CMS Data Navigator Glossary of Terms

Term	Definition
Access to Care	The degree to which individuals are inhibited or facilitated in their ability to gain entry to and to receive care and services from the health care system. Factors influencing this ability include geographic and financial considerations, among others.
Accountable Care Organizations (ACO)	Accountable Care Organizations (ACOs) are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their Medicare patients.
Activities of Daily Living (ADL)	Activities of daily living (ADLs) refer to an individuals daily self-care activities such as feeding oneself, bathing, dressing, etc.. Ability or inability to perform ADLs can be used as a measurement of the functional status of an individual.
Activity Limitation	A difficulty encountered by an individual in executing a task or action.
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).
Admissions	The formal acceptance by a hospital or other health care facility of a patient who is to be provided with health care services or treatment for at least one night or more.
Ambulatory	All types of health services that do not require an overnight hospital stay, including diagnosis, observation, treatment and rehabilitation that is provided on an outpatient or professional basis.
Ambulatory Surgical Center (ASC)	A place other than a hospital that does outpatient surgery. Ambulatory surgery centers (ASC), also are known as "outpatient surgery centers" or "same day surgery centers".
Behavioral Health/Mental Health	Health services that include mental and emotional health, psychiatric care, addiction and substance abuse treatment. Services are provided by different kinds of providers, including certified counselors, psychiatrists, psychologists and neurologists.
Body Mass Index (BMI)	Body mass index (BMI) is a measure of body fat based on height and weight that applies to adult men and women.
Budget	Spending on Medicare and Medicaid provided services.
Center for Consumer Information & Insurance Oversight (CCIIO)	The Center for Consumer Information and Insurance Oversight (CCIIO) is charged with helping implement many provisions of the Affordable Care Act related to private health insurance.
Center for Medicare and Medicaid Innovations (CMMI)	The CMS Innovation Center fosters health care transformation by finding new ways to pay for and deliver care that improve care and health while lowering costs. The Center identifies, develops, supports, and evaluates innovative models of payment and care service delivery for Medicare, Medicaid and CHIP beneficiaries using an open, transparent, and competitive process.
Chart Book	A book or collection of charts centered around a certain topic.
Children's Health Insurance Program (CHIP)	The Children's Health Insurance Program (CHIP) provides health coverage to children in families with incomes too high to quality for Medicaid, but unable to afford private coverage. CHIP provides federal matching funds to states to provide health insurance coverage.

Term	Definition
Chronic Condition	Conditions that last a year or more and require ongoing medical attention and/or limit activities of daily living.
Claims	A claim is a request for payment for services and benefits you received. Claims are also called bills for all Part A and Part B services billed through Fiscal Intermediaries. "Claim" is the word used for Part B physician/supplier services billed through the Carrier. (See Carrier; Fiscal Intermediaries; Medicare Part A; Medicare Part B.)
Coding and Coding Rules	Methods and policies for translating diagnoses and procedures into a numbering system.
Community Health Center	Health centers that provide primary care to low-income people. Fees often set on a sliding-scale based on income.
Community Treatment	Community based treatment for people with mental illness or substance abuse issues.
County	Data are organized at the County level. Counties are the primary legal divisions of most states.
Covered Services	Allowable services that are paid for by Medicare, Medicaid, or other health insurance.
Demonstrations	Innovative projects to test and measure the effect of potential program changes.
Diagnosis-Related Groups (DRG)	A classification system that groups patients according to diagnosis, type of treatment, age, and other relevant criteria. Under the prospective payment system, hospitals are paid a set fee for treating patients in a single DRG category, regardless of the actual cost of care for the individual.
Dialysis Center	A hospital unit that is approved to furnish the full spectrum of diagnostic, therapeutic, and rehabilitative services required for the care of the ESRD dialysis patients (including inpatient dialysis) furnished directly or under arrangement. Dialysis is the medical procedure that removes waste material and fluid build-up in patients whose kidneys do not function properly.)
Disparity	Disparities in care are differences in the delivery of health care, access to health care services and medical outcomes based on ethnicity, geography, gender and other factors.
Disproportionate Share Hospitals (DSH)	Disproportionate Share Hospitals (DSH) are hospitals that serve a significantly disproportionate number of low-income patients that are not paid by other payers, such as Medicare, Medicaid, CHIP, or other health insurance. These hospitals are eligible to receive adjustment payments.
Dual Eligibles	Dual Eligibles are beneficiaries that are eligible for both Medicare and Medicaid.
Durable Medical Equipment (DME)	Medical equipment that is ordered by a doctor for use in the home. Some examples are walkers, wheelchairs, or hospital beds. DME is paid for under both Medicare Part B and Part A for home health services.
Eligibility	The process whereby an individual is determined to be eligible for health care coverage through the Medicare or Medicaid program.
Emergency Room / Department	A portion of the hospital where emergency diagnosis and treatment of illness or injury is provided.

Term	Definition
Encounters	Encounters (or visits) are documented face-to-face contact between a beneficiary and provider.
End Stage Renal Disease (ESRD)	Permanent kidney failure that requires a regular course of dialysis or a kidney transplant.
Enrollment	The number of beneficiaries enrolled in a specific Medicare or Medicaid program.
Entitlement	An entitlement is a guarantee of access to benefits based on established rights or by legislation. An individual is considered entitled to Medicare, Medicaid, or CHIP benefits if they are successfully enrolled in these entitlement programs.
Expenditures	The amounts paid for provided health care services. These amounts may or may not be equivalent to the actual costs.
External Source	Documents that are not contained on the CMS.gov website.
Fact Sheet	Brief documents that provide background information, the latest data, current snapshots, and key trends on important health policy topics.
Falls	Injuries resulting from a fall.
Federally Qualified Health Center (FQHC)	Health centers that have been approved by the government for a program to give low cost health care. Medicare pays for some health services in FQHCs that are not usually covered, like preventive care. FQHCs include community health centers, tribal health clinics, migrant health services, and health centers for the homeless.
Health Employer Data and Information Set (HEDIS)	A set of standard performance measures that can give you information about the quality of a health plan. You can find out about the quality of care, access, cost, and other measures to compare managed care plans. The Centers for Medicare & Medicaid Services (CMS) collects HEDIS data for Medicare plans.
Home Health Agency (HHA)	An agency that provides health care services in the home. Home health care includes, but is not limited to: skilled nursing care, physical therapy, occupational therapy, speech therapy, and care by home health aides.
Hospice	Hospice is a special way of caring for people who are terminally ill, and for their family. This care includes physical care and counseling. Hospice care is covered under Medicare Part A (Hospital Insurance).
Hospital	Hospitals are health care institutions that provide services including medical, surgical, or psychiatric treatment. Hospitals usually provide inpatient care.
Hospital Referral Region	Data are organized at the Hospital Referral Region level. Hospital Referral Regions (HRRs) are 306 regions aggregrated from hospital service areas based on patterns of care for major cardiovascular surgery and neurosurgery as defined by the Dartmouth Atlas of Health Care. See www.dartmouthatlas.org.
Inpatient	Health care that you get when you are admitted to a hospital.
Interactive Tools	Tools that allow interactive data manipulation such as pivot tables or dashboards.
Long Term Care (LTC)	Long term care (LTC) is custodial, assistive or supervisory care provided to persons over a period of time. LTC generally takes place in the home, an assistive living facility, or nursing home. Medicare does not pay for this type of care if this is the only kind of care you need.

Term	Definition
Mammogram	A special x-ray of the breasts. Medicare covers the cost of a mammogram once a year for women over 40.
Managed Care	A system of health care in which patients agree to visit only certain doctors and hospitals, and in which the cost of treatment is monitored by a managing company.
Medicaid	A joint federal and state program that helps provide health care coverage for people with low incomes and limited resources.
Medicaid Managed Care	States may provide Medicaid benefits through a managed care delivery system, where the state contracts with an organization to provide Medicaid benefits for a set payment from the state.
Medicaid-Expansion	Medicaid Expansion is a provision of the Affordable Care Act (2010) that requires states to expand Medicaid eligibility to include all individuals and families with incomes up to 133% of the federal poverty level (FPL).
Medical Homes	Medical homes are an approach where a doctor leads a team of coordinated care for a chronically ill patient.
Medical Imaging	Medical imaging is imaging done of the human body for medical purposes. Examples of medical imaging are Computed Tomography (CT), Magnetic Resonance Imaging (MRI), Positron Emission Tomography (PET), ultrasound, and X-Ray.
Medicare	Medicare is a health insurance program, administered by the United States government, for people who are aged 65 and over; to those who are under 65 and are permanently physically disabled or who have a congenital physical disability; or to those who meet other special criteria like the End Stage Renal Disease program (ESRD).
Medicare Administrative Contractor (MAC)	A company under contract with the federal government to handle claims processing for Medicare services.
Medicare Advantage	A Medicare Advantage Plan (also known as Medicare Part C) is a Medicare health plan choice where private companies approved by Medicare provide Medicare benefits. Medicare Advantage plans provide all Part A and B coverage and most include Medicare Prescription drug coverage. Medicare Advantage plans may offer extra coverage such as vision, hearing and dental. Types of Medicare Advantage plans include Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), Special Needs Plans (SNPs), Private Fee-for-Service (PFFS) plans.
Medicare Qualified Entity Program	"Qualified entities" are entities allowed to receive standardized extracts of Medicare claims data under Parts A, B, and D for the evaluation of the performance of providers and suppliers, and to generate public reports regarding such performance. This program is legistated under section 10332 of the Affordable Care Act. Qualified entities must apply and be certified.
Minority Health	Minority health focuses on health care disparities between different races and ethnic groups.
National	Data are inclusive of the entire United States.
Nursing Home	A licensed nursing facility with the staff and equipment to give skilled nursing care and/or skilled rehabilitation services, and other related health services.
Operating Costs	The actual costs of providing health care services including procedures, therapies, and medications.

Term	Definition
Outcomes	Results of a treatment or program.
Outpatient	Medical or surgical care that does not include an overnight hospital stay. Medical or surgical care received from a clinic or hospital but not admitted as an inpatient. Outpatient care may include emergency department services, observation services, outpatient surgery, lab tests or X-rays.
Pain Management	Treatment of chronic or acute pain. Pain management may include physical therapy, behavioral therapy, biofeedback and pain-relieving devices.
Part A	Medicare Part A (also called Hospital Insurance) covers inpatient hospital stays, hospice care, home health care, and care provided in skilled nursing facilities.
Part B	Medicare Part B (also called Medical Insurance) covers doctors' services, outpatient care, durable medical equipment, home health services and other medical and preventive services.
Part C	Medicare Part C (also known as Medicare Advantage) is a Medicare health plan choice where private companies approved by CMS provide benefits to Medicare beneficiaries . Part C health plans provide all Part A and B coverage and most include Medicare Prescription drug coverage. Part C plans may offer extra coverage such as vision, hearing and dental. Types of Part C plans include Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), Special Needs Plans (SNPs), and Private Fee-for-Service (PFFS) plans.
Part D	Medicare Part D is an optional prescription drug insurance program available to Medicare beneficiaries for a monthly premium.
Payment Error Rate	A measurement of payments made that did not meet statutory, regulatory or administrative requirements.
Payment Sources	Source of payments made for health care services.
Payments	Payments made for health care services.
Persons Served	Number of persons serviced by a certain program or provider.
Pharmacy	A pharmacy is an establishment in which prescription medications are dispensed.
Physician Fee Schedule	The Medicare Physician Fee Schedule is a complete listing of fees used by Medicare to pay doctors or other providers/suppliers.
Physician Services	Services provided by an individual licensed under state law to practice medicine or osteopathy. Physician services given while in the hospital that appear on the hospital bill are not included.
Prescription Drug Plans	Plans offered by private companies that provide Medicare Prescription Drug Coverage (also known as Part D). Plans differ in monthly premiums, drugs covered, cost-sharing amounts and in their networks of participating pharmacies.
Prescription Drugs	Prescription drugs or prescription medication is licensed and restricted medication that requires a prescription from a physician or other authorized medical practitioner before it can be obtained. These differ from over-the-counter medications that can be obtained without a prescription.
Preventive Services	Health care to keep you healthy or to prevent illness (for example, Pap tests, pelvic exams, flu shots, and screening mammograms).

Term	Definition
Professional	A medical professional is an individual who provides medical care, such as a physician, nurse practitioner, therapist, psychiatrist, etc.
Prospective Payment System (PPS, IPPS, OPPS)	A Prospective Payment System (PPS) is 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 inpatient hospital services).
Providers	Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier, etc.) providing medical services covered under Medicare Part B. Any organization, institution, or individual that provides health care services to Medicare beneficiaries. Physicians, ambulatory surgical centers, and outpatient clinics are some of the providers of services covered under Medicare Part B.
Psychiatric Facility	A facility for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.
Psychiatric Treatment Center	A facility or distinct part of a facility for psychiatric care that provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.
Publically Available Data File - for download	Non-identifiable data that are within the public domain.
Publically Available Data File - for purchase	CMS Data files that have been edited and stripped of all information that could be used to identify individuals. In general the data files contain aggregate level information on Medicare beneficiary or provider utilization.
Publications	A published document such as a journal or book.
Quality	Quality is how well the health plan keeps its members healthy or treats them when they are sick. Good quality health care means doing the right thing at the right time, in the right way, for the right person and getting the best possible results.
Quality Improvement Organization	Groups of practicing doctors and other health care experts. They are paid by the federal government to check and improve the care given to Medicare patients. They must review your complaints about the quality of care given by: inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Private Fee-for Service plans, and ambulatory surgical centers.
Readmissions	A readmission is when an individual is admitted back to a hospital or other inpatient care center after being discharged from an earlier hospital stay within a defined period of time (generally 30 days).
Regional	Data are organized at a defined Regional level, such as the four U.S. Census defined regions (North, East, South, West).
Reports	Reports provide overviews, analysis and interpretation of important health policy issues.
Research	Investigation or experimentation in order to gain knowledge.
Restricted Use Data File	Identifiable data sets to be used only for reasons compatible with the purpose for which the data are collected. Data are subject to the Privacy Act, privacy release approvals, and the availability of computing resources and require a CMS data use agreement.

Term	Definition
Satisfaction	Satisfaction refers to fulfillment of a patient's needs or expectations.
Screenings	Screenings are routine tests used to prevent and diagnose diseases. Examples are mammography, pap tests, and blood pressure screenings.
Short Stay Hospital (SSH)	A hospital that provides acute inpatient care.
Skilled Nursing Facility (SNF)	A licensed nursing facility with the staff and equipment to give skilled nursing care and/or skilled rehabilitation services, and other related health services.
State	Data are organized at the U.S. state level, which can also include the District of Columbia and U.S. territories.
State Health Insurance Exchanges	A state health insurance exchange is a new entity created by the Affordable Care Act (2010). States are required by the year 2014 to create "exchanges", a competitive marketplace for individuals and small businesses to purchase affordable health insurance plans.
Statistics	Tables and figures that organize data, but do not interpret it.
Substance Abuse Treatment	Substance abuse treatment or drug rehabilitation is the treatment of the addiction to and abuse of drugs.
Suppliers	Individuals, agencies, or companies (aside from doctors or hospitals) that provide medical equipment or services. Some examples are ambulance companies, medical equipment rental businesses, and laboratories.
Survey	Survey data are a sample used to represent a whole population.
Trends	Trends refer to changes in data over a period of time.
Utilization	Utilization is the amount available health care services or programs are used by an eligible population.
Vendors	Individuals, agencies, or companies (aside from doctors or hospitals) that provide medical equipment or services. Some examples are ambulance companies, medical equipment rental businesses, and laboratories.