care facility).

Discounted fee-for-service – A common risk-sharing payment method similar to fee-for-service except that the amount of money a provider charges for their health services is discounted based on a negotiated amount of percentage that is agreed on between the provider and the health plan.

Disease Management – The process in which a physician or clinical team coordinates treatment and manages a patient's chronic disease (such as asthma, diabetes, chronic obstructive lung disease or epilepsy) on a long-term, continuing basis, rather than providing single episodic treatments. Assists in providing cost-effective health care using preventive methods, such as monitoring weights or lab values, diet, medication and exercise.

Disposable Personal Income – The amount of a person's income that is left over after money has been spent on basic necessities such as rent, food and clothing.

Disproportionate Share Hospital (DSH) Adjustment – A payment adjustment under Medicare's prospective payment system or under Medicaid for hospitals that serve a relatively large volume of low-income patients.

Disproportionate Share Hospital (DSH) Payments – Payments made by a state's Medicaid program to hospitals that the state designates as serving a disproportionate share of low-income or uninsured patients. These payments are in addition to the regular payments such hospitals receive for providing inpatient care to Medicaid beneficiaries. States have some discretion in determining how much eligible hospitals receive. The amount of federal matching funds that a state can use to make payments to DSH hospitals in any given year is capped at an amount specified in the federal Medicaid statute.

DNV (Det Norske Veritas) GL Healthcare – A national accreditation organization with deeming authority from CMS to evaluate and monitor the quality of care provided in hospitals and other health care institutions and to provide accreditation to those institutions. DNV GL Health care accreditation standards integrate the CMS Conditions of participation with the ISO 9001 Quality Management Program.

Doctor of Nursing Practice (D.N.P.) – A doctoral degree focused on nursing practice that is an alternative to a research-focused doctoral degree (Ph.D.).

Doughnut Hole – A gap in prescription drug coverage under Medicare Part D, where beneficiaries enrolled in Part D plans pay 100% of their prescription drug costs after their total drug spending exceeds an initial coverage limit, until such time as they qualify for catastrophic coverage.

DRG Creep – The prohibited practice of classifying patients at a higher level of severity in order for a health care provider to receive higher Medicare payments.

Drug Enforcement Administration (DEA) – The mission of the Drug Enforcement Administration is to enforce the controlled substances laws and regulations of the U.S. and bring to the criminal and civil justice system, those organizations and principal members of organizations, involved in the growing, manufacture, or distribution of controlled substances appearing in or destined for illicit traffic in the U.S.; the DEA recommends and supports non-enforcement programs aimed at reducing the availability of illicit controlled substances on the domestic and international markets.

Drug Formulary – List of prescription drugs covered by an insurance plan or used within a hospital. A positive formulary lists eligible products while a negative one lists exclusions.

Dual Eligible – Describes people who are eligible for both Medicare and Medicaid benefits, including low-income seniors and younger people with disabilities.

Durable Medical Equipment (DME) – Equipment that is primarily and customarily used to serve a medical purpose, can withstand repeated use and is appropriate for use in the home like hospital beds, walkers, wheel chairs and oxygen concentrators.

Durable Power of Attorney for Health Care – A type of advance directive that allows a person to designate in advance another person to act on their behalf if they are unable to make a decision to accept, maintain, discontinue or refuse any health care services.

Duty of Care – Taking the care and exercising the judgment that any reasonable and prudent person would exhibit in the process of making informed decisions, including acting in good faith consistent with what a member of the board truly believes is in the best interest of the organization.

Duty of Loyalty – A standard that calls upon the board and its members to consider and act in good faith to advance the interest of the organization. It incorporates a duty to disclose situations that may present a conflict of interest as well as a duty to avoid competition with, and appropriation of, the assets of the organization.

Duty of Obedience – A standard that requires obedience to the organization's mission, bylaws and policies, as well as honoring the terms and conditions of other standards of appropriate behavior such as laws, rules, and regulations.

Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) – As part of the Medicaid program, the law requires that all states have a program for eligible children under age 21 to receive a medical assessment, medical treatments and other measures to correct any problems and treat chronic conditions.

Economic Credentialing – The use of economic criteria unrelated to quality of care or professional competency in determining an individual's qualifications for initial or continuing hospital medical staff membership or privileges. Economic credentialing is any practice by which a hospital conditions the granting of staff privileges on the physician providing a certain volume of services at, or referring a certain number of patients to, the hospital or the physician not investing in competing facilities. Economic credentialing is a term of disapproval used by the American Medical Association.

Effectiveness – The degree to which care is provided in the correct manner, given the current state of scientific knowledge and evidence based guidelines, to achieve the desired or projected outcome(s).

Efficacy – The degree to which the care of the individual has been shown to accomplish the desired or projected outcome(s).

Efficiency – The relationship between the outcomes (results of care) and the resources used to deliver care, while avoiding waste of resources.

Elective (Surgery or Procedure) – A health care procedure that is not an emergency and that the patient and doctor plan in advance, such as a total knee replacement.

Electrodiagnostic Services – Diagnostic testing services for nerve and muscle function including services such as nerve conduction studies and needle electromyography.

Electron Beam Computed Tomography (EBCT) – A high tech computed tomography scan used to detect coronary artery disease by measuring coronary calcifications.

Electronic Claim – A claim submitted by a health care provider to an insurer or third-party payer via technology that meets electronic filing requirements prescribed by HIPAA.

Electronic Data Interchange (EDI) – Computer-to-computer exchange of data and documents using a standardized format. Common health care uses of this technology include claims submission, payment, eligibility determination and referral authorization.

Electronic Health Record (EHR) – An electronic health record is a digital version of a patient's chart. One of the key features of an EHR (sometimes called Electronic medical record or EMR) is that health information can be created and managed by authorized providers in a digital format capable of being shared with other providers across more than one health care organization.

Electronic Prescribing (e-Prescribing) – Electronic prescribing is when a doctor sends a prescription electronically to a pharmacy.

Eligibility – The status that defines who receives health care services and benefits and for what period of time they qualify to use those benefits.

Eligibility Verification – The process of confirming that a person is a subscriber to a health plan, which, with some insurance plans, means confirming the member's benefit plan and co-payment responsibilities.

Emergency – A medical condition that starts suddenly and requires immediate care.

Emergency Department or Emergency Room (ED or ER) – A hospital department that provides immediate emergency medical care on a 24-hour basis for acutely ill or injured people who arrive without an appointment by their own means or by an ambulance.

Emergency Medical Services System (EMS) – A system of personnel, facilities, and equipment administered by a public or nonprofit organization delivering emergency medical services within a designated geographic area. is a system that provides emergency medical care.

Emergency Medical Treatment and Active Labor Act (EMTALA) – Congress enacted the Emergency Medical Treatment and Labor Act to ensure public access to emergency services regardless of ability to pay. Section 1867 of the Social Security Act imposes specific obligations on Medicare-participating hospitals that offer emergency services to provide a medical screening examination when a request is made for examination or treatment for an emergency medical condition (EMC), regardless of an individual's ability to pay.

Emergency Preparedness Plan – A planned framework to manage natural disasters, major incidents or mass casualty events that require assessment and treatment of patients who need emergency medical care. These plans typically are practiced at least annually through simulated disasters.

Emergency Room Visits – The number of visits to the emergency department of a hospital. When emergency outpatients are admitted to the inpatient areas of the hospital, they are counted as emergency room visits and subsequently, as inpatient admissions.

Emergency Room Services – Evaluation and treatment of an illness, injury or condition that needs immediate medical attention in an emergency room.

Emergency Services – Urgent health services that are provided after the onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy.

Employee Assistance Programs (EAPs) – Programs under which employers contract with companies to provide alcohol, substance abuse and other mental health services for their employees if these services are not covered under their employee health care benefits.

Employee Benefit Survey – Survey of employers administered by the U.S. Bureau of Labor Statistics to measure the number of employees receiving particular benefits such as health insurance, paid sick leave and paid vacations.

Employee Retirement Income Security Act (ERISA) – The Employee Retirement Income Security Act of 1974 is a federal law that sets minimum standards for most voluntarily established retirement and health plans in private industry to provide protection for people in these plans. ERISA does not require any employer to establish a pension plan. It only requires that those who establish plans must meet certain minimum standards.

Employer Contribution – The contribution is the money a company pays for its employees' health care.

Employer Health Care Tax Credit – An incentive mechanism designed to encourage employers, usually small employers, to offer health insurance to their employees. The tax credit enables employers to deduct an amount, usually a percentage of the contribution they make toward their employees' premiums, from the federal taxes they owe. These tax credits are typically refundable so they are available to nonprofit organizations that do not pay federal taxes.

Employer Mandate – Under the Affordable Care Act's employer-shared responsibility provisions, certain employers must either offer minimum essential coverage that is affordable and that provides minimum value to their full-time employees and their dependents, or potentially make an employer-shared responsibility payment to the IRS.

Employer Pay-or-Play – *See Employer Mandate*

Employer Responsibility – Under the Affordable Care Act starting in 2014, if an employer with at least 50 full-time equivalent employees doesn't provide affordable health insurance and an employee uses a tax credit to help pay for insurance through an exchange, the employer must pay a fee to help cover the cost of the tax credits.

EMSystems/EMResource – EMSystems offers web-based health care information management solutions like EMResource, a web-based program that provides real-time information status, capacity and availability of resources for emergency department and transport services.

Enabling Services – A program that is designed to help the patient access health care services by offering transportation services or referrals to local social service agencies.

End-of-life Care – Services offered to patients suffering from chronic, severe and life-threatening diseases including comprehensive services that give patients and caregivers the resources and the confidence to manage symptoms, avoid emergency room admissions and frequent hospitalization, and remain in familiar and comfortable settings. This might also include palliative care or hospice care.

Endoscopic Retrograde Cholangiopancreatography (ERCP) – A procedure in which a catheter is introduced through an endoscope into the bile ducts and pancreatic ducts. Injection of contrast materials permits detailed X-ray of these structures. The procedure is used diagnostically as well as therapeutically to relieve obstruction or remove stones.

Endoscopic Ultrasound – Specially designed endoscope that incorporates an ultrasound transductor used to obtain detailed images of organs in the chest and abdomen. The endoscope can be passed through the mouth or the anus. When combined with needle biopsy the procedure can assist in diagnosis and staging of cancer.

Endowment Fund – A fund set up where the original investment is maintained to provide income for general or restricted use(s), as specified by the donor, institution or program.

Enrollee – A person who is covered by health insurance. *See also Beneficiary.*

Enrollment – Refers to the total number of covered people (the enrolled group) in a health plan. Can also refer to the process by which a health plan signs up people and groups for membership.

Enrollment (Insurance) Assistance Services – A program that provides enrollment assistance for patients who are potentially eligible for public health insurance programs such as Medicaid, state Children's Health Insurance or local/state indigent care programs.

Entitlements – Programs in which people receive services and benefits based on some specific criteria, such as income or age. Examples of entitlement programs include Medicaid, Medicare and veterans' benefits.

Environmental Assessment – A planning method involving identification of the major external factors expected to present opportunities or problems over the planning period and an analysis of the operational implication of those factors on the organization.

Environmental Health – An organized community effort to minimize the public's exposure to environmental hazards by identifying the disease or injury agent, preventing the agent's transmission through the environment and protecting people from the exposure to contaminated and hazardous environments.

Environmental Protection Agency (EPA) – The Environmental Protection Agency is an independent agency of the federal government whose mission is to protect human health and the environment.

Episode of Care – The collection of all medical and pharmaceutical services rendered to a patient for a given illness, disease or injury across all settings of care and across providers for the duration of that illness.

Equity Model – An arrangement that allows established practitioners to become shareholders in a professional corporation in exchange for tangible and intangible assets of their existing practices.

Essential Health Benefits – A set of health care service categories that must be covered by certain plans, starting in 2014. The Affordable Care Act defines essential health benefits to include at least ambulatory patient services; emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services, chronic disease management, and pediatric services.

Ethics Committee – A group of people, usually comprising an administrator, one or more physicians, a chaplain, a community representative and an ethicist, formed to help patients and families reach informed decisions and work with health care providers to make complex and difficult decisions regarding moral issues (i.e., end-of-life care).

Evaluation and Management – A set of codes used for patient billing and documentation to describe medical visits for patients.

Evidence-based Medicine (EBM) – Integration of individual clinical expertise with the best available external clinical evidence from systematic research for use in making decisions about the care of individual patients or the delivery of appropriate health care services.

Excess Bed Capacity – Greater hospital bed availability than patients receiving care or treatment.

Excess Capacity – Difference between the number of hospital beds being used for patient care and the number of beds available.

Exchange – A transparent and competitive insurance marketplace where people and small businesses can buy affordable and qualified health benefit plans.

Exclusions – Medical conditions specified in an insurance policy for which the insurer will provide no benefits.

Exclusive Contract – An agreement that gives a physician or physician group the right to provide all administrative and clinical services required for the operation of a hospital department and precludes other physicians from practicing that specialty in that institution for the period of the contract.

Exclusive Provider Organization (EPO) – A managed care plan where services are covered only if you go to doctors, specialists or hospitals in the plan's network except in an emergency.

Expenses – Includes all expenses for the reporting period including payroll, non-payroll and all operating expenses.

Expenses Per Adjusted Admission Stay – Total expenses divided by adjusted admissions. *See adjusted admission.*

Expenses Per Adjusted Inpatient Days – Expenses divided by adjusted inpatient days. *See adjusted inpatient days.*

Experimental Procedure – Health care services or procedures that public and private health insurance plans believe are not widely accepted as effective by American health care professionals or have not been scientifically proven to be effective for a particular disease or condition. Insurers typically do not cover such procedures.

Explanation of Benefits (EOB) – A statement provided by a health insurance company to covered people stating what medical treatment or services were paid for on their behalf. The Medicare version is called an explanation of Medicare benefits.

Extended Care Facility (ECF) – A skilled nursing facility or hospital unit for treatment of inpatients who require convalescent, rehabilitative or long-term skilled nursing care such as during the course of a chronic disease or the rehabilitation phase after an acute illness.

External Quality Review Organization (EQRO) – An external independent entity that conducts an annual review of the timeliness, access and quality of services and care provided to enrollees in Medicaid and CHIP managed care plans.

Extracorporeal Shock Wave Lithotripter (ESWL) – A medical device used for treating stones in the kidney or urethra. The device disintegrates kidney stones noninvasively through the transmission of acoustic shock waves directed at the stones.

False Claims Act – Federal law that imposes liability on people and companies that defraud government programs.

Family and Medical Leave Act (FMLA) – A Federal law that guarantees up to 12 weeks of job protected leave for certain employees when they need to take time off because of serious illness or disability, to have or adopt a child, or to care for another family member. When on leave under FMLA, you can continue coverage under your job-based plan.

Family Practitioner/Practice Physician (FP) – A doctor who specializes in the care and treatment of all family members, including adults and children. These physicians can perform a wide range of services, including delivering babies, but usually do not perform surgeries.

Favorable Selection – The enrollment of a higher-than-average number of low-risk or relatively healthy members into a managed care organization.

Federal Emergency Management Agency (FEMA) – The Federal Emergency Management Agency, a federal agency which is a division of the Department of Homeland Security, supports citizens and emergency personnel to build, sustain and improve the nation's capability to prepare for, protect against, respond to, recover from and mitigate all hazards.

Federal Employee Health Benefit Program (FEHBP) – A program that provides health insurance to employees of the U.S. federal government.

Federal Fiscal Year (FFY) – The federal government's accounting period that begins Oct. 1 and ends Sept. 30 of each calendar year. Fiscal years are referred to by the calendar year in which they end, for example, FFY2020 begins on October 1, 2019.

Federal Medical Assistance Percentage (FMAP) – Amount paid by the federal government to match state Medicaid spending based on a formula taking into account the state's per capita income relative to the nation. By law, the FMAP cannot be lower than 50%.

Federal Poverty Level (FPL) – A measure of income determined annually by the U.S. Department of Health and Human Services. The FPL is used to determine eligibility for certain programs and benefits (i.e., Medicaid).

Federal Register – A federal publication issued daily from the National Archives and Records Administration that contains federal agency final and proposed regulations and public notices.

Federally Qualified Health Center (FQHC) – Community-based health care providers that receive funds from the Health Resources and Services Administration Health Center Program to provide primary care services in underserved areas. They must provide care on a sliding fee scale based on ability to pay and operate under a governing board that includes patients. Federally qualified health centers may be community health centers, migrant health centers, health care for the homeless, and health centers for residents of public housing.

Fee Schedule – A list of fee maximums for specified medical services and procedures used to reimburse a physician or other providers on a fee-for-service basis. Medicare has a fee schedule for doctors who treat beneficiaries. Insurance companies have fee schedules that determine what they will pay under their policies.

Fee-for-Service (FFS) – Payment method in which each specific service provided to a patient is associated with a corresponding fee to be paid to the provider.

Fertility Clinic – A specialized program set in an infertility center or hospital that provides counseling and education and advanced reproductive techniques and other such services to help patients achieve successful pregnancies.

Fiduciary Relationship – Relationship in which an person or organization has an explicit or implicit obligation to act on behalf of another person's or organization's interests. A physician has such a relation with their patient, and a hospital trustee has one with a hospital.

First Dollar Coverage – A health insurance policy with no required deductible or co-payment having to be covered first.

Fiscal Intermediary – An organization that acts as an intermediary between the hospital and a third-party payer, such as Medicare. It receives billings from the hospital and makes payments on behalf of the payer for covered services. It is, in turn reimbursed by the third-party payer.

Fiscal Year – A 12-month period for which an organization plans the use of its funds, such as the federal government's fiscal year (October 1 to September 30). Hospitals can designate their own fiscal years. This is reflected in differences in time periods covered by the Medicare cost reports.

Fitness Center – Provides exercise, testing or evaluation programs and fitness activities to the community and hospital employees.

Fixed Costs – Costs, such as rent and utilities, that do not vary with the output or activity of an organization.

Flexible Benefits – An employer-administered program allowing employees to select and trade between health care and other benefits based on their specific needs. Also called cafeteria benefits.

Flexible Spending Account (FSA) – An arrangement set up through employers to pay for out-of-pocket medical expenses with tax-free dollars.

Food and Drug Administration (FDA) – The Food and Drug Administration is a federal agency that is responsible for protecting the public health by ensuring the safety, efficacy and security of human and veterinary drugs, biological products and medical devices. It also ensures the safety of our nation's food supply, cosmetics and products that emit radiation.

Formulary – A list of medications that a managed care company encourages or requires physicians to prescribe as necessary in order to reduce costs.

Foundation – A corporation, organized as a hospital affiliate or subsidiary, that purchases both tangible and intangible assets of one or more medical group practices. Physicians remain in a separate corporate entity but sign a professional services agreement with the foundation.

Freestanding Ambulatory Care Center – A licensed facility, separate from a hospital, that provides medical and surgical outpatient care.

Freestanding Emergency Center (FEC) or Freestanding Emergency Room – A licensed facility, separate from a hospital, that is equipped and staffed to provide primary care and medical care for injuries and illnesses, including those that are life-threatening. Freestanding ERs are owned by physicians, hospitals or other entities.

Freestanding Facilities – Health care facilities that are not physically, administratively or financially connected to a hospital. An example is a freestanding ambulatory surgery center.

Freestanding Outpatient Care Center – A facility owned and operated by the hospital that is physically separate from the hospital and provides various medical treatments and diagnostic services on an outpatient basis only. Laboratory and radiology services are usually available.

Freestanding Urgent Care Center – A facility owned by a physician, separate from a hospital, that provides primary care and treatment for injury or illness that requires immediate care but is not severe enough to require an ER visit. These centers are not equipped to treat medical emergencies, nor are they structured to provide follow-up care.

Full-time Equivalent Employee (FTE) – Total FTE personnel is calculated by dividing the hospital's total number of paid hours by 2080, the number of annual paid hours for one full-time employee. FTEs are units equivalent to employees.

Fully Insured Job-based Plan – A health plan purchased by an employer from an insurance company.

Gag Clause – A contractual agreement between a managed care organization and a provider that restricts what the provider can say about the managed care company.

Gainsharing – A financial collaboration that sets up a system in which participants receive benefits they achieve resulting from either productivity gains, increased efficiency or decreases in costs. Physicians participating in gainsharing arrangements will have a financial stake in controlling hospital costs.

Gatekeeper – A health care professional who controls a patient's entry into the health care system and coordinates, manages and authorizes all health care services provided to a covered beneficiary. May be a nurse, social worker, physician assistant or primary care physician.

Gatekeeper PPO – A point-of-service plan that requires members to choose a primary care physician and to use doctors and other providers in a network or face higher out-of-pocket costs.

General Medical-surgical Care – Provides acute care to patients in medical and surgical units on the basis of physicians' orders and approved nursing care plans.

Generalists, or General Practitioners, GP – Physicians who are distinguished by their training as not limiting their practice by health condition or organ system, and provide comprehensive and continuous services. Typically include family practitioners, general internists and general pediatricians.

Generally Accepted Accounting Principles (GAAP) – A framework of guidelines for financial accounting, including the standards, conventions and rules accountants follow in recording and summarizing transactions and in the preparation of financial statements.

Generic Drugs – Prescription drugs that have the same active-ingredient formula as brand-name drugs and are identical in dosage, safety, strength, route of administration, quality and intended use. Generic drugs are less expensive than the brand-name drug and are often prescribed as a cost-saving alternative.

Genetic Testing and Counseling – A service equipped with adequate laboratory facilities and directed by a qualified physician to advise parents and prospective parents on potential problems in cases of genetic defects.

Geographic Adjustment Factor – An adjustment to a provider's Medicare reimbursement rate based on estimated operating expenses in different geographic areas.

Geriatric Services – The branch of medicine dealing with the physiology of aging and the diagnosis and treatment of disease affecting the aged.

Global Budgeting – A way of containing hospital costs in which participating hospitals share a budget, agreeing together to set the maximum amount of money that will be paid for health care.

Global Payment – A fixed payment given to health care providers for clinically defined services provided to patients in a given period of time.

Governing Body – The legal entity ultimately responsible for hospital policy, organization, management, and quality of care. Also called the governing board, board of trustees, commissioners, or directors.

Government Accountability Office (GAO) – An independent non-partisan agency that investigates how the federal government spends taxpayer money by reviewing federal financial transactions, examining the expenditure of appropriations of federal agencies and reporting to the U.S. Congress.

Government, Nonfederal, State, Local – Controlled by an agency of state, county, or city government.

Graduate Medical Education (GME) – The period of medical training that follows graduation from medical school. Commonly referred to as internship, residency, and fellowship training that leads to state licensure and board certification.

Grandfathered – Exempt from certain provisions of this law.

Grandfathered Health Plan – A group health plan that was created—or an individual health insurance policy that was purchased—on or before March 23, 2010. Grandfathered plans are exempted from many changes required under the Affordable Care Act. Plans or policies may lose their "grandfathered" status if they make certain significant changes that reduce benefits or increase costs to consumers.

Gross Domestic Product (GDP) – The total current market value of all goods and services produced domestically during a given period. Differs from the gross national product by excluding net income that residents earn abroad.

Gross Inpatient Revenue – Revenue from services rendered to inpatients at full established rates (also known as "charges").

Gross Outpatient Revenue – Revenue from services rendered to outpatients at full established rates.

Group Health Insurance – The most common type of health insurance in the U.S.. The majority of health insurance is offered through businesses, union trusts or other groups and associations. For insurance purposes, most groups are composed of full-time employees.

Group Model HMO – HMO that contracts with one or more multi-specialty groups to provide medical services, at a negotiated rate, to beneficiaries.

Group Practice – Provision of medical services by three or more physicians formally organized to provide medical care, consultation, diagnosis or treatment through the joint use of equipment and personnel.

Group Practice without Walls – In this type of organization, the hospital sponsors the formation of a physician group or provides capital to physicians to establish one. The group shares administrative expenses, although the physicians remain independent practitioners.

Group Purchasing Organization (GPO) – A group purchasing organization is an entity that helps health care providers realize savings and efficiencies by aggregating purchasing volume and using that leverage to negotiate discounts with manufacturers, distributors and other vendors.

Grouper – A computer software program that uses clinical and other information to classify medical cases into the proper diagnosis related group based on nternational classification of diseases.

Guarantee Issue/Renewal – Requires insurers to offer and renew coverage, without regard to health status, use of services, or pre-existing conditions. This requirement ensures that no one will be denied coverage for any reason.

Hand Hygiene – Hand hygiene is a way of cleaning one's hands that substantially reduces potential pathogens on the hands. Hand hygiene is considered a primary measure for reducing the risk of transmitting infection among patients and health care personnel.

Health – Defined by the World Health Organization as a state of complete physical, mental and social well being and not merely the absence of disease or infirmity.

Health and Human Services (HHS) – The U.S. Department of Health and Human Services, formerly the Department of Health, Education and Welfare.

Health Care Benefits – The specific services and procedures covered by a health plan or insurer.

Health Care Financing Administration (HCFA) – The federal government agency in the Department of Health and Human Services that directs the Medicare and Medicaid programs. HCFA also does research to support these programs and oversees more than a quarter of all health care costs in the U.S.

Health Care Provider – An individual or institution that provides medical services. This term should not be confused with an insurance company which "provides" insurance.

Health Care Reform – Changes to the overall health care delivery system: its structure, financing, coverage, and services. That last major health reform initiative on a national level was the Patient Protection and Affordable Care Act, often shortened to the Affordable Care Act or nicknamed Obamacare, a U.S. federal statute enacted by Congress and signed into law on March 23, 2010.

Health Care System – Corporate body that owns or manages multiple entities including hospitals, long-term care facilities, home health, hospice, ambulatory surgery, other institutional providers and programs, physician practices or insurance functions.

Health Care Workforce Development – The use of incentives and recruiting to encourage people to enter into health care professions such as primary care and to encourage providers to practice in underserved areas.

Health Fair – Community health education events that focus on the prevention of disease and promotion of health through such activities as audiovisual exhibits and free diagnostic services.

Health Information Exchange (HIE) – Electronic health information exchange allows doctors, nurses, pharmacists, other health care providers and patients to appropriately access and securely share a patient's vital medical information electronically—improving the speed, quality, safety and cost of patient care.

Health Information Technology (HIT) – The exchange and management of health information in an electronic multi-system environment. Information is shared among patients, consumers, health care providers, payers and quality monitors. Health information technology includes electronic health records, personal health records, e-prescribing and other programs.

Health Insurance – Financial protection against the health care costs caused by treating disease or accidental injury.

Health Insurance Exchange/Connector – A purchasing arrangement through which insurers offer and smaller employers and people purchase health insurance.

Health Insurance Portability and Accountability Act of 1996 (HIPAA) – (1) A federal law that made many changes in employer-sponsored health plans. The law allows people to move from job to job without losing coverage as the result of pre-existing conditions. HIPAA also guarantees access to group coverage for employees in companies with 2 to 50 employees, and established the need to provide patients total access to their care information and have the ability to amend their records.

(2) HIPAA includes a medical privacy regulation issued by the U.S. Department of Health and Human Services that obligates hospitals, doctors and other providers to use a patient's health information only for treatment; obtaining payment for care, and for their own operations, including improving the quality of care they provide to their patients. Hospitals cannot use or disclose a patient's health information in other ways, such as marketing or research, unless they get the patient's written permission before doing so. In addition, providers must inform patients how their health data will be used, establish systems to track disclosure of patient information, and permit patients to inspect, copy and request to amend their own health information.

Health Insurance Purchasing Cooperatives (HIPCs) – Public or private organizations that get health insurance coverage for certain populations of people, combining everyone in a specific geographic region and basing insurance rates on the people in that area.

Health Maintenance Organization (HMO) – A health care organization that acts as both insurer and provider of comprehensive but specified medical services in return for prospective per capita (capitation) payments.

Health Plan – Any entity or organization that provides for or pays for health care services for a person or group of people.

Health Plan Employer Data and Information Set (HEDIS) – A set of more than 90 standardized measures of health plan performance. HEDIS allows comparisons between plans on quality, access and patient satisfaction, membership, utilization, financial information, and health plan management. HEDIS was developed by employers, HMOs and the National Committee for Quality Assurance.

Health Professional Shortage Area – Geographic area, population or facility designated by the federal government as having shortages of primary care, dental or mental health care providers.

Health Reimbursement Account (HRA) – A tax-exempt account that can be used to pay for current or future qualified health expenses. HRAs are established benefit plans funded solely by employer contributions, with no limits on the amount an employer can contribute. HRAs are often paired with a high-deductible health plan, but are not required to do so.

Health Research – Organized hospital research program in any of the following areas: basic research, clinical research, community health research or research on innovative health care delivery.

Health Resources and Services Administration (HRSA) – The Health Resources and Services Administration, an agency of the U.S. Department of Health and Human Services, and provides health care to people who are geographically isolated, or economically or medically vulnerable. HRSA supports the training of health professionals, the distribution of providers to areas where they are needed most and improvements in health care delivery. In addition, HRSA oversees organ, bone marrow, and cord blood donation. It compensates people harmed by vaccination, and maintains databases that flag providers with a record of health care malpractice, waste, fraud, and abuse for federal, state and local use.

Health Savings Account (HSA) – A health insurance option that includes a medical savings account designed to help people save for future qualified medical and retiree health expenses on a tax-free basis. Funds contributed to an account are not subject to federal income tax at the time of deposit. They often are paired with high-deductible health insurance policies. Also called medical savings account.

Health Screening – A preliminary procedure such as a test or examination to detect the most characteristic sign or signs of a disorder that may require further investigation.

Health Status – Refers to your mental and physical medical conditions, claims experience, receipt of health care, medical history, genetic information, evidence of insurability and disability.

Health care Common Procedure Coding System (HCPCS) – A uniform method for health care providers and medical suppliers to code professional services, procedures and supplies.

Health care Facilities Accreditation Program (HFAP) – Nationally recognized accreditation authority with deeming authority from CMS to survey all hospitals and other health care facilities for compliance with the Medicare conditions of participation and coverage.

Health care Financial Management Association (HFMA) – The Health care Financial Management Association is a nonprofit membership organization for health care financial management executives.

Heart Transplant – See definition for Transplant Services.

Hemodialysis – Provision of equipment and personnel for the treatment of renal insufficiency or failure on an inpatient or outpatient basis. There are two different types of dialysis - hemodialysis and peritoneal dialysis.

High Deductible Health Plan (HDHP) – A plan that features higher deductibles than traditional insurance plans. HDHPs can be combined with a health savings account or a health reimbursement arrangement to allow you to pay for qualified out-of-pocket medical expenses on a pre-tax basis.

High-risk Pool Plan (State) – Similar to the new Pre-Existing Condition Insurance Plan under the Affordable Care Act, for years many states have offered plans that provide coverage if you have been locked out of the individual insurance market because of a pre-existing condition. High-risk pool plans may also offer coverage if you're HIPAA eligible or meet other requirements. High-risk pool plans offer health insurance coverage that is subsidized by a state government. Typically, your premium is up to twice as much as you would pay for individual coverage if you were healthy.

High-cost Excise Tax – Under the Affordable Care Act starting in 2018, a tax on insurance companies that provide high-cost plans. This tax encourages streamlining of health plans to make premiums more affordable.

Hill-Burton Program – A federal program, named for its two principal congressional proponents, Hill and Burton, of financial assistance created by the Hospital Survey and Construction Act of 1946 for the construction and modernization of health care facilities. In return for this funding, hospitals are required to provide a specified level of charity care each year. The program stopped providing funds in 1997, but about 140 health care facilities nationwide are still obligated to provide free or reduced-cost care.

HIPAA Eligible Individual – Your status once you have had 18 months of continuous creditable health coverage. To be HIPAA eligible, at least the last day of your creditable coverage must have been under a group health plan. You also must have used up any COBRA or state continuation coverage. You must not be eligible for Medicare or Medicaid and not have other health insurance, and must apply for individual health insurance within 63 days of losing your prior creditable coverage.

HIV-AIDS services – An HIV-AIDS unit or services is designated and equipped specifically for diagnosis, treatment, continuing care planning, and counseling services for HIV-AIDS patients and their families.

Holding Company – A separate entity used to hold a variety of subsidiary groups that often perform related functions but have a distinct corporate identity.

Holistic Health – Health viewed from the perspective that the patient is collectively more than the sum of his or her parts. Beief that the body, mind, and spirit must be in harmony to achieve optimum health, and, therefore, that a multidisciplinary approach to health care is required.

Home Health Care – Health care services provided in a patient's home rather than a hospital or other institutional setting. The services provided include skilled nursing care, social services, physical, speech, or occupational therapy, and nursing assistant services. Health care is a covered service by Medicare and most private insurers and health plans, provided that the patient is eligible and qualifies for the service.

Horizontal Integration – A strategy creating a network of complementary or similar types of providers, such as a multi-organization system composed of acute-care hospitals. May be used as a competitive strategy by some hospitals and systems to control the geographic distribution of health care services.

Hospice – An organized program of holistic palliative care for the terminally ill that emphasizes alleviation and management of distressing symptoms such as pain or shortness of breath and comfort of spiritual and emotional needs. Hospice may include inpatient care, home care, respite care and family support. A hospice may be a freestanding facility, a unit of a hospital or other institution such as a long-term care facility, or a separate program of a hospital, agency or institution. Medicare, Medicaid and many private insurers and health plans provide a special hospice benefit that eligible patients can elect to receive.

Hospital Affiliation – Contractual agreement between a health plan and one or more hospitals, such as an agreement for a hospital to provide the inpatient benefits offered by a health plan. May also refer to arrangements between hospitals and other health care financing or provider organizations.

Hospital Consumer Assessment of Health care Providers and Systems (HCAHPS) – The HCAHPS, also known as the CAHPS® Hospital Survey or Hospital CAHPS®, is a standardized survey instrument and data collection methodology that has been in use since 2006 to measure patients' perspectives of hospital care. While many hospitals collect information on patient satisfaction, HCAHPS (pronounced "H-caps") created a national standard for collecting and public reporting information that enables valid comparisons to be made across all hospitals to support consumer choice.

Hospital Inpatient Quality Reporting Program – Under the Hospital Inpatient Quality Reporting Program, CMS collects quality data from hospitals paid under the Inpatient Prospective Payment System, with the goal of driving quality improvement through measurement and transparency by publicly displaying data to help consumers make more informed decisions about their health care. It is also intended to encourage hospitals and clinicians to improve the quality and cost of inpatient care provided to all patients. The data collected through the program are available to consumers and providers on the Hospital Compare web site. Data for selected measures are also used for paying a portion of hospitals based on the quality and efficiency of care.

Hospital Market Basket – A measure of all the goods and services a specific organization must purchase to provide care.

Hospital Pre-authorization – Managed care technique in which the insured obtains permission from a managed care organization before entering the hospital for non-emergency care.

Hospital Preparedness Program (HPP) – Provides leadership and funding through grants and cooperative agreements to states, territories and large metropolitan areas to improve capacity and enhance community and hospital preparedness for public health emergencies. The program is managed by the Office of the Assistant Secretary for Preparedness and Response.

Hospital Quality Alliance – National public-private collaboration that monitors and makes information about hospital performance accessible to the public and encourages efforts to improve quality.

Hospital Readmissions – A situation where a patient discharged from the hospital and wind up going back in for the same or related care within 30, 60 or 90 days.

Hospital Unit – The hospital operation, excluding activity pertaining to nursing-home-type unit, for the following items: Admissions, Beds, FTEs (full-time, part-time, and total), inpatient days, length of stay, net revenue, and total expense.

Hospital Unit of Institutions – A hospital unit that is not open to the public and is contained in a nonhospital unit. An example is an infirmary that is contained in a college.

Hospital-acquired Conditions – Reasonably preventable conditions or events during a hospital stay. Which includes conditions such as cather-associated urinary tract infections and foreign body retained after surgery. Medicare payments to hospitals may be reduced based on HACs that were not present on admission.

Hospitalist – Physicians whose primary professional focus is the general medical care of hospitalized patients. Their activities include patient care, teaching, research and leadership related to hospital medicine.

Hospital-physician Alliance (HPA) – A partnership between a hospital and a group of its staff physicians. Such alliances range from an informal sharing of expertise to a more structured arrangement involving computer networking, assistance with physician recruitment and physician practice development.

Hospitals in a Network – Hospitals participating in a group that may include other hospitals, physicians, other providers, insurers, or community agencies that work together to coordinate and deliver a broad spectrum of services to the community.

Hospitals in a System – Hospitals belonging to a corporate body that owns or manages health provider facilities or health-related subsidiaries. The system may also own non-health-related facilities such as a fitness center.

Image-guided Radiation Therapy (IGRT) – Automated system for image-guided radiation therapy that enables clinicians to obtain high-resolution X-ray images to pinpoint tumor sites, adjust patient positioning when necessary, and complete a treatment, all within the standard treatment time slot, allowing for more effective cancer treatments.

Immunization Program – Program that plans, coordinates and conducts immunization services in the community.

Incidence – The number of new cases of a particular problem or condition that are identified or arise in a specified area during a specified period of time.

Incident Report – A written report that documents a problem, occurrence or situation for which follow-up action is indicated. Examples include falls, accidental needle sticks and medication errors. Incident reports are used to identify opportunities to improve safety and reduce risk in a health care setting.

Incurred But Not Reported (IBNR) – An accounting term that means health care services have been provided but the bill has not yet reached the insurer. It allows calculating an insurer's liability and reserve needs. Incurred claims are the legal obligation an insurer has for services that have been provided during a specific period.

Indemnity Fee for Service – The traditional type of health insurance, in which the insured is reimbursed for covered expenses without regard to choice of provider. Payment up to a stated limit may be made either to the person incurring and claiming the expense, or directly to providers.

Indemnity Insurance – A system of health insurance in which the insurer pays for the costs of covered services after care has been given, and which usually defines the maximum amounts which will be paid for covered services. This is the most common type of insurance in the U.S.

Independent (or Individual) Practice Association (IPA) – An independent physician association is a business entity organized and owned by a network of independent physician practices for the purpose of reducing overhead or pursuing business ventures such as contracts with employers, accountable care organizations or managed care organizations. IPAs assist solo physicians in obtaining managed care contracts.

Independent Payment Advisory Board (IPAB) – Created by the Affordable Care Act in 2010, the IPAB seeks to achieve specified savings in Medicare without affecting coverage or quality. The IPAB is to issue recommendations to lower Medicare costs if spending exceeds targets established in the ACA.

Indian Health Services (IHS) – The Indian Health Service, an agency in the Department of Health and Human Services, is responsible for providing federal health services to American Indians and Alaska Natives. The IHS is the principal federal health care provider and health advocate for Native people, and its goal is to raise their health status to the highest possible level.

Indigent Care – Care given by health care providers to patients who are unable to pay for care and who are not eligible for health care coverage such as Medicaid, Medicare or private insurance.

Indigent Care Clinic – Health care services for uninsured and underinsured people where care is free of charge or charged on a sliding scale. This would include free clinics staffed by volunteer practitioners, but could also be staffed by employees with sponsoring health care organizations subsidizing the cost of service.

Indirect Medical Education – Reimbursement from Medicare to teaching hospitals that have residents in an approved graduate medical education program.

Individual Case Management – The determination by management professionals of individual patients' care (usually high-cost, high-resource intensive care) in order to find the most appropriate and cost-effective course of treatment, even if it involves paying for services not routinely covered by the health plan.

Individual Health Insurance Policy – Policies for people that aren't connected to job-based coverage. Individual health insurance policies are regulated under state law.

Individual Responsibility – Under the Affordable Care Act, starting in 2014, you must be enrolled in a health insurance plan that meets basic minimum standards. If you aren't, you may be required to pay an assessment. You won't have to pay an assessment if you have very low income and coverage is unaffordable to you, or for other reasons including your religious beliefs. You can also apply for a waiver asking not to pay an assessment if you don't qualify automatically.

Individual Mandate – The individual mandate, which took effect in 2014, is a requirement of the Affordable Care Act that most citizens and legal residents of the U.S. have health insurance. People who do not have health insurance must obtain it or pay a penalty.

Inpatient – Patient admitted to a hospital for a stay of longer than 24 hours for observation or to receive medically necessary care.

Inpatient Days – The number of adult and pediatric days of care, excluding newborn days of care, rendered during the entire reporting period.

Inpatient Palliative Care Unit – An inpatient palliative care ward is a physically discreet, inpatient nursing unit where the focus is palliative care (sometimes called comfort care). The patient care focus is on symptom relief for complex, seriously ill patients who may be continuing to undergo primary treatment, such as cancer treatment. Care is delivered by palliative medicine specialists.

Inpatient Surgeries – Surgical services provided to patients who remain in the hospital overnight.

Institute for Health care Improvement (IHI) – An independent nonprofit organization that focuses on improving health care. Today, IHI is an influential force in health and health care improvement in the U.S. and dozens of other countries.

Institutional Review Board (IRB) – A committee that provides peer review to protect the rights of human subjects through approval, monitoring and the review of medical research and clinical trials.

Insurance Co-op – A nonprofit entity in which the same people who own the company are insured by the company. Cooperatives can be formed at a national, state or local level, and can include doctors, hospitals and businesses as member-owners.

Insurance Exchange – State and federal health insurance marketplaces that are set up to facilitate the purchase of health insurance for people not covered by employer-based or government health insurance.

Integrated Delivery System (IDS) – An entity, usually under a parent holding company, that usually includes a hospital or hospitals, a large medical group and an insurance vehicle such as an HMO or PPO that collaborate to provide a coordinated continuum of services. Typically, all provider revenues flow through the organization.

Integrated Provider (IP) – A group of providers that offer comprehensive and coordinated care, and usually provides a range of medical care facilities and service plans including hospitals, group practices, a health plan and other related health care services.

Integrated Salary Model – In this arrangement, physicians are salaried by the hospital or other entity of a health system to provide medical services for primary care and specialty care.

Intensity of Service – The quantity and quality of resources used in producing a patient care service, such as a hospital admission or home health visit. Intensity of services may reflect, for example, the amount of nursing care, diagnostic procedures and supplies furnished.

Intensity-modulated Radiation Therapy (IMRT) – A type of three-dimensional radiation therapy, which improves the targeting of treatment delivery in a way that is likely to decrease damage to normal tissues and allows varying intensities.

Intensive Care Unit (ICU) – An ICU (sometimes referred to as Critical Care Unit or CCU) is an organized system for the provision of care to critically ill patients that provides intensive and specialized medical and nursing care, an enhanced capacity for monitoring and multiple modalities of physiologic organ support to sustain life during a period of life-threatening organ system insufficiency. ICUs are categorized by levels, based on their capacity to provide certain life-sustaining treatments.

Intergovernmental Transfer (IGT) – The transfer of public funds between governmental entities either between one level of government to another or within the same level of government. In health care this is a mechanism in which states may use revenue from local governments to help fund the state's share of allowable Medicaid expenditures, such as disproportionate share hospital payments.

Intermediate Care Facility (ICF) – A facility that provides nursing, supervisory and supportive services to elderly, disabled or chronically ill patients who do not require the degree of care or treatment that a skilled nursing facility provides.

Intermediate Nursing Care – Provides health-related services (skilled nursing care and social services) to residents with a variety of physical conditions or functional disabilities. These residents do not require the care provided by a hospital or skilled nursing facility, but do need supervision and support services.

Internal Medicine Physicians (Internists) – Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness. Unlike family practice physicians, they do not treat children.

International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10) – An international system, maintained and published by the World Health Organization, which is used by physicians and other health care providers for classifying and coding all diagnoses, symptoms and services using a six-digit code to classify diseases by diagnosis (diagnosis related groups). The 10th edition is in use.

International Organization for Standardization (ISO) – Organization established to develop a set of international standards for quality management in manufacturing and service businesses, including health care.

Interoperability – The ability of different information technology systems and software applications to communicate, exchange data and operate in a coordinated, seamless manner.

Interpretive Guidelines – The interpretive guidelines serve to interpret and clarify the Conditions for nursing and skilled facilities. The interpretive guidelines define or explain the relevant statute and regulations and do not impose any requirements that are not otherwise set forth in statute or regulation.

Intraoperative Magnetic Resonance Imaging (Interoperative MRI) – An integrated surgery system which provides an MRI system in an operating room.

Investor-owned Hospital – A hospital operated by a for-profit corporation in which the profits go to shareholders who own the corporation. Also referred to as a proprietary hospital.

ISO 9000 – Set of quality management standards developed by the ISO that establishes a quality assurance system to ensure that suppliers create products and services that meet certain standards.

Job-based Health Plan – Coverage that is offered to an employee, and often by an employer.

Joint Commission on the Accreditation of Health care Organizations (JCAHO) – A national private, nonprofit organization that accredits health care organizations and agencies and sets guidelines for operation for these facilities.

Joint Commission Resources (JCR) – A nonprofit affiliate of The Joint Commission that offers health care providers consulting services, educational services, electronic products and publications to assist in improving quality and safety and maintaining compliance with Joint Commission accreditation standards.

Joint Conference Committee (JCC) – A committee of trustees and physicians with administrative representation which serves primarily as a communications vehicle between the board and the medical staff. In some hospitals, the JCC also functions as a board-level quality assurance committee.

Joint Venture – Legal arrangement, for a finite time, between two or more entities (such as a hospital and a physician, two hospitals, or a hospital and an HMO) to develop a new entity or provide service(s) and/ or product(s) in which risks, benefits and equity are shared.

Labor-related Expenses – Payroll expenses plus employee benefits. Non-labor-related expenses refers to all other nonpayroll expenses, such as interest depreciation, supplies, purchased services and professional fees.

Length of Stay (LOS) – The number of days between a patient's admission and discharge from a hospital.

Licensed Facilities – Health care facilities that offer health care services, including hospitals, hospices, nursing homes and home health agencies, and require licensure to comply with federal or state laws or rules.

Licensed Practical Nurse (LPN) – A licensed nurse who has graduated from an approved school of practical (vocational) nursing, and works under the supervision of registered nurses or physicians to provide basic-level care. Full-time practical nursing training programs typically take 12 months to complete.

Licensure – A formal process by which a government agency grants a person the legal right to practice an occupation.

Lifetime Benefit Maximum – A cap on the amount of money insurers will pay toward the cost of health care services over the lifetime of the insurance policy. Lifetime benefits maximums are now prohibited under health reform.

Limitations – A cap or limit on the amount of services that may be provided. It may be the maximum cost or number of days that a service or treatment is covered.

Limited Service Hospital – A hospital, often located in a rural area, that provides a limited set of medical and surgical services.

Linguistic/Translation services – Services provided by the hospital designed to make health care more accessible to non-English speaking patients and their physicians.

Liquidity – Financial ratios that measure the ability of a corporation to meets its short-term liabilities as they come due. Degree to which an asset or security can quickly be bought or sold in the market with a minimum change in price.

Living Will – Document generated by a person for the purpose of providing guidance about the medical care to be provided if the person is unable to articulate these decisions. *See Advance Directive*.

Local Coverage Determinations (LCD) – Policies developed by Medicare and administrative contractors, deciding which procedures and treatments are reasonable and necessary for different types of conditions, and are eligible for insurance coverage.

Long-term Care – Ongoing health and social services provided for people who need assistance on a continuing basis because of physical or mental disability. Services can be provided in an institution, the home, or the community, and include informal services provided by family or friends as well as formal services provided by professionals or agencies.

Long-term – Hospitals are classified either short-term or long-term according to the average length of stay. A long-term hospital is one in which the average LOS is 30 days or more.

Long-term Care Facility (LTCF) – Residential health care facility that administers health, rehabilitative or personal services for a prolonged period of time. Long-term care facilities include nursing homes and assisted living facilities.

Long-term Care Hospital (LTCH) – Provides extended medical and rehabilitative services to patients with serious and often complex medical conditions that require a longer length of stay than customarily provided by an acute-care hospital. LTCHs provide care for such conditions as respiratory failure, non-healing wounds and medically complex diseases.

Magnet Hospital Recognition Program – The Magnet Recognition Program® was developed by the American Nurses Credentialing Center to recognize health care organizations that provide nursing excellence and to disseminate successful nursing practices and strategies.

Magnetic Resonance Imaging (MRI) – The use of a uniform magnetic field and radio frequencies to study tissue and structure of the body.

Maintenance Management Information System (MMIS) – Integrated computer system that automates claims processing and information retrieval for Medicaid.

Malpractice – Medical malpractice occurs when a hospital, doctor or other health care professional, through a negligent act or omission, causes an injury to a patient. The negligence might be the result of errors in diagnosis, treatment, aftercare or health management.

Malpractice Insurance – Coverage for medical professionals which pays the costs of legal fees and any damages assessed by the court in a lawsuit brought against a professional who has been charged with negligence.

Managed Care – A term covering a broad spectrum of arrangements for health care delivery and financing, including managed indemnity plans, health maintenance organizations, preferred provider organizations, point-of-service plans, and direct contracting arrangements between employers and providers.

Managed Care Contract – A contract between the hospital and a managed care organization.

Managed Care Network – A regional or national organization of providers owned by a commercial insurance company or other sponsor (e.g., a managed care plan) and offered to employers and other groups or organizations as either an alternative to, or a total replacement for, traditional indemnity health insurance.

Managed Care Organization (MCO) – A plan or company, such as an HMO, PPO, or exclusive provider organization, that uses the principles of managed care as a basic part of doing business.

Management Information System (MIS) – A system that produces the necessary information in proper form and at appropriate intervals for the management of a program or other activity.

Management Services Organization (MSO) – A corporation owned by the hospital or a physician-hospital joint venture that provides management services to one or more medical group practices. As part of a full-service management agreement, the MSO purchases the tangible assets of the practices and leases them back, employs all non-physician staff and provides all supplies and administrative systems for a fee.

Mandate – Law requiring that a health plan or insurance carrier must offer a particular procedure or type of coverage.

Mandated Benefits – Coverage that states require insurers to include in health insurance policies such as prenatal care, mammography screening and care for newborns.

Mandated Providers – The range of health care providers required by federal or state law to be included in any health plan.

Mandatory Benefits – Certain benefits or services, such as mental health services, substance-abuse treatment and breast reconstruction following a mastectomy, that state-licensed health insuring organizations are required to cover in their health insurance plans.

Marginal Cost – The cost of producing an extra unit of product. A key consideration in pricing and in calculating cost implications of business expansion or contraction.

Market Basket Index – An index of the annual change in the prices of goods and services that providers use for producing health services. There are separate market baskets for Medicare's prospective payment system's hospital operating and capital inputs; PPS-excluded facility operating inputs, SNF, home health agency and renal dialysis facility operating and capital inputs. This index allows for CMS to update its payment systems appropriately.

Market Share – In the context of managed care, part of the market potential for a managed care company that has been captured. Usually market share is expressed as a percentage of the market potential.

Market-driven Health Reform – Renovations in the general health care system, in both financing and delivery of services, that emanate from the private sector and are associated with managed care principles in which health provider organizations and networks compete on the basis of cost, quality, and access to care.

Master of Science in Nursing (M.S.N.) – An advanced nursing degree that registered nurses pursue to become a specialized nurse (i.e., nurse practitioner, clinical nurse specialist or nurse educator).

Meals on Wheels – An organized program, sometimes sponsored by a hospital, which delivers meals to people, usually the elderly, who are unable to prepare their own meals. Low cost, nutritional meals are delivered to people's homes on a regular basis.

Meaningful Use – Meaningful use is defined by the use of certified electronic health record technology in a meaningful manner.

Means Test – An assessment of a person's or family's income or assets so that it can be determined if they are eligible to receive public support, such as Medicaid.

Medicaid – A joint state-federal insurance program under Title XIX of the Social Security Act for low-income people. The program provides health care to qualifying people based on their citizenship status, income and assets. The federal government has established minimum eligibility levels and required covered populations, but states determine covered benefits and reimbursement rates and whether to expand coverage to optional populations.

Medicaid 1115 Transformation Waiver – States can design and improve their Medicaid programs by working within the flexibility allowed under existing federal Medicaid law, using longstanding tools such as Section 1115 waivers to best meet their state's unique needs.

Medicaid Integrity Contractors (MIC) – Firms chosen by the Centers for Medicare and Medicaid Services to perform audits, identify overpayments and conduct education on payment integrity and quality of care.

Medicaid Integrity Group (MIG) – The Centers for Medicare and Medicaid Services' MIG administers the Medicaid Integrity Program and regularly consults with the Medicaid Fraud and Abuse Technical Advisory Group.

Medicaid Integrity Program (MIP) – A comprehensive plan established by the Centers for Medicare and Medicaid Services to combat fraud, waste and abuse in the Medicaid program.

Medicaid Waivers – Authority granted by the Secretary of Health and Human Services to allow a state to continue receiving federal Medicaid matching funds even though it is no longer in compliance with certain requirements of the Medicaid statute. States can use waivers to implement home and community-based services programs, managed care and to expand coverage to populations who are not otherwise eligible for Medicaid.

Medical Error – A preventable adverse event that may or may not be evident or harmful to the patient. These can occur in diagnosis, treatment, preventative monitoring or lab reports or through the use of medical equipment.

Medical Executive Committee – Generally composed of the elected or appointed officers and chairs of clinical departments or divisions of the medical staff organization.

Medical Foundation – A tax-exempt medical group practice conducting research and offering educational programs.

Medical Group – An organized collection of physicians who have a common business interest through a partnership or some form of shared ownership. Some medical groups consist of a group of physicians representing a single specialty, other groups are made up of physicians from two or more specialties.

Medical Home (definition 1) – A health care 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.

Medical Home (definition 2) – A comprehensive and patient-centered model of care wherein a primary care provider leads a team that takes collective responsibility for care of a patient. This team is responsible for providing and coordinating the patient's health care or arranging for appropriate care with other qualified physicians or providers if needed. Also referred to as a patient-centered medical home.

Medical IRAs – Personal accounts which, like individual retirement plans, allow a person to accumulate funds for future use. The money in these accounts must be used to pay for medical services. The employee decides how much money he or she will spend on health care.

Medical Loss Ratio (MLR) – The percentage of premium dollars an insurance company spends on clinical services and quality improvement rather than on administrative costs or profits.

Medical Malpractice – Occurs when a health care professional causes harm to the patient during the course of treatment. *See Malpractice.*

Medical Power of Attorney – A legal document that allows people to designate another person to make health care decisions on their behalf if they are unable to make decisions themselves. Often referred to as a Durable Power of Attorney for Health Care.

Medical Record – An individual record kept for each patient containing sufficient information to identify the patient, to justify the diagnosis and treatment, and to document the results accurately.

Medical Savings Account (MSA) – A health insurance option consisting of a high-deductible insurance policy and tax-advantaged saving account. People pay for their own health care up to the annual deductible by withdrawing form the savings account or paying out of pocket. The insurance policy pays for most or all costs of covered services once the deductible is met. Also called a Health Savings Account.

Medical Staff Bylaws – The written rules and regulations that define the duties, responsibility and rights of physicians and other health professionals who are part of a hospital's medical staff.

Medical Staff Organization – That body that includes fully licensed physicians, and may include other licensed people permitted by law and credentialed and privileged by the hospital to provide inpatient care services independently in the hospital.

Medical Surgical Intensive Care – Provides patient care of a more intensive nature than the usual medical and surgical care, on the basis of physicians' orders and approved nursing care plans. These units are staffed with specially trained nursing personnel and contain monitoring and specialized support equipment for patients who, because of shock, trauma or other life-threatening conditions, require intensified, comprehensive observation and care.

Medical Technology – Includes drugs, devices, techniques and procedures used in delivering medical care and the support systems for that care.

Medical Underwriting – Underwriting or medical underwriting is a process that insurance companies routinely used prior to 2014 — particularly in the individual insurance market — to determine if an applicant was an acceptable risk, and if so, how much to charge in premiums based on the applicant's medical history. Since 2014, under new rules laid out in the Affordable Care Act, all new individual major medical plans are guaranteed issue, which means that medical underwriting is no longer allowed. Premium still vary in most states based on age and tobacco use.

Medically Indigent – A person who, by current income standards, is not poor but lacks the financial resources to afford necessary medical services.

Medically Necessary – Those covered services required to preserve and maintain the health status of a member or eligible person in accordance with the area standards of medical practice in the medical community where services are rendered.

Medically Underserved Area – A federal designation of a geographic location that has insufficient health resources to meet the medical needs of the population. More specifically, this is based on four variables: insufficient number of primary care providers, high infant mortality, high poverty or a large elderly population.

Medicare – Federal program under the Social Security Act that provides hospital and medical coverage to people 65 and older and to certain disabled people regardless of age. It has four parts: Part A covers inpatient costs (hospital insurance); Part B covers outpatient costs (medical insurance); Part C is the Medicare Advantage Program that provides managed care benefits for Part A and Part B; and Part D covers prescription drugs. The Medicare program is administered by the Centers for Medicare and Medicaid.

Medicare Administrative Contractor (MAC) – A private health care insurer that has regional jurisdiction, awarded by CMS, to manage enrollment, provide claims for payment, provide customer service and establish regional policy guidelines. MACs serve as the fiscal intermediary and point of contact for Medicare.

Medicare Advantage – Also referred to as Medicare Part C, the Medicare Advantage program allows Medicare beneficiaries to choose to receive their Medicare benefits through a private insurance plan rather than the traditional fee-for-service program.

Medicare Assignment – An agreement in advance by a physician to accept Medicare's allowed charge as payment in full (guarantees not to balance bill). Medicare pays its share of the allowed charge directly to physicians who accept assignment and provides other incentives under the Participating Physician and Supplier Program.

Medicare Cost Report (MCR) – Annual report required of institutions participating in the Medicare program that records each institution's total costs and charges associated with providing services to all patients, and thepercentage of these costs allocated to Medicare patients and the Medicare payments received.

Medicare Physician Fee Schedule – The resource-based fee schedule Medicare uses to pay for physicians' services. More than 10,000 physician services are listed in the fee schedule. The Medicare physician fee schedule pricing amounts are adjusted to reflect the variation in practice costs from area to area.

Medicare Geographic Classification Review Board (MGCRB) – The Medicare Geographic Classification Review Board makes determinations on geographic reclassification requests of hospitals who are receiving payment under the inpatient prospective payment system but wish to reclassify to a higher wage area for purposes of receiving a higher payment rate.

Medicare Hospital Insurance Tax – A tax under the Federal Insurance Contributions Act that is a U.S. payroll tax imposed by the Federal government on employees and employers to fund Medicare.

Medicare Payment Advisory Commission (MedPAC) – The Medicare Payment Advisory Commission is a nonpartisan legislative branch agency that provides the U.S. Congress with analysis and policy advice on the Medicare program.

Medicare Prescription Drug Donut Hole – Most plans with Medicare prescription drug coverage (Part D) have a coverage gap called a donut hole. This means that after a covered person and their drug plan have spent a certain amount of money for covered drugs, the covered individual has to pay all costs out-of-pocket for your prescriptions up to a yearly limit. Once they have spent up to the yearly limit, the coverage gap ends and the drug plan helps pay for covered drugs again.

Medicare-severity DRGs (MS-DRGs) – A refinement of the DRG classification system to more fairly compensate hospitals for treating severely ill Medicare patients by adding more DRGs to account for major complications and co-morbidity.

Medicare-supplement Policy – Health insurance policy that provides benefits for services Medicare does not cover. *See Medigap Insurance.*

Medigap Insurance – Privately purchased individual or group health insurance policies designed to supplement Medicare coverage. Benefits may include payment of Medicare deductibles, coinsurance and balance bills, as well as payment for services not covered by Medicare.

Member – The person enrolled in a health plan.

Merger – Union of two or more organizations by the transfer of all assets to one organization that continues to exist while all others are dissolved.

Methicillin-resistant Staphylococcus Aureus (MRSA) – A staph bacteria resistant to many antibiotics that can cause life-threatening infections. It is usually caused by contact with an infected wound, or contaminated hands or devices.

Metropolitan Statistical Area (MSA) – A geographic area that includes as least one city with 50,000 or more inhabitants, or a Census Bureau-defined urbanized area of at least 50,000 inhabitants and a total MSA population of at least 100,000 (75,000 in New England).

Mid-level Practitioner (MLP) – The term mid-level practitioner is defined by the Drug Enforcement Administration as an individual practitioner, other than a physician, dentist, veterinarian, or podiatrist, who is licensed, registered, or otherwise permitted by the U.S. or the jurisdiction in which he/she practices, to dispense a controlled substance in the course of professional practice.

Minimum Essential Coverage – The type of coverage a person needs to have to meet the individual responsibility requirement under the Affordable Care Act.

Mission Statement – A goal statement developed by health care organizations to provide direction and define purposes and objectives of the organization.

Mobile Health Services – Vans and other vehicles used to deliver primary care services.

Morbidity – The Centers for Disease Control and Prevention defines morbidity as any departure, subjective or objective, from a state of physiological or psychological well-being. In practical language, morbidity comprises disease, injury, and disability.

Mortality – Incidence of death in a defined population.

Multidisciplinary Team – An approach to caring for the patient that involves a multidisciplinary team of professionals with the goal of providing comprehensive, integrated care. The team often includes a physician, nurse and social worker and, may also include an occupational, physical, speech or respiratory therapist, a chaplain, dietician or a psychiatrist or psychologist.

Multi-Hospital System – Two or more hospitals owned, leased, contract managed or sponsored by a central organization. They can be either nonprofit or investor-owned hospitals.

Multi-institutional System – An organization affiliation among two or more health care organizations. Multi-institutional systems may be vertically or horizontally integrated. The tie among the institutions can be through ownership, lease, contract management and vertical integration.

Multispecialty Group – A physician practice environment where diverse fields of medicine may converge to bring patients and purchasers a more unified and comprehensive service package.

National Association of Insurance Commissioners (NAIC) – The national group of state officials who regulate insurance practices in each states.

National Committee for Quality Assurance (NCQA) – The National Committee for Quality Assurance is an independent nonprofit organization that works to improve health care quality through the administration of evidence-based standards, measures, programs and accreditation. NCQA also tracks the quality of care delivered nationwide by health plans.

National Drug Code (NDC) – The identifying number for medicines maintained by the Food and Drug Administration.

National Incident Management Systems (NIMS) – A nationwide systematic framework designed to guide departments and agencies at all levels of government, nongovernmental organizations, and the private sector to work together seamlessly and manage incidents involving all threats and hazards, regardless of cause, size, location or complexity.

National Institutes of Health (NIH) – Agency of the U.S. Department of Health and Human Services responsible for the nation's medical research.

National Labor Relations Board (NLRB) – The NLRB is an independent federal agency enforcing the National Labor Relations Act, which guarantees the right of most private sector employees to organize, to engage in group efforts to improve their wages and working conditions, determine whether to have unions as their bargaining representative, engage in collective bargaining and to refrain from any of these activities. It acts to prevent and remedy unfair labor practices committed by private sector employers and unions.

National Patient Safety Goals – National Patient Safety Goals are a series of specific actions that Joint Commission-accredited organizations are required to take in order to prevent medical errors such as miscommunication among caregivers, unsafe use of infusion pumps and medication mix-ups.

National Practitioner Data Bank (NPDB) – An electronic information repository created by the U.S. Congress that contains information on medical malpractice payments and certain adverse actions related to health care practitioners, entities, providers and suppliers. Established by Congress in 1986, it is a workforce tool that prevents practitioners from moving state to state without disclosure or discovery of previous damaging performance. This information is not made available to the public.

National Program of Cancer Registries – Administered by the CDC, this program collects data on the occurrence of cancer, the type of treatment conducted and the outcome.

National Provider Identifier (NPI) – Required by HIPAA, this is a unique 10-digit identification number assigned by CMS to each covered health care provider to use for billing purposes.

National Quality Forum – A membership-based organization that works to improve health care by establishing national priorities and goals, creating quality standards and continuously driving improvement among health care leaders.

Neonatal or Neonate – The part of an infant's life from the hour of birth through 27 days, 23 hours and 59 minutes. The infant is referred to as a newborn throughout this period.

Neonatal Intensive Care (NICU) – A unit that must be separate from the newborn nursery, providing intensive care to all sick infants including those with the very lowest birth weights (less than 1,500 grams). NICU has potential for providing mechanical ventilation, neonatal surgery and special care for the sickest infants. A full-time neonatologist serves as director of the NICU.

Neonatal Intermediate Care – A unit that must be separate from the normal newborn nursery and that provides intermediate or recovery care and some specialized services, including immediate resuscitation, intravenous therapy and capacity for prolonged oxygen therapy and monitoring.

Net Loss Ratio – A measure of a plan's financial stability, derived by dividing its medical costs and other expenses by its income form premiums.

Net Patient Revenue – The estimated net realizable amounts from patients, third-party payers and others for services rendered. The number includes estimated retroactive adjustments called for by agreements with third-party payers. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and then adjusted later as final settlements are determined.

Net Total Revenue – Net patient revenue plus all other revenue, including contributions, endowment revenue, governmental grants and all other payments not made on behalf of individual patients.

Network – A group of providers, typically linked through contractual arrangements, which provide a defined set of benefits.

Neurological Services – Services provided by the hospital dealing with the operative and nonoperative management of disorders of the central, peripheral and autonomic nervous system.

New Plan – Used in connection with the Affordable Care Act: A health plan that is not a grandfathered health plan and therefore subject to all of the reforms in the Affordable Care Act.

Non-contributory Plan – A group insurance plan that requires no payment from employees for their health care coverage.

Nondiscrimination – A requirement that job-based coverage not discriminate based on health status. Coverage under job-based plans cannot be denied or restricted. Job-based plans can restrict coverage based on other factors such as part-time employment that aren't related to health status.

Nongovernment, Nonprofit – Hospitals that are nongovernment, nonprofit are controlled by nonprofit organizations, including religious organizations (Catholic hospitals, for example), fraternal societies and others.

Nonparticipating Physician – A physician who does not sign a participation agreement and, is not obligated to accept assignment on all Medicare claims.

Nosocomial Infection – Infections acquired from a health care setting, also called hospital-associated infections. The patient must not have shown any symptoms of this infection upon being admitted to the hospital in order for it to be classified as such.

Non-for-profit Hospital – A nonprofit hospital is owned and operated by a private corporation whose excess of income over expenses is used for hospital purposes rather than returned to stockholders or investors as dividends. Sometimes referred to as a voluntary hospital. It is exempt from federal and state taxes and is required to report community benefits offered by the facility.

Nuclear Magnetic Resonance (NMR) Imaging – A diagnostic tool using visualization of cross-sectional images of body tissue and strong static magnetic and radio-frequency fields to monitor body chemistry non-invasively.

Nuclear Medicine – The use of radioisotopes to study and treat disease, especially in the diagnostic area.

Nurse Practitioner (NP) – All NPs must complete a master's or doctoral degree program and have advanced clinical training beyond their initial professional registered nurse preparation. Didactic and clinical courses prepare nurses with specialized knowledge and clinical competency to practice in primary care, acute care and long-term health care settings. NPs are qualified to prescribe medicine, order tests, conduct physical examinations and procedures and provide treatment.

Nursing Home – A health facility with inpatient beds and an organized professional staff that provides continuous nursing and other health-related, psychosocial and personal services to patients who are not in an acute phase of illness but who primarily require continued care on an inpatient basis.

Nursing Levels of Education – Designations of nursing education and proficiency. They are: licensed vocational or practical nurse (LVN or LPN); associate degree in nursing (A.D.N.); registered nurse (RN); Bachelor of Science in Nursing (B.S.N.); Master of Science in Nursing (M.S.N.); Doctor of Philosophy in Nursing (Ph.D.); and Doctor of Nursing Practice (D.N.P.).

Nursing-home-type Unit/Facility – A unit/ facility that primarily offers the following type of services to a majority of all admissions:

- **Skilled nursing:** The provision of medical and nursing care services, health-related services, and social services under the supervision of a registered nurse on a 24-hour basis.
- **Intermediate care:** The provision, on a regular basis, of health-related care and services to people who do not require the degree of care or treatment that a skilled nursing unit is designed to provide.
- **Personal care:** The provision of general supervision and direct personal care services for residents who require assistance in activities of daily living but not need nursing services or inpatient care. Medical and nursing services are available as needed.
- **Sheltered/residential care:** The provision of general supervision and protective services for residents who do not need nursing services or continuous personal care services in the conduct of daily life. Medical and nursing services are available as needed.

Nutrition Programs – Those services in a health care facility which are designed to provide inexpensive, nutritionally sound meals to patients.

Obstetrics – Levels should be designated: (1) unit provides services for uncomplicated maternity and newborn cases; (2) unit provides services for uncomplicated cases, the majority of complicated problems, and special neonatal services; and (3) unit provides services for all serious illnesses and abnormalities and is supervised by a full-time maternal/fetal specialist.

Occupancy – The inpatient census, generally expressed as a percentage of total beds which are occupied at any given time.

Occupational Health Services – Includes services designed to protect the safety of employees from hazards in the work environment.

Occupational Safety and Health Administration (OSHA) – Agency of the U. S. Department of Labor charged with making sure that workplaces are safe and healthy. Primary responsibilities include establishing rules, monitoring compliance through inspection and enforcing rules through penalties and fines for non-compliant organizations.

Occurrence Coverage – A common insurance policy type offered by medical malpractice insurance companies that responds to events that occur during the policy period regardless of when the claim is made.

Office for Civil Rights (OCR) – Division of the U.S. Department of Health and Human Services responsible for protecting fundamental nondiscrimination and health information privacy rights through the federal civil rights laws and HIPAA.

Office for the Advancement of Telehealth (OAT) – Federal office that is part of the Office of Rural Health Policy in the Health Resources and Services Administration created to promote the wider adoption of advanced technologies to provide health care services and education. Because the use of telecommunications and information technologies is especially important in rural areas that do not have access to specialty care, this office also provides funds that help support the use of these services.

Office of Inspector General (OIG) – Division of the U.S. Department of Health and Human Services responsible for fighting waste, fraud and abuse in Medicare, Medicaid and more than 100 other HHS programs.

Office of Management and Budget (OMB) – Located in the Executive Office of the President of the U.S., the OMB is the largest office that implements and enforces presidential policy throughout the government. OMB is charged with compiling the president's budget, managing government agencies, coordinating federal regulations, reviewing agency communications with Congress and creating executive orders and presidential memoranda.

Office Visit – An outpatient visit to a physician for routine care or care related to illness or injury.

Ombudsperson or Ombudsman – Person designated to receive and investigate complaints from beneficiaries about quality of care, inability to access care, discrimination and other issues.

Omnibus Budget Reconciliation Act (OBRA) – Congress refers to this as the many tax and budget reconciliation acts. Most of these acts contain language important to managed care, generally in the Medicare market segment.

Oncology Services – Inpatient and outpatient services for patients with cancer, including comprehensive care, support, and guidance, patient education, prevention, chemotherapy, counseling and other treatment methods.

Online Survey, Certification and Reporting (OSCAR) – The Online Survey Certification and Reporting (OSCAR) system was an administrative database of the Centers for Medicare and Medicaid Services for many years. Effective in 2012, the OSCAR system was replaced by the Certification and Survey Provider Enhanced Reporting (CASPER) system and the Quality Improvement Evaluation System (QIES).

Open Enrollment Period – Time each year during which people can enroll in a health insurance plan through the federal insurance exchange or Medicare. Employers also may have open enrollment periods during which employees and their dependents may enroll in a plan or change plans.

Open Medical Staff – Opening of hospital medical staff membership to all physicians in the community who meet membership and clinical privilege requirements.

Open Panel – A right included in an HMO, which allows the covered person to get non-emergency covered services from a specialist without getting a referral from the primary care physician or gatekeeper.

Open Physician Hospital Organization (Open PHO) – A joint venture between the hospital and all members of the medical staff who wish to participate. The open PHO can act as a unified agent in managed care contracting, own a managed care plan, own and operate ambulatory care centers or ancillary services projects or provide administrative services to physician members.

Open Staff – As applied to the medical staff as a whole, an agreement under which physicians provide administrative and clinical services to a hospital on a nonexclusive basis.

Operating Budget – Financial plan for the expected revenues and expenditures of day-to-day operations of the hospital. It is a combination of known expenses and expected costs as well as forecasted income over the course of a year.

Operating Margin – A financial measure of profitability calculated by dividing the income from operations by the total operating revenue and multiplying it by 100.

Opportunity Cost – The cost of a lost opportunity; that is, the value given up by using a resource in one way instead of in an alternative, better way.

Optical Colonoscopy – An examination of the interior of the colon using a long, flexible, lighted tube with a small built-in camera.

Organ Procurement Organization (OPO) – Local organizations throughout the U.S. designated by the Centers for Medicare and Medicaid Services are responsible for increasing the number of registered donors in their service areas, and for coordinating the donation process when actual donors become available.

Organized Health Care Arrangement (OHCA) – A recognized relationship under the HIPAA privacy rules that allow two or more covered entities working with the same patients to share protected health information in order to manage and benefit their joint operations. These organizations must be clinically or operationally aligned.

Orthopedic Services – Services provided for the prevention or correction of injuries or disorders of the skeletal system and associated muscles, joints and ligaments.

ORYX – Initiative of The Joint Commission that integrates the reporting of performance measurement data into the accreditation process. Organizations have flexibility in choosing the minimum six different measure sets they must report. The data collected in this program are shared publicly to allow for user comparisons.

Osteopathic Medicine – Osteopathic medicine provides all of the benefits of modern medicine including prescription drugs, surgery and the use of technology to diagnose disease and evaluate injury. It also offers the added benefit of hands-on diagnosis and treatment through a system of treatment known as osteopathic manipulative medicine. Osteopathic medicine emphasizes helping each person achieve a high level of wellness by focusing on health promotion and disease prevention.

Other Intensive Care – A specially staffed, specialty equipped, separate section of a hospital dedicated to the observation, care and treatment of patients with life threatening illnesses, injuries, or complications from which recovery is possible. This type of care often focuses on a particular specialty, such as neuroscience or cardiovascular.

Other Long-term Care – Provision of long-term care other than skilled nursing care or intermediate care for those who do not require daily medical or nursing services, but may require some assistance in the activities of daily living. This can include residential care, elderly care, or sheltered care facilities for developmentally disabled.

Other Special Care – Provides care to patients requiring care more intensive than that provided in the acute area, yet not sufficiently intensive to require admission to an intensive care unit. These units are sometimes referred to as definitive observation, step-down or progressive care units.

Out of Area – A place where the plan will not pay for services or benefits. Out of area can refer to geographical location as well as to benefits or services outside a specific group of providers.

Outcome and Assessment Information Set (OASIS) – Data elements developed for the purpose of performance improvement in home health care to measure individual patient outcomes and to identify opportunities to improve performance and patient satisfaction. Home health agencies must comply with OASIS collection and transmission requirements to become Medicare certified as mandated by the Medicare conditions of participation.

Outcomes – The end result of health care that is usually measured in terms of cost, mortality, health status, quality of life or patient function.

Outcomes Measurement – The process of systematically tracking a patient's clinical treatment and responses to that treatment using generally accepted and pre-defined outcome measures or quality indicators.

Outcomes Research – Investigation and evaluation research designed to determine the relative effectiveness of specific treatments for specific health conditions.

Outliers – Cases with extremely long lengths of stay (day outliers) or extraordinarily high costs (cost outliers) compared with others classified in the same diagnosis-related group. Hospitals receive additional payment for these cases.

Out-of-network Services – Health care services received by a plan member from a non-contracted provider. Reimbursement is usually lower when a member goes out of the network, and other financial penalties may apply.

Out-of-pocket Expense or Costs – Payments made by an individual for medical services. These may include direct payments to providers, payments for deductibles and coinsurance for covered services, services not covered by the plan, provider charges in excess of the plan's limits for enrollee premium payments.

Out-of-pocket Limit – The total amount of money, including deductibles, copayments and coinsurance, as defined in the contract, that plan members must pay out of their own pockets toward eligible expenses for themselves or dependents. Typically the insurer will pay for charges above and beyond the out-of-pocket limit.

Out-of-pocket Payments – Cash payments made by a plan member or insured person to the provider in the form of deductibles, coinsurance or copayments during a defined period (usually a calendar year) before the out-of-pocket limit is reached.

Outpatient Care – Treatment provided to patients who do not remain in the hospital for overnight care. Hospitals may deliver outpatient care on site or through a facility owned and operated by the hospital, but physically separate from the hospital.

Outpatient Care Center (Freestanding) – A facility owned and operated by the hospital, but physically separate from the hospital that provides various medical treatments on an outpatient basis only. In addition to treating minor illnesses or injuries, the center will stabilize seriously ill or injured patients before transporting them to a hospital. Laboratory and radiology services are usually available.

Outpatient Care Center or Services (Hospital-based) – Organized hospital health care services offered by appointment on an ambulatory basis. Services may include outpatient surgery, examination, diagnosis and treatment of a variety of medical conditions on a nonemergency basis, and laboratory and other diagnostic testing as ordered by staff or outside physician referral.

Outpatient Prospective Payment System (OPPS) – Method of financing health care that defines payments in advance for the provision of outpatient services and is based on the ambulatory payment classification.

Outpatient Surgery – Scheduled surgical services provided to patients who do not remain in the hospital overnight.

Outpatient Visit – A visit by a patient who is not lodged in the hospital while receiving medical, dental, or other services.

Over-the-counter (OTC) Drugs – Drugs sold without a prescription from a health care provider. Examples include medications for treatment of mild pain, fever or laxatives.

Paid Claims – The funds that health insurance plans pay to providers for approved services rendered. They do not include the patient's portion of those services.

Paid Claims Loss Ratio – The ratio of paid claims to premiums as a measure of a health plan's financial performance.

Pain Management Program – A recognized clinical service or program providing specialized medical care, drugs or therapies for the management of acute or chronic pain or other distressing symptom, administered by specially trained physicians and other clinicians, to patients suffering from acute illness of diverse causes.

Palliative Care – Specialized medical care for people with a serious illness focused on relieving suffering and improving the quality of life. Palliative care consists of pain management and emotional and spiritual support from a team of caregivers.

Palliative Care Inpatient Unit – An inpatient palliative care ward is a physically discreet, inpatient nursing unit where the focus is palliative or comfort care rather than a focus on cure of the disease. The patient care focus is on symptom relief for complex patients who may be continuing to undergo primary treatment. Care is delivered by palliative medicine specialists.

Palliative Care Program – An organized program providing specialized medical care, drugs or therapies for the management of acute or chronic pain or the control of symptoms administered by specially trained physicians and other clinicians. Provides supportive care services counseling on advance directives, spiritual care and social services to patients with advanced disease and their families.

Part A Medicare – Medical Hospital Insurance under Part A of Title XVIII of the Social Security Act, which covers beneficiaries for inpatient hospital, home health, hospice and limited skilled nursing facility services. Beneficiaries are responsible for deductibles and copayments. Part A services are financed by the Medicare HI Trust Fund, which consists of Medicare tax payments.

Part B Medicare – Medicare Supplementary Medical Insurance under Part B of Title XVII of the Social Security Act, which covers Medicare beneficiaries for physician services, medical supplies and other outpatient treatment. Beneficiaries are responsible for monthly premiums, copayments, deductibles and balance billing. Part B services are financed by a combination of enrollee premiums and general tax revenues.

Part C Medicare – A Medicare Advantage Plan (like an HMO or PPO) is another Medicare health plan choice a beneficiary may have as part of Medicare. Medicare Advantage Plans, sometimes called “Part C” or “MA Plans,” are offered by private companies approved by Medicare. If a beneficiary joins a Medicare Advantage Plan, the plan will provide all of Part A and Part B coverage. Medicare Advantage Plans may offer extra coverage, such as vision, hearing, dental, or health and wellness programs. Most include Medicare prescription drug coverage. Medicare pays a fixed amount for the care every month to the companies offering Medicare Advantage Plans. These companies must follow rules set by Medicare.

Part D Medicare – Medicare Supplementary Medical Insurance under Part D of Title XVII of the Social Security Act, which covers prescription drugs as enacted by the Medicare Modernization Act of 2006.

Partial Capitation – An insurance arrangement where the payment made to a health plan is a combination of a capitated premium and payment based on actual use of services. The proportions specified for these components determine the insurance risk faced by the plan.

Participating Physician or Provider – A physician or other provider who signs a Medicare participation agreement, agreeing to accept assignment on all Medicare claims for one year, or those who are under contract with a health plan to provide services.

Patient Advocate – A person who supports a patient as they navigate the health care system, andinvestigates and mediates patients’ problems and complaints regarding a health care provider’s services.

Patient Care Team – A multidisciplinary team organized under the leadership of a physician with each member of the team having specific responsibilities and the entire team contributing to the care of the patient.

Patient-centered Outcomes Research – Research that compares different medical treatments and interventions to provide evidence on which strategies are most effective in different populations and situations.

Patient Days – The number of calendar days of care provided to a hospital inpatient under the terms of the patient’s health plan, excluding the day of discharge.

Patient Dumping – The refusal to examine, treat, and stabilize any person irrespective of payer or class who has an emergency medical condition or is in active labor or contractions, once that person has been presented at a hospital emergency room or emergency department. A statutorily imposed liability occurs when a hospital capable of providing the necessary medical care transfers a patient to another facility or simply turns the patient away because of the patient’s inability to pay for services.

Patient Education Center – Written goals and objectives for the patient or family related to therapeutic regimens, medical procedures and self care. An example is a diabetes education center.

Patient Experience – Patient experience encompasses the range of interactions that patients have with the health care system, including their care from health plans, doctors, nurses, and staff in hospitals, physician practices and other health care facilities.

Patient Mix – The numbers and types of patients served by a hospital or health program, classified according to their home, socioeconomic characteristics, diagnosis or severity of illness.

Patient Protection and Affordable Care Act (PPACA) – Also known as the Affordable Care Act, this federal legislation was passed in March 2010, and contains major new health reform provisions.

Patient Representative – A person who investigates and mediates patients’ problems and complaints in relation to a hospital’s services or health plan’s coverage. Also called a patient advocate or patient ombudsman. This may be an organized hospital service.

Patient Safety and Quality Improvement Act (PSQIA) – The Patient Safety and Quality Improvement Act of 2005 (PSQIA) established a voluntary reporting system designed to enhance the data available to assess and resolve patient safety and health care quality issues.

Patient Safety Organization (PSO) – A collaboration of health care organizations that share in the goal of improving the safety and quality of health care delivery by learning from one another through the voluntary confidential sharing of privileged information in a legally secure environment.

Patient Satisfaction Survey – A questionnaire or survey used to solicit the perceptions of patients about the overall experience of care.

Patient Self-determination Act – Federal law that requires health care facilities to inform patients of their rights in deciding their medical care, determine if a patient has an advance directive such as a living will or medical power of attorney and consider patients' wishes - including those stated in an advance directive - in the development of treatment plans.

Patient's Rights – Guidelines that inform patients of their rights and responsibilities concerning their own health care, such as privacy and confidentiality.

Pay for Performance – A health care 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.

Payer (or Payor) – Any agency, insurer or health plan that pays for health care services and is responsible for the costs of those services, such as Medicare, Medicaid or a third-party payer (e.g. Blue Cross Blue Shield).

Payment Bundling – The Bundled Payments for Care Improvement Advanced (BPCI Advanced) Model is a new iteration of the Centers for Medicare and Medicaid Services (CMS) and the Center for Medicare and Medicaid Innovation (Innovation Center) continuing efforts in implementing voluntary episode payment models. The Model aims to support health care providers who invest in practice innovation and care redesign to better coordinate care, improve quality of care, and reduce expenditures, while improving the quality of care for Medicare beneficiaries.

Payment Rate – The total amount paid for each unit of service rendered by a health care provider, including both the amount covered by the insurer and the consumer's cost sharing. Sometimes referred to as payment level. *See Allowed Change.*

Payroll Expenses – Expense category that includes all salaries and wages. All professional fees and salary expenditures excluded from payroll, such as employee benefits, are defined as nonpayroll expenses and are included in total expenses.

Pediatric Cardiac Surgery – Cardiac surgery performed on children under age 18 that includes minimally invasive procedures, such as through a laparoscope or an endoscope and more invasive major surgical procedures that include open chest and open heart surgery.

Pediatric Cardiology Services – An organized clinical service offering diagnostic and interventional procedures to manage the full range of pediatric heart conditions.

Pediatric Diagnostic/Invasive Catheterization – A diagnostic procedure used to assist in diagnosing complex heart conditions in children.

Pediatric Intensive Care – Intensive care provided to pediatric patients that is of a more intensive nature than that usually provided. The unit is staffed with specially trained personnel and contains monitoring and specialized support equipment for treatment of patients who, because of shock, trauma or other life-threatening conditions, require intensified, comprehensive observation and care.

Pediatric Interventional Cardiac Catheterization – Non-surgical procedure that utilizes the same basic principles as diagnostic catheterization, then uses advanced techniques to improve the heart's function. It can be a less-invasive and less risky alternative to open-heart surgery.

Pediatric Medical-surgical Care – Acute care provided to pediatric patients on the basis of physicians' orders and approved nursing care plans.

Peer Review – Evaluation conducted by practicing physicians or other clinical professionals of the quality, appropriateness, effectiveness and efficiency of medical services ordered or performed by other practicing physicians or clinical professionals.

Peer Review Organization (PRO) – An independent organization contracted with CMS to review the medical necessity and quality of care provided to Medicare beneficiaries. PROs also conduct limited review of medical records and claims to evaluate the appropriateness of care provided.

Penalty – Required by the Affordable Care Act, a fee that must be paid if a person family chooses not to purchase health insurance. The penalty is calculated by either a percentage of household income or a rate per person - whichever one is higher.

Percent of Poverty – A term that describes the income level a person or family must have to be eligible for Medicaid.

Per Diem Cost – Refers to hospital or other inpatient institutional costs per day or for a day of care. Hospitals occasionally charge for their services on the basis of a per diem rate.

Per Diem Payments – Fixed daily payments that do not vary with the level of services used by the patient. This method generally is used to pay institutional providers, such as hospitals and nursing facilities. *See also Capitation.*

Per Member Per Month (PMPM) – The amount of money a health plan or provider receives per person every month. It is a way of calculating income and levels of payment. Also called per subscriber per month (PSPM) or per contract per month (PCPM).

Performance Measure – A quantitative tool (e.g., rate, ratio, index percentage) that indicates an organization's performance in relation to a specified process or outcome. This can be a comparative indicator such as a benchmark.

Performance Standards – Standards set by management or a payer that the provider will need to meet in order to maintain its credentialing, renew its contract, receive incentives or avoid penalty.

Personal Health Record (PHR) – A personal health record contains an individual patient's electronic health information. It is designed to be set up, accessed and managed by patients. A personal health record should meet the technical rules that ensure that it can be shared between, hospitals, doctors' offices, and clinics.

Personnel – Number of people on the hospital payroll at the end of the reporting period. Personnel are recorded in hospital statistics as full-time equivalents, which are calculated by adding the number of full-time personnel to one-half the number of part- time personnel, excluding medical and dental residents, interns and other trainees.

Pharmacy Benefit Management – Administration of prescription drug programs. This involves a third-party organization that negotiates price discounts and rebates on drugs to reduce expenditures, and provides information to participants about ways they can control prescription costs.

Physical Rehabilitation Inpatient Care – Inpatient care encompassing a comprehensive array of restoration services for the disabled, and all support services necessary to help patients attain their maximum functional capacity.

Physical Rehabilitation Outpatient Services – Outpatient program providing medical, health-related, therapy, social or vocational services to help disabled people attain or retain their maximum functional capacity.

Physician Assistant (PA) – A trained, licensed person who can perform similar duties of a physician, such as diagnosis and treatment of common ailments, but who must practice under the supervision of one or more supervising physicians and, if prescribing drugs, must have a prescriptive delegation agreement with the supervising physician(s).

Physician Credentialing – Originally, referred only to the process of verifying that a physician had the appropriate credentials to practice in the hospital. Today, the term refers more broadly to the entire process, delegated by the board to the medical staff, of medical staff appointment, reappointment, and delineation of clinical privileges. The board has ultimate accountability for physician credentialing.

Physician Extender – A health professional, such as a nurse or health educator, who works with patients to make the patient's time with the physician more efficient and productive.

Physician Organization (PO) – A practice of two or more physicians representing one or more specialties to provide health care services and negotiate on behalf of its members to accept managed care or discounted fee-for-service contracts. Also referred to as a physician practice or group practice.

Physician Payment Review Commission (PPRC) – Independent legislative advisory group created in 1986 to provide advice to the U.S. Congress on reforms in the methods used to pay physicians in the Medicare program.

Physician/Hospital Organization (PHO) – A structure in which a hospital and physicians - both in individual and group practices - negotiate as an entity directly with insurers. Also an organization that contracts with payers on behalf of one or more hospitals and affiliated physicians. The PHO may also undertake utilization review, credentialing, and quality assurance. Physicians retain ownership of their own practices, maintain significant business outside the PHO, and typically continue in their traditional style of practice.

Plan Administration – The management unit with responsibility to run and control a managed care plan. Responsibilities can include billing, personnel management, marketing, legal, purchasing, facility maintenance and account services.

Plan Year/Policy Year – A 12-month period of benefits coverage under a group health plan. This 12-month period may not be the same as the calendar year.

Point of Service (POS) Plans – A managed care insurance plan that allows patients to pay less for care if they use health care providers that fall within the plan's network. Additionally, this plan requires referral from a designated primary care doctor in order for a patient to see a specialist.

Population – Population refers to the residential population of the U.S.. This includes both civilian and military personnel. Note that population is being used to calculate the values for community health indicators per 1000 population.

Population Profile – A statistical summary of population-specific health care data used to assess health care delivery.

Portability – A person's ability to continue health insurance coverage when changing a job or residence without a waiving period or having to meet additional deductible requirements.

Positron Emission Tomography (PET) – An nuclear imaging technique that tracks metabolism and responses to therapy used in cardiology, neurology and oncology. It is particularly effective in evaluating brain and nervous system disorders.

Postnatal Care – Health care services received by a woman immediately following the delivery of her child.

Potentially Preventable Admissions (PPA) – A hospital stay that could have been avoided had there been access to ambulatory care or the correct health care coordination.

Potentially Preventable Complications (PPC) – A harmful event or negative outcome with respect to a person, including an infection or surgical complication, that occurs after the person's admission to an inpatient acute-care hospital and may have resulted from the care, lack of care, or treatment provided during the hospital stay rather than from a natural progression of an underlying disease.

Potentially Preventable Readmissions (PPR) – A return hospital admission shortly after discharge (usually within 30 days) as a result of problems from the previous hospitalization or a lack of appropriate follow-up.

Practice Guidelines – Systematically developed statements on medical practices that assist a practitioner in making decisions about appropriate health care for specific medical conditions. Managed care organizations frequently use these guidelines to evaluate appropriateness and medical necessity of care. Also called practice parameters.

Practice Pattern – The manner in which an individual provider uses medical resources to treat patients. Increasingly, managed care organizations and hospitals are monitoring physician practice patterns in an attempt to lower utilization of medical services.

Preadmission Certification – Process in which a health care professional evaluates an attending physician's request for a patient's admission to a hospital by using established medical criteria.

Pre-authorization – The process where, before a patient can be admitted to the hospital or receive other types of specialty services, the managed care company must approve of the proposed service in order to cover it.

Predictive analytics – Using different statistical techniques to look at historical data and assess the likelihood of future events based on that data.

Pre-existing Condition – A physical or mental condition that an insured patient is diagnosed with prior to the effective date of coverage. Under the Affordable Care Act, insurers can no longer deny coverage to people based on pre-existing conditions.

Pre-existing Condition Exclusion Period (Job-Based Coverage) – The time period during which a health plan won't pay for care relating to a pre-existing condition. Under a job-based plan, this cannot exceed 12 months for a regular enrollee or 18 months for a late-enrollee.

Pre-existing Condition Exclusion Period (Individual Policy) – The time period during which an individual policy won't pay for care relating to a pre-existing condition. Under an individual policy, conditions may be excluded permanently (known as an "exclusionary rider"). Rules on pre-existing condition exclusion periods in individual policies vary widely by state.

Preferential Discounts – Reimbursements to health care providers from insurance companies and other payers based on negotiated discounts off of providers' regular charges.

Preferred Provider Organization (PPO) – A pre-set arrangement in which purchasers and providers agree to furnish specified health services to a group of employees or patients. By receiving care from network providers, consumers receive a discounted rate and do not pay out-of-network costs. PPOs do not require plan members to select a primary physician but do allow plan members to see a specialist without a referral.

Premium – The money paid for insurance. Often, both employers and employees pay a premium.

Premium Cap – The maximum amount of money an insurance company can charge for coverage.

Premium Subsidies – A fixed amount of money or a designated percentage of the premium cost that is provided to help people purchase health coverage. Premium subsidies are usually provided on a sliding scale based on a person's or family's income.

Premium Tax – A state tax on insurance premiums.

Prepaid Group Practice Plan – A health maintenance organization under which specified health services are paid in advance and rendered by participating physicians. Enrollees make fixed periodic payments in advance or an insurance carrier contracts to pay in advance for the full range of health services.

Prepayment – Method of reimbursing or providing payment of health care services in advance of their use.

Present on Admission – A patient's current diagnosis upon arriving at a hospital. The pre-existing state of the patient must be reported to CMS. Hospitals can be penalized for conditions that appear upon discharge that were not there upon admission, such as infections or pressure ulcers.

Prevention or Preventive Health Care – Actions taken to reduce susceptibility or exposure to health problems (primary prevention), detect and treat disease in early stages (secondary prevention) or alleviate the effects of disease and injury (tertiary prevention).

Primary Care – A basic level of health care provided by the physician from whom an individual has an ongoing relationship and who knows the patient's medical history. Traditionally, primary care physicians are family physicians, internists, gynecologists and pediatricians.

Primary Care Department – A unit or clinic within the hospital that provides primary care services (e.g. general pediatric care, general internal medicine, family practice, gynecology) through hospital-salaried medical or nursing staff, focusing on evaluating and diagnosing medical problems and providing medical treatment on an outpatient basis.

Primary Care Network (PCN) – A group of primary care physicians who share the risk of providing care to members of a managed care plan.

Primary Care Physician or Provider (PCP) – A physician who treats a variety of health problems across patient age groups on a continual basis and frequently serves as the patient's first point of contact with the health care system. Primary care providers may be internal medicine physicians, obstetricians/gynecologists, pediatricians, physician assistants or nurses.

Principal Diagnosis – An ICD-10-CM diagnosis established after study as being chiefly responsible for occasioning the admission of a patient to the hospital for care. Also referred to as the principal inpatient diagnosis.

Prior Authorization – A cost-control procedure that requires a service or medication to be approved in advance by the doctor or the insurer.

Private Insurance – Health insurance that is provided by insurance companies such as commercial insurers and Blue Cross plans, self-funded plans sponsored by employers, HMOs or other managed care arrangements.

Private Inurement – When a nonprofit business operates in such a way as to provide more than incidental financial gain to a private individual, a practice frowned upon by the IRS.

Private Practice – A traditional arrangement wherein physicians are not employees of any entity and generally treat a variety of patients in terms of their payment sources.

Privileges – Prerogatives of licensed health professionals such as physicians, nurse practitioners or dentists to provide medical or other patient care services in the granting institution, within well-defined limits, based on the clinicians' professional license, experience, competence, ability and judgment. Also referred to as clinical privileges, medical staff privileges, this permission is granted by a governing board.

Product Lines – Groups of related business activities. A hospital's product line might be as broad as cardiac care or surgical care, or as specific as care by DRG or product code.

Productivity – The relationship between service input and output.

Professional Liability Insurance – The insurance physicians or other professionals such as nurses or dentists purchase to help protect themselves from the financial risks associated with medical liability claims.

Professional Standards Review (PSRO) – Physician-sponsored organization charged with reviewing the services provided to patients who are covered by Medicare, Medicaid and maternal and child health programs. The purpose of the review is to determine if the services rendered are medically necessary, provided in accordance with professional standards, economically sound and provided in the appropriate setting.

Profitability – A financial ratio that measures the earning power and earning record of a corporation.

Prospective Payment System (PPS) – A prospective payment system (PPS) is a method of reimbursement in which Medicare payment is made based on a predetermined, fixed amount.

Prospective Review – Process in which hospitalization or services are reviewed and authorized prior to administration to determine appropriateness and medical necessity of the proposed level of care.

Prosthetic and Orthotic Services – Services providing comprehensive prosthetic and orthotic evaluation, fitting and training, including the evaluation, fabrication and custom fitting of artificial limbs and orthopedic braces.

Protected Health Information – Individually identifiable health information that is transmitted or maintained in any form or medium (electronic, oral or paper) by a covered entity or its business associates, excluding certain educational and employment records. This includes identifiable demographic and other information relating to the past, present or future physical or mental health or condition of an individual, or the provision or payment of health care to an individual that is created or received by a health care provider, health plan, employer or health care clearinghouse.

Protocols – Standards or evidence-based practices developed to assist health care providers and patients to make decisions about particular steps in the treatment process.

Proton Beam Therapy – A form of radiation therapy which administers proton beams. While producing the same biologic effects as x-ray beams, but is more focused.

Provider – A hospital or health care professional who provides health care services to patients.

Provider Payment Rates – The total payment a provider, hospital, or community health center receives when they provide medical services to a patient.

Provider Reimbursement Review Board – Independent panel to which a certified Medicare provider of services may appeal if it is dissatisfied with a reimbursement decision by its Medicare contractor or by CMS.

Provider-sponsored Network (PSN) – An affiliation of providers (hospital, physician group or health system) that removes third-party or intermediary payers and offers a full range of health care services.

Provider-sponsored Organization (PSO) – A type of managed care plan that is operated by a group of doctors, hospitals and other health care providers that form a network of providers within which a person must stay to receive coverage for care.

Psychiatric Child-adolescent Services – Provides behavioral or mental health care to emotionally disturbed children and adolescents, including those admitted for diagnosis and those admitted for treatment.

Psychiatric Consultation-liaison Services – Provides organized psychiatric consultation/liaison services to nonpsychiatric hospital staff or departments on psychological aspects of medical care that may be generic or specific to individual patients.

Psychiatric Education Services – Provides psychiatric educational services to community agencies and workers such as schools, police, courts, public health nurses, welfare agencies and clergy.

Psychiatric Emergency Services – Services of facilities available on a 24-hour basis to provide immediate unscheduled out-patient care, diagnosis, evaluation, crisis intervention and assistance to people suffering acute emotional or mental distress.

Psychiatric Geriatric Services – Provides care to emotionally disturbed elderly patients, including those admitted for diagnosis and those admitted for treatment.

Psychiatric Inpatient Care – "Provides acute or long-term mental health care to emotionally disturbed patients, including patients admitted for diagnosis and those admitted for treatment of psychiatric problems.

Psychiatric Outpatient Services – Provides mental health care, including diagnosis and treatment, of psychiatric outpatients.

Psychiatric Partial Hospitalization Program – Organized hospital services of intensive day and evening outpatient services of three hours of more duration, distinguished from other outpatient visits of one hour.

Psychiatric Residential Treatment – Overnight psychiatric care in conjunction with an intensive treatment program in a setting other than a hospital.

Public Health – A field that seeks to improve lives and the health of communities through the prevention and treatment of disease and the promotion of healthy behaviors such as healthy eating and exercise.

Public Health Department – A department of a city or county government responsible for protecting and improving the lives of communities through promotion of healthy lifestyles, injury prevention and detection and control of infectious diseases throughout a defined geographic area.

Public Health Service (PHS) – A division of the U.S. Department of Health and Human Services responsible for the health and well-being of the American public by providing services for low-income families and people and battling communicable diseases. PHS' responsibility includes environmental health and clinical health services to prevent the spread of disease.

Public Plan Option – A proposal to create a new insurance plan administered and funded by federal or state government that would be offered along with private plans in a newly-created health insurance exchange.

Purchaser – An employer or company that buys health insurance for its employees.

Purchasing Pool – Health insurance providers pool the health care risks of a group of people in order to make the individual costs predictable and manageable.

Qualified Health Plan – Refers to insurance plans that have been certified as meeting a minimum benchmark of benefits (i.e. the essential health benefits) under the Affordable Care Act.

Quality (Health Care) – The degree to which health services for people and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.

Quality Assessment – An activity that monitors the level of health care (including patient, administrative and support services) provided to patients and compares it to pre-established criteria for professional performance. The medical record is used as documentation of the care provided.

Quality Assurance – The process of providing a desired level of quality care on a consistent basis. Quality assurance includes the continual monitoring and evaluation of current processes to determine consistency or areas of improvement.

Quality Assurance Committee (or Quality Committee) – A committee established by a professional organization or institution to evaluate and ensure the quality of care provided to patients. It can function independently on a range of topics about health care quality.

Quality Improvement Organization – Mostly private, nonprofit organizations staffed by physicians and other health care professionals whose purpose is to review items and services provided to Medicare beneficiaries to determine if services are reasonable and necessary, if they are provided in appropriate settings and if the quality of care is met. The mission of these program is to improve the effectiveness, efficiency, economy and quality of services delivered to Medicare beneficiaries.

Quality Improvement Program (QIP) – A continuing process of identifying problems in health care delivery, and testing and monitoring solutions for constant improvement. These programs are common features of Total quality managemen programs. Their aim is the elimination of variations in health care delivery through the removal of their causes and the elimination of waste through design and redesign processes.

Quality Indicator – A measure of the degree of excellence of the care provided. Common quality indicators of patient outcome are mortality and morbidity, health status, length of stay, readmission rate and patient satisfaction.

Quality Innovation Network – These networks of health care providers collaborate to improve health care services through education, outreach, sharing practices that have worked in other areas, using data to measure improvement, working with patients and families, and convening community stakeholders for communication and collaboration. By serving regions of two to six states each, these networks help best practices for better care spread faster, while still accommodating local conditions and cultural factors.

Quality of Care – The degree to which health care services for people and populations increases the likelihood of desired health outcomes and are consistent with current professional knowledge.

Radiology, Diagnostic – The use of all modalities of radiant energy in medical diagnoses and therapeutic procedures using radiologic guidance. This includes imaging techniques and methodologies using radiation emitted by X-ray tubes, radionnuclides, and ultrasonographic devices and radiofrequency electromagnetic radiation emitted by atoms.

Radiology, therapeutic – Using any of the various sources of radiant energy to diagnose and treat diseases. Services could include: megavoltage radiation therapy; radioactive implants; stereotactic radiosurgery; therapeutic radioisotope facility; and X-ray radiation therapy.

Rapid Response Team – A group of trained health care professionals who respond to hospitalized patients with early signs of clinical deterioration on non-intensive care units to prevent events such as cardiac arrest or respiratory failure.

Rate Review – A process that allows state insurance departments to review rate increases before insurance companies can apply them to patient accounts.

Rate Setting – A method of paying health care providers in which the federal or state government establishes payment rates for payers for various categories of health services.

Reasonable and Customary Charge – A charge for health care is consistent with the going rate or charge in a certain geographical area for identical or similar services.

Recovery Audit Contractor – After a payment is made to identify and correct improper payments to Medicare. Reviews claims on a post-payment basis.

Referral – A written order from a primary care physician to a specialist allowing a patient to seek certain medical services. If a referral is not provided, the health plan may not pay for the services.

Regional Health Information Organization – A type of health information exchange organization that convenes stakeholders within a defined area and governs health information exchange among them for the purpose improve health and care in that community.

Registered Nurse – A graduate from a college or university nursing education program who has met state board requirements and is licensed to practice by the state.

Registry – (1) A database for the incidence of specific diseases, patient demographics, treatment protocols and treatment outcomes for patients with these diagnoses. An example is a tumor registry for patients with cancer. (2) An official list of people with professional standing or credentials in specific health care occupations.

Rehabilitation Facility – A facility that provides medical, health-related, social, or vocational services to disabled people to help them attain their maximum functional capacity.

Rehabilitation Services – An array of restoration services for disabled and recuperating patients, including support services necessary to help them attain their maximum functional capacity.

Reimbursement – The amount paid to providers for services they provide to patients.

Reinstatement – Resumption of coverage under an insurance policy that has lapsed.

Reinsurance – A type of insurance purchased by primary insurers from secondary insurers (reinsurers) to protect against part or all losses the primary insurer might assume in honoring claims of its policyholders. This is also known as excess risk insurance.

Relative Value Scale – An index that assigns weights to each medical service. The weights represent the relative amounts to be paid for each service. The scale to develop Medicare fee schedule consists of three cost components: physician work, practice expense and malpractice expense.

Relative Value Unit – Measure of value used in the Medicare reimbursement formula for physician services. These units are often used in physician practice management to compare performance of physicians in a group.

Reporting Hospital Quality for Annual Payment Update – An initiative that requires hospitals to submit data for specific quality measures for health conditions common among people with Medicare and that typically result in hospitalization. Acutecare hospitals face a reduction of 2% in their annual PPS update for a given year unless they submit certain hospital quality data to CMS.

Rescission – The retroactive cancellation of a health insurance policy. Insurance companies will sometimes retroactively cancel a policy if a mistake is made on the application for an individual market insurance policy. Under the Affordable Care Act, rescission is illegal except for fraud or intentional misrepresentation of material fact as prohibited by the terms of the plan or coverage.

Resident – A medical school graduate participating in a graduate medical education program and receiving professional training under the supervision of a physician. First-year residents typically are referred to as interns.

Resident (Medical) – A physician in training who participates in an accredited program of graduate medical education sponsored by a hospital.

Resource-based Relative Value Scale – A fee schedule for physicians used by Medicare reflecting the value of one service relative to others for the resources required to perform the service.

Respite Care – Temporary relief to people caring for elderly or disabled relatives who require 24-hour care.

Restraint – A physical hold that restricts a patient's movement when the patient's behavior presents a danger to himself, staff or others.

Restricted Funds – Hospital resources that are restricted to particular purposes by donors and other external authorities. These funds are not available for the financing of general operating activities but may be used in the future when certain conditions and requirements are met.

Retirement Housing – A facility that provides social activities to older adults, usually retirees, who do not require health care, but some short-term skilled nursing care may be provided. A retirement center may furnish housing and may have acute hospital and long-term care facilities, or it may arrange for acute and long-term care through affiliated institutions.

Retrospective Reimbursement – Payments made after a service has been provided, such as fee-for-service reimbursement.

Return on Equity – After-tax earnings of a corporation divided by its shareholders' equity. Shareholders' equity is determined by deducting total liabilities and intangible assets from total assets.

Return on Investment – After-tax income for a specified period of time dividend by total assets; a financial tool to measure and relate a corporation's earnings to its total asset base.

Rider – An amendment to an insurance policy. Some riders will add coverage. For example, buying a maternity rider to add coverage for pregnancy to a policy.

Risk – The probable amount of loss foreseen by an insurer in issuing a contract. The term sometimes also applies to the person insured or to the hazard insured against.

Risk Adjustment – Risk adjustment uses the results of risk assessment to fairly compensate plans that, by design or accident, end up with a larger-than-average share of high-cost or lower-than-expected enrollees.

Risk Adjustment in Quality Programs – A method to increase payments to health insurers or providers who treat higher-risk populations and reduce incentives for the avoidance of higher-risk patients.

Risk Analysis – The process of evaluating the predicted costs of medical care for a group under a particular health plan. It helps managed care organizations and insurers determine which products, benefit levels, and prices to offer to best meet the needs of the group and the plan.

Risk Factor – Behavior or condition, based on scientific evidence or theory, is thought to directly influence susceptibility to a specific health problem.

Risk Management – The assessment and control of risk in a health care facility, including the analysis of possibilities of liability, methods to reduce risk of liability and methods to transfer risk to others or through insurance coverage. Risk management is commonly used to mean a formal program of malpractice reduction.

Risk Pools – Legislatively created programs that group people who cannot get insurance in the private market. Funding for the pool is subsidized through assessments on insurers or through government revenues. Maximum rates are tied to the rest of the market.

Robot-assisted Walking Therapy – A form of physical therapy that uses a robotic device to help patients relearn how to walk.

Robotic Surgery – Allows surgeons to perform many types of complex procedures with more precision, flexibility and control than is possible with conventional techniques. Robotic surgery is usually associated with minimally invasive surgery – procedures performed through tiny incisions.

Root Cause Analysis – A systematic quality improvement process used to identify causal factors that underlie variations in performance or adverse events.

Rural Health Center or Clinic – An outpatient facility in a nonurbanized area (per the U.S. Census Bureau) primarily engaged in furnishing physicians and other medical health services to ensure the health and safety of the patients served by the health center. Rural health centers serve areas designated for their shortage of personal health services or a health workforce. A physician is required to supervise mid-level practitioners consistent with state and federal laws.

Rural Health Network – An organization consisting of at least one critical-access hospital and at least one acute care hospital. Its provider participants enter into agreements for patient referral and transfer, the development and use of communication systems, and the provision of emergency and nonemergency transportation.

Rural Referral Center – A CMS classification for a rural facility that receives referrals from surrounding hospitals and provides high-volume acute care for a large number of complex cases.

Rural Hospital – A rural hospital is outside a Metropolitan Statistical Area, as designated by the U.S. Office of Management and Budget. Rural hospitals represent more than half of all hospitals in the U.S., providing essential access to inpatient, outpatient and emergency medical services in rural communities.

Safe Harbor – A set of federal regulations providing safe refuge for certain health care business arrangements from the criminal and civil sanction provisions of the Medicare Anti-Kickback Statute prohibiting illegal remuneration.

Safe Haven Law (Infant) – The decriminalization for a mother or parents to relinquish unharmed infants at designated sites. Child Protective Services assumes custody of the child and places him or her with an appropriate caregiver.

Safe Medical Devices Act – Federal law that requires personnel to report any incident in which a medical device may have caused or contributed to an adverse event, death, serious illness or serious injury to a patient.

Safety Net Providers – Public hospitals, community health centers, local health departments, clinics and other facilities that deliver large amounts of care to the uninsured or other vulnerable populations.

Sanctions – Negative incentives such as withholding funds or exclusion from a practice or hospital.

Sarbanes-Oxley Act – Federal law that protects shareholders and the general public from accounting errors and fraudulent practices in the enterprise, and improves the accuracy of corporate disclosures. The U.S. Securities and Exchange Commission administers the law, which sets deadlines for compliance and publishes rules about requirements.

Satellite Emergency Department – A facility owned and operated by the hospital but physically separate from the hospital for the provision of unscheduled outpatient services to patients whose conditions require immediate care. A freestanding emergency department has all necessary emergency staffing and equipment on-site.

Seamless Care – The experience by patients of smooth and easy movement from one aspect of comprehensive health care to another.

Secondary Care – Attention given to someone in need of specialty services after referral from a source of primary care.

Section 125 Plan – This plan allows employees to receive specified pretax benefits, including health benefits, whether the insurance is provided by the employer or purchased directly in the individual market.

Securities Exchange Commission – A federal agency whose mission is to protect investors; maintain fair, orderly, and efficient markets; and facilitate capital formation.

Self-insurance – An employer or group of employers that set aside funds to cover the cost of health benefits for their employees, thus assuming the financial risk. Benefits may be administered by the employer(s) or handled through an administrative services-only agreement with an insurance carrier or third-party administrator.

Sensitivity – Extent to which the criteria used to identify the target population results in the inclusion of people, groups or objects at risk.

Sentinel Event – An unexpected occurrence or variation involving death or serious physical or psychological injury, or the risk of such to a patient. Serious injury includes loss of limb or function. The Joint Commission requests the voluntary reporting of such events by accredited health care organizations to learn from collective root cause analyses and share this information with other health care organizations and the public.

Serious Adverse Event – The occurrence of patient harm in health care facilities that is often preventable and may be the unintended consequences of minor mishaps that sometimes combine to cause permanent damage or even death.

Service Area – The geographic area that a health plan serves. Some insurers are statewide or national, while others operate in specific counties or communities.

Simulated Rehabilitation Environment – Rehabilitation focused on retraining functional skills in a contextually appropriate environment (simulated home and community settings) or in a traditional setting (gymnasium) using motor learning principles.

Single Payer – One entity that functions as the only purchaser of health care services.

Single Payer System – A health care reform proposal in which health care costs are paid by taxes rather than by the employer and employee. Everyone would have coverage paid by the government.

Single Photon Emission Computerized Tomography – A nuclear medicine imaging technology that combines existing technology of gamma camera imaging with computed tomographic imaging technology to provide a more precise and clear image.

Site-neutral Payments – Payment or reimbursement of the same amount for the same service, regardless of treatment setting or practice setting.

Site-of-service Differential – The rate that a physician service is paid under the physician fee schedule, determined by the setting where the service was provided.

Skilled Nursing Care – Provides continuous non-acute medical and skilled nursing care services, therapy, and social services under the supervision of a licensed registered nurse on a 24-hour basis.

Skilled Nursing Facility – An institution that has a transfer agreement with one or more hospitals, provides primarily inpatient skilled nursing care and rehabilitative services, and meets other specific certification requirements.

Sleep Center – A specially equipped and staffed center for the diagnosis and treatment of sleep disorders such as sleep apnea.

Small Business Health Options Program – A marketplace created for small businesses with fewer than 50 FTEs to provide health and dental coverage to employees at an affordable price to the employer through tax credits.

Small Group Market – Firms with two to 50 employees can purchase health insurance for their employees through this market, which is regulated by states.

Social Work Services – Provide assistance and counseling to patients and their families in dealing with social, emotional, and environmental problems associated with illness or disability, often in the context of financial or discharge-planning coordination.

Socialized Medicine – A health care financing and delivery system in which physicians work for the government and receive a salary for their services.

Sole Community Provider – A health care facility designated by Medicare as meeting criteria including being at least 35 miles from similar hospitals with fewer than 50 beds. Also, because of distance, posted speed limits and predictable weather conditions, the travel time between the hospital and the nearest similar hospital is at least 45 minutes.

Solo Practice – Medical practice where the sole responsibility for practice decisions, regulatory compliance and management falls to the independent physician.

Special Enrollment Period – A time outside of the open enrollment period during which employees and their family have a right to sign up for job-based health coverage. Job-based plans must provide a special enrollment period of 30 days following certain life events that involve a change in family status (for example, marriage or birth of a child) or loss of other job-based health coverage.

Special Health Care Need – The health care and related needs of children who have chronic physical, developmental, behavioral or emotional conditions. Such needs are of a type or amount beyond that required by children generally.

Specialist – A physician whose training focuses on a particular area (e.g., neurology, cardiology, urology) rather than family medicine or general medicine. Specialists work at the secondary level of health care and provide services not all physicians can perform.

Specialty Hospital – A limited-service hospital designed to provide one medical specialty such as orthopedics or cardiology.

Specialty Medical Group – A single-specialty group of physicians or a multi-specialty group of physicians, such as an orthopedic group.

Sponsorship – A relation between a religious or other sponsoring organization and a hospital that may set limits on the activities undertaken in the hospital or is intended to further the objectives of the sponsoring organization but does not involve ownership or other legal relations.

Sports Medicine – Diagnostic screening and assessment and clinical and rehabilitation services for the prevention and treatment of sports-related injuries.

Staff Model HMO – A type of health maintenance organization in which enrollees pay premiums directly to the HMO, which hires physicians. The physicians are then paid a salary and predetermined bonuses.

Staffing Ratio – The total number of hospital full-time equaivalent employees divided by the average daily census.

Standard Benefit Package – A defined set of benefits provided to everyone covered under a health plan.

Standard of Care – In a medical malpractice action, the degree of reasonable skill, care and diligence exercised by members of the same health profession practicing in the same or similar locality the present state of medical or surgical science.

Stark Law – Federal law (Ethics in Patient Referrals Act, or Stark Law, after the congressman who introduced it) that bans physicians from referring patients to entities with which the physician has a financial relation. This financial relation could include ownership, investment or a structured compensation arrangement.

State Children's Health Insurance Program (CHIP or SCHIP) – A partnership between the federal and state governments that provides low-cost health coverage to children in families that earn too much money to qualify for Medicaid. In some states, CHIP covers pregnant women. Each state offers CHIP coverage, and works closely with its state Medicaid program. CHIP benefits are different in each state, but all states provide comprehensive coverage, like routine checkups, immunizations, physician visits and prescriptions.

State Continuation Coverage – A state-based requirement similar to COBRA that applies to group health insurance policies of employers with fewer than 20 employees. In some states, continuation coverage rules also apply to larger group insurance policies and add to COBRA protections. For example, in some states, if you're leaving a job-based plan, you must be allowed to continue your coverage until you reach the age of Medicare eligibility.

Stop-Loss Insurance – An insurance policy designed to reimburse a self-funded arrangement of one or more small employers for catastrophic, excess or unexpected expenses. Neither the employees nor others are third-party beneficiaries under the policy. Also known as excess risk insurance.

Stereotactic Radiosurgery – Stereotactic radiosurgery is a radiotherapy modality that delivers a high dosage of radiation to a discrete treatment area in as few as one treatment session.

Subacute Care – A comprehensive inpatient program for those who have experienced a serious illness, injury or disease, but who don't require intensive hospital services. The range of services considered subacute can include infusion therapy, respiratory care, cardiac services, wound care, rehabilitation services, postoperative recovery programs for knee and hip replacements, and cancer, stroke and AIDS care.

Supplemental Security Income – Federal cash assistance program for eligible people who are low-income, blind, disabled or age 65 or older. States may use SSI income limits to establish Medicaid eligibility. Eligibility for the monthly cash payments is based on the individual's current status despite previous work or contributions.

Support Groups – A hospital sponsored program that allows people with the same or similar problems to meet periodically to share experiences, problems and solutions to support each other. Examples are cancer and alzheimer's support groups or a Alzheimer's support group.

Support Services – Services other than medical, nursing, and ancillary services that provide support in the delivery of clinical services for patient care (e.g., housekeeping, food service and security).

Surgical Operations – Surgical procedures, whether major or minor, performed in the operating room. A surgical operation involving more than one surgical procedure is still considered only one surgical operation.

Surveillance Epidemiology and End Results – A component of the National Cancer Institute that, through the collection of data, works to provide information about cancer statistics in the U.S.

Swing Bed Providers or Swing Bed Hospitals – The Social Security Act permits certain small, rural hospitals to enter into a swing bed agreement, under which the hospital can use its beds, as needed, to provide either acute or skilled care. As defined in the regulations, a swing bed hospital is a hospital or critical access hospital participating in Medicare that has CMS approval to provide post-hospital skilled care and meets certain requirements. Medicare Part A (the hospital insurance program) covers post-hospital extended care services furnished in a swing bed hospital.

Tax Credit – An amount that a person/family can subtract from the amount of income tax they owe. If a tax credit is refundable, the taxpayer can receive a payment from the government to the extent that the amount of the credit is greater than the amount of tax they would otherwise owe.

Tax Deduction – An amount that a person/family can subtract from their adjusted gross income when calculating the amount of tax they owe. Generally, people who itemize their deductions can deduct the portion of their medical expenses, including health insurance premiums, that exceed 7.5% of their adjusted gross income.

Tax Equity and Fiscal Responsibility Act of 1982 – A federal law that established target rate-of-increase limits on reimbursements for inpatient operating costs per Medicare discharge. A facility's target amount is derived from costs in a base year updated to the current year by the annual allowable rate of increase. Medicare payments for operating costs generally may not exceed the facility's target amount. These provisions still apply to hospitals and units excluded from PPS.

Tax Preference for Employer-Sponsored Insurance – The amount that employers contribute to health benefits are excluded, without limit, from most workers' taxable income. Contributions made by employees toward the premium cost for health insurance are made on a tax-free basis. In contrast, people who do not receive health insurance through an employer may only deduct the amount of their total health care expenses that exceeds 7.5% of their adjusted gross income.

Teaching Hospitals – Hospitals that have accredited physician residency training programs and typically are affiliated with a medical school.

Teen Outreach Services – Programs focusing on teens that encourages an improved health status and a healthful lifestyle including physical, emotional, mental, social, spiritual and economic health through education, exercise, nutrition and health promotion.

Telehealth – The use of electronic information and telecommunications technologies to support long-distance clinical health care, patient and professional health-related education, public health and health administration. Telehealth is a broader scope of remote health care services than telemedicine and can refer to non-clinical services, such as provider training, administrative meetings and continuing medical education.

Telemedicine – Technology that allows medical services to be conducted over a large geographic distance (for example, with rural areas that lack specialists) by using electronic or other media to transmit images or information.

Tertiary Care – Highly specialized medical care, often received after referral from a primary or secondary care provider, usually over an extended period of time, that involves advanced and complex procedures and treatments performed by medical specialists.

Tertiary Hospital – A large medical care institution, (e.g. teaching hospital, medical center, or research institution) that provides highly specialized technologic care.

The Joint Commission – An independent, voluntary, nonprofit accreditation body that conducts accreditation surveys for hospitals and other health care organizations, monitoring the quality of care provided based on established standards. The Joint Commission maintains a "deemed status" arrangement with CMS for Medicare certification for hospitals and many other programs such as home health, as well as with many states and other regulatory bodies for some form of licensure.

Third-party Administrator – An independent person or firm that provides a variety of services including processing claims and helping with employee benefit plans. Self-insured organizations may use TPAs.

Third-party Payer – An organization (private or public) that pays for or insures at least some of the health care expenses of its beneficiaries. Third-party payers include Blue Cross/Blue Shield, commercial health insurers, Medicare and Medicaid. The person receiving the health care service is the first party, and the person or institution providing the service is the second party.

Tobacco Treatment/Cessation program – Organized hospital services with the purpose of ending tobacco-use habits of patients addicted to tobacco/nicotine.

Tomography – A diagnostic technique using X-ray photographs representing a detailed cross-section of tissue structures at a predetermined depth.

Tort Reform – Changes in the legal rules governing medical malpractice lawsuits.

Total Margin – A measure that compares total hospital revenue and expenses for inpatient, outpatient and non-patient care activities. The total margin is calculated by subtracting total expenses from total revenue and dividing by total revenue.

Total Quality Management – A management approach to long-term success where all members of an organization participate in improving processes, products, services and the culture in which they work as well as foster efficiency and team involvement, and satisfy the needs and expectations of customers.

Traditional Indemnity Insurance – The traditional type of health insurance in which the insured is reimbursed for covered expenses without regard to choice of provider.

Transition of Care – The movement of a patient from one health care provider or setting to another.

Transplant Services – The branch of medicine that transfers an organ or tissue from one person to another or from one body part to another to replace a diseased structure or to restore function or to change appearance.

Transportation to Health Facilities – A long-term care support service designed to help the mobility of the elderly. Some programs offer improved financial access by offering reduced rates and barrier-free buses or vans with ramps and lifts to help the elderly or handicapped. Others offer subsidies for public transport systems or operate mini-bus services exclusively for use by senior citizens.

Trauma Center (Certified) – A facility to provide emergency and specialized intensive care to critically ill and injured patients. Level 1: A regional resource trauma center capable of providing total care for every aspect of injury and plays a leadership role in trauma research and education. Level 2: A community trauma center, capable of providing trauma care to all but the most-severely injured patients who require highly specialized care. Level 3: A rural trauma hospital, capable of providing care to a large number of injury victims and can resuscitate and stabilize more-severely injured patients so they can be transported to Level 1 or 2 facilities. Level 4: Provides the initial evaluation and assessment of injured patients, and transfers patients pursuant to a well-defined transfer plan.

Triage – A process for sorting injured or ill people into groups based on their need for or likely benefit from immediate medical treatment.

TRICARE (formerly CHAMPUS) – A federal health plan, that allows active-duty military personnel, retired military personnel under age 65 and their dependents to receive government-subsidized health care from civilian providers.

Trustee – A member of a hospital governing body. May also be referred to as a director or commissioner.

Turnover – The rate at which an employer loses staff. Voluntary turnover is when the employee initiates the termination.

U.S. Senate Health Education, Labor and Pensions Committee – Standing U.S. Senate committee charged with reviewing proposed legislation for measures that affect education, labor, pensions, occupational safety, health and public welfare.

UB-04 – The common claim form used by hospitals, long-term care and home health care to bill for services.

Ultrasound – The use of acoustic waves above the range of 20,000 cycles per second to visualize internal body structures.

Unbundling – A billing process that occurs when multiple procedure codes are billed for a group of procedures that are covered by a single comprehensive code. Two types of practices lead to unbundling. The first is unintentional and results from a misunderstanding of coding. The second is intentional and is used by providers to manipulate coding to maximize payment.

Uncompensated Care – Care rendered by hospitals or other providers without payment from the patient or a government-sponsored or private insurance program. It includes charity care, which is provided without the expectation of payment, and bad debts, for which the provider has made an unsuccessful effort to collect payment from the patient.

Underinsured – People who may have some type of health care insurance, such as catastrophic care, but lack coverage for ordinary health care costs.

Underwriting – The process by which an insurance carrier examines someone's medical history and decides whether it will issue coverage.

Uniform Billing – Forms (e.g., UB-04) and codes used in medical claims billing for institutional hospitals, nursing homes, hospices, home health agencies and other providers.

Uninsurable – People an insurance company does not want to insure, usually because of bad health.

Uninsured – People who do not have health care coverage.

Universal Access – The right and ability to receive a comprehensive, uniform and affordable set of confidential, appropriate and effective health services.

Universal Coverage – A proposal guaranteeing health insurance coverage for all Americans.

Unrestricted Funds – Includes hospital resources not restricted to particular purposes by donors or other external authorities.

Upcode – To bill for a service more intense, extensive or costly than that which was provided.

Update Factor – A recommended yearly increase in payment by providers based on the estimated changes in total cost of care for the next year.

Urban Hospital – A hospital in a Metropolitan Statistical Area, designated by the U.S. Office of Management and Budget. An urban area is a geographically defined, integrated social and economic unit with a large population base.

Urgent Care Center – A free-standing emergency care facility that may be sponsored by a hospital, a physician(s) or a corporate entity. Sometimes referred to as a minor emergency facility or urgicenter.

Usual, Customary and Reasonable – Amounts charged by health care providers that are consistent with charges from similar providers for the same or nearly the same services in a given area.

Utilization – Usage rate for a particular health care facility, type of medical care or treatment, physician visit, or health care coverage, often measured within a population or covered group.

Utilization Management or Utilization Review – The review of services delivered by a health care provider to evaluate the appropriateness, necessity and quality of the prescribed services.

Vacancy – Open full-time positions divided by the total number of full-time employees.

Value-based Purchasing – A Centers for Medicare and Medicaid Services initiative to reimburse providers for care to Medicare beneficiaries based on quality performance (a pay-for-performance program).

Variable Cost – Any cost that varies with output or organizational activity (e.g., labor and materials).

Vertical Integration – A health care system that provides a range or continuum of care such as outpatient, acute hospital, long-term, home and hospice care.

Violence Prevention Programs for the Community – Programs that attempts to make a positive impact on the type(s) of violence a community is experiencing. A program that targets the underlying circumstances that contribute to violence such as poor housing, insufficient job training, or substance abuse through direct involvement and support, education, mentoring, anger management, crisis intervention and training programs would qualify.

Violence Prevention Programs for the Workplace – A violence prevention program with goals and objectives for preventing workplace violence against staff and patients.

Virtual Colonoscopy – Noninvasive screening procedure used to visualize, analyze and detect cancerous or potentially cancerous polyps in the colon.

Vital Signs – Measurements of body temperature, pulse, respiratory rates and blood pressure.

Vital Statistics – Official government records of events such as births, deaths, marriages, divorces and fetal deaths.

Volunteer – Someone who serves a hospital without financial remuneration and who, under the direction of the volunteer services department or committee, augments but does not replace paid personnel and professional staff.

Waiting Period – The amount of time someone must wait from the date he or she is accepted into a health plan (or from when he or she applies) until the insurance becomes effective and he or she can receive benefits.

Waiver – A provision in a health insurance policy in which specific medical conditions someone already has are excluded from coverage.

Well-Baby and Well-Child Visits – Routine visits for comprehensive preventive health services that occur when a baby is young and annual visits until a child reaches age 21. Services include physical exam and measurements, vision and hearing screening, and oral health risk assessments.

Wellness Programs – Educational and other programs designed to tell people about healthy lifestyles, and to direct them to programs and facilities that encourage and support these behaviors. Employers may initiate these programs as part of larger efforts to control health care costs, reduce absenteeism and strengthen employee relations.

Withhold – A percentage of providers' fees that managed care companies hold back from providers that is only given to them if the amount of care they provide (or that the entire plan provides) is under a budgeted amount for each quarter or the whole year.

Women, Infants and Children Program – A federal supplemental nutrition program that provides federal grants to states for low-income pregnant, breastfeeding and non-breastfeeding postpartum women as well as children up to age 5 who are at nutritional risk.

Women's Health Center/Services – An area set aside for coordinated education and treatment services specifically for and promoted to women. Services may include obstetrics and a range of other services.

Workers' Compensation Coverage – States require employers to provide coverage to compensate employees for work-related injuries or disabilities.

Working Capital – A company's amount of capital available for spending. Detailed as part of the statement of cash flows and the balance sheet, it is current assets minus current liabilities.

World Health Organization – A specialized agency of the United Nations concerned with international public health. WHO's primary role is to direct international health within the United Nations' system and to lead partners in global health responses, such as to major infectious disease outbreaks.

Wound Management Services – Services for patients with chronic wounds and nonhealing wounds often resulting from diabetes, poor circulation, improper seating and immunocompromising conditions. The goals are to progress chronic wounds through stages of healing, reduce and eliminate infections, increase physical function to minimize complications from current wounds and prevent future chronic wounds.

Young Adult Health Plan – Health plans designed to meet the needs of young adults. These plans tend to offer lower premiums in exchange for high deductibles or limited benefit packages.

Zone Program Integrity Contractors – Organizations hired by the Centers for Medicare and Medicaid Services to perform medical review, data analysis and Medicare evidence-based policy auditing activities.

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