Advanced Certificate in Healthcare Case Management

Healthcare Finance and Economics

A

Acute Care Revenue Cycle – The series of administrative and clinical processes that generate payments for services provided in an acute care setting. Related terms: billing, claims management, denial mitigation. Example: A hospital's acute care revenue cycle begins with patient registration, proceeds through coding, claim submission, and ends with payment posting. Challenges include high denial rates and complex payer contracts.

Adjusted Claim Rate (ACR) – A metric that compares the number of claims submitted to the number of claims adjusted for errors or rejections. Related terms: claim edit, reimbursement efficiency. Example: An ACR of 92% indicates that 8% of submitted claims required correction before payment.

Allowed Amount – The maximum payment a health plan will make for a covered service, after any patient responsibility (copay, deductible, coinsurance) is applied. Related terms: negotiated rate, fee schedule. Example: If the allowed amount for an MRI is $1,200 and the patient's coinsurance is 20%, the insurer pays $960 and the patient owes $240.

Amortization (in Healthcare Finance) – The systematic allocation of the cost of an intangible asset (e.G., Software license) over its useful life. Related terms: depreciation, capital budgeting. Example: A $500,000 electronic health record (EHR) system amortized over 5 years results in an annual expense of $100,000.

Annualized Rate of Return (ARR) – The percentage return earned on an investment over a one-year period, used to compare projects of different durations. Related terms: net present value (NPV), internal rate of return (IRR). Example: A telehealth platform costing $2 million and generating $300 000 in net cash flow per year has an ARR of 15%.

Anticipated Revenue – Projected income based on historical utilization, payer mix, and contract terms. Related terms: forecasting, budget variance. Example: A clinic estimates $5 million in anticipated revenue for the upcoming fiscal year, assuming a 5% increase in patient volume.

Asset Turnover Ratio – A measure of how efficiently an organization uses its assets to generate revenue. Calculated as Revenue ÷ Average Total Assets. Related terms: efficiency metrics, return on assets (ROA). Example: A health system with $2 billion in revenue and $4 billion in average assets has an asset turnover of 0.5.

Average Length of Stay (ALOS) – The average number of days a patient remains hospitalized. Related terms: case mix index (CMI), bed utilization. Example: An ALOS of 4.2 Days for cardiac patients influences staffing and cost projections.

Bad Debt Expense – Amounts owed by patients that are unlikely to be collected and are written off. Related

terms: uncollectible accounts, patient responsibility. Example: A hospital writes off $250 000 in bad debt after exhaustive collection attempts.

Balance Sheet – Financial statement that reports an organization's assets, liabilities, and equity at a specific point in time. Related terms: statement of financial position, liquidity ratios. Example: Review of a health system's balance sheet reveals a strong cash position but growing long-term debt.

Barriers to Entry (Healthcare Markets) – Structural or regulatory obstacles that limit new competitors, such as licensing, capital intensity, and network effects. Related terms: market concentration, antitrust. Example: High capital costs for building a new hospital act as a barrier to entry.

Benchmarking – The process of comparing performance metrics to industry standards or peer organizations. Related terms: best practices, performance improvement. Example: A health plan benchmarks its claim denial rate against the national average of 6%.

Benefit Design – The structure of health plan benefits, including cost-sharing, covered services, and provider networks. Related terms: plan formulary, consumer directed health plans. Example: A high-deductible health plan (HDHP) shifts more cost to members, affecting utilization patterns.

Benefit-Cost Ratio (BCR) – The ratio of benefits (often expressed in monetary terms) to costs of a health intervention. A BCR greater than 1 indicates that benefits exceed costs. Related terms: cost-effectiveness analysis, economic evaluation. Example: A vaccination program with a BCR of 3.5 Generates $3.50 In health savings for every $1 spent.

Billing Cycle – The periodic process by which services rendered are documented, coded, and submitted for payment. Related terms: charge capture, revenue cycle. Example: A practice's billing cycle runs monthly, closing on the last day of each month.

Bundled Payments – A single, comprehensive payment that covers all services related to a treatment episode. Related terms: episode of care, value-based purchasing. Example: A joint replacement bundled payment might include surgeon fees, hospital stay, and post-acute rehab.

Business Case Analysis – Structured evaluation of the financial, clinical, and strategic implications of a proposed initiative. Related terms: ROI, scenario planning. Example: Before adopting a new robotic surgery platform, a health system conducts a business case analysis to project revenue uplift and cost offsets.

C

Capitation – A payment arrangement where a provider receives a fixed amount per patient per period, regardless of services rendered. Related terms: global fee, risk adjustment. Example: A primary care practice under capitation receives $45 per member per month, incentivizing preventive care.

Capital Expenditure (CapEx) – Funds used by an organization to acquire, upgrade, or maintain physical assets such as facilities or equipment. Related terms: depreciation, investment budgeting. Example: A hospital's $120 million CapEx this year includes a new ICU wing and MRI machines.

Capital Lease – A lease agreement that transfers substantially all risks and benefits of ownership to the lessee, often treated as an asset on the balance sheet. Related terms: finance lease, operating lease. Example: A health system enters a capital lease for a $30 million imaging suite, recording the asset and corresponding liability.

Case Mix Index (CMI) – A relative value indicating the complexity and resource intensity of a hospital's patient population. Calculated as total DRG relative weight ÷ total discharges. Related terms: DRG, reimbursement adjustment. Example: A CMI of 1.45 Signals higher-complexity cases, leading to higher per-discharge payments.

Cash Flow Statement – Financial report that shows cash inflows and outflows from operating, investing, and financing activities. Related terms: free cash flow, liquidity analysis. Example: Positive operating cash flow indicates that day-to-day activities generate sufficient cash.

Charge Master (UB-04) – Comprehensive list of billable services, procedures, and items with associated prices used by hospitals for billing. Related terms: price transparency, coding. Example: Updating the charge master to reflect new CPT codes helps ensure accurate reimbursement.

Co-Insurance – Percentage of costs that the insured must pay after meeting the deductible. Related terms: coinsurance, patient cost-share. Example: A 20% co-insurance on a $2 000 procedure results in a $400 patient responsibility.

Co-Pay – Fixed amount a patient pays for a covered service at the time of care. Related terms: out-of-pocket, cost sharing. Example: A $30 co-pay for an office visit.

Cost Allocation – Method of assigning indirect costs (overhead) to specific services, departments, or products. Related terms: absorption costing, activity-based costing (ABC). Example: Using square footage to allocate facility costs to each department.

Cost-Benefit Analysis (CBA) – Systematic approach to estimate the strengths and weaknesses of alternatives by comparing total expected costs to benefits. Related terms: net present value, benefit-cost ratio. Example: A CBA of a new outpatient surgery center shows a net benefit of $15 million over ten years.

Cost-Effectiveness Analysis (CEA) – Comparison of the relative costs and outcomes (often measured in QALYs) of two or more interventions. Related terms: incremental cost-effectiveness ratio (ICER), health economics. Example: A CEA finds that a new drug costs $50 000 per QALY gained, above the $30 000 willingness-to-pay threshold.

Cost-to-Serve – Total expense incurred to deliver a specific service or product to a patient, including direct and indirect costs. Related terms: profitability analysis, service line economics. Example: The cost-to-serve for a cataract surgery includes surgeon fees, OR time, implants, and post-op follow-up.

Credit Rating (Healthcare Entity) – Assessment of an organization's creditworthiness by agencies such as Moody's or S&P. Related terms: bond issuance, debt financing. Example: An 'A-' rating enables a hospital to borrow at lower interest rates.

DRG (Diagnosis-Related Group) – Classification system that groups inpatient stays with similar clinical characteristics and resource usage for payment purposes. Related terms: case mix, prospective payment system (PPS). Example: DRG 291 (Heart Failure & Shock) carries a fixed reimbursement amount based on national averages.

DRG Weight – Relative value assigned to each DRG reflecting the expected resource consumption; used to calculate payments. Related terms: case mix index, payment adjustment. Example: A DRG weight of 1.8 Indicates 80% higher expected cost than the base weight of 1.0.

EBITDA (Earnings Before Interest, Taxes, Depreciation, and Amortization) – Indicator of operating performance that excludes non-operating expenses. Related terms: operating margin, cash flow proxy. Example: A health system reports EBITDA of $350 million, reflecting core profitability.

Effective Date (Contractual) – The date on which a new payer contract or rate schedule becomes enforceable. Related terms: rate start date, contract renewal. Example: The 2025 Medicare Physician Fee Schedule's effective date is January 1, 2025.

Electronic Health Record (EHR) Incentive Program – Federal initiative (now known as the Promoting Interoperability Program) that provides financial incentives for meaningful use of certified EHR technology. Related terms: MU, value-based purchasing. Example: A practice receives a $30 000 incentive for meeting Stage 3 criteria.

Encumbrance – A commitment of funds that limits the ability to spend them elsewhere, often used in budgeting for capital projects. Related terms: budgetary control, reserve. Example: An encumbrance of $5 million is placed on a new oncology building.

Enterprise Value (EV) – Total market value of a company, including equity, debt, and minority interest, minus cash. Related terms: valuation, acquisition analysis. Example: A health system with a market cap of $2 billion, debt of $500 million, and cash of $100 million has an EV of $2.4 Billion.

Equity Financing – Raising capital by issuing shares of ownership. Related terms: stock issuance, dilution. Example: A healthcare startup secures $25 million in equity financing from venture capitalists.

Expense Ratio – Proportion of total expenses to total revenue, used to assess cost efficiency. Calculated as Expenses ÷ Revenue. Related terms: operating margin, cost management. Example: An expense ratio of 0.78 Means 78% of revenue is consumed by expenses.

External Benchmark – Comparative data derived from organizations outside the immediate peer group, often national or industry-wide. Related terms: peer comparison, normative data. Example: Using CMS Hospital Compare data as an external benchmark for readmission rates.

F

Fee-for-Service (FFS) – Payment model where providers are reimbursed separately for each service rendered. Related terms: volume-driven, service line revenue. Example: An outpatient clinic receives distinct payments for office visits, labs, and imaging under FFS.

Financial Leverage – Use of borrowed capital to increase the potential return on investment. Measured by debt-to-equity or debt-to-assets ratios. Related terms: capital structure, risk. Example: A health system with a debt-to-equity ratio of 2.0 Is highly leveraged.

Financial Modeling – Creation of quantitative representations (spreadsheets, simulations) to forecast financial performance under various scenarios. Related terms: sensitivity analysis, scenario planning. Example: Modeling the impact of a 10% reduction in inpatient admissions on cash flow.

Fixed Costs – Expenses that do not vary with patient volume, such as rent, salaries of permanent staff, and depreciation. Related terms: variable costs, break-even analysis. Example: A hospital's fixed costs total $450 million annually.

Floating Rate Debt – Borrowing whose interest rate adjusts periodically based on a reference index (e.G., LIBOR). Related terms: interest rate risk, hedging. Example: A $200 million bond issued at LIBOR + 2% is a floating rate instrument.

FQHC (Federally Qualified Health Center) – Community-based health care providers receiving enhanced reimbursement and grant funding to serve underserved populations. Related terms: Section 330, sliding fee scale. Example: An FQHC reports a 30% Medicaid payer mix.

Frictional Cost – Additional expense incurred when patients transition between care settings (e.G., Discharge to skilled nursing). Related terms: care coordination, post-acute cost. Example: Frictional costs rise when discharge planning is inadequate.

Full-Risk Contract – Agreement where a provider assumes financial responsibility for all costs of a defined patient population, often linked to quality metrics. Related terms: capitation, global budget. Example: A health system signs a full-risk contract for a Medicare Advantage population, receiving a fixed per-member amount.

G

Gap Analysis – Assessment that compares current performance against desired standards or benchmarks to identify improvement opportunities. Related terms: performance gap, strategic planning. Example: A gap analysis reveals a 4% shortfall in patient satisfaction relative to the target.

General Ledger (GL) – Central accounting record that aggregates all financial transactions. Related terms: chart of accounts, accounting system. Example: Revenue entries from the billing system flow into the GL for month-end closing.

Gross Margin – Difference between revenue and the cost of goods sold (COGS), expressed as a dollar amount or percentage. Related terms: profitability, contribution margin. Example: A surgical center's gross margin of 45% indicates that 55% of revenue covers overhead and other expenses.

Gross Revenue – Total amount billed before contractual adjustments, discounts, or allowances. Related terms: net revenue, charge master. Example: Gross revenue of $800 million may be reduced to $560 million net after payer contracts.

Groupon Effect (Healthcare Pricing) – Phenomenon where deep discounts on services attract price-sensitive patients but can erode perceived value. Related terms: price elasticity, market segmentation. Example: Offering a $99 flu shot may increase volume but lower average revenue per patient.

H

Healthcare Cost Containment – Strategies aimed at controlling the growth of health care expenditures while maintaining quality. Related terms: utilization management, price transparency. Example: Implementing prior authorization for high-cost imaging is a cost-containment measure.

Healthcare Inflation – Rate at which health care costs increase, often outpacing general inflation. Related terms: price index, cost escalation. Example: U.S. Healthcare inflation averaged 5.4% Annually over the past decade.

Health Maintenance Organization (HMO) – Managed care plan that provides a network of providers and often requires referrals for specialist care. Related terms: network adequacy, capitation. Example: An HMO contracts with a regional hospital system for all inpatient services.

Health Savings Account (HSA) – Tax-advantaged savings account paired with high-deductible health plans for paying qualified medical expenses. Related terms: consumer-directed health plan, pre-tax contribution. Example: An employee contributes $3 000 annually to an HSA.

Health Technology Assessment (HTA) – Systematic evaluation of medical technologies' clinical effectiveness, cost-effectiveness, and broader impact. Related terms: evidence-based medicine, coverage decision. Example: An HTA determines that a new robotic system is not cost-effective for a low-volume center.

Hospital Acquired Condition (HAC) – Condition that a patient develops during a hospital stay, for which CMS may withhold additional payments. Related terms: quality metrics, penalty. Example: A central line-associated bloodstream infection (CLABSI) is a HAC.

Hospital Readmission Rate – Percentage of patients who return to the hospital within a specified period (often 30 days) after discharge. Related terms: quality measure, penalty. Example: A 12% readmission rate may trigger Medicare penalties.

Hospital Value-Based Purchasing (VBP) – CMS program that adjusts payments based on quality and efficiency metrics. Related terms: pay-for-performance, quality scores. Example: A hospital improves its VBP score from 20 to 30, increasing reimbursement.

HRSA (Health Resources and Services Administration) – Federal agency that provides funding and oversight for health centers, rural hospitals, and workforce programs. Related terms: grant funding, Section 330. Example: An HRSA grant supports telehealth expansion in a rural clinic.

I

ICD-10-CM (International Classification of Diseases, 10th Revision, Clinical Modification) – Coding system for diagnoses used in billing and reporting. Related terms: CPT, clinical documentation. Example: Accurate

ICD-10-CM coding is essential for DRG assignment.

ICU Utilization Rate – Proportion of hospital admissions that require intensive care. Related terms: critical care, capacity planning. Example: An ICU utilization rate of 18% guides staffing models.

Impaired Asset – Asset whose fair market value has declined below its carrying amount, requiring a write-down. Related terms: asset impairment, valuation. Example: A $10 million imaging suite is impaired to $7 million due to obsolescence.

Incentive Alignment – Structuring contracts so that provider financial incentives promote desired outcomes, such as quality or efficiency. Related terms: pay-for-performance, risk sharing. Example: Bonus payments for meeting readmission targets align incentives.

Indemnity Plan – Traditional health insurance that reimburses policyholders for a set portion of incurred expenses. Related terms: fee-for-service, out-of-pocket. Example: An indemnity plan pays 80% of eligible costs after the deductible.

Inflation-Adjusted Return – Investment return expressed after removing the effects of inflation, reflecting real purchasing power. Related terms: real rate of return, nominal return. Example: A 7% nominal return with 3% inflation yields a 4% real return.

Internal Rate of Return (IRR) – Discount rate that makes the net present value of cash flows from an investment equal to zero. Related terms: NPV, project appraisal. Example: An IRR of 12% on a new outpatient clinic exceeds the organization's hurdle rate of 10%.

Inter-Facility Transfer (IFT) – Movement of a patient from one health care setting to another for specialized care. Related terms: continuity of care, transfer agreements. Example: Transferring a trauma patient from a community hospital to a Level-I trauma center.

Interest Coverage Ratio – Ability of an organization to meet interest payments on debt, calculated as EBIT ÷ Interest Expense. Related terms: leverage, solvency. Example: An interest coverage ratio of 5.0 Indicates ample capacity.

Inventory Turnover – Frequency at which inventory is used and replenished over a period. Calculated as Cost of Goods Sold ÷ Average Inventory. Related terms: stock management, working capital. Example: An inventory turnover of 8 suggests efficient supply management.

IPO (Initial Public Offering) – Process by which a privately held company offers shares to the public for the first time. Related terms: equity financing, underwriting. Example: A large health system completes an IPO to raise capital for expansion.

J

Joint Commission Accreditation – Nationwide certification indicating compliance with health care quality and safety standards. Related terms: quality improvement, regulatory compliance. Example: Maintaining accreditation is essential for Medicare participation.

K

Key Performance Indicator (KPI) – Quantifiable metric used to evaluate success in achieving strategic objectives. Related terms: dashboard, benchmarking. Example: Average days to bill (ADT) is a KPI for revenue cycle efficiency.

L

Laboratory Fee Schedule – Pre-determined pricing list for lab tests negotiated with payers. Related terms: clinical pathology, reimbursement. Example: The fee schedule assigns $45 to a basic metabolic panel.

Leverage Ratio – Metric indicating the proportion of debt used to finance assets, such as debt-to-equity. Related terms: financial risk, capital structure. Example: A leverage ratio of 1.8 Signals moderate debt reliance.

Liability Management – Strategies to control and refinance existing debt to improve cash flow and reduce interest expense. Related terms: debt restructuring, refinancing. Example: Issuing a new 10-year bond at a lower rate replaces an older 20-year high-interest issue.

Line of Credit (LOC) – Revolving loan facility that allows borrowing up to a pre-approved limit. Related terms: working capital, short-term financing. Example: A $25 million LOC provides flexibility for seasonal cash needs.

Limited Partnership (LP) – Business structure where general partners manage operations and limited partners contribute capital with limited liability. Related terms: investment vehicle, tax shelter. Example: An LP funds the construction of a new ambulatory surgery center.

Liquidity Ratio – Measures ability to meet short-term obligations, such as current ratio (Current Assets ÷ Current Liabilities). Related terms: solvency, working capital. Example: A current ratio of 1.5 Indicates healthy liquidity.

Long-Term Debt – Borrowings with maturities greater than one year, used for major capital projects. Related terms: bond issuance, debt service. Example: $400 Million in long-term debt finances a new cancer center.

Loss Ratio – Ratio of incurred claims to earned premiums for an insurer. Related terms: underwriting, profitability. Example: A loss ratio of 85% means $0.85 Of every premium dollar is paid out in claims.

M

Managed Care Organization (MCO) – Entity that provides or arranges health care services for members, often through contracts with providers. Related terms: network, capitation. Example: An MCO negotiates rates with hospitals for its member population.

Margin of Safety – Difference between actual sales and break-even sales, expressed in units or dollars. Related terms: break-even analysis, risk assessment. Example: A margin of safety of $20 million protects against revenue shortfalls.

Medical Necessity – Clinical criteria used by payers to determine if a service is appropriate and covered. Related terms: utilization review, coverage determination. Example: Documentation must establish medical necessity for an MRI to receive payment.

Medical Loss Ratio (MLR) – Percentage of premium dollars spent on clinical services and quality improvement, as required by the ACA. Related terms: profitability, regulatory compliance. Example: An MLR of 85% meets the 80-85% threshold for large group markets.

Medicare Advantage (MA) – Private-sector plans that contract with CMS to provide Medicare benefits and often additional services. Related terms: risk adjustment, star rating. Example: MA plans receive capitated payments adjusted for beneficiary health status.

Medicare Part A – Federal health insurance covering inpatient hospital, skilled nursing facility, hospice, and some home health services. Related terms: fee-for-service, DRG. Example: Part A pays a fixed amount per admission based on DRG weight.

Medicare Part B – Covers outpatient services, physician fees, preventive care, and medical supplies. Related terms: fee schedule, claim processing. Example: Part B reimburses physicians using the Physician Fee Schedule (PFS).

Medicare Part C (Medicare Advantage) – See Medicare Advantage.

Medicare Part D – Prescription drug coverage administered through private plans. Related terms: formulary, pharmacy benefit manager (PBM). Example: Part D plans negotiate drug rebates with manufacturers.

Medicare Shared Savings Program (MSSP) – Initiative encouraging ACOs to achieve cost savings while meeting quality benchmarks. Related terms: accountable care organization, risk sharing. Example: An ACO shares 50% of savings after meeting quality thresholds.

Mitigation (Denial Management) – Process of addressing and correcting claim denials to recover revenue. Related terms: appeals, revenue integrity. Example: Effective mitigation can reduce denial rates from 12% to under 5%.

Mixed-Case Payment Model – Combination of fee-for-service, capitation, and performance-based payments within a single contract. Related terms: blended payment, risk adjustment. Example: A primary care contract includes capitation for preventive services and FFS for procedures.

MMR (Medical Management Review) – Clinical evaluation of utilization, appropriateness, and cost of services. Related terms: utilization management, clinical pathways. Example: MMR identifies overuse of high-cost imaging.

MoM (Month-over-Month) Growth – Percentage change in a metric from one month to the next. Related terms: trend analysis, seasonality. Example: MoM revenue growth of 2.5% Indicates steady expansion.

Monetary Policy Impact on Healthcare Financing – Central bank actions (interest rates, quantitative easing) that affect borrowing costs for health systems. Related terms: interest expense, capital markets. Example:

Lower Fed rates reduce interest expense on existing bonds.

Net Present Value (NPV) – Present value of cash inflows minus outflows, using a discount rate to account for time value of money. Related terms: IRR, discounted cash flow. Example: A project with an NPV of $10 million is financially attractive.

Net Revenue – Gross revenue after contractual adjustments, discounts, and allowances; the actual amount received. Related terms: cash collections, allowances. Example: A hospital's gross revenue of $800 million may translate to $560 million net revenue after payer contracts.

Network Adequacy – Assessment of whether a health plan's provider network offers sufficient access to covered services. Related terms: provider contracts, access standards. Example: State regulations may require a primary care provider within 10 miles of any member.

Non-Operating Income – Revenue generated from activities not related to core health care services, such as investments or rent. Related terms: interest income, auxiliary services. Example: A health system reports $15 million in non-operating income from an endowment.

Operating Margin – Ratio of operating income to net patient revenue, indicating profitability of core services. Calculated as (Operating Income ÷ Net Revenue) × 100. Related terms: gross margin, EBITDA. Example: An operating margin of 6% is typical for a large academic medical center.

Operating Expense Ratio (OER) – Proportion of operating expenses to net patient revenue. Related terms: cost management, efficiency. Example: An OER of 78% shows that 22% of revenue remains for profit or reinvestment.

Operating Leverage – Degree to which a firm can increase operating income by increasing revenue, due to fixed cost structure. Related terms: break-even point, cost structure. Example: High operating leverage means small revenue gains produce larger profit gains.

Out-of-Network (OON) Charges – Fees billed when a patient receives care from a provider not contracted with their insurer. Related terms: balance billing, network adequacy. Example: OON charges often result in higher patient out-of-pocket costs.

Overhead Allocation – Distribution of indirect costs (administration, utilities) to service lines or departments. Related terms: cost allocation, absorption costing. Example: Overhead allocated on a per-procedure basis helps determine true profitability.

P

Patient Acuity – Measure of the severity of a patient's condition, influencing staffing and resource needs. Related terms: case mix, triage. Example: Higher acuity patients require more intensive nursing ratios.

Patient Cost-Share – Portion of health care expenses that the patient must pay, including deductible, co-pay, and co-insurance. Related terms: out-of-pocket maximum, financial responsibility. Example: A $1 500 deductible is part of the patient cost-share.

Patient Revenue Cycle – End-to-end process from appointment scheduling to final payment receipt for a patient's encounter. Related terms: front-end, back-end. Example: Efficient patient revenue cycle reduces days in accounts receivable.

Pay-for-Performance (P4P) – Reimbursement model that ties payments to achievement of specific quality or efficiency metrics. Related terms: value-based care, quality incentives. Example: A provider receives a bonus for meeting a 90% vaccination rate.

Pay-for-Value – Broad term encompassing reimbursement structures that reward quality and outcomes rather than volume. Related terms: value-based purchasing, bundled payments. Example: Transitioning from FFS to pay-for-value aims to reduce unnecessary utilization.

Payment Adjustment Factor – Modifier applied to base rates to reflect payer-specific considerations such as geographic wage index or case mix. Related terms: DRG adjustment, price index. Example: A 1.03 Adjustment factor increases the base Medicare rate by 3%.

Penalty Rate – Additional charge imposed for non-compliance with quality or reporting standards (e.G., HAC penalties). Related terms: financial penalty, regulatory fee. Example: A hospital incurs a $500 000 penalty for excessive readmissions.

Per-Member Per-Month (PMPM) – Metric that expresses cost or revenue on a monthly basis for each enrolled member. Related terms: utilization rate, budgeting. Example: Pharmacy spend of $15 PMPM for a health plan.

Performance Indicator – Specific measure used to assess effectiveness of a process or program. Related terms: KPI, benchmark. Example: Average claim processing time is a performance indicator for the billing department.

Pharmacy Benefit Manager (PBM) – Third-party administrator that manages prescription drug benefits, negotiating rebates and formulary design. Related terms: rebate, formulary. Example: A PBM secures a 20% rebate on a brand-name drug.

Physician Fee Schedule – Established rates that insurers pay physicians for specific services, often based on relative value units (RVUs). Related terms: RVU, CMS PFS. Example: A level-3 office visit is reimbursed at $110 under the schedule.

Plan Sponsor – Entity (employer or organization) that offers a health benefit plan to its members. Related terms: benefit design, group health.