Appendix J

Glossary of Terms

Access: Potential and actual entry of a population into the health care delivery system.

Accounts receivable: The full amount of patient care charges owed to a hospital or other health care facility. Average days in accounts receivable refers to the average number of days it takes a hospital or other facility to collect the full amount of patient care charges.

Accreditation by JCAHO: A statement by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) that an eligible health care organization, such as a hospital, complies wholly or substantially with JCAHO standards.

Acute care: Services within a hospital setting intended to maintain patients for medical and surgical episodic care over a relatively short period of time.

Admissions: Number of patients, excluding newborns, accepted for hospital inpatient service during a particular reporting period (American Hospital Association definition).

Allowed (or allowable) charge (under Medicare): See *customary, prevailing, and reasonable charges.*

Alternative facility licensure: The process by which a State creates a new category of licensed health care facility or new licensure rules for existing categories of facilities for the purpose of maintaining the viability and accessibility of certain facilities or services.

Ambulatory care: Medical services provided to patients who are not inpatients of hospitals. It includes outpatient hospital care.

Ambulatory surgery: Scheduled surgical services provided to patients who do not remain in a hospital overnight. The surgery may be performed in hospital operating suites or procedure rooms within a freestanding ambulatory care center.

Ancillary services or technology: Medical technology or services used directly to support basic clinical services, including diagnostic radiology, radiation therapy, clinical laboratory, and other special services.

Antitrust laws: Laws such as the Clayton Act (15 U.S.C. 12-27) that prohibit institutional mergers and acquisitions, exclusive contracts, joint ventures, and other business dealings in areas that may substantially reduce competition or have the tendency to produce a monopoly, and consequently have a detrimental effect on consumer welfare.

Assignment: A process whereby a Medicare beneficiary assigns his or her right to payment from Medicare to the physician or supplier. In return, the physician or supplier agrees to accept Medicare's reasonable or ***allowed*** charge as payment in full for covered services. The physician (or supplier) may not charge the beneficiary more than the applicable deductible and coinsurance amounts. For physicians and suppliers who do not accept assignment, payment is made by Medicare directly to the beneficiary, who is responsible for paying the bill. In addition to the deductible and coinsurance amounts, the beneficiary is liable for any difference between the physician's actual charge and Medicare's reasonable (allowed) charge.

Average length of stay: Average stay of hospital patients from admission to discharge during a particular reporting period; derived by dividing the number of inpatient days by the number of admissions for the period.

Bad **debts:** Patient care charges owed to a facility that the facility considers to be largely uncollectable.

Balance billing: In the Medicare program, the practice of billing a Medicare beneficiary in excess of Medicare's allowed charge. The "balance billing" amount would be the difference between Medicare's allowed charge and the physician's (or other qualifying provider's) billed charge. (See ***customary, prevailing, and reasonable charges; allowed charge;*** and ***billed charge.)***

Billed charge: In the Medicare program, the physician's (or supplier's) actual (billed) charge for a service. Compare with ***customary, prevailing, and reasonable charges.***

Birthweight: The weight of an infant at the time of delivery.

Board-certified physician: A physician who has completed requirements of advanced training and practice in a particular medical specialty and has passed examinations offered by the national certifying board for that specialty.

Breakeven financial status: The point in operations at which a business (e.g., health care facility) neither loses money nor makes a profit.

Capital expenditures: The costs (including borrowing costs) of purchasing a capital asset (e.g., plant, equipment).

Carrier (Medicare): See ***Medicare intermediaries or carriers.***

Case mix: The relative frequency of admissions of various types of patients, reflecting different needs for hospital resources.

Certificate of Need (CON) laws: A certificate required by State law and issued by the State Health Planning and Development Agency to an individual or organization proposing to constructor modify a health facility, or offer a new or different health service. CON recognizes that the proposed facility is needed (i.e., it does not create an excessive supply of services or add unnecessary costs to the health care system).

Certification by HCFA: A statement by the Health Care Financing Administration (HCFA) that a hospital or health care institution meets HCFA's conditions of participation. Certification by HCFA is required for Medicare and Medicaid reimbursement.

Certified **Rural Health Clinic (RHC):** A facility (or part of a facility), engaged mainly in the provision of outpatient primary medical care, that is eligible to receive cost-based Medicare and Medicaid reimbursement primarily by virtue of its: (1) location in a Census-defined rural health manpower shortage area (HMSA) or medically underserved area (MUA), and (2) employment of at least one midlevel practitioner (i.e., physician's assistant, nurse practitioner, or nurse-midwife).

Community Health Centers (CHCs): Health care facilities funded by the U.S. Department of Health and Human Services to provide comprehensive primary health services in both rural and urban areas where there are shortages of medical personnel and services.

Community **Mental Health Center (CMHC): An** organization (or affiliated group of organizations), that received Federal funding under the Community Mental Health Centers Act of 1963 to make available a comprehensive set of community-based mental health services, including emergency and outpatient care, consultation and education, and partial and complete hospitalization.

Computed Tomography (CT) scanner: A diagnostic device that combines X-ray equipment with a computer and a cathode ray tube (television-like device) to produce images of cross-sections of the body.

Congenital abnormality or anomaly: Any abnormality, whether genetic or not, that is present at birth.

Contiguous area: As it relates to HMSAs, an area in close proximity to an area under consideration for designation as a ***HMSA*** (proximity is based on travel time from the population center of the service area to the center of the contiguous areas).

Continuity of care: Medical care that proceeds without interruption across time and across different sites and levels of care.

Contract-managed **hospitals:** General daily management of a hospital by another organization under a formal contract. Managing organization reports directly to the board of trustees or owners of the managed hospital. The managed hospital retains total legal responsibility and ownership of the facility (American Hospital Association definition).

Cooperative or alliance of hospitals and other facilities: A formal organization working on behalf of its individual members for specific purposes (e.g., sharing of services, development of staff education programs, legislative advocacy).

"Crow-fly" miles: A ten-n used to describe the straight-line or shortest distance in miles between a given number of hospitals regardless of the actual or practical means (e.g., roads) available to travel between these hospitals.

Customary, prevailing, and reasonable (CPR) charge method (Medicare): The method used by carriers to determine the approved charge for a particular Part B service from a Particular physician or supplier based on the actual charge for the service, previous charges for the service by the physician or supplier in question, and previous charges by peer physicians or suppliers in the same locality. Customary charge: In the absence of unusual medical circumstances, the maximum amount that a Medicare carrier will approve for payment for a particular service provided by a particular physician practice. The carrier computes the customary charge on the basis of the actual amount that a physician practice or supplier generally charges for a specific service. Prevailing charge: In the absence of unusual medical circumstances, the maximum amount a Medicare carrier will approve for payment for a particular service provided by any physician practice within a particular peer group and locality (see "prevailing charge locality"). Generally, this amount is equal to the lowest charge in an array of customary charges that is high enough to include 75 percent of all the relevant customary charges. Approved or reasonable charge: An individual charge determination made by a Medicare carrier on a covered Part B medical service or supply. In the absence of unusual medical circumstances, it is the lowest of: 1) the physician's or suppliers' customary charge for that service; 2) the prevailing charge for similar services in the locality; 3) the actual charge made by the physician or supplier; and (4) the carrier's private business charge for a comparable service. Also called allowed charge or reasonable charge.

Day treatment: A specialized and intensive form of mental health service, less restrictive than inpatient care, in which the partially hospitalized patient receives treatment for 5 to 6 hours a day.

Degree of shortage: See ***Priority groups.***

Diagnosis-Related Groups (DRGs): Groupings of diagnostic categories drawn from the International Classification of Diseases and modified by 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 mandated for Medicare's prospective hospital payment system by the Social Security Amendments of 1983 (Public Law 98-21).

Direct reimbursement: Payment for services that is submitted directly to the health care practitioner who provided those services.

Downsizing (of hospitals and other health care facilities): Taking actions such as reducing the number of

beds and staff with the goal of reducing expenses in order to cope with diminished demand for services.

DRG outliers: Cases with unusually high or low resource use. Defined by the Social Security Amendments of 1983 (Public Law 98-21) as atypical hospital cases that have either an extremely long length of stay or extraordinarily high costs when compared to most discharges classified in the same diagnosis-related group. (See ***Diagnosis-Related Groups)***

Electronic fetal monitoring: Continuous monitoring of the fetal heart rate and uterine contractions through the use of an electrode and an amniotic fluid catheter and pressure transducer attached to the mother's abdomen. This process is used to detect abnormal fetal cardiac patterns during labor and delivery.

Endowments: Funds established by an institution to accept monetary contributions from private sources.

Essential Access Community Hospital (EACH): A newly designated type of rural hospital created by Congress in 1989 (Public Law 101-239). Limited to hospitals in only a few States, EACHs will be facilities of at least 75 beds that provide backup to ***Rural Primary Care Hospitals*** as part of a patient referral network Designated facilities will automatically qualify for Medicare's payment rules for Sole ***Community Hospitals.***

"Evaluative and management services": Services, such as office visits, that may involve but do not depend in a major way on any medical devices.

Expenses **per inpatient day:** Expenses incurred for inpatient care only, derived by dividing total expenses by the number of inpatient days during a particular period (American Hospital Association definition).

Extracorporeal **shock wave lithotripsy (ESWL):** A technique for disintegrating urinary tract stones that uses shock waves generated outside a patient's body and does not require a surgical incision.

Federal Tort Claims Act (FTCA): Enacted in 1946 [28 U. S.C.A. sec. 1346(b) (Supp. 1988)], the FTCA allows an injured party to sue the United States Government.

Fee schedule (for physician services): An exhaustive list of physician services in which each entry is associated with a specific monetary amount that represents the approved payment level under a given insurance plan.

Fertility rate: The annual number of live births per 1,000 women of childbearing age (15 to 49 years) in a defined population as a proportion of the estimated mid-year population of women 15 to 49 years of age.

Fetal death: The product of conception which, after separation from its mother, does not breathe or show other signs of life required to meet the World Health Organization's criteria for a live birth. Compare ***live birth.***

Fetal mortality ratio: The annual number of fetal deaths as a proportion of the annual number of live births.

Fixed costs: An operating expense that does not vary, at least over the short term, with the volume of services provided.

Freestanding facilities: Facilities that are not physically, administratively, or financially connected to a hospital, such as a freestanding ambulatory surgery center.

Frontier counties: Counties with population densities of 6 or fewer persons per square mile.

Geographic Practice Cost Index (GPCI): An index used by Medicare and some researchers to examine differences in physician practice costs across geographic areas. The index is based on per-unit costs.

Gross patient revenue: Consists of the full amount of revenue from services rendered to patients, including payments received from or on behalf of individual patients.

Health Maintenance Organization (HMO): A health care organization that, in return for prospective per capita payments, acts as both insurer and provider of comprehensive but specified medical services. A defined set of physicians provide services to a voluntarily enrolled population. Prepaid group practices and individual practice associations are types of HMOs.

Health Manpower Shortage Areas (HMSAs): Areas, population groups, and facilities designated by the Federal Government as having shortages of health personnel. HMSAs, which are currently designated for primary care, dental, and psychiatric personnel, are determined primarily by population-to-practitioner ratios.

Health Manpower **Shortage Area Placement Opportunity List (HPOL):** A list of the most needy ***HMSAs*** used by the National Health Service Corps in the placement of volunteer and obligated personnel.

Hill-Burton program: A Federal program begun in 1946 to fund health facility construction in areas of need and foster coordination among health care facilities.

Hospital or health care facility cooperative/alliance: See ***Cooperative or alliance of hospitals and other facilities***

Hospital or health care district/authority: A geographic area created and controlled by a political subdivision of a State, county, or city solely for the purpose of establishing and maintaining medical care or health-related care institutions.

Index of Medical Underservice (IMU): The sum of the weighted values of four indicators of unmet health care needs in an area (i.e., infant mortality rate, percent of the population 65 and older, percent of the population living in poverty, and population-to-primary care physician ratio) that is used to determine its status as a ***Medically Underserved Area. IMU*** values range from O to 100, with lower scores indicating increasing medical underservice.

Indirect reimbursement: A situation wherein a health care practitioner can be reimbursed for his or her

services, but can only obtain such reimbursement through the employing physician or health care facility.

Infant mortality: Death in the first year of life. It includes ***neonatal mortality*** and ***postneonatal mortality.***

Infant mortality rate: The annual number of deaths among children less than 1 year old as a proportion of the annual number of live births.

Inpatient care: Medical services provided to patients admitted to hospitals for overnight stay.

Inpatient days: Number of adult and pediatric days of care, excluding newborn days of care, in a hospital rendered during a particular reporting period (American Hospital Association definition).

Insufficient-capacity criteria: Criteria specific to primary care and dental ***HMSA*** designations that signify the inability to obtain health services in a timely fashion (e.g., unusually long waiting times for appointments, high percentage of area practitioners not accepting new patients).

Intensive care: Hospital service units designed to meet the special needs of patients who are seriously or critically ill or who otherwise need intense and specialized nursing care.

Joint Venture: A relationship in which two or more parties enter into a business as co-owners of a specific project(s) to share in profits and losses.

Live birth: According to the World Health Organization, ''the complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of pregnancy, which, after such separation, breathes or shows any other evidence of life such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles. " This definition is the basis for most States' requirements governing the reporting of live births. Compare ***fetal death.***

Local **health departments (LHDs):** Municipal or county government-operated facilities providing basic personal and environmental health services.

Long-term care: Health care for nonacute conditions (e.g., convalescent care for a person with an extended or permanent disability). Includes skilled nursing care (long-term care requiring the supervision and frequent services of a skilled nurse) and intermediate care (the routine provision of health-related care to individuals not requiring skilled nursing care).

Low birthweight babies: Live births weighing less than 5-½ pounds (2,500 grams).

Magnetic resonance **imaging (MRI):** A technique that produces images of the body by measuring the reaction of nuclei (typically of hydrogen protons) in magnetic fields to radiofrequency waves.

Maternal mortality: Maternal mortality includes deaths due to complications of pregnancy, childbirth, and the puerperium (the period of 42 days following the termination of pregnancy). Causes of maternal mortality include uterine hemorrhage, toxemia, and underlying medical conditions that complicate pregnancy such as diabetes and infections (e.g., tuberculosis, syphilis).

Maternal mortality rate: The annual number of maternal deaths related to pregnancy as a proportion of the annual number of live births.

Medicaid: A Federal-State medical assistance program authorized in 1965 to pay for health care services used by people defined as medically needy or categorically needy. Categorically needy persons are low-income aged, blind, disabled, first-time pregnant women, or families with dependent children. Medically needy persons are any of the above whose incomes are above eligibility limits for the categorically needy but who have high medical expenses that reduce their resources below established limits.

Medically Underserved Areas (MUAs): Areas determined by the Federal Government to have inadequate access to health care as determined by the ***Index of Medical Underservice (IMU).***

Medically Underserved Populations (MUPs): Populations not meeting ***MUA*** criteria that are designated as undersexed based on unusual local conditions that may affect the area/population.

Medicare: A nationwide, federally administered health insurance program authorized in 1965 to cover the cost of hospitalization, medical care, and some related services for eligible persons over age 65, persons receiving Social Security Disability Insurance payments for 2 years, and persons with end-stage renal disease. Medicare consists of two separate but coordinated programs-hospital insurance (Part A) and supplementary medical insurance (Part B). Health insurance protection is available to insured persons without regard to income.

Medicare conditions of participation: Requirements that hospitals and other institutional providers must meet in order to be allowed to receive payment for Medicare patients. An example is the requirement that hospitals conduct utilization review.

Medicare intermediaries **or carriers:** Fiscal agents (typically Blue Cross plans or commercial insurance firms) under contract to the Health Care Financing Administration for administration of specific Medicare tasks. These tasks include determining reasonable costs for covered items and services, making payments, and guarding against unnecessary use of covered services for Medicare Part A payments. Intermediaries also make payments for home health and outpatient hospital services covered under Part B.

Medicare/Medicaid beneficiary: One who receives coverage for health services under Medicare or Medicaid.

Medicare operating margin: Revenues received by a health care provider from Medicare less the provider's operating costs covered by Medicare payments, di-

vialed by Medicare revenues and multiplied by 100. Medicare revenues and costs not covered under Medicare's prospective payment system (e.g., capital expenditures, medical education costs) are excluded.

Merger **(of health facilities): The** union of two or more formerly independent institutions under a single ownership, accomplished by the complete acquisition of one institution's assets or stock by another institution.

Migrant Health Center (MHC): A center that receives Federal funds to provide primary health care to migrant and seasonal farmworkers and their families.

Metropolitan Statistical Area (MSA): As defined by the U.S. Office of Management and Budget, an MSA is a county or group of counties that includes either a city of at least 50,000 residents, or an urbanized area with at least 50,000 people that is itself part of a county/counties with at least 100,000 total residents.

Multihospital system: Two or more hospitals that are owned, leased, sponsored, or contract-managed by a central organization (American Hospital Association definition).

Negative operating margin: A loss that occurs when costs of operation exceed revenues.

Neonatal intensive care unit (NICU): A specialized hospital unit combining high technology and highly trained staff that treats seriously ill newborns.

Neonatal mortality rate: The annual number of neonatal deaths as a proportion of the annual number of live births.

Neonatal mortality: Death during the first 4 weeks of life.

Net patient revenue: For a hospital or other health care facility, consists of ***gross patient revenue*** less deductions for contractual adjustments (amounts of patient charges not paid by insurers), ***bad debts,*** charity, and other factors.

Net total revenue: Consists of ***net patient revenue*** plus all other revenue of a hospital or other health care facility, including contributions, endowment revenue, government grants, and all other payments not attributable to patient care.

Nonmetropolitan Statistical Area (NonMSA): Any area not in an MSA.

Obstetric care: Medical care received during pregnancy, labor and delivery, and the period immediately following birth.

Occupancy: Ratio of average number of inpatients (excluding newborns) receiving care to the average number of beds in a hospital set up and staffed for use (i.e., statistical beds) during a particular reporting period (American Hospital Association definition).

Operating costs: The ongoing expense of operating a health care facility.

Outmigration: As used in this report, the movement by rural residents outside their communities (particularly to urban areas) to receive health care and other services.

Outpatient care: Services provided in a hospital and that do not include an overnight stay.

Outpatient surgery: See ***Ambulatory surgery.***

Overhead costs: Includes costs to a health care facility that are not direct labor (i.e., payroll expenses) such as employee fringe benefits and other expenses indirectly related to patient care operations.

Partial hospitalization: A planned transitional program of mental health treatment services after psychiatric hospitalization or residential treatment when a patient no longer needs 24-hour care.

Patient margin: A measure of the profitability of patient care, calculated as (patient care revenues minus total costs) divided by patient care revenues. See also ***net patient revenues.***

Peer Review Organizations (PROS): PROS are organizations established in 1982 (public Law 97-248) with which the U.S. Department of Health and Human Services contracts to review the appropriateness of settings of care and the quality of care provided to Medicare beneficiaries.

Perinatal care: Medical care pertaining to or occurring in the period shortly before or after birth; variously defined as beginning with the completion of the 20th to 28th week of gestation and ending 7 to 28 days after birth.

Perinatal mortality: Fetal and neonatal deaths combined.

Perinatal mortality ratio: The annual number of perinatal deaths as a proportion of the annual number of live births.

Physician Payment Review Commission: A commission established by the Comprehensive Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272) to make recommendations to Congress and the Secretary of Health and Human Services on various issues relating to changes in physician payment under Medicare.

Positive operating margin: A surplus that occurs when revenues exceed costs of operation.

Postneonatal mortality: Deaths that occur from 28 days to age one.

Postneonatal **mortality rate: The** annual number of postneonatal deaths as a proportion of the annual number of live births.

Preceptorship: An arrangement whereby a student takes part of his or her training under the supervision of an active practitioner at that practitioner's worksite. For example, an office-based physician in a rural area may serve as a preceptor for a medical student, instructing the student in the various aspects of rural medical practice.

Premature births: Babies born between 20 and 36 weeks gestation. (also called preterm births)

Prenatal care: Medical services delivered from conception to labor. Prenatal care and intrapartum care combined are referred to as maternity care. Early prenatal care is care received in the first trimester of pregnancy.

Prevailing charge (Medicare): See ***Customary, prevailing, and reasonable (CPR) method.***

Prevailing charge locality (Medicare): A particular geographic locality within which Medicare determines prevailing charges and sets payment under Part B for medical services provided by physicians and other qualifying health care practitioners. There are approximately 240 separate prevailing charge localities in the United States.

Primary care: A basic level of health care, usually provided in an outpatient setting, that emphasizes a patient's general health needs.

Primary care physicians (as defined **for HMSA designation purposes):** Family and general practitioners, general pediatricians, obstetricians and gynecologists, and general internists.

Priority groups: The ranking of designated ***HMSAs*** into four groups according to population-to-practitioner ratios and indications of high need and insufficient capacity (group 1 HMSAs indicate greatest need).

"Procedural" services: Services that are dependent in a substantial way on the use of a medical device. Contrast ***"evaluative and management services."***

Procedure (medical or surgical): A medical technology involving any combination of drugs, devices, and provider skills and abilities. Appendectomy, for example, may involve at least drugs (for anesthesia), monitoring devices, surgical devices, and the skilled actions of physicians, nurses, and support staffs.

Prospective payment: Payment for medical care on the basis of rates set in advance of the time period in which they apply. The unit of payment may vary from individual medical services to broader categories, such as hospital case, episode of illness, or person (capitation). Compare ***retrospective cost-based reimbursement.***

Prospective Payment Assessment Commission (ProPAC): A commission established by the same law that created the DRG-based prospective payment system for Medicare (Public Law 98-21) to advise the Secretary of Health and Human Services on various activities needed to maintain and improve that payment system.

Provider participation (in Medicare or Medicaid): The provision of care by a physician to patients who are covered by either ***Medicare*** or ***Medicaid.***

Quality of care: The degree to which actions taken or not taken increase the probability of beneficial health outcomes and decrease risk and other untoward outcomes, given the existing state of medical science and art.

Rational service areas: To be proposed for ***HMSA*** designation, an area must be "rational" for the delivery of services based on criteria governing the size and boundaries of the area and consideration of such factors as established transportation routes and language barriers.

Relative Value Scale (RVS): A list of all physician services containing a cardinal ranking of those services with respect to some conception of value, such that the difference between the numerical rankings for any two services is a measure of the difference in value between those services. (A "resource-based relative value scale" will soon be used by Medicare for reimbursement of physician services.)

Reproductive-age **women:** Women between and including the ages of 15 and 44 years.

Respiratory Distress Syndrome (RDS): An acute respiratory disorder that in premature infants is thought to be caused by a deficiency of pulmonary surfactant. In severe form, patients often need mechanical assistance to breathe.

Retrospective cost-based reimbursement: A payment method for health care services in which hospitals (or other providers) are paid their incurred costs of treating patients after the treatment has occurred. In this country, the term has traditionally referred to hospital payment, since other providers have generally been paid on the basis of charges instead of costs.

Rural Primary Care Hospital (RPCH): A newly designated type of rural hospital created by Congress in 1989 (Public Law 101-239). Limited to hospitals in only a few States, RPCHs will be small facilities that provide emergency and minimal inpatient care and will be eligible for special reimbursement under Medicare (also see ***Essential Access Community Hospitals).***

Rural Referral Centers (RRCs): Tertiary-care rural hospitals, usually large, that serve a wide geographic area. Hospitals that qualify as RRCs must meet certain size and referral characteristics, and are eligible to receive special considerations under Medicare's prospective payment system.

"Safe harbor" regulations: Regulations proposed by the U.S. Department of Health and Human Services that would specify which practices of hospitals and other health care providers would not be unethical under the Medicare and Medicaid anti-kickback provisions.

Sentinel health events: Medical conditions that, by virtue of their presence or prevalence in a population, indicate a lack of access to acceptable, quality primary care services. Examples include dehydration in infants; measles, mumps, or polio in children; and advanced breast cancer or invasive cervical cancer in adult women.

Skilled nursing facility (SNF): A facility that provides skilled nursing care (see ***long-term care).*** A "distinct-

part SNF" is a distinct unit within the hospital that provides such care (i.e., beds set up and staffed specifically for this service), is owned and operated by the hospital, and meets Medicare certification criteria.

Sliding fee scale: A schedule of discounts in charges for services based on the consumer's ability to pay, according to income and family size.

Sole Community Hospital (SCH): A rural hospital, usually small, that is presumed to be the only source of local inpatient hospital care to area residents by nature of their isolated location, weather conditions, travel conditions, or absence of other hospitals. Federally designated SCHs receive special considerations under Medicare's prospective payment system.

Strategic planning: A rational process by which an health care organization (e.g., hospital) determines its best course of action. This involves effectively balancing community needs for health services with the organization's strengths and ability to use available resources, and producing practical plans to implement strategies that are financially feasible and acceptable to consumer needs (American Hospital Association definition).

Sudden Infant Death Syndrome (SIDS): The sudden and unexpected death of an infant, for reasons that remain unclear even after autopsy. SIDS is the most common cause of death in the post-neonatal period.

Swing beds: Licensed acute-care beds designated by a hospital to provide either acute or long-term care services. A hospital qualifying to receive Medicare and Medicaid reimbursement for care provided to swing bed patients must be located in a rural area (as defined by the U.S. Bureau of the Census), have less than 100 acute care beds, and when applicable must have received a certificate of need for the provision of long-term care services from its State health planning and development agency.

Tax appropriations: Subsidies available to health care facilities from State or local government taxes.

Tax-exempt revenue bonds: Bonds generally are evidence of a debt in which the issuer (borrower) promises to repay the bond's holder. A revenue bond is issued by a government (borrower) to taxpayers (bondholder) to raise funds in anticipation of tax receipts, and then repaid from tax revenues once they are received. Most bonds issued by governments are tax-exempt, that is, the bondholder pays no Federal income tax on interest earned.

Third-party payment: Payment by a private insurer or government program to a medical provider for care given to a patient.

Total hospital margin: A measure of hospital profitability, calculated as (total revenues minus total costs) divided by total revenues. Total revenues include private contributions and public subsidies as well as patient care and other revenue.

Ultrasound: High-frequency sound waves that can be focused and used to picture tissues, organs, structures, or tumors within the body. Ultrasound is particularly useful for ***in utero*** examinations of the fetus.

Uncompensated care costs: Deductions from patient care revenues that are attributable to charity care and ***bad debts*** (for which the health care facility never expects to receive payment).

Unusually high-needs criteria: Criteria specific to the type of ***HMSA*** (i.e., primary care, dental, psychiatric) that are indicative of an unusually high need for medical care (e.g., poverty rates, population without fluoridated water supply, and high prevalence of alcoholism).