GLOSSARY OF TERMS

Aged—One of the categories used for classifying Medicare enrollees and Medicaid eligibles. Under Medicare, persons age 65 or over are included in this category if they are: entitled to monthly SSA benefits or payments from the RRB, uninsured for SSA or RRB benefits but transitionally insured for Medicare, or not included in the previously mentioned groups, but based on meeting certain criteria, elect to purchase HI and/or SMI coverage by paying the appropriate monthly premium. Persons age 65 or over identified as having ESRD are included. Under Medicaid, persons age 65 or over are included if, in addition to initially being age 65 or over met certain means (income and resources) criteria or incur medical expenses for health care that when deducted from income qualifies the individual for Medicaid.

Allowed Charge—An individual charge determination (approved amount) made by a Medicare Administrative Contractor on a covered Part B medical service or supply.

Ambulatory Surgical Center (ASC)—A facility that operates solely for purposes of providing surgical services to beneficiaries not requiring hospitalization and whose expected stay in the ASC does not exceed 24 hours. An ASC is either independent or operated by a hospital.

Assigned Claim—A claim for which the physician or supplier agrees to accept the amount approved by Medicare as the total payment. Medicare pays the physician or supplier 80 percent of the Medicare-approved fee schedule (less any unmet deductible). The doctor or supplier can charge the beneficiary only for the coinsurance, which is the remaining 20 percent of the approved amount. A participating physician or supplier agrees to accept assignment on all claims.

Balance Billing—A type of cost sharing under Medicare in which a beneficiary is responsible for the difference between the physician's submitted charge and the Medicare allowed charge on unassigned claims. Currently, a non-participating physician cannot charge a Medicare beneficiary more than 115 percent of the amount listed in the Medicare fee schedule for unassigned physician claims.

Beneficiary—A person who has health care insurance through the Medicare and Medicaid programs.

Benefit Payments—Benefit payments under Medicare comprise all withdrawals from the HI and SMI trust funds to directly pay providers for services rendered for covered services to Medicare enrollees under the FFS payment system and monthly premiums to managed care and other Medicare Choice organizations under capitated payment systems. Under FFS, payments recorded on bills (referred to as program payments) and payments made independently of the billing system (e.g., lump-sum adjustments to interim rates and end-of-year adjustments from cost settlements) are included. Estimates of benefit payments by Federal FY or CY are prepared by the CMS Office of the Actuary both on a paid and on an incurred basis.

Benefit Period—The unit of time for measuring the use of Part A benefits (spell of illness). A benefit period begins the first day an enrollee is furnished inpatient hospital or extended care services by a qualified provider, and it ends when the enrollee has not been an inpatient of a hospital or other facility primarily providing skilled nursing or rehabilitation services for 60 consecutive days. There is no limit to the number of benefit periods an enrollee can have. The enrollee must pay the hospital insurance deductible for each new benefit period.

BETOS Code – A Berenson-Eggers Type of Service code. BETOS codes define high-level groupings of HCPCS (procedure) codes. These grouping are easily understood clinical categories that permit objective assignment, are stable over time, and are relatively immune to minor changes in technology or practice patterns.

Brand Name Drug – A drug marketed under a proprietary, trademark-protected name. A drug is classified as "brand" using the Food and Drug Administration (FDA) approval category of New Drug Application (NDA), NDA authorized generic, or Biologic License Application (BLA).

Buy-In—A Medicare beneficiary who is also eligible for Medicaid, and for whom Medicare Part B premiums and/or Part A premiums are paid by a State Medicaid program (refer to dual eligible, Medicare-Medicaid enrollee, QMB, QDWI, and SLMB).

Calendar Year (CY)—The 12-month period running from January 1-December 31 that is used for establishing the payment of the voluntary Part A and the Part B premiums, deductibles, and coinsurance requirements. It is used as the basis for tabulating Medicare enrollment, program utilization and cost sharing, and program payments.

Cancer Hospitals – Prospective Payment System-exempt hospitals dedicated to cancer treatment and are excluded from payment under the Inpatient Prospective Payment System.

Centers for Medicare & Medicaid Services (CMS)—The Federal Agency within DHHS that runs Medicare. In addition, CMS works with the States to run the Medicaid and CHIP programs. CMS works to make sure that the beneficiaries in these programs are able to get high-quality health care. CMS also runs the federally-facilitated Marketplace.

Children's Hospitals—Hospitals with inpatients predominantly age 18 or younger.

Chronic Conditions Warehouse— The Chronic Conditions Data Warehouse (CCW) is a CMS research database designed to make Medicare, Medicaid, Assessments, and Part D Prescription Drug Event data more readily available to support research designed to improve the quality of care and reduce costs and utilization.

Claim—A request to a Medicare Administrative Contractor, to a State by a beneficiary, or by a provider acting on behalf of a beneficiary for payment of benefits under Medicare or Medicaid.

Clinical Laboratory— A laboratory defined by the Clinical Laboratory Improvement Amendments (CLIA) as any facility which performs laboratory testing on specimens obtained from humans for the purpose of providing information for health assessment and for the diagnosis, prevention, or treatment of disease.

Coinsurance—The portion of reimbursable hospital and medical expenses, after subtraction of any deductible, that Medicare does not cover and for which the beneficiary is responsible; or, for which Medicaid may pay in the case of certain dually entitled beneficiaries. Under Part A, there is no coinsurance for the first 60 days of inpatient hospital care; from the 61st-90th day of inpatient care, the daily coinsurance amount is equal to one-fourth of the inpatient hospital deductible. For each of the 60 lifetime reserve days used, the daily coinsurance amount is equal to one-half of the inpatient hospital deductible. There is no coinsurance for the first 20 days of SNF care; from the 21st-100th day of SNF care, the daily coinsurance amount is equal to one-eighth of the inpatient hospital deductible. Under Part B, after the annual deductible has been met, Medicare pays 80 percent of the allowed amount for covered services and supplies; the remaining 20 percent is the coinsurance payable by the enrollee. There is no coinsurance for home health services, or for clinical laboratory services under Part B.

Community Mental Health Center—A facility that provides mental health services and performs the following core services: outpatient services, 24-hour-a-day emergency psychiatric services, day treatment or other partial hospitalization services or psychosocial rehabilitation services, and screening for beneficiaries being considered for admission to State mental health facilities.

Comprehensive Outpatient Rehabilitation Facility—A facility established and operated at a single fixed location exclusively for the purpose of providing diagnostic, therapeutic, and restorative services to outpatients by or under the supervision of a physician.

Cost Sharing—The generic term that includes copayments, coinsurance, deductibles, and out-of-pocket payments for balanced billing. Excludes monthly premium for Part-B coverage, Part-D coverage, voluntary HI coverage, and supplemental insurance.

*Copayments***—**A specified dollar amount, typically modest, that insured persons must pay for a particular unit of service, such as an office visit, emergency room visit, or the filling of a prescription.

*Coinsurance***—**Medicare Part A: A specified per-day dollar amount. Medicare Part B: A percentage share of the cost of services, after deductibles.

*Deductibles***—**Specified amounts of spending which a beneficiary must incur before insurance begins to make payments.

Covered Day of Care—A day of care which was covered in full or in part by HI Medicare benefits. This excludes days of care prior to the start of the program on July 1, 1966, days of care prior to the person's entitlement to HI benefits, and days of care after exhaustion of benefits (refer to total days of care).

Covered Services—Services and supplies for which Medicare and Medicaid will reimburse.

Creditable Coverage—Prescription drug coverage provided by entities, such as employers or unions (whose policies include prescription drug coverage) that is expected to pay on average as much as the standard Medicare prescription drug coverage.

Critical Access Hospitals—A small facility that provides outpatient services, as well as inpatient services on a limited basis, to people in rural areas.

Current Procedural Terminology (CPT) Codes—A medical code set used for reporting medical services and procedures performed by physicians or other qualified providers. CPT is a trademark of the American Medical Association (AMA) and codes and descriptions are copyrighted.

Deductible—The amounts paid by enrollees or by a third party for covered services before Medicare or Medicaid makes reimbursements. The Medicare HI deductible applies to each new benefit period. The Medicare SMI deductible applies each year.

Department of Health and Human Services (DHHS)—Administers many of the social programs of the Federal Government dealing with the health and welfare of the citizens of the U.S.

Disabled—One of the categories used for classifying Medicare enrollees and Medicaid eligibles. Disabled persons under age 65 receiving Social Security or RRB disability insurance benefits for 24 months are eligible for Medicare coverage. Persons under age 65 who are diagnosed with ESRD are eligible to receive Medicare coverage without the Social Security disability insurance 24-month requirement. In this online report, ESRD beneficiaries are included with the disabled unless otherwise noted. Under Medicaid, the disabled category refers to low-income individuals of any age who are eligible as persons meeting SSA's programmatic definition of disability. This includes individuals receiving SSI as well as those whose incomes are too high for SSI, but qualify under separate Medicaid income standards.

Discharge—A formal release from a hospital (under Medicare or Medicaid), a SNF (under Medicare), or a NF (under Medicaid). Discharges include persons who died during their stay, were discharged to home, or were transferred to another facility.

Disproportionate Share Hospitals – Disproportionate Share Hospitals serve a significantly disproportionate number of low-income patients and receive payments from the Centers for Medicare & Medicaid Services to cover the costs of providing care to uninsured patients.

Dual Eligible—Also referred to as Medicare-Medicaid Enrollee. An individual who is entitled to Medicare Parts A and/or B and is eligible for a form of Medicaid benefits (depending on the services and limitations placed by the State), as well as payment of Medicare monthly premium, deductibles, and/or coinsurance. Under Part D, individuals eligible for both Medicare and Medicaid receive a low-income subsidy for the Medicare drug plan premium and assistance with cost sharing for prescriptions.

Durable Medical Equipment (DME)—Medical supplies, and items used in a beneficiary's home, such as hospital beds, wheelchairs, assistive devices, oxygen, etc.

Eligibility—Meeting the requirements for coverage under Medicare and/or Medicaid.

Eligible—*Medicare:* a person who is able to enroll in the Medicare program or a portion of the Medicare program, but has chosen not to do so. For example, many Medicare beneficiaries who are enrolled in Part A have chosen not to enroll in Part B, although they could. *Medicaid:* a person who is enrolled in the Medicaid program and eligible to receive Medicaid services.

End Stage Renal Disease (ESRD)—Permanent kidney failure. To survive, the patient must either receive a kidney transplant or periodic kidney dialysis. Individuals with ESRD are eligible for Medicare benefits under a special entitlement.

Enrollee—A person who is eligible for coverage and is enrolled in the Medicare and/or Medicaid.

ESRD Enrollees—Individuals who have chronic kidney disease requiring renal dialysis or a kidney transplant are considered to have ESRD. To qualify for Medicare coverage, such individuals must be fully or currently insured under Social Security or the Railroad Retirement System or be the dependent of an insured person. Eligibility for Medicare coverage begins the first day of the fourth month of dialysis treatments; coverage may begin sooner if the patient participates in a self-care dialysis training program provided by a Medicare-approved training facility. Also, coverage may begin on admittance to a Medicare-approved hospital to receive a kidney transplant or to receive dialysis before the transplant if the transplant takes place in that same month or within the following 2 months.

ESRD Facility—A facility which is approved to furnish at least one specific ESRD service. Such facilities are: Renal Transplantation Center, Renal Dialysis Center, Renal Dialysis Facility, Self-Dialysis Unit, and Special Purpose Renal Dialysis Facility.

Federal Hospital Insurance (HI) Trust Fund—A trust fund of the U.S. Treasury in which monies collected from taxes on annual earnings of employees, employers, and self-employed persons covered by Social Security are deposited. Disbursements from the fund are made to help pay for benefit payments and administrative expenses incurred by the HI program.

Federally Qualified Health Center (FQHC)—Federally funded nonprofit health centers or clinics that serve medically underserved areas and populations. 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. Typically, Medicaid provides higher payment rates for outpatient facilities designated as FQHCs compared to facilities not so designated.

Federal Supplementary Medical Insurance (SMI) Trust Fund—A trust fund of the U.S. Treasury consisting of amounts deposited in or appropriated to the fund as provided by Title XVIII of the Social Security Act. SMI is comprised of 2 parts, Part B and Part D, each with its own separate account within the SMI Trust Fund. Both parts are financed by beneficiary premiums (beneficiaries who voluntarily enroll), contributions from the States (Part D only), and by the general fund of the U.S. Treasury. Disbursements from the fund are made for benefit payments and administrative expenses incurred by the SMI program.

Fee-for-Service (FFS) Enrollees—Medicare beneficiaries enrolled in the traditional health care system (or Original Medicare).

Fee-for-Service (FFS) Reimbursement—The payment that physicians and other providers receive for services provided, under the traditional health care payment system.

Generic Dispensing Rate – The number of prescriptions filled as generic divided by the total number of prescriptions.

Generic Drug – A term referring to the chemical ingredient of a drug rather than the trademarked brand name under which the drug is sold. A drug is classified as "generic" using the FDA approval category of Abbreviated New Drug Application (ANDA).

Geographic Classifications:

All Areas—The United States, Guam, Puerto Rico, Virgin Islands, American Samoa, Northern Mariana Islands, other outlying areas (including foreign countries and unknown).

Territories, Possessions and Other—American Samoa, Guam, Puerto Rico, Northern Mariana Islands, Virgin Islands, Foreign Countries, Unknown, and Other Outlying Areas comprise this category.

Place of Residence—The beneficiary's place of residence classification is a mailing address, not necessarily an actual place of residence. Some beneficiaries have their checks mailed to a post office or to a representative-payee in a State or county that may differ from their own residence.

Metropolitan Statistical Area—A Core Based Statistical Area associated with at least one urbanized area that has a population of at least 50,000. The Metropolitan Statistical Area comprises the central county or counties containing the core, plus adjacent outlying counties having a high degree of social and economic integration with the central county or counties as measured through commuting.

Micropolitan Statistical Area—A Core Statistical Area associated with at least one urban cluster that has a population of at least 10,000, but less than 50,000. The Micropolitan Statistical Area comprises the central county or counties containing the core, plus adjacent outlying counties having a high degree of social and economic integration with the central county or counties as measured through commuting.

Non-Core-Based Statistical Area—All remaining counties, often labeled "noncore" counties because they are not part of "core-based" metropolitan or micropolitan areas.

Healthcare Common Procedure Coding System (HCPCS)—A Medicare coding system for all services performed by a physician, other health care professional, or supplier. Level I of the HCPCS is comprised of CPT codes, maintained by the American Medical Association, which are used to identify services and procedures by physician or other health care professionals. Level II codes are used primarily to identify products, supplies, and services (such as ambulance and DME, prosthetic, orthotics and supplies) not included in the CPT codes. State Medicaid agencies, with local modifications, use this system as a basis for reimbursement for ambulatory services.

Home Health Agency (HHA)—A public or private organization that provides skilled nursing services and other therapeutic services in the patient's home, under the care of physicians, and that meets certain conditions to ensure the health and safety of the individual. HHA services are furnished under an established plan and periodically reviewed by a physician. They include part-time or intermittent skilled nursing care; physical, occupational, or speech therapy; medical social services; medical supplies and appliances (other than drugs and biological); home health aide services; and services of interns and residents.

Hospice—A public agency or private organization that is primarily engaged in providing pain relief, symptom management, and supportive services to patients that are certified to be terminally ill. Medicare beneficiaries may elect to receive hospice care instead of standard Medicare benefits for terminal illnesses. Under Medicaid, beneficiaries electing hospice no longer receive Medicaid covered therapeutic services.

Income Related Monthly Adjustment Amount (IRMAA) – The portion of the beneficiary's premium-due amount for those beneficiaries charged with a higher premium due to higher income levels. IRMAA applies to Medicare Part B and Medicare Part D.

Independent Laboratory – A laboratory that has been recognized by a laboratory-accrediting organization to test and evaluate products to a product safety standard, and is free from commercial, financial, and other pressures that may influence the results of the testing and evaluation process.

Inpatient Hospital Services—Items and services furnished to an inpatient of a hospital by the hospital, including room and board, nursing and related services, diagnostic and therapeutic services, and medical or surgical services.

Inpatient Prospective Payment System—Hospitals that have contracted with Medicare to provide acute inpatient care and accept a predetermined rate as payment in full.

Institutional Services—For Medicare, includes those services provided by hospitals (outpatient and inpatient), HHAs, hospices, SNFs, and other outpatient facilities. For Medicaid, also includes NFs and ICFs/MR.

International Classification of Diseases - 9th Revision, Clinical Modification (ICD-9-CM)—A diagnosis and procedure classification system. ICD-9-CM codes are the basis for grouping patients into MS-DRGs.

Lifetime Reserve—In Original Medicare, a Medicare Part A enrollee has a non-renewable lifetime reserve of 60 days of inpatient hospital care to draw on if the 90 covered days per benefit period are exhausted. Patients are required to pay a daily coinsurance amount equal to one-half of the inpatient hospital deductible for each lifetime reserve day.

Long Term Care Hospitals—Certified as acute-care hospitals, but long term care hospitals focus on patients who, on average, stay more than 25 days.

Low-Income Subsidy—The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), which established the Medicare Prescription Drug Program, also provides for extra help (a subsidy) with prescription drug costs for eligible individuals whose income and resources are limited. The subsidy provides assistance with the premium, deductible, and co-payments of the program paid by the Federal government to the drug plan in which the Medicare beneficiary enrolls.

Managed Care Reduction (MCR) – Amount of the adjustment made to the Part B premium, per the Benefits Improvement and Protection Act of 2000 (BIPA). In some cases, a managed care plan will receive a rebate from Medicare, which must then be passed on to the enrollees in the form of a reduced premium.

Medicaid—The joint Federal/State entitlement program, enacted in 1965 as Title XIX of the Social Security Act, that pays for medical care on behalf of certain groups of low-income persons.

Medicare—The federal health insurance program for people who are 65 or older, certain younger people with disabilities, and people with End Stage Renal Disease.

Medicare Administrative Contractor (MAC)—A company under contract with the federal government to handle claims processing for Medicare services. There are three different MACs: A/B MAC which processes both Part A and B claims, DME MAC which processes durable medical equipment (DME) claims, and HH&H MAC which process home health and hospice (HH&H) claims.

Medicare Advantage and Other Health Plan Enrollees— Medicare beneficiaries enrolled in health plans that are offered by private companies approved by Medicare to provide health care coverage offered at a uniform premium and uniform level of cost-sharing to all Medicare beneficiaries residing in the service area (or segment of the service area). Each type of plan has special rules and exceptions.

Medicare Advantage Prescription Drug Plan (MAPD)—A Medicare Advantage (Part C) plan that includes prescription drug coverage. These plans are offered by private companies that contract with Medicare to provide Part A, Part B, and Part D benefits, and include Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), Private Fee-for-Service (PFFS) plans, or Medicare Medical Savings Account (MSA) plans.

Medicare Dependent Hospitals – A hospital located in a rural area, with 100 or fewer beds, not classified as a sole community hospital and has at least 60 percent of its inpatient days or discharges attributable to Medicare beneficiaries with hospital coverage.

Medicare-Medicaid Enrollee—Also known as Dual Eligible beneficiary. An individual who is entitled to Medicare Parts A and/or B and is eligible for a form of Medicaid benefits (depending on the services and limitations placed by the State), as well as payment of Medicare monthly premium, deductibles, and/or coinsurance. Under Part D, individuals eligible for both Medicare and Medicaid receive a low-income subsidy for the Medicare drug plan premium and assistance with cost sharing for prescriptions.

Medicare Part A or Hospital Insurance (HI)—Medicare HI (also known as Medicare Part A) is an insurance program providing basic protection against the costs of hospital and related post-hospital services for individuals who: are age 65 or over and are eligible for retirement benefits under the Social Security or the RRB system; are under age 65 who have been entitled for at least 24 months to disability benefits under the Social Security or RRB system; are medically determined to have ESRD and are covered by the Social Security or RRB system; beginning in July 2001, are persons with Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease) who are allowed to waive the 24-month waiting period; or beginning March 30, 2010, are in the vicinity of Libby, Montana who are diagnosed with an asbestos-related condition. Part A helps cover inpatient hospital care, skilled nursing facility (SNF) care, hospice care, and some home health care.

Medicare Part B or Supplementary Medical Insurance (SMI)—Traditionally known as Medicare Part B, this is a voluntary insurance program that provides insurance benefits for physicians' services, outpatient care, ambulatory services, medical supplies and services, durable medical equipment, some home health care services, and preventive services to aged and disabled individuals who elect to enroll under the program in accordance with the provisions of Title

XVIII of the Social Security Act. The SMI program is financed by enrollee premium payments and contributions from funds appropriated by the Federal Government. A separate account in the SMI trust fund now also accounts for the Part D drug benefit.

Medicare Part D—Prescription drug coverage for Medicare beneficiaries who choose to participate. Coverage is provided through Prescription Drug Plans (PDPs) or Medicare Advantage Plans. A separate account in the SMI trust fund accounts for the Part D drug benefit. Part D is financed through general revenues, beneficiary premiums, and state contributions.

Medicare Part D Coverage Phases:

Deductible Phase—The Part D coverage phase in which Part D enrolled beneficiaries pay the full cost of covered prescription drugs until they meet their Part D deductible.

Initial Coverage Phase—During this phase, after the deductible has been met, the plan pays for a portion of each prescription drug and the beneficiary will pay a copayment or coinsurance amount.

Coverage Gap Phase—This Part D coverage phase, also known as the "donut hole", begins after the beneficiary and the drug plan have spent a certain amount for covered drugs. During this phase, the beneficiary will pay no more than 25% of the plan's cost for covered brand-name prescription drugs and no more than 25% of the plan's cost for covered generic drugs.

Catastrophic Coverage Phase—During this phase, beneficiaries pay lower coinsurance or copayment amounts for their covered prescription drugs for the rest of the year.

Medicare Severity Diagnosis Related Groups (MS-DRGs)—A classification system which categorizes patients into groups that are clinically coherent and homogeneous with respect to inpatient short stay hospital resource use. (Formerly known as DRGs).

National Provider Identifier—A unique identification number for health care providers used by health plans.

Non-Dual Eligible – A Medicare enrollee who does not receive Medicaid benefits.

Observation Stay – An outpatient hospital stay in which a Medicare beneficiary receives observation care. Observation care is a well-defined set of specific, clinically appropriate services that include ongoing short term treatment, assessment, and reassessment. These services help in the decision to either admit a beneficiary to an inpatient hospital, or to discharge the beneficiary. Observation services are commonly ordered for patients who present to the emergency department and who then require a significant period of treatment or monitoring in order to make a decision concerning their admission or discharge. In the majority of cases, the decision whether to discharge a patient from the hospital following

resolution of the reason for the observation care or to admit the patient as an inpatient can be made in less than 48 hours, usually in less than 24 hours. In only rare and exceptional cases do reasonable and necessary outpatient observation services span more than 48 hours.

Office of the Actuary (OACT)—This CMS component provides actuarial, economic and statistical services to various CMS components, other Federal agencies, the Medicare Board of Trustees, Congress, national advisory commissions, health research groups, and outside organizations.

Organ Procurement Organizations—An organization that performs or coordinates the procurement, preservation, and transport of organs and maintains a system for locating prospective beneficiaries for available organs.

Original Medicare Enrollees—Medicare beneficiaries enrolled in the traditional health care system (or Fee-for-Service).

Outpatient Hospital Services—Services furnished to outpatients by a participating hospital for diagnosis or treatment of an illness or injury. Outpatient hospital care may include emergency department services, observation services, outpatient surgery, lab tests, or X-rays.

Outpatient Physical Therapy and/or Outpatient Speech Pathology Facility—A rehabilitation agency, clinic or public health agency which provides outpatient physical therapy, occupational therapy and/or speech pathology services, designed by qualified personnel to upgrade physical functions.

Outpatient Services—Medical and other services provided by a hospital or other qualified facility or supplier, such as community mental health center, rural health clinic, X-ray mobile unit, or freestanding dialysis unit. Such services include: outpatient physical therapy, diagnostic X-ray and laboratory tests, and X-ray and other radiation therapy.

Part B Penalty—An amount added to the monthly Part B premium for late enrollment. The monthly Part B premium may increase by 10% for each full 12-month period if a beneficiary is eligible for Part B but delays signing up.

Participating Physician or Supplier—A physician/supplier that agrees to accept assignment on all Medicare claims under the Medicare SMI program. Accepting Medicare assignment means the physician/supplier agrees to be paid directly by Medicare, to accept the payment amount Medicare approves for the services, and to bill the beneficiary for only the Medicare deductible and coinsurance amounts, if applicable. In Medicaid, participating providers agree to accept Medicaid reimbursement as payment in full.

Penalty Addition – The penalty portion of the beneficiary's premium-due amount resulting from late enrollment. The Part A premium penalty is charged for twice the number of years enrollment is delayed. The penalty for late enrollment in Part B is an additional 10% for each 12-month period of delay. The penalty for late enrollment in a Part D plan is 1% of the "national base beneficiary premium" times the number of full, uncovered months a beneficiary did not have Part D or creditable coverage.

Personal Health Care Expenditures (PHCE)—Health care goods and services purchased directly by or for individuals. They exclude: health expenditures for government administration and net cost of health insurance, government public health activities, research, and structures and equipment.

Person With Utilization—A concept used for measuring utilization of covered services and program payments for these services. In general, under Medicare, a person with utilization is considered to be a Medicare enrollee who used a covered health care or medical service under fee-for-service (Original Medicare) and incurred expenses greater than the deductible amount, resulting in the program making a payment on the enrollee's behalf. (When the term person with utilization is used to describe a person who used a covered service regardless of having met the deductible, it will be indicated by the footnotes.) Under Medicaid, a person served is considered to be a person for whom some sort of payment has been made for selected categories of service or coverage within the categories reported in the applicable Medicaid statistical reporting systems. Under the HCFA-2082 reporting system, person served generally referred to persons for whom Medicaid made a payment to a provider under fee-for-service. The concept was expanded in the Medicaid Statistical Information System to include persons for whom managed care capitated premiums and certain private health insurance premiums were made. Under Medicaid a person served is variously referred to as a Medicaid recipient or beneficiary. (Note: For utilization reporting, the payment of the Medicare Part B premium alone for a Medicare/Medicaid dual eligible beneficiary has never been construed as qualifying the person to be considered a person served.) For both programs, persons are counted once for each type of covered service used, regardless of the number of services used. That is, a person receiving the same service two or more times in a year is counted as one person served. For example, persons having two or more hospitalizations during a year are counted as one person served for inpatient hospital services. In addition, persons are counted once in aggregate or overall categories, regardless of the different categories of services used. Thus a person who receives inpatient hospital services and nursing home care (skilled nursing facility under Medicare, nursing facility under Medicaid) services in a year is counted separately as receiving each of these services, but is counted only once in calculating all persons with utilization.

Physician Services—Under Medicare, physicians' services are services provided by an individual licensed under State law to practice medicine or osteopathy. Services covered by hospital bills are not included.

Portable X-Ray Supplier—A portable x-ray supplier moves its x-ray equipment from place to place, performing x-ray services at various locations, and can be either a mobile facility or portable unit.

Premium—A monthly fee that may be paid to Medicare or Medicaid. Medicare HI enrollees who are Social Security or RRB beneficiaries and who qualify for coverage through age or disability are not required to pay premiums. Aged persons who are not eligible for automatic HI enrollment may pay a monthly premium to obtain HI coverage. SMI enrollees pay a monthly premium that is updated annually to reflect changes in program costs. Under Part D, most drug plans charge a monthly fee that varies by plan.

Prescription Drug Events (Fills) - The number of all Medicare Part D standardized 30-day fills. The standardized 30-day fill is derived from the number of days supplied on the Medicare Part D claim divided by 30.

Prescription Drug Plan (PDP)—A stand-alone drug plan that adds prescription drug coverage to Original Medicare, some Medicare Cost Plans, some Medicare PFFS plans, and Medicare Medical Savings Account Plans. These plans are offered by insurance companies and other private companies approved by Medicare.

Primary Care—Basic or general health care, traditionally provided by family practice, pediatrics, and internal medicine.

Principal Diagnosis—Under Medicare, the medical condition that is chiefly responsible for the admission of a patient to a hospital or for services provided by a physician or other provider. Under Medicaid, the diagnosis reported as the principal diagnosis on the last dated claim for a hospital stay.

Program Payments—The money amount Medicare paid for covered health care services, as accumulated from the fully-adjudicated claims data that has been accreted to CMS' system-of-record databases. Not included in program payments are interim payments to institutional providers, payments to institutional providers resulting from adjustments to the end of FY cost reports, capitation payments for prepaid group health plans, beneficiary cost-sharing amounts, and administrative costs.

Prospective Payment System (PPS)—A method of provider 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.

Provider—A Medicare provider is a facility, supplier, physician, or other individual or organization that furnishes health care services. Under Medicaid, a provider is an individual, group, or agency that provides a covered Medicaid service to a Medicaid enrollee.

Psychiatric Hospitals—An institution that is primarily engaged in providing, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill patients, maintains clinical records necessary to determine the degree and intensity of the treatment provided to the mentally ill patient, and meets staffing requirements sufficient to carry out active programs of treatment for individuals who are furnished care in the institution.

Psychiatric Units—A distinct unit of acute care hospitals and critical access hospitals providing inpatient psychiatric treatment.

Qualified Disabled and Working Individuals (QDWI)—Medicaid is required to pay Medicare Part A premiums only for certain disabled individuals who lose Medicare coverage because of work. These are individuals whose income is below 200 percent of the Federal Poverty Level, whose resources are not more than twice the value allowed under SSI, and who are not otherwise eligible for Medicaid.

Qualified Medicare Beneficiary (QMB)—A low-income Medicare beneficiary who qualifies for certain assistance under Medicaid. The beneficiary must have Medicare Part A and income less than or equal to 100 percent of the Federal Poverty Level and resources below twice the value allowed under SSI. For those who qualify, the Medicaid program must pay Medicare Part A premiums (if applicable), Part B premiums, and Medicare deductibles and coinsurance amounts for Medicare covered services depending on the Medicaid State plan. Some of these individuals may qualify for full Medicaid benefits and are sometimes referred to as “QMB pluses”.

Qualifying Individual (QI)—These individuals are entitled to Medicare Part A, have income of at least 120% but less than 135% of the Federal Poverty Level, resources that do not exceed twice the limit for SSI eligibility, and are not otherwise eligible for Medicaid. Medicaid pays their Medicare Part B premiums only. There is an annual cap on the amount of money available, which may limit the number of individuals in the group.

Railroad Retirement Board (RRB)—Independent agency of the Federal Government charged with administering the retirement-survivor and unemployment-sickness benefit program for railroad workers and their families.

Reduced Base Premium – Part A – The reduced monthly Part A premium amount for Medicare beneficiaries with 30-39 quarters of qualifying work history.

Reduced Base Premium – Part B – The reduced base Part B premium amount for Medicare beneficiaries qualifying for the variable supplementary medical insurance (VSMI) premium (see definition for VSMI).

Rehabilitation Hospitals—Free-standing rehabilitation hospitals that provide an intensive rehabilitation program, and patients who are admitted must be able to tolerate three hours of intensive rehabilitation services per day.

Rehabilitation Units—Rehabilitation units in acute care hospitals that provide an intensive rehabilitation program, and patients must be able to tolerate three hours of intensive rehabilitation services per day.

Religious Non-Medical Institutions—A facility that provides non-medical health care items and services to people who need hospital or skilled nursing facility care, but for whom that care would be inconsistent with their religious beliefs.

Reported Cost – The basis for determining payments to Critical Access Hospitals (CAHs). This differs from the Prospective Payment System (PPS) used to determine payments to traditional hospitals.

Retiree Drug Subsidy—Enables employers and unions to continue assisting their Medicare-eligible retirees in obtaining more generous drug coverage.

Revenue Center—A facility cost center for which a separate charge is billed on an institutional claim.

Rural Health Clinics—A federally qualified health center (FQHC) that provides health care services in rural areas where there's a shortage of health care services.

Short-Stay Hospital (SSH)—A hospital in which the average length of a stay is 25 or fewer days.

Skilled Nursing Facility (SNF)—In Medicare, an institution that has a transfer agreement with one or more participating hospitals, is primarily engaged in providing skilled nursing care and rehabilitative services to inpatients, and meets specific regulatory certification requirements.

Social Security Act—The Titles of the 1965 Social Security Act include: Title II—Old Age, Survivors, and Disability Insurance Benefits (OASDI); also, Social Security; Title IV-A AFDC; Title IV-B—Child Welfare; Title IV-D—Child Support; Title IV-E—Foster Care and Adoption; Title IV-

F—Job Opportunities and Basic Skills Training; Title V—Maternal and Child Health Services; Title XVI—SSI; Title XVIII—Medicare; Title XIX—Medicaid; Title XX—Social Services; and Title XXI—State Children's Health Insurance Program.

Sole Community Hospital – A rural hospital located at least 35 miles from the nearest like hospital (excluding critical access hospitals and Indian Health Service hospitals), provides short-term, acute care and is paid under the Medicare Inpatient Prospective Payment System.

Specified Low Income Medicare Beneficiary (SLMB)—A low-income Medicare beneficiary who qualifies for certain assistance under Medicaid. The beneficiary must have Medicare Part A and income above 100 percent, but less than 120 percent of the Federal Poverty Level and resources below twice the value allowed under SSI. For those who qualify, the Medicaid program pays the Medicare Part B premium. Some of these individuals may qualify for full Medicaid benefits and are sometimes referred to as "SLMB pluses".

Standard Base Premium – Part A – The Part A base premium amount a beneficiary, who paid Medicare taxes for less than 30 quarters, pays (or has paid for on their behalf) each month for Part A coverage.

Standard Base Premium – Part B – The Part B base premium amount that a beneficiary pays each month for Part B coverage, either paid by the beneficiary or paid for on his or her behalf.

Supplier—An organization that has been issued a Medicare supplier number, and which provides DME (such as wheelchair, walker, and oxygen equipment), medical devices (such as artificial limbs and braces), or medical supplies (such as surgical dressings).

Swing Bed Hospitals—A hospital or critical access hospital (CAH) participating in Medicare that has CMS approval to provide post-hospital SNF care and meets certain requirements. The hospital can use its beds, as needed, to provide either acute or SNF care.

Teaching Hospitals— Hospitals that received a payment(s) under a Medicare direct graduate medical education (GME), inpatient hospital prospective payment system (IPPS) indirect medical education (IME), or psychiatric hospital IME programs during the most recent calendar year.

Total Days of Care—Any day during which inpatient hospital services were furnished to a person eligible for HI benefits under Medicare including covered and non-covered days of care.

Total Drug Cost – The aggregate drug cost paid for prescription drugs covered under the Medicare Part D program. This amount includes ingredient cost, dispensing fee, sales tax, and any applicable vaccine administration fees and is based on the amounts paid by the Part D plan, Medicare beneficiary, government subsidies, and any other third-party payers.

Total Personal Health Care Expenditures (PHCE)—The sum of all expenditures for health care by Medicare, Medicaid, private insurance, out-of-pocket, and all other public and private sources.

Transplant Center—A hospital that provides organ transplants and other medical and surgical specialty services required for the care of transplant patients.

Utilization—A measure of the extent to which the members of a covered group use a program or obtain a particular service, or category of procedures, over a given period of time. Usually expressed as the number of services used per year or per number of persons eligible for the services.

Variable Supplementary Medical Insurance (VSMI) - The premium paid by those held harmless. A special rule for Social Security recipients, called the "hold harmless rule", ensures that Social Security income amount will not decline from one year to the next because of increases in Medicare Part B premiums. The hold-harmless rule applies to most, but not all, Social Security recipients. Most people who receive Social Security disability or retirement benefits and Medicare Part B are eligible for protection under this rule. These not eligible are new Medicare enrollees, IRMAA beneficiaries, and beneficiaries who do not have their Medicare Part B premium amounts automatically deducted from their Social Security checks.

Waiver—An exception to the usual requirements of Medicare or the usual requirements of Medicaid granted to a State by CMS, authorized through the following sections of the Social Security Act or Social Security Amendments:

*402 of the Social Security Amendments of 1967***—**Provides Medicare demonstration authority to test alternative methods of Medicare payment and changes to the Medicare benefit package.

*1115 of the Social Security Act***—**Allows States to waive provisions of Medicaid law to test new concepts which are congruent with the goals of the Medicaid Program. Radical, system-wide changes are possible under this provision.