Speaking Healthcare™

A trustee's guide to healthcare terms and abbreviations

HTNYS
Healthcare Trustees
of New York State

Speaking Healthcare™ was created by governWell to help hospital and health system trustees better understand the complex and often confusing language that is used in healthcare. The glossary was developed through a multi-association collaboration with governWell™. It includes over 1,000 words that are often used in briefings, documents and discussions in the boardroom.

What's inside

This trustee's guide to healthcare terms and abbreviations was developed through a multi-association collaboration with governWell and is posted on this website with governWell's permission.

A

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, as well as 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 another third–party coverage for health services; the location of health facilities and their hours of operation; travel time and distance to health facilities; and 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.[1]

Accountable care organization – A network of physicians, hospitals and other healthcare providers that voluntarily share financial and medical responsibility for providing coordinated high-quality care to Medicare patients.[2]

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 healthcare 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 Healthcare, Commission on Accreditation of Rehabilitation Facilities and Healthcare Facilities Accreditation Program, as well as many smaller accrediting agencies for specialty programs such as home healthcare and ambulatory care. Accreditation needs to be renewed every few years to remain in effect.

Accreditation Council for Graduate Medical Education – 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 healthcare organization meets specified standards to achieve external accreditation. Typically, this involves an on-site review at the healthcare 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 – 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.[3]

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).[2]

Acute long-term care – Providers that offer specialized acute hospital care to medically complex patients who are critically ill, have multi-system complications and/or failure, and require hospitalization in a specialized facility offering treatment programs and therapeutic intervention on a 24/7 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 – 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 – Estimated payment rates that health plans with Medicare risk contracts would have received for their Medicare enrollees if 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 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 – 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 healthcare organization, insurer or managed care plan for managing health services, including claims processing, billing, marketing, member services, provider relations and other overhead expenses.

Administrative services only – 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 healthcare facility of a patient who is to be provided with room, board and healthcare treatment or services for at least one night or more.[2]

Admission, discharge, transfer system – Software application used by hospitals and other healthcare 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 healthcare organization's governing board to admit patients into its hospital or healthcare 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), as well as 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 (also called 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 surgery is indicated.

Adult interventional cardiac catheterization – Non-surgical procedure that uses 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 – Written notice given by a healthcare 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 for 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 healthcare and a do not resuscitate order. 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.[4]

Advanced practice registered nurse – A registered clinical nursing professional who has received advanced training and education in their 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.[5]

Adverse drug reaction – 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 – Occurs when a larger proportion of persons with poorer health status enroll in specific plans or insurance options, while a larger proportion of persons 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 with 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 – Informally known as Obamacare, this federal legislation was signed into law in 2010 and contains 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 healthcare costs.

Against medical advice – The self-discharge of a patient who leaves a healthcare facility against the advice of their physician or the medical staff.

Agency for Healthcare Research and Quality – Public health service agency within the U.S. Department of Health and Human Services. AHRQ's mission is to support research designed to improve the outcomes and quality of healthcare, 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/aggregate total margin – A Prospective Payment System 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 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 where patient requires supervised withdrawal.

Alcoholism, drug abuse or dependency outpatient services – Organized hospital services that provide medical care and/or rehabilitative treatment services to outpatients for whom the primary diagnosis is alcoholism or other chemical or drug dependency.

All Patient Refined Diagnosis Related Groups – 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 healthcare professional who provides a range of diagnostic, technical and therapeutic healthcare services to patients. Allied health professionals include paramedics, physician assistants, certified nurse midwives, nurse practitioners, nurse anesthetists, registered nurses, respiratory therapists, physical therapists and a variety of other medical team members. Allied health professionals comprise almost 60 percent of the healthcare 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 healthcare provider in which case the patient/consumer may have to pay the difference.

All-payer system – A system by which all third-party payers of healthcare bills — the government, private insurers, big companies and individuals — pay the same rates, set by the government, for the same medical service. This system does not allow 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 – A child abduction alert system issued to the public by various media outlets in the U.S. and Canada 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 or physician's office; usually implies that an overnight stay in a healthcare facility is not necessary.

Ambulatory patient classifications – 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 DRG, an outpatient visit can combine several different ambulatoy patient groups. 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 – A freestanding 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. ASCs are distinct from same day surgical units within hospital outpatient departments for purposes of Medicare payments.

American College of Healthcare Executives – An international professional society of healthcare executives who lead hospitals, healthcare systems and other healthcare organizations. ACHE provides the Fellow of the American College of Healthcare Executives designation, signifying certification in healthcare management, and offers healthcare education.

American Hospital Association – The national organization that represents and serves all types of hospitals, healthcare networks and their patients and communities. Nearly 5,000 hospitals, healthcare 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 healthcare leaders and is a source of information on healthcare issues and trends.[6]

American Medical Association – The largest national professional association for physicians, founded in 1847. AMA's mission is "to promote the art and science of medicine and the betterment of public health." The AMA publishes the peer-reviewed *Journal of the American Medical Association*.[7]

American Nurses Association – The largest professional organization for registered nurses, founded in 1896 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 individuals, families, communities and populations."[8]

American Nurses Credentialing Center – ANCC credentials both organizations and individuals who advance nursing. 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 healthcare 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, the Centers for Medicare & Medicaid Services collects quality data 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 healthcare.[2]

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

Antitrust laws – State and national laws that prohibit healthcare 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 healthcare 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 – Partnership between health and educational institutions, the purpose of which is to improve the supply, distribution, quality, use and efficiency of healthcare 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.[2]

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

Artificial intelligence – AI enables computer systems to perform tasks normally requiring human intelligence. AI tools show promise for improving healthcare and having positive impacts including cost savings and better health outcomes. They can help predict health trajectories, recommend treatments and automate administrative tasks. AI can also analyze data, automate labor-intensive processes, find operational efficiencies, provide business insights, make predictions, identify disparities and reveal new ways of solving problems.[7]

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

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

Associate Degree in Nursing – 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 after passing a state licensure exam.

Association health plan – Health insurance plans that 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, or both, or are largely exempt from regulations.

Attending physician – A physician who is on the medical staff of a hospital or healthcare facility and who 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 and/or outpatient basis.

Augmented intelligence – The AMA House of Delegates uses the term augmented intelligence as a conceptualization of artificial intelligence that focuses on AI's assistive role, emphasizing that its design enhances human intelligence rather than replaces it.[7]

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 a member of a hospital's auxiliary who may or may not serve as an in-service volunteer at the hospital.

Average daily census – 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 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. ALOS 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.

B

"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 – Four-year degree awarded by an accredited college or university that allows an individual to become a registered nurse 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/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 individuals with incomes between 133 and 200 percent of poverty, in lieu of having these individuals 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 percent of what it would have paid to subsidize these enrollees in the health insurance exchange. This is branded in New York as the Essential Plan.[2]

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 as 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 – A best practice is a method that has been generally accepted as superior to other approaches because it tends to produce higher quality results. Best practices are often based on benchmarking.

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

Biomedical ethics – A term used to describe philosophical questions and decision-making involving morals, values and ethics in the provision of healthcare. Many ethical issues that arise in healthcare 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 and/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.

Births – 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 – Non-profit, 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; 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 considered 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 persons who supervise all matters pertaining to the preservation of the life and health of the people within 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.[9]

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 is 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 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 healthcare 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: second-degree burns of more than 25% total body surface area for adults or 20% total body surface area for children: third-degree burns of more than 10% total body surface area; any severe burns of the hands, face, eyes, ears or feet; or all inhalation injuries, electrical burns or 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.

C

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 as well as patients who are immunosuppressed.

Cafeteria plan – This type of benefit plan gives employees a set amount of funds that they can choose to spend on 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 healthcare facility's planned capital expenditures (e.g., buildings and equipment) to determine their necessity and appropriateness.

Capital expense – An expenditure 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 and pacemaker/defibrillator implantation and follow-up.

Cardiac (or 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.

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 patient treatment across several healthcare 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 Research and Policy.

careLearning – An online education company operated by state hospital associations and designed to help healthcare organizations by providing reliable, trusted and easily accessible talent management solutions.[10]

Carrier – An insurance company or a health plan that has some financial risk or that manages healthcare 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. Also, carve-out may refer to a population subgroup for which separate healthcare 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; often used for patients with specific diagnoses or who require high-cost or extensive healthcare 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 healthcare. 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 healthcare 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 – The average diagnosis-related group weight for all cases paid under the Prospective Payment System. 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 due to 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 their 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 – A 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 – An infection that occurs when bacteria enters the urinary tract through an indwelling urinary catheter. CAUTIs have been associated with increased morbidity, mortality, healthcare costs and length of stay.[11]

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 – The federal agency within 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 health, safety and security threats, both foreign and in the U.S. Whether diseases start at home or abroad, are chronic or acute, curable or preventable, human error or deliberate attack, CDC fights disease.[13]

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

Central line-associated bloodstream infection – A serious infection that occurs when bacteria enter the bloodstream through a central venous catheter, also known as a central line. CLABSIs result in thousands of deaths each year and billions of dollars in added costs to the U.S. healthcare system, yet these infections are preventable. CDC is providing guidelines and tools to the healthcare community to help end CLABSIs.[14]

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 – 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.

Certified health plan – A managed healthcare 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/pastoral care services – A service ministering religious or spiritual activities and providing pastoral counseling to patients, their families and staff of a healthcare 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; however, 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 healthcare services on an inpatient or outpatient basis to a person classified by the hospital as financially or medically indigent.

Chatbot – A chatbot is defined as a computer program designed to simulate conversation with human users, especially over the Internet. Chatbots are also known as smart bots, interactive agents, digital assistants or artificial conversation entities. A chatbot is an example of an artificial intelligence system and a widespread example of intelligent human-computer interaction.[4]

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.[15]

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

Chief executive officer – 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 – The senior executive designated by the CEO with 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/chief medical officer – 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 known as president of the medical staff, medical director or chief medical officer. The chief of staff/CMO ensurea 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.[16]

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

Children's Health Insurance Program – 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.[17]

Children's wellness program – A program that encourages improved health status and a healthy 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 healthcare profession that emphasizes the body's ability to heal itself.[18]

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, 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 healthcare 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 healthcare 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/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 healthcare provider for medical care or healthcare services rendered to an enrollee under a healthcare plan or to an insured under a health insurance policy that includes required data elements for timely processing.

Client's rights – Those rights to which an individual 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 individual's medical information.

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

Clinical decision support system – A CDSS is intended to improve healthcare delivery by enhancing medical decisions with targeted clinical knowledge, patient information and other health information. A traditional CDSS is comprised of software designed to be a direct aid to clinical decision-making, in which the characteristics of an individual patient are matched to a computerized clinical knowledge base and patient-specific assessments or recommendations are then presented to the clinician for a decision. CDSSs today are primarily used at the point-of-care, for the clinician to combine their knowledge with information or suggestions provided by the CDSS. Increasingly, however, there are CDSSs being developed with the capability to leverage data and observations otherwise unobtainable or uninterpretable by humans.[4]

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

Clinical Laboratory Improvement Amendments – The Centers for Medicare & Medicaid Services regulates all laboratory testing (except research) performed on humans in the U.S. through the CLIA. In total, CLIA covers approximately 260,000 laboratory entities. 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.[2]

Clinical pathway – A healthcare 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 healthcare 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.[19]

Clinical quality measure – A metric that helps assess and track the quality and safety of healthcare services and providers. CQMs evaluate various aspects of patient care, including health outcomes, clinical processes, patient safety, efficient use of healthcare 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 healthcare services used outside of 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/or high 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.

COBRA – The Consolidated Omnibus Budget Reconciliation Act gives workers and their families who lose their health benefits the right to choose 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 individuals may be required to pay the entire premium for coverage up to 102 percent of the cost to the plan.[20]

"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 creep.

Code of Federal Regulations – A codified collection of regulations issued by 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.

Coinsurance – Amount a health insurance policy (calculated as a percentage) 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 is an immigration neutral nonprofit organization that helps foreign educated healthcare professionals live and work in their country of choice by assessing and validating their academic and professional credentials. CGFNS International provides foreign students and healthcare 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 healthcare professionals by advocating for ethical recruitment practices and continuously monitoring the global landscape for developing trends in employment recruitment and workplace norms.[21]

Community – Community is defined as people and organizations who are impacted by the programming and solutions. These are people and organizations outside hospital walls but within a hospital's service area/town/city/county. Examples include patients, community groups, community-based organizations, faith-based organizations and local public health departments.[6]

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 healthcare, 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 not-for-profit healthcare organizations.

Community Benefit Inventory for Social Accountability – This Lyon Software assists not-for-profit hospitals in tracking and reporting community benefits and features a blend of both statistical and narrative information. It also helps hospitals to create an annual community benefit report. The CBISA software was created based on reporting guidelines developed by the Catholic Health Association and the Voluntary Hospital Association.[12]

Community health center – A local, community-based ambulatory healthcare 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 and/or special-needs populations. Health centers help 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 healthcare system.[22]

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

Community health improvement plan – 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.[23]

Community Health Information Network – A web-based network that permits the electronic exchange of clinical, financial and administrative information among unaffiliated healthcare entities in order to improve the efficiency and delivery of healthcare in a community. Also known as community health management information system.

Community health needs assessment – 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 healthcare services, special targeted populations, health problems in the community and barriers to access to healthcare services, and estimate projected future needs. 501(c)3 hospitals are required to conduct a CHNA every three years.[23]

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.[24]

Community outreach – A program that systematically interacts with the community to identify those in need of services, alerting persons and their families to the availability of services, locating needed services and enabling persons 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.[25]

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

Comparative effectiveness research – Research that 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 healthcare delivery, organization and financing, as well as 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.[26]

CompAnalyst – A web-based compensation and benefits survey tool that allows hospitals to compare their data to other hospitals and certain non-healthcare related companies.[27]

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 healthcare provider.

Complementary and alternative medicine services – 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, massage therapy, etc. In the U.S., approximately 40 percent of adults and children are using some form of complementary and alternative medicine services.[28]

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

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

Computerized axial tomography – 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 CAT scan may be used to help diagnose disease, plan treatment or find out how well treatment is working. Also called CT scan, computed tomography scan and computerized tomography.[29]

Computerized physician order entry – Process of electronic entry in which physicians directly enter medication orders or care instructions for a patient into a computer.

Concurrent review – A 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 – Standards designated by the Centers for Medicare & Medicaid Services that hospitals, critical access hospitals and other healthcare 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 individuals who have a need, reason and permission for such access.

Conflict of interest – 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 – 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.[5]

Consumer price index, medical care component – Measure of inflation encompassing the cost of all purchased healthcare services. The medical care index is one of eight major groups in the CPI 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.[30]

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

Continuing education – 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 – Continuing education related to the current professional practices of physicians.

Continuous quality improvement – An 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, 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 and 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 healthcare 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 – HMOs 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 – Agreement between health plans and insurers to avoid the same services being paid for more than once.

Copayment (Copay) – 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 healthcare is rendered. Typical copayments are fixed or variable flat amounts for physician office visits, prescriptions or hospital services.

Core-based statistical area – CBSAs of the county or counties or equivalent entities associated with at least one core (urbanized area or urban cluster) of at least 10,000 population, 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.[31]

Core measures – Standardized quality measures selected to align reporting and improve patient care. The measures were established by the Centers for Medicare & Medicaid Services, The Joint Commission, payers and healthcare 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 healthcare system moves towards value-based reimbursement models.[32]

Coronavirus disease (COVID-19) – Pneumonia caused by severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2). COVID-19 represents a spectrum of clinical manifestations that typically include fever, dry cough and fatigue, often with pulmonary involvement. SARS-CoV-2 is highly contagious and most individuals within the population at large are susceptible to infection.[4]

Corporate Practice of Medicine – The 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 healthcare 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 healthcare 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 healthcare 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 – 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 diagnosis-related group cost weighting.[2]

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 healthcare costs are paid by their insurance or by the government.

Covered entity – Defined by HIPAA as health plans, healthcare clearinghouses and healthcare providers who electronically transmit in connection with a transaction for which HHS has adopted a standard.[33]

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

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

Credentialing and privileging – Process by which a hospital obtains, verifies and assesses the qualifications of a practitioner (e.g., physician, dentist, nurse midwife) and determines the scope of practice for him or her 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 – An independent organization that confirms the professional credentials of providers for a managed care organization or healthcare

organization rather than requiring the providers to share 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; TRICARE; Federal Employees Health Benefits Program; Indian Health Service; 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; 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 wellbeing and the early identification of disease and ill health prior to the onset and recognition of symptoms, so as to permit early treatment.

Critical access hospital – Designated within the Medicare Rural Hospital Flexibility Program as a limited service rural, not-for-profit 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. The U.S. Department of Health and Human Services requires hospitals designated as a CAH to have no more than 25 inpatient beds; maintain an annual average length of stay of no more than 96 hours for acute inpatient care; offer 24-hour-a-day, 7-day-a-week emergency care; and be located in a rural area at least a 35-mile drive away from any other hospital or CAH. (CAHs receive 101 percent of reasonable costs for reimbursement of inpatient and outpatient services for Medicare patients.) Medicare does not include CAHs in the hospital Inpatient Prospective Payment System or the hospital Outpatient PPS.[2]

Cultural competence – The integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices and attitudes used in appropriate cultural settings to increase the quality of services with the intention of producing better outcomes.[6]

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

Current liabilities – Obligations that will become due and payable with cash within one year.

Current Procedural Terminology – Coding system for physician services developed by the American Medical Association; 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.

Cybersecurity – Prevention of damage to, protection of and restoration of computers, electronic communications systems, electronic communications services, wire communication, and electronic communication, including information contained therein, to ensure its availability, integrity, authentication, confidentiality and nonrepudiation.[2]

Cybersecurity incident – A deliberate, negligent or reckless action that leads, or could lead, to the loss, damage, compromise, corruption or disclosure of information and resources. Cybersecurity incidents affecting hospitals and health systems have led to extended care disruptions caused by multi-week outages; patient diversion to other facilities; and strain on acute care provisioning and capacity, causing canceled medical appointments and delayed medical procedures (particularly elective procedures). Cybersecurity incidents put patients' safety at risk and impact local and surrounding communities that depend on the availability of the local emergency department, radiology unit or cancer center for life-saving care.[2]

D

Data use agreement – 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 individual must pay for healthcare 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 – In order to participate in and receive federal payment from Medicare or Medicaid programs, a healthcare organization must meet the government requirements for program participation, including a certification of compliance with the health and safety requirements called 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, such as the Centers for Medicare & Medicaid Services, or by a national accrediting organization, such as The Joint Commission or DNV, that has been recognized by the Centers for Medicare &

Medicaid Services (through a process called "deeming") as having standards and a survey process that meet or exceed Medicare's requirements. Healthcare organizations that achieve accreditation through a "deemed status" survey are determined to meet or exceed Medicare and Medicaid requirements. Many states also offer a deemed status arrangement for meeting licensure regulations in that state.[34]

Defensive medicine – Healthcare 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 healthcare 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.

Demographic data – Data that describe the characteristics of enrollee populations within a managed care entity. Demographic data include but are not limited to age, sex, race/ethnicity and primary language.[2]

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 individual for whom a parent, relative or other person may claim a personal exemption tax deduction. Under the Affordable Care Act, individuals may be able to claim a premium tax credit to help cover the cost of coverage for themselves and their dependents.[35]

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 – Prospective payment rates based on DRGs have been established as the basis of Medicare's hospital reimbursement system. 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.[2]

Diagnostic radioisotope facility – The use of radioactive isotopes (radiopharmaceuticals) as tracers or indicators to detect an abnormal condition or disease.

Digital health – A specialty in medicine and other health professions applying information and communications technologies to manage illnesses and health risks and to promote wellness. Digital health has a broad scope, which includes the use of wearable devices, mobile devices, telehealth and telemedicine, health information technology and big data efforts.[4]

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 healthcare services at a certain price. A third party may be included to provide administrative and financial services.

Directors and officers liability coverage – Insurance protection for directors and officers of corporations against suits or claims brought by shareholders or others alleging that the directors and/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 its health services is discounted based on a negotiated amount 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 healthcare 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 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 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.

Diversity – Diversity describes the ways in which people differ such as race, ethnicity, nationality, socioeconomic status, religion, economic class, education, age, gender, gender identity or expression, sexual orientation, marital status, mental and physical ability and learning styles. Diversity is all-inclusive and supportive of the proposition that everyone and every group should be valued.[6]

DNV (Det Norske Veritas) GL Healthcare Inc. – A national accreditation organization with deeming authority from the Centers for Medicare & Medicaid Services to evaluate and monitor the quality of care provided in hospitals and other healthcare institutions and to provide accreditation to those institutions. DNV GL Healthcare accreditation standards integrate CMS Conditions of Participation with the ISO 9001 Quality Management Program.[36]

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

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 healthcare provider to receive higher Medicare payments.

Drug Enforcement Administration – The mission of the DEA is to enforce the controlled substances laws and regulations of the U.S. and bring to the criminal and civil justice system of the U.S., or any other competent jurisdiction, 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.; and to recommend and support non-enforcement programs aimed at reducing the availability of illicit controlled substances on the domestic and international markets.[37]

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. Some insurers will not reimburse for prescribed drugs not listed on the formulary; others may have limited reimbursement for non-formulary drugs.

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

Durable medical equipment – 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, wheelchairs and oxygen concentrators.

Durable power of attorney for healthcare – A type of advance directive that allows an individual 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 healthcare 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.

E

Early and Periodic Screening, Diagnosis and Treatment Program – 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 and/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 knowledge (using scientific knowledge and evidence-based guidelines), to achieve the desired or projected outcome(s).[38]

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.[38]

Elective – A healthcare 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 – A high tech computed tomography scan used to detect coronary artery disease by measuring coronary calcifications.

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

Electronic data interchange – Computer-to-computer exchange of data and documents using a standardized format. Common healthcare uses of this technology include claims submission and payment, eligibility determination and referral authorization.

Electronic health record – 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 healthcare organization. EHRs are built to share information with other healthcare providers and organizations such as laboratories, specialists, medical imaging facilities, pharmacies, emergency facilities, and school and workplace clinics. They contain information from all clinicians involved in a patient's care.[39]

Electronic prescribing (e-prescribing) – When a doctor sends a prescription electronically to a pharmacy.

Eligibility – The status that defines who receives healthcare 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 copayment responsibilities.

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

Emergency department or emergency room – A hospital department that provides immediate emergency medical care on a 24-hour basis for acutely ill or injured persons who present without an appointment by their own means or by an ambulance.

Emergency medical services system – A system of personnel, facilities and equipment administered by a public or not-for-profit organization delivering emergency medical services within a designated geographic area. Once it is activated by an incident that causes serious illness or injury, the focus of EMS is emergency medical care of the patient(s). EMS is an intricate system, and each component of this system has an essential role to perform as part of a coordinated and seamless system of emergency medical care.[40]

Emergency Medical Treatment and Active Labor Act – Congress enacted EMTALA 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, including active labor, regardless of an individual's ability to pay. Hospitals are then required to provide stabilizing treatment for patients with EMCs. If a hospital is unable to stabilize a patient within its capability, or if the patient requests, an appropriate transfer should be implemented.[2]

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. Hospitals, communities and/or regions have plans that may include additional staff, evacuation and/or sheltering in place. These plans typically are practiced at least annually through simulated disasters.

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

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 services – Urgent health services 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 place the patient's health in serious jeopardy.

Employee assistance programs – 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 healthcare 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 – A federal law that sets minimum standards for most voluntarily established retirement and health plans in private industry to provide protection for individuals 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.[41]

Employer contribution – The money a company pays for its employees' healthcare.

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 non-profit organizations that do not pay federal taxes.

Employer mandate – Under the Affordable Care Act's employer shared responsibility provisions, certain employers (called applicable large employers or ALEs) 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. The employer shared responsibility provisions are sometimes referred to as "the employer mandate" or "the pay or play provisions." The vast majority of employers will fall below the ALE threshold number of employees and, therefore, will not be subject to the employer shared responsibility provisions.[42]

Employer pay or play – *See Employer mandate*.

Employer responsibility – Under the Affordable Care Act, 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 healthcare 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 healthcare services by offering transportation services and/or referrals to local social services 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 – 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 persons (i.e., the enrolled group) in a health plan. Can also refer to the process by which a health plan signs up individuals 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. The specific services offered could include explanation of benefits, assisting applicants in completing the application and locating all relevant documents, conducting eligibility interviews and/or forwarding applications and documentation to state/local social services or health agencies.

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 and/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 exposure to contaminated and hazardous environments.

Environmental Protection Agency – An independent agency of the federal government whose mission is to protect human health and the environment.[43]

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 (inpatient, outpatient, ambulatory) and across providers, for the duration of that illness.

e-Prescribing – An important part of the nation's push to enhance the safety and quality of the prescribing process. E-prescribing allows providers in the ambulatory care setting to send prescriptions electronically to the pharmacy and can be a stand-alone system or part of an integrated electronic health record system.[4]

Equality – The condition under which every individual is treated in the same way and is granted the same rights and responsibilities, regardless of their individual differences.[6]

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 healthcare service categories that must be covered by certain plans. The Affordable Care Act defines essential health benefits to "include at least the following general categories and the items and services covered within the categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care." Insurance policies must cover these benefits in order to be certified and offered in Exchanges, and all Medicaid state plans must cover these services.

Ethics committee – A group of individuals, 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 healthcare providers in order to make complex and difficult decisions regarding moral issues (e.g., end-of-life care). The ethics committee also provides staff education and advises on policy development.

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

Evidence-based medicine – 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 and/or the delivery of appropriate healthcare 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 individuals and small businesses can buy affordable and qualified health benefit plans. Affordable insurance exchanges offer a choice of health plans that meet certain benefits and cost standards.

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 – 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).[44]

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

Expenses per adjusted admission stay – Total expenses divided by adjusted admissions. *See Adjusted admissions.*

Expenses per adjusted inpatient days – Expenses divided by adjusted inpatient days. *See Adjusted inpatient days.*

Experimental procedure – Healthcare services or procedures that: (1) public and private health insurance plans believe are not widely accepted as effective by American healthcare professionals; or (2) have not been scientifically proven to be effective for a particular disease or condition. Insurers typically do not cover such procedures.

Explanation of Benefits – A statement provided by a health insurance company to covered individuals stating what medical treatment and/or services were paid for on their behalf. The Medicare version is called an Explanation of Medicare Benefits.

Extended care facility – 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 – 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.[45]

Extracorporeal shock wave lithotripter – 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.

F

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

Family and Medical Leave Act – Federal law that guarantees up to 12 weeks of job protected leave for certain employees when they need to take time off due to 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 – 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 – A division of the Department of Homeland Security that 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.[46]

Federal Employee Health Benefit Program – A program that provides health insurance to employees of the U.S. federal government. Federal employees choose from a menu of plans that include fee-for-service plans, plans with a point of service option and health maintenance organization plans. There are more than 170 plans offered; a combination of national plans, agency-specific plans and more than 150 HMOs serving only specific geographic regions. The various plans compete for enrollment as employees can compare the costs, benefits and features of different plans.

Federal fiscal year – 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, FFY2026 begins on Oct. 1, 2025.

Federal Medical Assistance Percentage – 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 percent.

Federal poverty level – 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 (e.g., 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 – Community-based healthcare providers that receive funds from the HRSA Health Center Program to provide primary care services in underserved areas. They must meet a stringent set of requirements, including providing care on a sliding fee scale based on ability to pay and operating under a governing board that includes patients. FQHCs may be Community Health Centers, Migrant Health Centers, Health Care for the Homeless and Health Centers for Residents of Public Housing.[47]

Fee schedule – A list of fee maximums for specified medical services and procedures used to reimburse a physician and/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 – 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 as well as advanced reproductive techniques such as treatment for endometriosis, male factor infertility, in vitro fertilization and other services to help patients achieve successful pregnancies.

Fiduciary relationship – Relationship in which an individual 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 relationship with their patient, and a hospital trustee has one with a hospital.

First dollar coverage – A health insurance policy with no required deductible or copayment 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 (Oct. 1 to Sept. 30). Fiscal years are referred to by the calendar year in which they end; for example, the federal fiscal year 2025 began Oct. 1, 2024. Hospitals can designate their own fiscal years, and 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 healthcare and other benefits based on their specific needs. Also called cafeteria benefits.

Flexible spending account – An arrangement you set up through your employer to pay for many of your out-of-pocket medical expenses with tax-free dollars. These expenses include insurance copayments and deductibles and qualified prescription drugs, insulin and medical devices. You decide how much of your pre-tax wages you want taken out of your paycheck and put into an FSA. You don't have to pay taxes on this money. Your employer's plan sets a limit on the amount you can put into an FSA each year. There is no carry-over of FSA funds. This means that FSA funds you don't spend by the end of the plan year can't be used for expenses in the next year. An exception is if your employer's FSA plan permits you to use unused FSA funds for expenses incurred during a grace period of up to 2.5 months after the end of the FSA plan year.

Food and Drug Administration – A federal agency that is responsible for protecting public health by ensuring the safety, efficacy and security of human and veterinary drugs, biological products and medical devices; and by ensuring the safety of our nation's food supply, cosmetics and products that emit radiation.[48]

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 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 – Healthcare 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 – Refers to employees; total FTE personnel is calculated by dividing the hospital's total number of paid hours by the number of annual paid hours for one full-time employee. FTEs are units equivalent to employees (i.e., one FTE is equal to one employee working full-time).

Fully insured job-based plan – A health plan purchased by an employer from an insurance company.

G

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 healthcare professional who controls a patient's entry into the healthcare system and coordinates, manages and authorizes all healthcare services provided to a covered beneficiary. This may be a nurse, social worker, physician assistant or 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) – Physicians who are distinguished by their training as not limiting their practice by health condition or organ system, who provide comprehensive and continuous services, and who make decisions about treatment for patients presenting with undifferentiated symptoms. Typically include family practitioners, general internists and general pediatricians.

Generally accepted accounting principles – 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. A genetic test is the analysis of human DNA, RNA, chromosomes, proteins and certain metabolites in order to detect heritable disease-related genotypes, mutations, phenotypes or karyotypes for clinical purposes. Genetic tests can have diverse purposes, including the diagnosis of genetic diseases in newborns, children and adults; the identification of future health risks; the prediction of drug responses; and the assessment of risks to future children.

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

Geriatric service – The branch of medicine dealing with the physiology of aging and the diagnosis and treatment of disease affecting the aged. Services could include: adult day care; Alzheimer's diagnostic and assessment services; comprehensive geriatric assessment; emergency response system; geriatric acute care unit; and/or geriatric clinics.

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 healthcare.

Global payment – A fixed payment given to healthcare 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. The governing body provides oversight and is accountable to the owner(s) of the hospital, which may be a corporation, the community, local government or stockholders.

Government Accountability Office – 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 Congress.

Government, nonfederal, state, local – Controlled by an agency of state, county or city government.

Graduate medical education – 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. GME programs are evaluated and accredited by the Accreditation Council for Graduate Medical Education.

Grandfathered – As used in connection with the Affordable Care Act, exempt from certain provisions of this law.

Grandfathered health plan – As used in connection with the Affordable Care Act, 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. A health plan must disclose in its plan materials whether it considers itself to be a grandfathered plan and must also advise consumers how to contact the U.S. Department of Labor or the U.S. Department of Health and Human Services with questions.

Gross domestic product – 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 and/or treatment through the joint use of equipment and personnel. The income from the

medical practice is distributed in accordance with methods determined by members of the group. Group practices have a single-specialty or multi-specialty focus.

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 – A GPO is an entity that helps healthcare providers — such as hospitals, nursing homes, surgery centers and clinics, and home health agencies — realize savings and efficiencies by aggregating purchasing volume and using that leverage to negotiate discounts with manufacturers, distributors and other vendors. Hospitals and other healthcare providers use group purchasing to obtain the best products at the best value.[49]

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

H

Hand hygiene – A way of cleaning one's hands that substantially reduces potential pathogens (harmful microorganisms) on the hands. Hand hygiene is considered a primary measure for reducing the risk of transmitting infection among patients and healthcare personnel. Hand hygiene procedures include the use of alcohol-based hand rubs (containing 60%-95% alcohol) and hand washing with soap and water.[50]

Health – Defined by the World Health Organization as "a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity."[51]

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

Healthcare benefits – The specific services and procedures covered by a health plan or insurer.

Healthcare ecosystem – Consists of providers, payers, consumers and regulators; essentially all that is required to deliver healthcare to individuals.[6]

Health Care Financing Administration – The federal government agency within 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 healthcare costs in the U.S.

Healthcare provider – An individual or institution that provides medical services (e.g., a physician, hospital, laboratory). This term should not be confused with an insurance company that "provides" insurance.

Healthcare reform – Changes to the overall healthcare delivery system: its structure, financing, coverage and services. The 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.[52]

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

Healthcare workforce development – The use of incentives and recruiting to encourage people to enter into healthcare professions such as primary care and to encourage providers to practice in underserved areas.

Health disparities – Differences in outcomes or disease burden among disparate groups.[6]

Health equity – The attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language or other factors that affect access to care and health outcomes.[2]

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 inequities – Differences in health outcomes that are avoidable, unfair and unjust, and make some population groups more likely to have poorer health outcomes than others.[6]

Health information exchange – Allows doctors, nurses, pharmacists, other healthcare 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.[53]

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

Health insurance – Financial protection against the healthcare costs caused by treating disease or accidental injury.

Health insurance exchange/connector – A purchasing arrangement through which insurers offer and smaller employers and individuals purchase health insurance. State, regional or national exchanges have been established to set standards for what benefits are covered, how much insurers should charge and the rules insurers must follow in order to participate in the insurance market. Individuals and small employers select their coverage within these arrangements.

Health Insurance Portability and Accountability Act of 1996 – A federal law that allows individuals 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. 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 – 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 – A healthcare 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 healthcare services for an individual or group of people.

Health Plan Employer Data and Information Set – A set of more than 90 standardized measures of health plan performance. HEDIS allows comparisons between plans on quality, access and patient satisfaction, membership and utilization, financial information, and health plan management. HEDIS was developed by employers, HMOs and the National Committee for Quality Assurance.[54]

Health professional shortage area – Geographic area, population or facility designated by the federal government as having shortages of primary care, dental or mental healthcare providers.

Health reimbursement account – 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 be.

Health-related social needs – Social and economic needs that individuals experience that affect their ability to maintain their health and wellbeing. HRSNs put individuals at risk for worse health outcomes and increased healthcare use. HRSN refers to individual-level factors such as financial instability and lack of access to healthy food, affordable and stable housing and utilities, healthcare and transportation.[2]

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

Health Resources and Services Administration – An agency of the U.S. Department of Health and Human Services that provides healthcare to people who are geographically isolated, and/or economically or medically vulnerable. This includes people living with HIV/AIDS, pregnant women, mothers and their families and those otherwise unable to access high-quality healthcare. HRSA supports the training of health professionals, the distribution of providers to areas where they are needed most and improvements in healthcare delivery. In addition, HRSA oversees organ, bone marrow and cord blood donation. It compensates individuals harmed by vaccination and maintains databases that flag providers with a record of healthcare malpractice, waste, fraud and abuse for federal, state and local use.[55]

Health savings account – A health insurance option that includes a medical savings account designed to help individuals 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 medical conditions (both physical and mental health), claims experience, receipt of healthcare, medical history, genetic information, evidence of insurability and disability.

Healthcare and public health sector-specific cybersecurity performance goals – The Department of Health and Human Services helps the healthcare and public health critical infrastructure sector prepare for and respond to cyber threats, adapt to the evolving threat landscape and build a more resilient sector. These voluntary healthcare specific cybersecurity performance goals help healthcare organizations prioritize implementation of high-impact cybersecurity practices. The HPH CPGs are designed to

better protect the healthcare sector from cyberattacks, improve response when events occur and minimize residual risk. HPH CPGs include both essential goals to outline minimum foundational practices for cybersecurity performance and enhanced goals to encourage adoption of more advanced practices.[4]

Healthcare Common Procedure Coding System – A uniform method for healthcare providers and medical suppliers to code professional services, procedures and supplies.

Healthcare Facilities Accreditation Program – Nationally recognized accreditation organizaiton with deeming authority from the Centers for Medicare & Medicaid Services to survey all hospitals and other healthcare facilities for compliance with the Medicare Conditions of Participation and Coverage.

Healthcare Financial Management Association – A non-profit membership organization for healthcare financial management executives.

Heart transplant – *See 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 – 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 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 of financial assistance created by the Hospital Survey and Construction Act of 1946 for the construction and modernization of healthcare facilities. In return for this funding, hospitals are required to provide a specified level of charity care each year. Named for its two principal congressional proponents, Hill and Burton, the program stopped providing funds in 1997, but about 140 healthcare facilities nationwide are still obligated to provide free or reduced-cost care. Since 1980, more than $6 billion in uncompensated services have been provided to eligible patients through Hill-Burton.[56]

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; you must not have other health insurance; and you must apply for individual health insurance within 63 days of losing your prior creditable coverage. When you're buying individual health insurance, HIPAA eligibility gives you greater protections than you would otherwise have under state law.

HIV/AIDS services – Designated and equipped units or services specifically for diagnosis, treatment, continuing care planning and counseling services for HIV/AIDS patients and their families. General inpatient care for HIV/AIDS refers to inpatient diagnosis and treatment for human immunodeficiency virus and acquired immunodeficiency syndrome patients, but a dedicated unit is not available. Specialized outpatient program for HIV/AIDS refers to special outpatient program providing diagnostic, treatment, continuing care planning and counseling 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 their parts; that body, mind and spirit must be in harmony to achieve optimum health, and, therefore, that a multidisciplinary approach to healthcare is required.

Home health care – Healthcare 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 such as bathing on an intermittent basis (for example, twice per week). Healthcare 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 healthcare 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 as well as 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 healthcare financing or provider organizations.

Hospital Consumer Assessment of Healthcare Providers and Systems – 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.[57]

Hospital Inpatient Quality Reporting Program – Under this program, the Centers for Medicare & Medicaid Services 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 healthcare. 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 website. Data for selected measures are also used for paying a portion of hospitals based on the quality and efficiency of care.[58]

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 – 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.[59]

Hospital readmission – A situation where you were discharged from the hospital and wind up going back in for the same or related care within 30, 60 or 90 days. The number of hospital readmissions is often used in part to measure the quality of hospital care, since it can mean that your follow-up care wasn't properly organized, or that you weren't fully treated before discharge.

Hospital unit – The hospital operation, excluding activity pertaining to nursing home-type unit (as described later), 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 within a nonhospital unit. An example is an infirmary that is contained within a college.

Hospital-acquired conditions – "Reasonably preventable" conditions or events during a hospital stay, which include conditions, such as cather-associated urinary tract infections and foreign body retained after surgery. These conditions are considered: (a) high cost or high volume or both, (b) result in the assignment of a case to a diagnosis-related group that has a higher payment when present as a secondary diagnosis, and (c) could reasonably have been prevented through the application of evidence based guidelines. The Centers for Medicare & Medicaid Services began publishing HAC performance on the Hospital Compare website in 2011. Medicare payments to hospitals may be reduced based on HACs that were not present on admission.[60]

Hospitalist – Physician whose primary professional focus is the general medical care of hospitalized patients. Activities include patient care, teaching, research and leadership related to hospital medicine.[61]

Hospital-physician alliance – 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. Examples of formal HPA structures include physician-hospital organizations for managed care contracting, management service organizations for practice management and integrated delivery systems for development of a broad range of clinical services.

Hospitals in a network – Hospitals participating in a group that may include other hospitals, physicians, other providers, insurers and/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 and/or manages health provider facilities or health-related subsidiaries; the system may also own non-health-related facilities such as a fitness center.

I

Image-guided radiation therapy – 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.

Implicit biases – Attitudes and stereotypes that people unknowingly hold, also known as unconscious or hidden biases. Many studies have indicated that implicit biases affect individuals' attitudes and actions, thus creating real-world implications.[6]

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. The purpose of the report is to document the exact details of the occurrence while they are fresh in the minds of those who are involved or witness the event. Incident reports are used to identify opportunities to improve safety and reduce risk in a healthcare setting.

Inclusion/inclusiveness – A dynamic state of operating in which diversity is leveraged to create a fair, healthy and high-performing organization or community. An inclusive environment ensures equitable access to resources and opportunities for all. It also enables individuals and groups to feel safe, respected, engaged, motivated and valued for who they are and for their contributions toward organizational and societal goals.[6]

Incurred but not reported – An accounting term that means healthcare 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 individual 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 – 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 and/or managed care organizations. IPAs assist solo physicians in obtaining managed care contracts.[63]

Independent Payment Advisory Board – 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 Service – An agency within the Department of Health and Human Services, the IHS is the principal federal healthcare provider and health advocate for American Indians and Alaska Natives, and its goal is to raise their health status to the highest possible level.[64]

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

Indigent care clinic – Healthcare services for uninsured and underinsured persons 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 healthcare 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 utilization 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 mandate – 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 would have to obtain it or pay a penalty. The federal tax penalty was eliminated in 2019.

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 – 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 Healthcare Improvement – An independent nonprofit organization that focuses on improving healthcare. IHI's mission is "Everyone has the best care and health possible." To accelerate the path to the health and care we need, IHI created the Triple Aim, a framework for optimizing the health system. Today, IHI is an influential force in health and healthcare improvement in the U.S. and dozens of other countries.[65]

Institutional racism – Institutional racism refers specifically to the ways in which institutional policies and practices create different outcomes for different racial groups. The institutional policies may never mention any racial group, but their effect is to create advantages for white people and oppression and disadvantage for people from groups classified as people of color.[6]

Institutional Review Board – 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 non-profit 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 individuals not covered by employer-based or government health insurance. A federal exchange is available for those living in states that have chosen not to create their own.

Integrated delivery system – 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 – 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 healthcare 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 – 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 – 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 (sometimes referred to as critical care unit or CCU). ICUs are categorized by levels, based on their capacity to provide certain life-sustaining treatments.[66]

Intergovernmental transfer – The transfer of public funds between governmental entities either between one level of government to another or within the same level of government. In healthcare 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 – 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) – 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.[67]

International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10) – An international system, maintained and published by the World Health Organization, used by physicians and other healthcare 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 currently in use.

International Organization for Standardization – Organization established to develop a set of international standards for quality management in manufacturing and service businesses, including healthcare.

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

Interpretive Guidelines – Serve to interpret and clarify the conditions (or requirements for SNFs and NFs). The Interpretive Guidelines merely define or explain the relevant statute and regulations and do not impose any requirements that are not otherwise set forth in statute or regulation.[68]

Intraoperative magnetic resonance imaging (Interoperative MRI) – An integrated surgery system which provides an MRI system in an operating room. Intraoperative MRI exists when an MRI (low-field or high-field) is placed in the operating theater and is used during surgical resection without moving the patient from the operating room to the diagnostic imaging suite.

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.

J,K

Job-based health plan – Coverage that is offered to an employee (and often their family) by an employer.

Joint Commission on the Accreditation of Healthcare Organizations – Now known as The Joint Commission, a national private, non-profit organization that accredits healthcare organizations and agencies and sets guidelines for operation for these facilities.

Joint Commission Resources – A nonprofit affiliate of The Joint Commission that offers healthcare 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 – 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 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.

L

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

Length of stay – The number of days between a patient's admission and discharge from a hospital; a standard measurement of hospital usage. Average length of stay is determined by total discharge days divided by total discharges. A standard measurement of hospital usage.

Licensed facilities – Healthcare facilities that offer healthcare 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 – A licensed nurse who has graduated from an approved school of practical (vocational) nursing, and works under the supervision of registered nurses and/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 an individual the legal right to practice an occupation; grants an organization the legal right to engage in an activity, such as operation of a hospital; and prohibits all other individuals and organizations from legally doing so, to ensure that public health, safety and welfare are reasonably well protected.

Lifetime benefit maximum – A cap on the amount of money insurers will pay toward the cost of healthcare services over the lifetime of the insurance policy. Lifetime benefit maximums are now prohibited.

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.

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

Liquidity – Financial ratios that measure the ability of a corporation to meet 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 – 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 individuals 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 – Residential healthcare facility that administers health, rehabilitative and/or personal services for a prolonged period of time. Long-term care facilities include nursing homes and assisted living facilities.

Long-term care hospital – 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. An LTCH must be certified as an acute-care hospital that meets criteria to participate in the Medicare program and has an average inpatient length of stay greater than 25 days.

M

Machine learning – A type of artificial intelligence that enables computers to learn without being programmed by humans. Machine learning allows a computer to analyze data to do a task without being explicitly programmed. Machine learning can help process massive amounts of data that are hard for humans to do at scale, across different modalities like images, audio, free text, genomic data and others. It also helps us discover relationships in the data that are hard for traditional methods to find.[7]

Magnet Hospital Recognition Program – Developed by the American Nurses Credentialing Center to recognize healthcare organizations that provide nursing excellence and to disseminate successful nursing practices and strategies.[69]

Magnetic resonance imaging – The use of a uniform magnetic field and radio frequencies to study tissue and structure of the body. This procedure enables the visualization of biochemical activity of the cell in vivo without the use of ionizing radiation, radioisotopic substances or high-frequency sound.

Maintenance Management Information System – Integrated computer system that automates claims processing and information retrieval for Medicaid.[70]

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

Malware – A program that is inserted into a system, usually covertly, with the intent of compromising the confidentiality, integrity or availability of the victim's data, applications or operating system or otherwise annoying or disrupting the victim.[2]

Managed care – A term covering a broad spectrum of arrangements for healthcare 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 – 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 – A system that produces the necessary information in proper form and at appropriate intervals for the management of a program or other activity. The system ideally measures program progress toward objectives and reports costs and problems needing attention. Special efforts have been made in the Medicaid program to develop information systems for each state program.

Management services organization – 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/administrative systems for a fee.

Mandate – Law requiring that a health plan or insurance carrier 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 healthcare 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. The number and type of these mandatory benefits vary across states.

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; and SNF, home health agency and renal dialysis facility operating and capital inputs. This index allows for the Centers for Medicare & Medicaid Services to update its payment systems appropriately.

Market share – In the context of managed care, that 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 – Changes in the general healthcare 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. Thus, the strategy is based on marketplace dynamics of competition and price rather than government regulation, management or rate setting.

Master of Science in Nursing – An advanced nursing degree that registered nurses pursue in order to become a specialized nurse (e.g., 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 individuals' homes on a regular basis.

Meaningful use – Defined by the use of certified electronic health record technology in a meaningful manner (for example, electronic prescribing); ensuring that the certified EHR technology is connected in a manner that provides for the electronic exchange of health information to improve the quality of care; and that in using certified EHR technology the provider must submit to the Secretary of Health and Human Services information on quality of care and other measures. The Centers for Medicare & Medicaid Services grants an incentive payment to eligible professionals or eligible hospitals who can demonstrate that they have engaged in efforts to adopt, implement or upgrade certified EHR technology.[72]

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 individuals. The program provides healthcare to qualifying individuals 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.[73]

Medicaid Integrity Contractors – Firms chosen by the Centers for Medicare & Medicaid Services to perform audits, identify overpayments and conduct education on payment integrity and quality of care.[74]

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

Medicaid Integrity Program – A comprehensive plan established by the Centers for Medicare & 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 coverage to populations who are not otherwise eligible.[75]

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 – A healthcare setting where patients receive comprehensive primary care services; have an ongoing relationship with a primary care provider who directs and coordinates their care; have enhanced access to non-emergent primary, secondary and tertiary care; and have access to linguistically and culturally appropriate care. Also 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 healthcare 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 they will spend on healthcare.

Medical loss ratio – The percentage of premium dollars an insurance company spends on clinical services and quality improvement rather than on administrative costs or profits. The Affordable Care Act requires insurers in the large group market to have a ratio of 85 percent. Insurers in the small group and individual markets must have a ratio of 80 percent. Managed care plans in Medicaid and CHIP must have a ratio of 85 percent.[76]

Medical malpractice – Medical malpractice occurs when a hospital, doctor or other healthcare 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.[71]

Medical power of attorney – A legal document that allows individuals to designate another person to make healthcare decisions on their behalf if they are unable to do so themselves. Often referred to as a durable power of attorney for healthcare.

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. The purposes of the record are to (1) serve as the basis for planning and continuity of patient care; (2) provide a means of communication among physicians and other professionals contributing to the patient's care; (3) furnish documentary evidence of the patient's course of illness and treatment; (4) serve as a basis for review, study and evaluation; and (5) provide data for use in research and education. The content of the record is confidential.

Medical savings account – A health insurance option consisting of a high-deductible insurance policy and tax-advantaged saving account. Individuals pay for their own healthcare up to the annual deductible by withdrawing from 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, responsibilities and rights of physicians and other health professionals who are part of a hospital's medical staff.

Medical staff organization – The body that includes fully licensed physicians, and may include other licensed individuals 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. Includes mixed intensive care units.

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

Medical underwriting – A process that insurance companies routinely used prior to 2014 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.[77]

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 over and to certain disabled individuals 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 & Medicaid Services.

Medicare administrative contractor – A private healthcare insurer that has regional jurisdiction, awarded by the Centers for Medicare & Medicaid Services, 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 Beneficiary Quality Improvement Project – The MBQIP was created to improve the quality of care patients receive in critical access hospitals. MBQIP focuses these efforts in the 45 states that participate in the Medicare Rural Hospital Flexibility Program. Through Flex, MBQIP works with rural CAHs to use quality measure data for quality improvement activities. MBQIP supports CAHs in reporting on quality measures. Most quality measures are collected through the Centers for Medicare & Medicaid Services quality reporting programs. These measures help CAHs understand healthcare processes, outcomes, patient perceptions of care and organizational structure to guide decisions about improvements to healthcare services.[55]

Medicare cost report – 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, as well as the percentage of these costs allocated to Medicare patients and the Medicare payments received.

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.[79]

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 both employees and employers to fund Medicare.

Medicare Payment Advisory Commission – A nonpartisan legislative branch agency that provides Congress with analysis and policy advice on the Medicare program.[80]

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. Pricing amounts are adjusted to reflect the variation in practice costs from area to area.[78]

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 individual 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 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 Rural Hospital Flexibility (Flex) Program – Enables states to support critical access hospitals in quality improvement, quality reporting, performance improvement and benchmarking; assists facilities seeking designation as CAHs; and establishes or expands programs for the provision of rural emergency medical services. The Flex Program aims to provide training and technical assistance to build capacity, support innovation and promote sustainable improvement in the rural healthcare system. The overall goal of the Flex Program is to ensure that high-quality healthcare services are available in rural communities and aligned with community needs.[55]

Medicare-severity DRGs – A refinement of the diagnosis-related group classification system to more fairly compensate hospitals for treating severely ill Medicare patients by adding diagnosis-related groups 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. Medigap insurance must conform to one of ten federally standardized benefit packages.

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 – 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/devices.

Metropolitan statistical area – A geographic area that includes at 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).

mHealth – Mobile-health technology (mHealth) lets healthcare providers collect data on handheld electronic devices such as cell phones or tablets and use that data to predict the optimal timing for delivering treatments and health-education messages to patients.[4]

Mid-level practitioner – 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 they practice, to dispense a controlled substance in the course of professional practice. Examples of mid-level practitioners include, but are not limited to, healthcare providers such as nurse practitioners, nurse midwives, nurse anesthetists and physician assistants who are authorized to dispense controlled substances by the state in which they practice.[81]

Minimum essential coverage – The type of coverage a person needs to have to meet the individual responsibility requirement under the Affordable Care Act. This includes individual market policies, job-based coverage, Medicare, Medicaid, CHIP, TRICARE and certain other coverage.

Mission statement – A goal statement developed by healthcare 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 wellbeing. In practical language, morbidity comprises disease, injury and disability. Morbidity rates refer to either incidence or prevalence.

Mortality – Incidence of death in a defined population.

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

Multi-hospital system – Two or more hospitals owned, leased, contract managed or sponsored by a central organization. They can be either not-for-profit or investor-owned hospitals.

Multi-institutional system – An organization affiliation among two or more healthcare 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.

N

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

National Committee for Quality Assurance – An independent nonprofit organization that works to improve healthcare quality through the administration of evidence-based standards, measures, programs and accreditation. NCQA also helps track the quality of care delivered nationwide by health plans.

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

National Incident Management Systems – 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 – Agency of the U.S. Department of Health and Human Services responsible for the nation's medical research. The largest biomedical research agency in the world, the NIH is made up of 27 components that each focus on a specific area of research, the majority of which are funded directly by Congress. NIH's mission is to seek fundamental knowledge about the nature and behavior of living systems and the application of that knowledge to enhance health, lengthen life and reduce illness and disability.[82]

National Labor Relations Board – 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, to determine whether to have unions as their bargaining representative, to engage in collective bargaining, and to refrain from any of these activities. The NLRB acts to prevent and remedy unfair labor practices committed by private sector employers and unions.[83]

National Patient Safety Goals – 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.[84]

National Practitioner Data Bank – An electronic information repository created by the Congress that contains information on medical malpractice payments and certain adverse actions related to healthcare 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.[85]

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 – Required by HIPAA, this is a unique 10-digit identification number assigned by the Centers for Medicare & Medicaid Services to each covered healthcare provider to use for billing purposes. The purpose of these provisions is to improve the efficiency and effectiveness of the electronic transmission of health information.[2]

National Quality Forum – A membership-based organization that works to improve healthcare by establishing national priorities and goals, creating quality standards and continuously driving improvement among healthcare leaders.[86]

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 – 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 1500 grams). NICU has potential for providing mechanical ventilation, neonatal surgery and special care for the sickest infants born in the hospital or transferred from another institution. A full-time neonatologist serves as director.

Neonatal intermediate care – A unit that must be separate from the normal newborn nursery and that provides intermediate and/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 from 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, that delivers 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 – As 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. In the individual health insurance market, a plan that your family is purchasing for the first time will generally be a new plan. In the group health insurance market, a plan that your employer is offering for the first time will generally be a new plan. New employees and new family members may be added to existing grandfathered group plans — so a plan that is "new to you" and your family may still be a grandfathered plan. In both the individual and group markets, a plan that loses its grandfathered status will be considered a new plan. A health plan must disclose in its plan materials whether it considers itself to be a grandfathered plan and must also advise consumers how to contact the U.S. Department of Labor or the U.S. Department of Health and Human Services with questions.

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

Nondiscrimination – A requirement that job-based coverage not discriminate based on health status. Coverage under job-based plans cannot be denied or restricted. You also can't be charged more because of your health status. 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 not-for-profit organizations, including religious organizations (Catholic hospitals, for example), fraternal societies and others.

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

Nosocomial infection – Infections acquired from a healthcare 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. Such an infection can be measured by its rate of frequency of occurrence.

No Surprises Act – Went into effect on Jan. 1, 2022, with the goal of protecting patients from "surprise medical bills" when they receive emergency care and/or when they receive non-emergency care from an out-of-network provider at an in-network facility. The Act prohibits "balance billing" for out-of-network situations where the patient did not have a choice of provider. Balance billing is when a provider charges the consumer for the part of the bill not covered by their insurance company. The Act still holds patients liable for their in-network cost sharing, while allowing providers and insurers an opportunity to negotiate reimbursement. The Act also requires providers and health insurance companies to help patients access and understand healthcare cost information.[2]

Not-for-profit hospital – A not-for-profit 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 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 – 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 healthcare settings. NPs are qualified to prescribe medicine, order tests, conduct physical examinations and procedures, and provide treatment.[87]

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, including licensed vocational or practical nurse, associate degree in nursing, registered nurse, Bachelor of Science in Nursing, Master of Science in Nursing, Doctor of Philosophy in Nursing and Doctor of Nursing Practice.

Nursing-home-type unit/facility – A unit/facility that primarily offers the following types 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 individuals 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 who do 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 within a healthcare facility designed to provide inexpensive, nutritionally sound meals to patients.

O

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, that 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 – Agency of the U.S. Department of Labor charged ensuring workplaces are safe and healthy. Primary responsibilities include establishing rules, monitoring compliance through inspection and enforcing rules through penalties and fines for non-compliance.

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 – 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 – Federal office that is part of the Office of Rural Health Policy (within HRSA) created to promote the wider adoption of advanced

technologies in providing healthcare 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 – 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 – 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/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.

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

Open enrollment period – The 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 – 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 – Local organizations throughout the U.S., designated by the Centers for Medicare & Medicaid Services, responsible for increasing the number of registered donors in their service areas and for coordinating the donation process when actual donors become available. OPOs evaluate potential donors, discuss donation with surviving family members and arrange for the surgical removal and transport of donated organs. To increase donor registration, OPOs implement community outreach strategies to encourage people to sign up in their state donor registry.[88]

Organized health care arrangement – 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 – An 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.[89]

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.[90]

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. It

provides special expertise and facilities for the support of vital function and utilizes the skill of medical nursing and other staff experienced in the management of these problems. 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 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. Patients admitted to this area are usually transferred here from an intensive care unit once their condition has improved. 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 – Data elements developed for the purpose of performance improvement in home healthcare 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 CoPs.

Outcomes – The result of healthcare that is usually measured in terms of cost, mortality, health status and quality of life or patient function. Outcome measures are the specific criteria used to determine or describe the outcome.

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 – Healthcare 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 as well as payments for deductibles and coinsurance for covered services, for services not covered by the plan, for provider charges in excess of the plan's limits and 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 and/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. In addition to treating minor illnesses or injuries, a freestanding center will stabilize seriously ill or injured patients before transporting them to a hospital. Laboratory and radiology services are usually available.

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 healthcare 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 – Method of financing healthcare 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. The surgery may be performed in operating suites also used for inpatient surgery, specially designated surgical suites for outpatient surgery or procedure rooms within an outpatient care facility.

Outpatient visit – A visit by a patient who is not lodged in the hospital while receiving medical, dental or other services. Each visit an outpatient makes to a discrete unit constitutes one visit regardless of the number of diagnostic and/

or therapeutic treatments that the patient receives. Total outpatient visits should include all clinic visits, referred visits, observation services, outpatient surgeries and emergency room visits.

Over-the-counter drugs – Drugs sold without a prescription from a healthcare provider. Examples include medications for treatment of mild pain or fever.

P

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, such as copayments. Paid claims are only those costs for which the plan is responsible according to the contract between the provider and the plan.

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 along with emotional and spiritual support from a team of caregivers.

Palliative care inpatient unit – 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 and/or the control of symptoms administered by specially trained physicians and other clinicians; and supportive care services, such as 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 Hospital Insurance 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 (Hospital Insurance) and Part B (Medical Insurance) coverage. Medicare Advantage Plans may offer extra coverage, such as vision, hearing, dental and/or health and wellness programs. Most include Medicare prescription drug coverage (Part D). 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.[91]

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 – An individual who supports a patient as they navigate the healthcare system. This individual investigates and mediates patients' problems and complaints regarding a healthcare 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. The goal is to empower the patient and doctor with additional information to make sound healthcare decisions.

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 days are used in accounting, in which each day represents a unit of time and are used in calculating the cost of care. Each calendar day of

care provided to a hospital inpatient under the terms of the patient's health plan excluding the day of discharge. "Patient days" is a measure of institutional use and is usually stated as the accumulated total number of inpatients (excluding newborns) each day for a given reporting period, tallied at a specific time (e.g., midnight) per 1,000 use rate, or patient days/1,000. Patient days are calculated by multiplying admissions by average length of stay.

Patient "dumping" – The refusal to examine, treat and stabilize any person irrespective of payer/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 and/or family related to therapeutic regimens, medical procedures and self care. An example is a diabetes education center.

Patient experience – Encompasses the range of interactions that patients have with the healthcare system, including their care from health plans and from doctors, nurses and staff in hospitals, physician practices and other healthcare facilities.[92]

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 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 – Defined by the Institute of Medicine as "the prevention of harm to patients." Emphasis is placed on the system of care delivery that (1) prevents errors; (2) learns from the errors that do occur; and (3) is built on a culture of safety that involves healthcare professionals, organizations, boards of trustees and patients.[4]

Patient Safety and Quality Improvement Act – Established a voluntary reporting system designed to enhance the data available to assess and resolve patient safety and healthcare quality issues. To encourage the reporting and analysis of medical errors, PSQIA provides federal privilege and confidentiality protections for patient safety information, called patient safety work product. PSQIA also authorizes the Agency for Healthcare Research and Quality to list patient safety organizations. They are the external experts that collect and review patient safety information.[93]

Patient Safety Organization – A collaboration of healthcare organizations that share in the goal of improving the safety and quality of healthcare delivery by learning from one another through the voluntary confidential sharing of privileged information in a legally secure environment. Organizations eligible to become federally certified PSOs under the Patient Safety and Quality Improvement Act include public or private entities, for-profit or nonprofit entities, provider entities such as hospital chains and other entities that establish special components to serve as PSOs.

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 healthcare 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 and/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 a patient of their rights and responsibilities concerning their own healthcare, such as privacy and confidentiality.

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

Payer (or payor) – Any agency, insurer or health plan that pays for healthcare 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 an iteration of the Centers for Medicare & Medicaid Services and the Center for Medicare and Medicaid Innovation (Innovation Center) continuing efforts in implementing voluntary episode payment models. The model aims to support healthcare 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. BPCI Advanced will qualify as an Advanced Alternative Payment Model under the Quality Payment Program. The overarching goals of the BPCI Advanced Model are care redesign, healthcare provider engagement, patient and caregiver engagement, data analysis/feedback and financial accountability.[94]

Payment rate – The total amount paid for each unit of service rendered by a healthcare provider, including both the amount covered by the insurer and the consumer's cost sharing: sometimes referred to as payment level. Also used to refer to capitation payments to health plans. For Medicare payments

to physicians, this is the same as the allowed charge. *See Allowed charge.*

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 (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.

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. 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.

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 – Nonsurgical 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 – An independent organization contracted with the Centers for Medicare & Medicaid Services 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.

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 derived by dividing their total costs by the number of inpatient days of care given.

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 Capitation.*

Per member per month – 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 or per contract per month.

Performance measure – A quantitative tool (e.g., rate, ratio, index, percentage and so on) 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 – 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, for example, hospitals, doctors' offices and clinics.

Personnel – Number of persons 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, as well as 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 and/or

vocational services to help disabled persons attain or retain their maximum functional capacity.

Physician assistant – A trained, licensed individual 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 (medical, education, training, licenses, etc.) 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 – A practice of two or more physicians representing one or more specialties to provide healthcare 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 – Independent legislative advisory group created in 1986 to provide advice to Congress on reforms in the methods used to pay physicians in the Medicare program.

Physician Hospital Organization – (1) A structure in which a hospital and physicians — both in individual and group practices — negotiate as an entity directly with insurers. (2) 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. To find out when your plan year begins, you can check your plan documents or ask your employer. (Note: For individual health insurance policies this 12-month period is called a "policy year.")

Point-of-care testing – Clinical laboratory testing conducted close to the site where patient care treatment is provided. POCT provides rapid turnaround of test results so that appropriate treatment can be implemented, leading to improved clinical or economic outcomes compared to laboratory testing. Technological advances, such as miniaturization of electronics and improved instrumentation, have revolutionized POCT, enabling the development of smaller and more accurate devices. POCT can be performed by various healthcare professionals and, in some cases, even by patients themselves.[4]

Point of service plans – A managed care insurance plan that allows patients to pay less for care if they use healthcare providers that fall within the plan's network. Additionally, this plan requires referral from a primary care doctor in order for a patient to see a specialist. Similar to an HMO plan, a patient will designate a primary care physician that falls within the network, but similar to a PPO plan, patients are allowed to seek care outside of the network — they will likely just have to absorb most of the cost.

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 1,000 population.

Population health management – Refers to the process of improving clinical health outcomes of a defined group of individuals through improved care coordination and patient engagement supported by appropriate financial and care models.[6]

Population profile – A statistical summary of population-specific healthcare data used to assess healthcare delivery.

Portability – An individual'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 – A 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. PET scanning produces sectional images depicting metabolic activity or blood flow rather than anatomy. It provides metabolic functional information for the monitoring of chemotherapy, radiotherapy and surgical planning.

Postnatal care – Healthcare services received by a birthing person immediately following the delivery of their child.

Potentially preventable admission – A hospital stay that could have been avoided had there been access to ambulatory care or the correct healthcare coordination.

Potentially preventable complication – 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 – 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 healthcare 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 healthcare 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.

Precision medicine – An emerging approach to disease prevention and treatment that considers the unique genes and environment of each patient. The ultimate goal of precision medicine is to provide the right treatment at the right time, tailored to a patient's individual needs.[4]

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 individuals 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 healthcare providers from insurance companies and other payers based on negotiated discounts off of providers' regular charges.

Preferred Provider Organization – A pre-set arrangement in which purchasers and providers agree to furnish specified health services to a group of employees/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. There are different kinds of premiums. A per-person premium is a fixed amount of money paid by employers and employees for insurance. A wage-based premium is based on a percentage of payroll.

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 an individual'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 healthcare 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 the Centers for Medicare & Medicaid Services. 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 healthcare – 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 healthcare provided by the physician from whom an individual has an ongoing relationship and who knows the patient's medical history. Primary care services emphasize a patient's general health needs such as preventive services, treatment of minor illnesses and injuries or identification of problems that require

referral to specialists. 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 and/or nursing staff, focusing on diagnosing medical problems and providing medical treatment on an outpatient basis.

Primary care network – A group of primary care physicians who share the risk of providing care to members of a managed care plan. The PCP in a primary care network is accountable for the total healthcare services of a plan member, including referrals to specialists, supervision of the specialists' care and hospitalization.

Primary care physician or provider – 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 healthcare 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 and/or the insurer. Without prior authorization, the health plan or insurer will not pay for the test, drug or services and could result in increased costs for the patient.

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 not-for-profit 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 individual's professional license, experience, competence, ability and judgment. Also referred to as clinical privileges or 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 diagnosis-related group or product code.

Productivity – The relationship between service input and output. Typically productivity measures for labor costs include FTEs per patient day, FTEs per admission and FTEs per bed.

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 – 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.[95]

Profitability – A financial ratio that measures the earning power and earning record of a corporation.

Prospective Payment System – A method of reimbursement in which Medicare payment is made based on a predetermined, fixed amount. The payment amount for a particular service is derived based on the classification system of that service (for example, diagnosis related groups for inpatient hospital services). The Centers for Medicare & Medicaid Services uses separate PPSs for reimbursement to acute inpatient hospitals, home health agencies, hospices, hospital outpatient, inpatient psychiatric facilities, inpatient rehabilitation facilities, long-term care hospitals and skilled nursing facilities.[96]

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 healthcare to an individual that is created or received by a healthcare provider, health plan, employer or healthcare clearinghouse.

Protocols – Standards or evidence-based practices developed to assist healthcare providers and patients to make decisions about particular steps in the treatment process.

Proton beam therapy – Radiation therapy which administers proton beams. While producing the same biologic effects as X-ray beams, the energy distribution of protons differs from conventional X-ray beams in that they can be more precisely focused in tissue volumes in a three-dimensional pattern resulting in less surrounding tissue damage than conventional radiation therapy permitting administration of higher doses.

Provider – A hospital or healthcare professional who provides healthcare services to patients. May also be an entity (e.g., hospital, nursing home, physician group practice, treatment center, etc.) or a person (e.g., physician, nurse, physician's assistant, etc.).

Provider payment rates – The total payment a provider, hospital or community health center receives when they provide medical services to a patient. Providers are compensated for patient care using a set of defined rates based on illness category and the type of service administered.

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 the Centers for Medicare & Medicaid Services.[2]

Provider-sponsored network – An affiliation of providers (hospital, physician group or health system) that removes third-party or intermediary payers and offers a full range of healthcare services.

Provider-sponsored organization – A type of managed care plan that is operated by a group of doctors, hospitals and other healthcare providers that form a network of providers within which an individual must stay to receive coverage for care.

Psychiatric child-adolescent services – Provides behavioral or mental healthcare to emotionally disturbed children and adolescents, including those admitted for diagnosis and those admitted for treatment.

Psychiatric consultation-liaison service – Provides organized psychiatric consultation-liaison services to nonpsychiatric hospital staff and/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, clergy and so forth. The purpose is to expand the mental health knowledge and competence of personnel not working in the mental health field and to promote good mental health through improved understanding, attitudes and behavioral patterns.

Psychiatric emergency services – Services of facilities available on a 24-hour basis to provide immediate unscheduled outpatient care, diagnosis, evaluation, crisis intervention and assistance to persons 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 healthcare to emotionally disturbed patients, including patients admitted for diagnosis and those admitted for treatment of psychiatric problems, on the basis of physicians' orders and approved nursing care plans. Long-term care may include intensive supervision to the chronically mentally ill, mentally disordered or other mentally incompetent persons.

Psychiatric outpatient services – Provides psychiatric outpatients mental healthcare, including diagnosis and treatment.

Psychiatric partial hospitalization program – Organized hospital intensive day/evening outpatient services of three hours or 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 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 – A division of the U.S. Department of Health and Human Services responsible for the health and wellbeing of the American public by providing services for low-income families and individuals battling communicable diseases. PHS' responsibility includes environmental health as well as 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 healthcare risks of a group of people in order to make the individual costs predictable and manageable.

Q

Quadruple Aim – In 2014, the Quadruple Aim — adapted from the Institute for Healthcare Improvement's widely-accepted Triple Aim — was suggested as a framework to optimize healthcare system performance. The framework encompasses reducing costs, and improving population health and patient experience, with a new fourth domain: healthcare team wellbeing. These performance dimensions can be applied to far-reaching, crucial healthcare challenges, such as reducing the massive rates of burnout present in healthcare workers and combating rising healthcare costs.[4]

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. This allows consumers to verify that the plan they have purchased will meet at least the minimum requirements of the individual mandate.

Quality assessment – An activity that monitors the level of healthcare (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/or ensure the quality of care provided to patients. It can function independently on a broad range of topics related to healthcare quality.

Quality Improvement Organization – Mostly private, nonprofit organizations in every state staffed by doctors and other healthcare 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 the appropriate setting and if the quality of care is met. By law, the mission of the QIO program is to improve the effectiveness, efficiency, economy and quality of services delivered to Medicare beneficiaries.[97]

Quality Improvement Program – A continuing process of identifying problems in healthcare delivery and testing and continually monitoring solutions for constant improvement. QIP is a common feature of total quality management programs. The aim of QIP is the elimination of variations in healthcare 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 healthcare actually provided. Selected quality indicators of patient outcome are mortality and morbidity, health status, length of stay, readmission rate, patient satisfaction and so on.

Quality Innovation Network – A product of Quality Improvement Organizations, often referred to as a QIN-QIO. These are networks of healthcare providers who collaborate to improve services through education, outreach and 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, QIN-QIOs are able to help best practices for better care spread more quickly, while still accommodating local conditions and cultural factors.[2]

Quality of care – The Institute of Medicine defines healthcare quality as "the degree to which healthcare services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge."[98]

Quaternary care – Quaternary care is an advanced level of specialized care. It is considered an extension of tertiary care. However, it is even more specialized and highly unusual. Because it is so specific, not every hospital or medical center offers quaternary care. Some may only provide quaternary care for particular medical conditions or systems of the body. The types of quaternary care include experimental medicine and procedures and uncommon and specialized surgeries.[99]

Quintuple Aim – The Quintuple Aim was established in 2021 and adapted from the Institute for Healthcare Improvement's widely-accepted Triple Aim. The Quintuple Aim adds health equity to the previous four pillars of healthcare transformation: patient experience, outcomes, costs and clinician wellbeing. This model arises from our contemporary understanding of social determinants of health, which account for 70-80% of medical outcomes. Particularly, the COVID-19 pandemic highlighted prevalent health disparities and questioned the ethicality of the current distributions of resources in our communities. It also demonstrated that equity would produce better health for all members of society. Today, SDOHs are understood to include housing, food, transportation and more. Each of these impacts the individual and greater society, with implications for the development and prognosis of disease, access to care and cost.[4]

R

Radiology (Diagnostic) – The branch of radiology that deals with the utilization of all modalities of radiant energy in medical diagnoses and therapeutic procedures using radiologic guidance. This includes, but is not restricted to, imaging techniques and methodologies utilizing radiation emitted by X-ray tubes, radionuclides and ultrasonographic devices and the radiofrequency electromagnetic radiation emitted by atoms.

Radiology (Therapeutic) – The branch of medicine concerned with radioactive substances and using various techniques of visualization, with the diagnosis and treatment of disease using any of the various sources of radiant energy. Services could include megavoltage radiation therapy, radioactive implants, stereotactic radiosurgery, therapeutic radioisotope facility and X-ray radiation therapy.

Ransomware – A type of malicious software cyber actors use to deny access to systems or data. The malicious cyber actor holds systems or data hostage until the ransom is paid. After the initial infection, the ransomware attempts to spread to shared storage drives and other accessible systems. If the demands are not met, the system or encrypted data remain unavailable, or data may be deleted.[6]

Rapid response team – A group of trained healthcare professionals who respond to hospitalized patients with early signs of clinical deterioration on non-intensive care units to prevent events such as cardiac arrest.

Rate review – A process that allows state insurance departments to review rate increases before insurance companies can apply them to you.

Rate setting – A method of paying healthcare providers in which the federal or state government establishes payment rates for all payers for various categories of health services.

Reasonable and customary charge – Charge for healthcare which is consistent with the going rate or charge in a certain geographical area for identical or similar services.

Recovery audit contractor – The Medicare Fee for Service Recovery Audit Program's mission is to identify and correct Medicare improper payments through the efficient detection and collection of overpayments made on claims of healthcare services provided to Medicare beneficiaries, and the identification of underpayments to providers, so that the Centers for Medicare & Medicaid Services can implement actions that will prevent future improper payments in all 50 states. A recovery audit contractor reviews claims on a post-payment basis.[100]

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 of improving health and care in that community.

Registered nurse – Graduate from a college or university nursing education program who has met state board requirements and is licensed to practice by the state.

Registry – A database on 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. Also an official list of individuals with professional standing and/or credentials in specific healthcare occupations.

Rehabilitation facility – A facility that provides medical, health-related, social and/or vocational services to disabled persons to help them attain their maximum functional capacity.

Rehabilitation services – A wide array of restoration services for disabled and recuperating patients, including all 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 (insurers that provide healthcare coverage directly to policyholders) from other secondary insurers, called re-insurers, to protect against part or all losses the primary insurer might assume in honoring claims of its policyholders. Also known as excess risk insurance.

Relative value scale – An index that assigns weights to each medical service: the weights represent the relative amount to be paid for each service. The RVS used in the development of the 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. RVUs are often used in physician practice management to compare performance of doctors within a group.

Remote patient monitoring – A type of digital health platform which enables patients to be evaluated outside of a typical clinical visit, in their home or in their community. RPM programs collect data using symptom surveys, wearable sensors and other medical devices, and send this information to a healthcare practitioner to facilitate clinical assessment and decision-making.[4]

Reporting Hospital Quality Data 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. Acute-care hospitals face a reduction of 2 percent in their annual Prospective Payment System update for a given year unless they submit certain hospital quality data to the Centers for Medicare & Medicaid Services.

Rescission – The retroactive cancellation of a health insurance policy. Insurance companies will sometimes retroactively cancel your entire policy if you made a mistake on your initial application when you buy an individual market insurance policy. Under the Affordable Care Act, rescission is illegal except in cases of fraud or intentional misrepresentation of material fact as prohibited by the terms of the plan or coverage.

Resident – A medical school graduate participating in an accredited program of graduate medical education sponsored by a hospital and receiving professional training under the supervision of a physician. First-year residents typically are referred to as interns.

Residency – A crucial phase in a physician's training, following the completion of medical school. It is a supervised clinical training period and an intensive, full-time job — requiring 60-80 hours per week — which provides physicians, also referred to as residents or trainees, with hands-on experience and increasing autonomy in delivering healthcare under the guidance of experienced attending physicians.[7]

Resource-based relative value scale – A fee schedule for physicians used by Medicare reflecting the value of one service relative to others in terms of the resources required to perform the service.

Respite care – Temporary relief to people who are caring for elderly or disabled relatives who require 24-hour care; that is, offering them a break from their caregiving activities.

Restraint – A physical hold that restricts a patient's movement when the patient's behavior presents a danger to themself, staff or others.

Restricted funds – Includes all 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 which provides housing to older adults, usually retired persons, who do not require comprehensive healthcare services. Some short-term skilled nursing care may be provided. A retirement center may furnish housing and may also 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 divided by total assets; a financial tool to measure and relate a corporation's earnings to its total asset base.

Rider (Exclusionary rider) – A rider is an amendment to an insurance policy. Some riders will add coverage (for example, if you buy a maternity rider to add coverage for pregnancy to your policy). In most states today, an exclusionary rider is an amendment, permitted in individual health insurance policies, that permanently excludes coverage for a health condition, body part or body system. Starting in September 2010, under the Affordable Care Act, exclusionary riders cannot be applied to coverage for children. Effective 2014, exclusionary riders are not be permitted in any health insurance.

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 in order 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 aids managed care organizations and insurers in determining which products, benefit levels and prices to offer in order to best meet the needs of both the group and the plan.

Risk factor – Behavior or condition which, 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 within a healthcare 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 together individuals 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 assist patients who are relearning 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 – Systematic quality improvement process used to identify causal factors that underlie variations in performance or adverse events.

Rural Emergency Hospital – A new provider type established by the Consolidated Appropriations Act of 2021 to address the growing concern over closures of rural hospitals. The REH designation provides an opportunity for critical access hospitals and certain rural hospitals to avert potential closure and continue to provide essential services for the communities they serve. Conversion to a REH allows for the provision of emergency services, observation care and additional medical and health outpatient services, if elected by the REH, that do not exceed an annual per patient average of 24 hours. This provider type became effective on Jan. 1, 2023, and promotes equity in healthcare for those living in rural communities by facilitating access to needed services.[2]

Rural health center or clinic – An outpatient facility in a non-urbanized area (per the U.S. Census Bureau) primarily engaged in furnishing physicians' and other medical health services in accordance with certain federal requirements designed to ensure the health and safety of the individuals served by the health center. Rural health centers serve areas designated for their shortage of personal health services or a health workforce. A physician (MD or DO) is required to supervise the mid-level practitioner consistent with state and federal law.

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 regarding patient referral and transfer, the development and use of communication systems and the provision of emergency and non-emergency transportation.

Rural referral center – A Centers for Medicare & Medicaid Services classification for a rural facility that receives referrals from surrounding hospitals and provides high-volume acute care for a large number of complex cases. Several criteria must be met to be classified as an RRC.

Rural hospital – A facility located outside a Metropolitan Statistical Area, as designated by the U.S. Office of Management and Budget effective June 6, 2003. An urban area is a geographically defined, integrated social and economic unit with a large population nucleus. 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.[101]

S

Safe Harbor – A set of federal regulations providing safe refuge for certain healthcare 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 parent or parents to relinquish unharmed infants at designated sites. Child Protective Services assumes custody of the child and places them with an appropriate caregiver.

Safe Medical Devices Act – Federal law that requires that personnel 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 of 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 on requirements. The Sarbanes-Oxley Act of 2002 is mandatory.

Satellite emergency department – A facility owned and operated by the hospital for the provision of unscheduled outpatient services to patients whose conditions require immediate care. A freestanding ED is not physically connected to a hospital, but 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 healthcare to another.

Secondary care – Attention given to a person in need of specialty services, following referral from a source of primary care.

Section 125 plan – Allows employees to receive specified benefits, including health benefits, on a pre-tax basis. IRS Section 125 plans enable employees to pay for health insurance premiums on a pre-tax basis, 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. The SEC

strives to promote a market environment that is worthy of the public's trust.[102]

Self-insured – Employer or group of employers who 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 persons, groups or objects at risk.

Sentinel event – An unexpected occurrence or variation involving death or serious physical or psychological injury, or such a risk to a patient. Serious injury includes loss of limb or function. The event is called "sentinel" because it sounds a warning that requires immediate attention. The Joint Commission requests the voluntary reporting of such events by accredited healthcare organizations in order to learn from the collective root cause analyses and share this information with other healthcare organizations and the public.

Serious adverse event – The occurrence of patient harm in healthcare facilities that is often preventable and may be the unintended consequences resulting from individual 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 healthcare services.

Single-payer system – A healthcare reform proposal in which healthcare costs are paid by taxes rather than by the employer and employee. All people 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 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 2-50 employees can purchase health insurance for their employees through this market, which is regulated by states.

Small Rural Hospital Improvement Program – Funded through the Health Resources and Services Administration, this program helps rural hospitals with 49 or fewer beds. Hospitals use SHIP funds to improve operations including hardware, software and training. Funding varies by program and state. The program serves over 1,600 small, rural hospitals and critical access hospitals across the U.S. SHIP helps hospitals to improve on how to collect data for reports; help boost quality outcomes; improve accountability of care; and maintain accurate billing and coding.[55]

Social determinants of health/Social drivers of health – The conditions in the environments where people are born, live, learn, work, play, worship and age that affect a wide range of health, functioning and quality-of-life outcomes and risks.[1]

Social work services – Organized services that are properly directed and sufficiently staffed by qualified individuals who 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 healthcare financing and delivery system in which doctors work for the government and receive a salary for their services.

Societal factors – The multifaceted conditions, circumstances and causes that influence the health of patients, including social determinants of health. These include, for example, racism, sexism, generational poverty or redlining.[6]

Sole community provider – A healthcare facility designated by Medicare as meeting criteria including being located 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 like 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 you and your 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 healthcare need – The healthcare 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 healthcare 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 relationship between a religious or other sponsoring organization and a hospital that may set limits on the activities undertaken within the hospital or is intended to further the objectives of the sponsoring organization but does not involve ownership or other legal relationships.

Sports medicine – Provision of 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 employees divided by the average daily census.

Standard benefit package – A defined set of benefits provided to all people 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 in light of the present state of medical or surgical science.

Stark Law – Federal law that bans physicians from referring patients to entities with which the physician has a financial relationship. This financial relationship could include ownership, investment or a structured compensation arrangement.

State Children's Health Insurance Program – 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 check-ups, immunizations, doctor visits and prescriptions.[103]

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, state 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 other individuals are third-party beneficiaries under the policy. Also known as excess risk insurance.

Stereotactic radiosurgery – A radiotherapy modality that delivers a high dosage of radiation to a discrete treatment area in as few as one treatment session. SRS includes gamma knife, cyberknife, etc.

Structural barriers – Obstacles that collectively affect a group disproportionately and perpetuate or maintain stark disparities in outcomes. Structural barriers can be policies, practices and other norms that favor an advantaged group while systematically disadvantaging a marginalized group.[6]

Structural racism – Structural racism is the normalization and legitimization of an array of dynamics — historical, cultural, institutional and interpersonal — that routinely advantage white people while producing cumulative and chronic adverse outcomes for people of color. It is a complex system by which racism is developed, maintained and protected.[6]

Subacute care – A level of care that is usually described as 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 individuals 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 without regard to previous work or contributions.

Support groups – A hospital-sponsored program that allows a group of individuals with the same or similar problems who meet periodically to share experiences, problems and solutions in order to support each other. Examples are cancer support groups or an Alzheimer's support group.

Support services – Services other than medical, nursing and ancillary that provide support in the delivery of clinical services for patient care (e.g., housekeeping, food service and security).

Surgical operations – Those 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 on 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 nursing care. As defined in the regulations, a swing bed hospital is a hospital or critical access hospital participating in Medicare that has Centers for Medicare & Medicaid Services approval to provide post-hospital SNF care and meets certain requirements. Medicare Part A (the hospital insurance program) covers post-hospital extended care services furnished in a swing bed hospital.[104]

Systemic causes of health – Systemic causes are the fundamental causes of the social inequities that lead to poor health. These include, for example, racism, sexism, generational poverty or redlining.[6]

T

Tax credit – An amount that a person/family can subtract from the amount of income tax that 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 that 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 – Under the current tax code the amount that employers contribute to health benefits are excluded, without limit, from most workers' taxable income and any contributions made by employees toward the premium cost for health insurance are made on a tax-free basis. In contrast, individuals who do not receive health insurance through an employer may only deduct the amount of their total healthcare 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 – A program focusing on the teenager which 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 healthcare, patient and professional health-related education, public health and health administration. Telehealth is a broader scope of remote healthcare services than telemedicine and can refer to non-clinical services, such as provider training, administrative meetings and continuing medical education, in addition to clinical services.

Telemedicine – Technology that allows medical services to be conducted over a great 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 in a state-of-the-art facility.

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 (formerly JCAHO) – An independent, voluntary, not-for-profit accreditation body sponsored by the American College of Physicians, American College of Surgeons, American Hospital Association, American Medical Association and American Dental Association founded in 1951. The Joint Commission conducts accreditation surveys for hospitals and other healthcare organizations, monitoring the quality of care provided based on standards established by The Joint Commission. The Joint Commission maintains a "deemed status" arrangement with the Centers for Medicare & Medicaid Services for Medicare certification for hospitals and many other of its 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 assisting 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 healthcare expenses of its beneficiaries. Third-party payers include Blue Cross/Blue Shield, commercial health insurers, Medicare and Medicaid. The individual receiving the healthcare services is the first party, and the individual 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 healthcare 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. Services could include bone marrow transplant program and heart, lung, kidney, liver, intestine, corneal or tissue transplant.

Transportation to health facilities – A long-term care support service designed to assist the mobility of the elderly. Some programs improve financial access by offering reduced rates and barrier-free buses or vans with ramps and lifts to assist the elderly or handicapped; others offer subsidies for public transport systems or operate mini-bus services exclusively for use by individuals 65+.

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, which is 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, which is capable of providing trauma care to all but the most severely injured patients who require highly specialized care. Level 3: A rural trauma hospital, which is capable of providing care to a large number of injury victims and can resuscitate and stabilize more severely injured patients so that 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.[105]

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 healthcare from civilian providers.

Triple Aim – The National Academy of Medicine has developed a widely accepted approach that describes high-value healthcare as: safe, timely, effective, efficient, equitable and patient-centered — STEEEP for short. The Institute for Healthcare Improvement later translated this into a framework for action, the Triple Aim, which is made up of better patient outcomes, improved patient satisfaction and lower costs. The Triple Aim has since been expanded to the Quintuple Aim, which includes physician and health professional wellbeing and health equity.[7]

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. Some examples of "voluntary resignation" or termination would be those occurring as a result of a new job, dissatisfaction, personal reasons, retirement or returning

to school. Involuntary turnover is when the employer initiates the termination. Some examples of "involuntary resignation" or termination would be those occurring as a result of absenteeism, conduct, failure to obtain license, reduction in workforce, layoffs or reorganization.

U

U.S. Senate Health Education, Labor and Pensions Committee – Standing committee charged with reviewing proposed legislation related to measures that affect education, labor, pensions, occupational safety, health and public welfare.[106]

UB-04 – The common claim form used by hospitals, long-term care and home health care to bill for services.[2]

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 in order 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 both 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 due from the patient.

Underinsured – A descriptive term for people who may have some type of healthcare insurance, such as catastrophic care, but lack coverage for ordinary healthcare costs.

Underwriting – The process by which an insurance carrier examines a person's medical history and decides whether it will issue coverage.

Uniform billing – Forms (e.g., the UB-04) and codes used in medical claims billing in the U.S. for institutional providers like hospitals, nursing homes, hospices, home health agencies and other providers.

Uninsurable – Those persons an insurance company does not want to insure, usually because of bad health.

Uninsured – Individuals who do not have healthcare coverage.

United States Medical Licensing Examination® – The exam administered by the National Board of Medical Examiners. The Federation of State Medical Boards and the NBME sponsor the USMLE. The USMLE provides state medical boards with a common evaluation system for licensure applicants.[7]

Universal access – The right and ability to receive a comprehensive, uniform and affordable set of confidential, appropriate and effective health services.

Universal coverage (or universal health coverage) – A proposal guaranteeing health insurance coverage for all Americans. The World Health Organization defines UHC as "Universal health coverage means that all people and communities can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship."[107]

Unrestricted funds – Includes all hospital resources not restricted to particular purposes by donors or other external authorities. All of the hospital's resources are available for the financing of general operating activities.

Upcode – To bill for a service more intense, extensive or costly than that which was actually 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 – Located inside 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 freestanding 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 healthcare 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 healthcare facility, type of medical care or treatment, physician visit or healthcare coverage, often measured within a population or covered group.

Utilization management or utilization review – The review of services delivered by a healthcare provider to evaluate the appropriateness, necessity and quality of the prescribed services.

V

Vacancy – Open (vacant) full-time positions divided by the total number of full-time employees.

Value-based care – A healthcare model focused on enhancing patient outcomes and quality of care. Unlike traditional fee-for-service that links payments to the number and type of services performed, value-based care arrangements tie

payment amounts for services provided to patients to the results that are delivered. By aligning incentives and payment, this approach can potentially result in more evidence-based, preventive and equitable whole-person care.[7]

Value-based purchasing – A Centers for Medicare & 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 healthcare system providing a range or continuum of care such as outpatient, acute hospital, long-term, home and hospice care.

Violence Prevention Programs for the Community – An organized program that attempts to make a positive impact on the type(s) of violence a community is experiencing. For example, it can assist victims of violent crimes (e.g., rape) or incidents (e.g., bullying) to hospital or community services to prevent further victimization or retaliation. A program that targets the underlying circumstances that contribute to violence, such as poor housing, insufficient job training and/or substance abuse through means, such as direct involvement, education, mentoring, anger management, crisis intervention and training programs.

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 (In-service) – A person 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. Typically, there is an organized hospital department responsible for coordinating the services of volunteers working within the institution.

W

Waiting period – The amount of time a person must wait from the date they are accepted into a health plan (or from when they apply) until the insurance becomes effective and they can receive benefits.

Waiver – A provision in a health insurance policy in which specific medical conditions a person already has are excluded from coverage.

Wearable tech/medical devices – With the rise of mobile medicine and the development of new technologies, such as smart sensing, the field of smart wearable devices has developed rapidly in recent years. These intelligent devices not only assist people in pursuing a healthier lifestyle but also provide a constant stream of healthcare data for disease diagnosis and treatment by actively recording physiological parameters and tracking metabolic status. Wearable medical devices have become a mainstay of the mobile medical market.[4]

Webinar – A conference with an audio portion via telephone and visual materials accessible through a web-based virtual meeting. This type of program can be fully interactive.

Well-baby and well-child visits – Routine doctor 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 inform individuals 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 healthcare costs, reduce absenteeism and strengthen employee relations.

Withhold – A percentage of providers' fees that managed care companies hold back from providers which 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 of the Food and Nutrition Services under the Department of Agriculture 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 found to be at nutritional risk.

Women's health center/services – An area set aside for coordinated education and treatment services specifically for and promoted to women as provided by this special unit. Services may or may not include obstetrics but include a range of services other than OB.

Worker's 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 less current liabilities.

World Health Organization – A specialized agency of the United Nations that is concerned with international public health. WHO's primary role is to direct international health within the United Nations system and lead partners in global health responses, such as to major infectious disease outbreaks.[108]

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. Wound management services are provided on an inpatient or outpatient basis, depending on the intensity of service needed.

X,Y

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 and/or limited benefit packages.

Z

Zone Program Integrity Contractors – Organizations (formerly program safeguard contractors) hired by the Centers for Medicare & Medicaid Services to perform medical review, data analysis and Medicare evidence-based policy auditing activities.[2]

Acronyms

A

AAFP – American Academy of Family Physicians

AAHSA – American Association of Homes and Services for the Aging

AAMC – Association of American Medical Colleges

AAMS – Association of Air Medical Services

AAP – American Academy of Pediatrics

AAPCC – adjusted average per capita cost

AARP – American Association of Retired Persons

ABA – American Bar Association

ABIM – American Board of Internal Medicine

ABN – Advance Beneficiary Notice of Non-coverage

ACA – Affordable Care Act

ACE – Acute Care Episode

ACC – American College of Cardiology

ACCME – Accreditation Council on Continuing Medical Education

ACE – Association for Continuing Education

ACG – ambulatory care group

ACGMW – Accreditation Council for Graduate Medical Education

ACHE – American College of Healthcare Executives

ACHI – Association for Community Health Improvement

ACLS – advanced cardiac life support

ACO – Accountable Care Organization

ACR – adjusted community rating

ACS – alternate care site

ACS – American Cancer Society

ACS – American College of Surgeons

ACU – ambulatory care unit

AD – advance directive

ADA – American Dental Association

ADA – Americans with Disabilities Act

ADC – average daily census

ADE – adverse drug event

ADR – adverse drug reaction

ADL – activities of daily living

ADN – associate degree in nursing

ADS – alternate delivery systems

AFL-CIO – American Federation of Labor-Committee for Industrial Organizations

AHA – American Heart Association

AHA – American Hospital Association

AHAPAC – American Hospital Association Political Action Committee

AHC – academic health center

AMGA – American Medical Group Association

AHC – academic health center

AHCA – American Health Care Association

AHE – Association for the Healthcare Environment

AHEC – Area Health Education Centers

AHIP – America's Health Insurance Plans

AHLA – American Health Lawyers Association

AHPA – American Health Planning Association

AHRMM – Association for Healthcare Resource & Materials Management

AHRQ – Agency for Healthcare Research and Quality

AHVRP – Association of Health Volunteer Resource Professionals

AICPA – American Institute of Certified Public Accountants

AIDS – Acquired Immune Deficiency Syndrome

AIU – adopt, implement, upgrade

ALOS – average length of stay

AMA – against medical advice

AMA – American Medical Association

AMRPs – Access Monitoring Review Plans (Medicaid)

ANA – American Nurses Association

ANCC – American Nurses Credentialing Center

ANSI – American National Standards Institute

AOA – American Osteopathic Association

AONE – American Organization of Nurse Executives

A/P – accounts payable

APA – American Psychiatric Association

APA – American Psychological Association

APC – ambulatory patient classification

APD – adjusted patient day

APG – ambulatory patient group

APHA – American Public Health Association

APIC – Association for Professionals in Infection Control and Epidemiology

APRN – Advanced Practice Registered Nurse

A/R – accounts receivable

ARDS – acute respiratory distress syndrome

ARRA – American Recovery and Reinvestment Act of 2009

ARRT – American Registry of Radiologic Technologists

ASAE – American Society of Association Executives

ASC – ambulatory surgery center

ASCP – American Society of Clinical Pathology

ASHE – American Society for Healthcare Engineering

ASHMM – American Society for Healthcare Materials Management

ASHP – American Society of Health-Systems Pharmacists

ASHRM – American Society for Healthcare Risk Management

ASO – Administrative Services Only

ASPR – Assistant Secretary for Preparedness and Response

AWI – area wage index

B

BAA – Business Associate Agreement

BCBSA – Blue Cross Blue Shield Association

BLS – Bureau of Labor Statistics

BME – Board of Medical Examiners

BP – blood pressure

BLS – basic life support

BSN – Bachelor of Science in Nursing

C

CABG – coronary artery bypass graft

CAE – Certified Association Executive

CAH – critical access hospital

CAHPS – Consumer Assessment of Healthcare Providers and Systems

CAPC – Center to Advance Palliative Care

CARF – Commission on Accreditation of Rehabilitation Facilities

CAT – computerized axial tomography

CAUTI – catheter-associated urinary tract infection

CBISA – Community Benefit Inventory for Social Accountability

CBO – Congressional Budget Office

CCD – continuity of care document

CCH – Commerce Clearing House

CCR – continuity of care record

CCHIT – Certification Commission for Health Information Technology

CCN – Centers for Medicare & Medicaid Services certification number

CCU – critical care unit

CDC – Centers for Disease Control and Prevention

CDSS – clinical decision support system

CE – continuing education

CEO – chief executive officer

CFO – chief financial officer

CFR – Code of Federal Regulations

CHA/CHAUSA – Catholic Health Association of the United States

CHC – community health center

CHE – Certified Healthcare Executive

CHF – congestive heart failure

CHIP – Children's Health Insurance Program

CHIP – community health improvement plan

CHNA – community health needs assessment

CIO – chief information officer

CIP – critical infrastructure protection

CLIA – Clinical Laboratory Improvement Act

CLT – clinical laboratory technician

CME – continuing medical education

CMI – case mix index

CMIO – chief medical information officer

CMO – chief medical officer

CMS – Centers for Medicare & Medicaid Services

CNM – certified nurse midwife

CNO – chief nursing officer

CNS – clinical nurse specialist

COA – Certificate of Authority

COB – coordination of benefits

COBRA – Consolidated Omnibus Budget Reconciliation Act

COE – Center of Excellence

COI – certificate of insurance

COLA – cost-of-living adjustment

CON – Certificate of Need

COO – chief operating officer

CoP – Condition of Participation (Medicare and Medicaid)

COPD – chronic obstructive pulmonary disease

CPA – Certified Public Accountant

CPHQ – Certified Professional in Healthcare Quality

CPI – consumer price index

CPOE – computerized provider order entry

CPR – cardiopulmonary resuscitation

CPT – current procedural terminology

CSW – clinical social worker

CQI – continuous quality improvement

CQM – clinical quality measure

CR – change request

CRNA – certified registered nurse anesthetist

CT – computerized tomography

CVA – cerebral vascular accident (or stroke)

CXO – chief experience officer (referring to patient experience)

CY – calendar year

D

D&O – directors' and officers' liability coverage

D/C – discharge (or discontinue)

DEA – Drug Enforcement Administration

DHHS – Department of Health and Human Services

DHS – Department of Homeland Security

DME – director of medical education

DME – durable medical equipment

DNR – do not resuscitate order

DNV – Det Norske Veritas

DO – doctor of osteopathy

DOA – dead on arrival

DOD – Department of Defense

DOJ – Department of Justice

DOL – Department of Labor

DOS – date of service

DOT – Department of Transportation

DPOA – durable power of attorney

DRG – diagnosis-related group

DSA – digital subtraction angiography

DSH – disproportionate share hospital

Dx – diagnosis

E

ECF – extended care facility

ECU – environmental control unit

ED – emergency department

EDI – electronic data interchange

EDP – electronic data processing

EDS – electronic data systems

EEG – electroencephalogram

EEOC – Equal Employment Opportunity Commission

EH – eligible hospital

EHR – electronic health record

EKG/ECG – electrocardiogram

E&M – evaluation and management

eMAR – electronic medication administration record

EMG – electromyogram

EMPI – enterprise master person index

EMR – electronic medical record

EMRAM – EMR Adoption Model

EMS – emergency medical services

EMT – emergency medical technician

EMTALA – Emergency Medical Treatment and Active Labor Act

EOB – Explanation of Benefits

EOMB – Explanation of Medicare Benefits

EOP – emergency operation plan

EP – eligible professional

EP – eligible provider

EP – emergency preparedness

EPA – Environmental Protection Agency

ePHR – electronic personal health record

EPO – exclusive provider organization

EPSDT – early and periodic screening, diagnosis and treatment (services)

ER – emergency room

ERISA – Employee Retirement Income Security Act of 1994

ESRD – end-stage renal disease

F

FACHE – Fellow of the American College of Healthcare Executives

FAH – Federation of American Hospitals

FASB – Financial Accounting Standards Board

FBI – Federal Bureau of Investigation

FCC – Federal Communications Commission

FCE – functional capacity evaluation

FCRA – Fair Credit Reporting Act

FDA – Food and Drug Administration

FEC – freestanding emergency center

FEMA – Federal Emergency Management Agency

FFS – fee for service

FFY – federal fiscal year

FI – fiscal intermediary

FLEX – Medicare Rural Hospital Flexibility Program

FMAP – federal medical assistance percentage

FMEA – failure mode and effects analysis

FMG – foreign medical graduate

FMLA – Family Medical Leave Act

FOIA – Freedom of Information Act

FP – family practitioner

FPL – federal poverty level

FQHC – federally qualified health center

FRA – federal reimbursement allowance

FSA – flexible spending account

FSMB – Federation of State Medical Boards

FTC – Federal Trade Commission

FTE – full-time equivalent

FY – fiscal year

FYE – fiscal year ending

FYI – for your information

G

GAAP – generally accepted accounting principles

GAO – Government Accounting Office

GDP – gross domestic product

GI – gastrointestinal

GME – graduate medical education

GNC – general nursing care

GNP – gross national product

GP – general practice (physician)

H

HAC – hospital-acquired condition

HAI – hospital-acquired infection

HANYS - Healthcare Association of New York State

HavBed – hospital available beds

HCAHPS – Hospital Consumer Assessment of Healthcare Providers and Systems (required by the Centers for Medicare & Medicaid Services)

HCPCS – Healthcare Common Procedure Coding System

HCW – healthcare worker

HEDIS – health plan employer data and information set

HERF - Healthcare Educational and Research Fund

HFMA – Healthcare Financial Management Association

HH – home health

HHA – home health agency

HHS – U.S. Department of Health and Human Services

HHS/ASPR – U.S. Department of Health and Human Services Assistant Secretary for Preparedness Response

HIDI – Hospital Industry Data Institute

HIE – health information exchange

HIMSS – Healthcare Information and Management Systems Society

HINN – Hospital Issued Notice of Noncoverage

HIO – Health Information Exchange Organization

HIPAA – Health Insurance Portability and Accountability Act of 1996

HIS – hospital information system

HIT – health information technology

HITECH Act – Health Information Technology for Economic and Clinical Health Act

HITAC – Health Information Technology Advisory Committee

HIV – human immunodeficiency virus

HIX – health insurance exchange

HL7 – health level seven

HMBI – hospital market basket index

HMO – health maintenance organization

H&P – history and physical

HPP – Hospital Preparedness Program

HPSA – health professional shortage area

HR – human resources

HRET – Hospital Research and Educational Trust

HRSA – Health Resources and Services Administration

HSA – health savings account

HSP – health service plan

HTNYS - Healthcare Trustees of New York State

HVA – hazard vulnerability assessment

I

IBNR – incurred but not reported

ICCU – intensive coronary care unit

ICD-10-CM – International Classification of Diseases, 10th Revision, Clinical Modification (U.S. standard)

ICD-11-CM – International Classification of Diseases, 11th Revision, Clinical Modification

ICF – intermediate care facility

ICN – intermediate care nursery

ICN – internal control number

ICU – intensive care unit

IDS – integrated delivery system

IG – Inspector General

IHF – International Hospital Federation

IHI – Institute for Healthcare Improvement

IHS – Indian Health Service

IICU – infant intensive care unit

IME – independent medical evaluation

IME – indirect medical education

IP – inpatient

IPA – independent practice association

IPPS – Inpatient Prospective Payment System

IRB – Institutional Review Board

IRF – inpatient rehabilitation facility

IRS – Internal Revenue Service

IS – information system

IT – information technology

ITV – interactive televideo

IV – intravenous

J,K

J5 – Jurisdiction 5

JAMA – *Journal of the American Medical Association*

JCC – joint conference committee

JCR – Joint Commission Resources (affiliate of The Joint Commission)

L

LACIE – Lewis and Clark Information Exchange

LCSW – licensed clinical social worker

LDR – labor and delivery room

LIS – lab information system

LOINC – logical observation identifiers, names and codes (laboratory)

LOL – limitation of liability

LOS – length of stay

LPN – licensed practical nurse

LSC – Life Safety Code

LTC – long-term care

LTCU – long-term care unit

LVN – licensed vocational nurse

M

MA – Medicare Advantage

MAC – maximum allowable costs

MAC – Medicare Administrative Contractor

MAPIR – Medical Assistance Provider Incentive Repository

MBQIP – Medicare Beneficiary Quality Improvement Project

MCH – maternal child and family health

MCI – mass casualty incident

MCO – managed care organization

MD – doctor of medicine

MDP – medical disclosure panel

MEC – medical executive committee

MedPAC – Medicare Payment Advisory Commission

MGCRB – Medicare Geographic Classification Review Board

MHA – Master of Healthcare Administration

MI – myocardial infarction

MIC – Medicaid Integrity Contractor

MIG – Medicaid Integrity Group

MIP – Medicaid Integrity Program

MIPPA – Medicare Improvement for Patients and Provider Act

MLP – mid-level practitioner

MLR – medical loss ratio

MMA – Medicare Modernization Act

MMI – maximum medical improvement

MMR – measles, mumps and rubella

MPI – master patient index

MPH – Master of Public Health

MRI – magnetic resonance imaging

MSA – medical savings account

MSA – metropolitan statistical area

MSN – Medicare Summary Notice

MRSA – methicillin-resistant *Staphylococcus aureus*

MSO – management service organization

MSP – Medicare Secondary Payer

MT – medical technologist

MU – meaningful use

N

NAM – National Academy of Medicine

NACH – National Association of Children's Hospitals

NAHC – National Association for Home Care

NAHQ – National Association of Healthcare Quality

NAIC – National Association of Insurance Commissioners

NAMI – National Alliance for Mental Illness

NAMSS – National Association of Medical Staff Service Professionals

NB – newborn

NBME – National Board of Medical Examiners

NCHS – National Center for Health Statistics

NCI – National Cancer Institute

NCN – National Commission on Nursing

NCQA – National Committee for Quality Assurance

NDC – National Drug Code

NECPA – National Energy Conservation Policy Act (Title III)

NEJM – *New England Journal of Medicine*

NFRA – Nursing Facility Reimbursement Allowance

NGA – National Governors' Association

NHA – National Healthcareer Association

NHI – National Health Insurance

NICU – neonatal intensive care unit

NIH – National Institutes of Health

NIMH – National Institute of Mental Health

NIMS – National Incident Management Systems

NIOSH – National Institute for Occupational Safety and Health

NIST – National Institute for Standards and Technology

NLN – National League for Nursing

NLRB – National Labor Relations Board

NP – nurse practitioner

NPI – National Provider Identifier

NPDB – National Practitioner Data Bank

NPO – "nothing by mouth" (from Latin)

NPRM – notice of proposed rule-making

NQF – National Quality Forum

NRC – Nuclear Regulatory Commission

NRHA – National Rural Health Association

O

OB – obstetrics (or obstetrician)

OB/GYN – obstetrics and gynecology

OBRA – Omnibus Budget Reconciliation Act

OBS – office-based surgery

OCD – obsessive-compulsive disorder

OIG – Office of Inspector General

OMB – Office of Management and Budget

ONC/ONCHIT – Office of the National Coordinator for Health Information Technology

OOP – out of pocket

OP – outpatient

OPO – Organ Procurement Organization

OPPS – Outpatient Prospective Payment System

OR – operating room

OSHA – Occupational Safety and Health Administration

OT – occupational therapy/occupational therapist

OTC – over-the-counter

P

P4P – pay for performance

P&L – profit and loss

PA – physician assistant

PAC – political action committee

PACS – picture archiving and communication system (radiology images)

PAT – pre-admission testing

PCA – patient-controlled analgesia

PCA – personal care assistant

PCCM – primary care case management

PCMH – patient centered medical home

PCN – primary care network

PCP – primary care physician

PDP – prescription drug plan

PDR – Physician's Desk Reference

PECOS – Provider Enrollment, Chain, and Ownership System (Medicare)

PET – positron emission tomography

PFS – patient financial services

PHI – personal or protected health information

PHIX – Public Health Information Exchange

PHO – Physician Hospital Organization

PHR – personal health record

PHS – public health service

PIP – Periodic Interim Payment (Medicare)

POA – present on admission

POS – point of service plan

PPACA – Patient Protection and Affordable Care Act

PPE – personal protective equipment

PPO – permanent partial disability

PPO – preferred provider organization

PPP – preferred provider plan

PPRC – Physician Payment Review Commission

PPS – Prospective Payment System

Pre-Ex – pre-existing condition

PRN – "when necessary" (from the Latin "pro re nata")

PRO – peer review organization

ProPAC – Prospective Payment Assessment Commission

PRRB – Provider Reimbursement Review Board

PSN – provider sponsored network

PSO – provider sponsored organization

PSRO – Professional Standards Review Organization

PT – physical therapy/physical therapist

PTA – physical therapy assistant

Q

QA – quality assurance

QHI – Quality Health Indicator

QI – quality improvement

QIN – Quality Innovation Network

QIO – Quality Improvement Organization

R

R&D – research and development

RAC – recovery audit contractors

RAD – radiation-absorbed dose

RBRVS – resource-based relative value scale

RCA – root cause analysis

REH – Rural Emergency Hospital

RFP – request for proposal

RHIA – registered health information administrator

RHIT – registered health information technologist

RHQDAPU – Reporting Hospital Quality Data for Annual Payment Update

RHV – rural health visioning

RIS – radiology information system

RN – registered nurse

ROA – return on assets

ROI – return on investment

RPB – Regional Policy Board

RPh – registered pharmacist

RRT – registered respiratory therapist

RT – respiratory therapy/respiratory therapist

RVU – relative value unit

Rx – prescription

S

SAD – self-administered drugs

SCU – special care unit

SE – sentinel event

SEC – Securities and Exchange Commission

SHAEF – State Hospital Association Executives' Forum

SHIP – Small Rural Hospital Improvement Program

SHSMD – Society for Health Care Strategy and Market Development

SICU – surgical intensive care unit

SIDS – sudden infant death syndrome

SLP – speech language pathologist

SMSA – standard metropolitan statistical area

SNA – Student Nurses Association

SNF – skilled nursing facility

SNOMED CT – Systematized Nomenclature of Medicine-Clinical Terms

SPECT – single photon emission computed tomography

SRS – social and rehabilitation services

SSA – Social Security Administration

SSI – Supplemental Security Income

SSI – surgical site infection

SSN – Social Security Number

T

TDD – telecommunication devices for deaf persons

TJC – The Joint Commission

The Alliance – The Health Alliance of MidAmerica

THR – total hip replacement

TKR – total knee replacement

TPA – third-party administrator

TTD – temporary total disability

U

UB-04 – Uniform Billing (2004 version)

UB-92 – Uniform Billing (1992 Version)

UHI – Universal Health Insurance

UR – utilization review

URC – utilization review coordinator

URI – upper respiratory infection

USP – U.S. Pharmacopeia

UTI – urinary tract infection

V

VA – Veterans Administration

VBP – value-based purchasing

VHA – previously the Voluntary Hospitals of America (now simply VHA)

VRE – Vancomycin-resistant *Enterococcus*

W,X

WHO – World Health Organization

WI – wage index

Y

YTD – year to date

Z

ZPIC – Zone Program Integrity Contractor

References

[1] Definition from healthypeople.gov. (2024).

[2] Updated, adapted from or includes terminology from resources provided by Centers for Medicare and Medicaid Services. (2024).

[3] Updated and adapted from the definition from healthcare.gov. (2019).

[4] Updated, adapted from or includes terminology from resources provided by the federal government or National Institutes of Health. (2024).

[5] Includes terminology from the Bureau of Labor Statistics. (2019).

[6] Updated, adapted from or includes terminology from resources provided by the AHA. (2024).

[7] Updated, adapted from or includes terminology from the AMA. (2024).

[8] Updated from American Nurses Association. (2019).

[9] Updated with the definition from the National Cancer Institute. (2019). NCI Dictionary of Cancer Terms.

[10] Updated from careLearning. (2019). About Us.

[11] Updated from CDC. (2019, May 9). Urine Culture Stewardship Overview.

[12] Updated from Lyon Software. (2019). Community Benefit Inventory for Social Accountability.

[13] Updated from CDC. (2019, November 15). About Centers for Disease Control and Prevention.

[14] Updated from CDC. (2011, February 7). Central Line-associated Bloodstream Infections: Resources for Patients and Healthcare Providers.

[15] Updated to include information from the American Society for Clinical Oncology. (2019, May 29). Understanding Chemotherapy.

[16] Updated to reflect terminology from the American Association for Physician Leadership. (2019).

[17] Updated from healthcare.gov. (2019). Children's Health Insurance Program Eligibility Requirements.

[18] Updated from the National Center for Complementary and Integrative Health. (2019, April 30). Chiropractic.

[19] Edited to reflect current terminology from The Joint Commission. (2019).

[20] Updated from U.S. Department of Labor. (2019). Continuation of Health Coverage – COBRA.

[21] Updated from CGFNS International. (2019). About Us.

[22] Updated with terminology from the National Association of Community Health Centers. (2019).

[23] Updated from CDC. (2018, July 24). Community Health Assessment and Health Improvement Plans.

[24] Updated from AHA. (2019). Fast Facts on U.S. Hospitals.

[25] Updated from healthcare.gov. (2019). Community Rating.

[26] Updated from the Harvard School of Public Health. (2012, December 14). What is CER?

[27] Updated from CompAnalyst. (2019). CompAnalyst: A Salary.com Solution: Compensation Data Solution.

[28] Updated from the National Center for Complementary and Integrative Health. (2017, September 24). The Use of Complementary and Alternative Medicine in the U.S.

[29] Updated from National Cancer Institute. (2019). Computerized Axial Tomography Scan – NCI Dictionary of Cancer Terms.

[30] Updated from the Bureau of Labor Statistics. (2019, April 24). How BLS Measures Price Change for Medical Care Services in the Consumer Price Index.

[31] Updated from the U.S. Census Bureau. (2019, September 16). Core Based Statistical Areas and Related Areas.

[32] Updated from CMS. (2017, July 28). Core Measures.

[33] Updated from HHS. (2017, June 16). Covered Entities and Business Associates.

[34] Updated from The Joint Commission. (2019). Federal deemed status.

[35] Updated from healthcare.gov. (2019). Dependent – Glossary.

[36] Updated from DNV GL. (2019). Accreditation.

[37] Updated from DEA. (2019). Mission.

[38] Updated from World Health Organization. (2017, February 16). What is Quality of Care and why is it important?

[39] Definition validated with healthit.gov. (2019, September 10). What is an electronic health record?

[40] Updated from ems.gov. (2019). What is EMS?

[41] Definition consolidated and updated from the U.S. Department of Labor. (2019). ERISA.

[42] Updated from the IRS. (2019). Employer Shared Responsibility Provisions.

[43] Definition updated from EPA. (2019, October 25). About EPA.

[44] Definition updated from healthcare.gov. (2019). Exclusive Provider Organization Plan – healthcare.gov Glossary.

[45] Updated from Medicaid.gov. (2019). Quality of Care External Quality Review.

[46] Updated from FEMA. (2019). Home.

[47] Updated from Health Resources and Services Administration. (2018, May 8). Federally Qualified Health Centers.

[48] Updated from FDA. (2019).

[49] Updated definition from Healthcare Supply Chain Association. (2019). FAQ.

[50] Definition from the NIH. (2016, March 1). Hand Hygiene.

[51] Validated as current with the World Health Organization. (2019). Constitution.

[52] Updated definition with terminology from healthcare.gov. (2019). Affordable Care Act (ACA).

[53] Updated definition from the healthit.gov. (2019, May 1). What is HIE?

[54] Edited and validated with National Committee for Quality Assurance. (2019). HEDIS and Performance Measurement.

[55] Updated definition from HRSA.

[56] Updated from HRSA. (2019, April). Hill-Burton Free and Reduced-Cost Health Care.

[57] Updated from CMS. (2019). The HCAHPS Survey – Frequently Asked Questions.

[58] Updated from CMS. (2017, September 19). Hospital Inpatient Quality Reporting Program.

[59] Validated currency with Alliance for Health Policy. (2019).

[60] Updated from CMS. (2019, October 3). Hospital-acquired Conditions.

[61] Updated definition from Society of Hospital Medicine. (2013, March). History and Mission.

[62] Updated from WHO. (2019). International Classification of Diseases, 11th Revision (ICD-11).

[63] Updated definition from American Academy of Family Physicians. (2019). Independent Physician Associations Definition.

[64] Updated from the Indian Health Service. (2019). Agency Overview.

[65] Updated from the Institute for Healthcare Improvement. (2019).

[66] Updated from National Institutes of Health. (2017, February). What is an intensive care unit? A report of the task force of the World Federation of Societies of Intensive and Critical Care Medicine.

[67] Updated from the American College of Physicians. (2019). About Internal Medicine.

[68] Updated from CMS. (2019). Quality Safety and Oversight – Guidance to Laws and Regulations.

[69] Updated from the ANCC. (2019). ANCC Magnet Recognition Program®.

[70] Validated with Medicaid. (2019).

[71] Updated from the American Board of Professional Liability Attorneys. (2017). What is Medical Malpractice?

[72] Updated from the CDC. (2019). Meaningful Use Introduction.

[73] Updated from National Conference of State Legislatures. (2019). Medicaid 1115 Waivers by State.

[74] Validated with CMS. (2019). Medicaid Integrity Program – General Information.

[75] Validated with CMS. (2018). State Medicaid Plans and Waivers.

[76] Validated with CMS. (2018). Medical Loss Ratio.

[77] Updated fromhealthinsurance.org. (2019). What is underwriting?

[78] Updated from CMS. (2019). Overview.

[79] Updated from CMS. (2019). Medicare Geographic Classification Review Board.

[80] Updated definition from MedPAC. (2019.)

[81] Updated from DEA. (2019). Mid-level Practitioners Authorization by State.

[82] Updated from NIH. (2017, July). Mission and Goals.

[83] Updated definition from the NLRB. (2019). Introduction to the NLRB.

[84] Definition obtained from The Joint Commission. (2019). National Patient Safety Goals.

[85] Consolidated and updated from the NPDB. (2019). About Us.

[86] Validated as current with NQF. (2019). National Quality Forum.

[87] Updated from AANP. (2019). What's a Nurse Practitioner?

[88] Updated definition from organdonor.gov. (2019). Glossary of Organ Donation Terms.

[89] Updated and validated with The Joint Commission. (2019). Facts about ORYX® for Hospitals.

[90] Updated from American Association of Colleges of Osteopathic Medicine. (2019). What is Osteopathic Medicine?

[91] Updated from CMS. (2014). What is Medicare Part C?

[92] Added from AHRQ. (2019). What Is Patient Experience?

[93] Updated with definition from HHS. (2017, March). What Is Patient Experience?

[94] Updated from CMS. (2019). BPCI Advanced.

[95] Validated with SSA. (2003). Program Operations Manual System (POMS).

[96] Updated from CMS. (2019). Prospective Payment Systems – General Information.

[97] Consolidated and updated with language from CMS. (2019). Quality Improvement Organizations.

[98] Updated definition from AHRQ. (2019).

[99] Definition from Economics By Design. (2022, October). What are Levels of Care? A Simple Guide.

[100] Updated from CMS. (2019). Medicare Fee for Service Recovery Audit Program.

[101] Updated definition from HRSA. (2019, May). Rural Hospital Programs.

[102] Definition from Security and Exchange Commission. (2019).

[103] Updated definition from benefits.gov. (2019). State Children's Health Insurance Program.

[104] Current definition from CMS. (2017). Swing Bed Providers.

[105] Updated from Trauma Center Association of America. (2019). Trauma Center Levels Defined.

[106] Updated from senate.gov. (2019). About.

[107] Updated definition from WHO. (2019). What is health financing for universal coverage?

[108] Definition from WHO. (2019).

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