TERMS AND DEFINITIONS

60% rule (Inpatient Rehabilitation Hospital)
Center for Medicare and Medicaid Services (CMS) rule that requires 60% of patients admitted to an inpatient rehabilitation facility (IRF) fall under 13 diagnostic categories. Compliance is tracked closely since meeting this rule is mandatory to maintain an IRF hospital license.

Academic Medical Center (AMC)
A healthcare organization that is often linked to a medical school and hospital complex with the mission of teaching medical students and physicians in training, research, and patient care in close affiliation or as part of a degree-granting university.

Accountable Care Organization (ACO)
A network of health care providers that band together to provide patients the full continuum of health care services. The network would receive a payment for all care provided to a patient and would be accountable for the quality and cost of care. Proposed pilot programs in Medicare and Medicaid would provide financial incentives for these organizations to improve quality and reduce costs by allowing them to share in savings achieved as a result of these efforts.

Accrediting Organization (AO)
Non-governmental organizations which regularly survey healthcare providers and suppliers to ensure they meet certain health and safety standards. These may include The Joint Commission or similar entities.

Ambulatory Care (also referred to at outpatient care)
All types of health services provided on an outpatient basis, in contrast to services provided in the home or to persons who are admitted to a hospital (inpatients). Services that do not require an overnight stay.

American Academy of Physical Medicine and Rehabilitation (AAPM&R)
AAPM&R is a national medical specialty organization representing more than 10,000 physicians who are specialists in physical medicine and rehabilitation (PM&R). Members come from academic and non-academic clinical practice settings.

American Medical Rehabilitation Providers Association (AMRPA)
AMRPA is a trade organization dedicated solely to the interests of IRFs and IRF units, outpatient rehabilitation centers, and other medical rehabilitation providers.

Ancillary Services
Supplemental services, including but not limited to laboratory, radiology, pharmacy, physical, occupational, speech and respiratory therapy.

Association of Academic Physiatrists (AAP)
AAP is an organization of physiatry professionals who are dedicated to improving patient care by advancing the specialty through research and education. Primarily represents physiatrists in academic practice.

Average Daily Census (ADC)
The average number of inpatients receiving care in a hospital over a specific period (month, quarter, year).

Average Length of Stay (ALOS)
The average time patients spend in a hospital during a specific period.

Case Mix Group (CMG)
A case-mix classification system is used under the IRF PAI prospective payment system (PPS). A CMG classifies IRF patients covered by Medicare Part A based on their primary admitting condition, functional motor and cognitive scores (GG) and age.

Case Mix Index (CMI)
A metric used to measure the relative costliness and resource intensity of patients in various healthcare settings, including IRFs, LTCHs, and SNFs. It reflects the patient population's diversity, clinical complexity, and resource needs. Also see CMG, MS-LTC-DRG, and PDPM. A higher CMI indicates a more complex and resource-intensive patient population.

Center for Medicare and Medicaid Innovation (CMMI)
A federal agency within CMS, tasked with designing, implementing, and testing new healthcare payment and service delivery models. Addresses rising costs, quality of care, and inefficient spending with the goal of improving care, lowering costs, and better aligning payment systems. Authorized under the Affordable Care Act (ACA).

Center for Medicare and Medicaid Services (CMS)
Federal agency within the Department of Health and Human Services which administers Medicare, Medicaid, and the State Children's Health Insurance Program.

CMS Mandatory Post Acute Care (PAC) Assessments
Assessment tools used to collect patient assessment data per the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT ACT). Assessment data is used for quality measure calculation, improvement of patient care (outcomes), and IRF and SNF payment. Penalties for non-compliance with assessment completion and transmission to CMS will result in a 2% reduction in Medicare payments.

- Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF PAI) – IRF Assessment
- Minimum Data Set (MDS) – SNF Assessment
- Continuity of Care Record and Evaluation (CARE) Assessment – LTCH Assessment

Cost Shifting
Recouping the cost of providing uncompensated or under-reimbursed care by increasing revenue from some payers to offset losses.

Cost to Charge Ratio (CCR)
The ratio of a hospital's costs (total expenses exclusive of bad debt) to its charges (gross patient and other operating revenue).

Current Procedural Terminology (CPT) Code
A procedure code set developed by the American Medical Association and managed by an Editorial Panel.

Diagnosis Related Groups (DRGs)
A case-mix classification system is used under the Inpatient Prospective Payment System (IPPS). A DRG groups diagnostic categories from the International Classification of Diseases (ICD) and considers the presence of a surgical procedure, patient age, presence or absence of significant comorbidities or complications, and other relevant criteria. DRGs are the case-mix measure used by Medicare to pay inpatient hospitals.

Direct Margin
The income remaining after subtracting all direct costs associated with providing services. For healthcare providers, these direct costs typically include expenses such as medical supplies, direct labor (e.g., salaries of healthcare providers), and other consumable production supplies. Direct margin reflects how much profit is generated from core services after covering the immediate costs of delivering those services.

Discharge Function Score Measure
A patient/resident's capacity to perform daily activities related to self-care (eating, oral hygiene, toileting, mobility, ambulation) that reflects how successful IRFs, LTCHs, and SNFs are at achieving or exceeding an expected level of functional ability for its patients/residents at discharge. A higher score indicates that a greater population of patients/residents are achieving or exceeding an expected level of functional ability at discharge. Certain standardized assessments (e.g. IRF PAI) include admission and discharge functional scores.

Dual Eligible Patient
An individual who is eligible for Medicare and some level of Medicaid benefits. Most dual eligibles qualify for full Medicaid benefits, including nursing home services, and Medicaid pays their Medicare premiums and cost-sharing. For other dual eligibles, Medicaid provides the "Medicare Savings Programs" through which enrollees receive assistance with Medicare premiums, deductibles, and other cost-sharing requirements.

EBIDA
Earnings Before Interest, Depreciation, and Amortization. A financial metric used to measure a company's profitability by excluding interest expenses, depreciation, and amortization from net income. Unlike EBITA, EBIDA includes taxes, making it a more conservative measure of a company's operational performance.

EBITA
Earnings Before Interest, Taxes, and Amortization. A financial metric used to measure a company's profitability by excluding interest, taxes, and amortization expenses. Helpful in evaluating financial performance by describing operational efficiency and cash flow.

False Claims Act (FCA)
The filing of fraudulent health insurance claims for financial or personal gain. The Federal FCA prohibits healthcare providers from knowingly submitting false or fraudulent claims for payment from federal healthcare programs (e.g. Medicaid, Medicare, Tricare). FCA violations can result in severe financial penalties.

Fee For service (FFS)
Method of billing for health services under which a physician or provider charges separately for each patient encounter for service rendered. Under a fee-for-service system, expenditures increase if the fees increase, if more units or services are provided, or if more expensive services are substituted for less expensive ones. This system contrasts with salary, per capita, ACO, or global payment systems, where the payment to the provider is not changed by the number of services actually used.

Functional Vacancy Rate
The percentage of unfilled positions and leave of absences at a given time, measured by (unfilled positions + leave of absences) / (unfilled positions + total headcount).

Graduate Medical Education (GME)
The medical training period following graduation from medical school is commonly referred to as internship, residency, and fellowship training. CMS partly finances GME through Medicare direct and indirect payments. Indirect Medical Education (IME) refers to the additional costs that teaching hospitals incur to train medical students.

Gross Patient Service Revenue (GPSR)
The total charges at the facility's full established rates for the provision of patient care before deductions from revenue are applied.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)
A federal regulation mandating standards to protect patient information. It includes privacy and security requirements that healthcare providers must adhere to; non-compliance may result in fines and penalties.

Information Blocking
A federal regulations that aims to prevent practices that could interfere with the access, exchange or use of electronic health information; gives patients more control over their health information, including timely access to their electronic medical records in the form and format they request. Non-compliance may result in fines and penalties.

Length of Stay (LOS)
A healthcare metric measuring the number of days a patient stays in the hospital per admission.

Margin
The difference between hospital revenues and hospital costs as a percentage of hospital costs.

Medicare Payment Advisory Commission (MedPAC)
MedPAC is an independent federal body that advises the US Congress on issues affecting the Medicare program.

Medicare Severity Long-Term Care Diagnostic Related Group (MS-LTCH-DRG)
A case mix classification used under the LTCH prospective payment system (PPS). MS-LTC-DRGs are the same Medicare Severity Diagnosis-Related Groups (MS-DRGs) that the CMS uses under the Inpatient Prospective Payment System (IPPS), but they are weighted to reflect the different resources used by LTCH patients.

Net Patient Service Revenue (NPSR)
Total gross revenue from service to inpatients and outpatients minus total deductions from revenue (i.e., the revenue actually collected by hospitals for services to patients).

Office of Inspector General (OIG)
A federal agency, part of HHS, responsible for reducing waste, fraud and abuse in HHS programs. Provides compliance resources to healthcare providers.

Patient Acuity
A measurement of the level of care a patient needs based on the severity of illness. See also terms related to Patient Acuity: CMI, CMG, DRGs, MS-LTCH DRG, PDPM.

Patient Driven Payment Model (PDPM)
A case mix classification system used under the SNF prospective payment system (PPS). PDPM classifies SNF patients covered by Medicare Part A based on their clinical characteristics and care needs including therapy, nursing and non-therapy ancillaries (specific diagnoses and services including intravenous medication or HIV/AIDs).

Physician Organization (PO) or Regional Care Organization (RCO)
These terms describe physician linkages and alliances that allow physicians to manage risk and capitation. Information systems, physician relationships, and financial integration allow these organizations to be more integrated than the traditional solo practice or IPA relationship between healthcare providers and/or managed care organizations that are working to develop a "seamless" continuum of healthcare services.

Post-Acute Care (PAC)
The care services that a patient receives after an acute illness or hospitalization including inpatient rehabilitation facilities (IRF), skilled nursing facilities (SNF) long-term care hospitals (LTCH), and home health (HH) agencies.

Post-Acute Care Quality Reporting Program (PAC QRP), Quality Measures (QMs), Standardized Patient Assessment Data Elements (SPADES)
PAC QRP: A program that creates quality reporting requirements for post-acute care providers, as mandated by the IMPACT Act. Every year, the quality measures that PAC providers must report are published. The goal of the QRP is to improve Medicare beneficiary outcomes through shared decision-making, care coordination, and enhanced discharge planning.

QM: Standardized tools used to assess the quality of care provided by healthcare providers. They help to standardize processes and structure to reduce variation, achieve predictable results, and improve outcomes for patients, healthcare systems, and organizations

SPADEs: As per the IMPACT Act, SPADES are required to be collected across PAC settings. They are a set of standardized data elements used to assess patient health and outcomes across different healthcare settings. The goal of SPADES is to enable cross-setting data collection, outcome comparison, exchangeability of data, and comparison of quality within and across PAC settings.

Prospective Payment System (PPS)
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, DRGs for acute inpatient hospital services, CMGs for IRFs, LTC-DRGs for LTCHs, PDPM for SNF).

Relative Value Units (RVUs)
A measure used in the Medicare reimbursement formula for physician services. They are the basic component of the Resource-Based Relative Value Scale (RBRVS), a methodology used by CMS and private payers to determine physician payment.

Revenue Cycle, Healthcare

The entire process of managing the financial aspects of patient care, from the moment a patient schedules an appointment until the healthcare provider receives full payment for the services rendered. This cycle includes several key steps:

1. Patient Registration: Collecting patient information and verifying insurance coverage.
2. Service Delivery: Providing medical care to the patient.
3. Charge Capture: Recording the services provided and assigning appropriate billing codes.
4. Claim Submission: Sending claims to insurance companies for reimbursement.
5. Payment Processing: Receiving payments from insurers and patients
6. Denial Management: Addressing any denied claims and resubmitting them if necessary.
7. Collections: Following up on unpaid balances and collecting payments from patients.

Sentinel Event

Any unanticipated event in a healthcare setting resulting in death or serious physical or psychological injury to a patient or patients, not related to the natural course of the patient's illness. Sentinel events specifically include loss of a limb or gross motor function, and any event for which a recurrence would carry a risk of a serious adverse outcome. The event is called "sentinel" because it sends a signal or sounds a warning that requires immediate attention.

Serious Reportable Events (SRE)

Adverse events that are of concern to both the public and healthcare professionals and providers; clearly identifiable and measurable, and thus feasible to include in a reporting system; and of a nature such that the risk of occurrence is significantly influenced by the policies and procedures of the healthcare facility. The law also prohibits hospitals from charging for these events or seeking reimbursement for SRE-related services.

The Joint Commission (TJC)

A national private, nonprofit organization whose purpose is to encourage the attainment of uniformly high standards of institutional medical care. Establishes guideline for the operation of hospitals and other health facilities and conducts surveys and accreditation programs.

Vacancy Rate

The percentage of unfilled positions at a given time, measured by unfilled positions/(unfilled positions + total headcount).

Worked Relative Value Units (wRVUs)

Weights given to CPT codes by CMS to estimate the time involved to complete a CPT code. Influences the fee schedule and tells a story of productivity.