

Appendix E

Glossary of Terms

- Access:** Potential and actual entry of a population into the health care delivery system.
- Acute:** In medical care, used to describe a condition that has a sudden onset, sharp rise, and short course (compare with chronic).
- Adverse event (outcome):** Any disease or injury. Usually used in the context of an injury that arises during the course of medical treatment, e.g., a premature death or unnecessary morbidity.
- Age-adjusted mortality rate:** The death or mortality rate adjusted for the age distribution of the population under study. Age adjustment allows a direct comparison of the overall mortality experience of two or more populations, or examination of mortality over time in a single population, by using a single statistic. Age adjustment is necessary because populations differ in their proportions of people in different age categories, and different age groups have different mortality rates; for example, death rates for 25 to 34 year olds are much lower than for 55-64 year olds. Comparing populations without adjusting for the different age distributions of persons within each population could lead to erroneous conclusions about the relative health of the populations being compared.
- Aid to Families with Dependent Children (AFDC):** A program, established by the Social Security Act of 1935, providing cash payments to needy children (and their caretakers) who lack support because at least one parent is dead, disabled, continually absent from the home, or unemployed. Eligible families must meet income and resource criteria specified by the State.
- Alcoholic cirrhosis of the liver:** A liver condition caused by continued alcoholic intake over time, which destroys liver cells and stimulates the formation of collagen nodules that impede the liver's functioning by causing it to shrink and harden. Alcoholic cirrhosis can be fatal.
- Allowable costs or charges:** Costs or charges that are within the limits recognized as reimbursable under a particular insurance program (e.g., Medicare).
Ambulatory care: See *outpatient care*.
- Amyotrophic lateral sclerosis (ALS):** A degenerative disease of the spinal motor neurons that control skeletal muscles, resulting in gradual paralysis and ultimately, death. The cause of the disorder, which most frequently attacks men in their 40s, is unknown. Also known as Lou Gehrig's Disease.
- Ancillary services or technology:** In this report, medical technology or services used directly to support basic clinical services, including diagnostic radiology, radiation therapy, clinical laboratory, physical therapy, and other special services.
- Anencephaly:** A neural tube defect characterized by a failure of the brain to develop.
- Asthma:** Constriction of the bronchial tubes, producing wheezing and difficulty breathing, in response to irritation, allergy, or other stimuli.
- Beneficiary:** An individual receiving benefits (e.g., Medicaid). In this report, someone who is enrolled and participating in the Medicaid program. See *enrollee*.
- Benefit package:** The package of health care services covered by a particular insurer.
- Billed charges:** The physician's (or supplier's) actual (billed) charge for a service. Compare with *customary, prevailing, and reasonable charges*.
- Bronchitis:** Inflammation of the bronchial tubes of the lungs.
- Capitated payment:** Periodic (e.g., monthly) payment to a health care provider to cover all costs of providing all or selected types of health care services to a single individual (i.e., per capita). The provider assumes financial risk for patients whose actual costs exceed the average.
- Capitated services:** Health care services covered under a capitated payment (see *capitated payment*).
- Cavitation rate:** See *capitated payment*.
- Case-managed fee-for-service system:** A system of health care delivery where each patient is enrolled with a primary care provider who preauthorizes all the patient's health care and where all authorized health services are paid for on a fee-for-service basis.
- Case management:** As used in this report, a system wherein a single "gatekeeper" (the case manager) provider monitors, coordinates, or preauthorizes all or selected health care services for an enrolled patient.
- Catastrophic cost:** High cost related to treatment of severe or lengthy illness or disability.
- Categorically eligible Medicaid beneficiary:** An individual qualifying for Medicaid under the federally mandated coverage groups which include: *Aid to Families with Dependent Children (AFDC)* participants; unemployed parent families; *poverty level medical (PLM)* women and children; foster care children; and, certain aged, blind, and disabled individuals.
- Charity care:** Care provided free of charge to individuals who the provider knows are unable to pay for services rendered (compare with *uncompensated care*).

Chronic: Persistent or long-lasting (compare with *acute*).

Coinsurance: That percentage of covered medical expenses, after subtraction of any deductible, for which an insured person *is* responsible. Under Medicare Part B, after the annual deductible has been met, Medicare will generally pay 80 percent of approved charges for covered services and supplies; the remaining 20 percent is the coinsurance, for which the beneficiary is liable. Also see *copayment* and *deductible*.

Comorbidity: Coexisting health problems that tend to worsen the patient's overall clinical condition.

Community health center (CHC): An organization that provides primary health care and other health-related services to individuals in the local community. As of 1989, there were about 1,200 community health centers providing services at more than 2,000 sites throughout the country. Roughly half of these centers were receiving Federal grants under section 330 of the Public Health Services Act, which authorizes grants to public and private nonprofit organizations that provide primary health care to populations or areas that are "medically underserved." (See also *federally qualified health center*.)

Community hospital: A hospital—public or private—whose services are available to the general public. Excludes military and veterans hospitals.

Condition-treatment (CT) pair: The basic unit of the prioritized list compiled by the Oregon Health Services Commission, which couples medical condition codes from the *International Classification of Diseases (ICD-9)* with corresponding treatment/therapy codes from the *Physicians' Current Procedural Terminology, 4th Edition (CPT-4)*. An example of a (CT) pair is the condition appendicitis, with the treatment appendectomy.

Control group: In a randomized clinical trial or other experiment, the group with which the group receiving experimental treatment is compared. The control group generally receives either a standard treatment, a placebo, or no treatment. The control group can be established by random assignment of subjects, or by nonrandomized distribution. Nonrandom methods include **historical controls**, in which individuals treated with a "control treatment" outside the study proper, at some time previous to the trial, are compared with the experimentally treated individuals; and **matched controls**, in which individuals in the control group are selected for their similarity to members of the experimental group. In the case of evaluating the Oregon Medicaid population, for example, individuals in the program could be matched and compared to another State's Medicaid population.

Copayment: In insurance, a form of cost sharing whereby the insured pays a specific amount at the point of

service or use (e.g., \$10 per visit). See also *coinsurance* and *deductible*.

Coronary artery bypass graft (CABG) surgery: A surgical procedure in which a blood vessel from elsewhere in the body is used to bypass a constricted portion of one or more arteries feeding the heart muscle. This procedure has become the primary surgical approach to the treatment of coronary artery disease.

Coronary artery disease: Narrowing or blockage of the coronary arteries, which usually results in reduced blood flow to the heart muscle.

Coronary heart disease: See *coronary artery disease*.

Cost-based reimbursement: Reimbursement based on the actual or reported costs of a provider for delivering a health care service or services.

Cost-benefit analysis (CBA): An analytical technique that compares the costs of a project or technological application to the resultant benefits, with both costs and benefits expressed by the same measure. This measure is nearly always monetary.

Cost-effectiveness analysis (CEA): An analytical technique that compares the costs of alternative projects to the resultant benefits, with costs and benefits/effectiveness expressed by different measures. Costs are usually expressed in dollars, but benefits/effectiveness are ordinarily expressed in terms such as "lives saved," "disability avoided," "quality-adjusted life years saved," or some other relevant objective.

Coverage (Medicaid): In the Medicaid program, 'coverage' refers to the benefits available to eligible beneficiaries. It differs from payment, which refers to the amount and methods of payment for covered services. See also *benefit package*.

Covered services: See *coverage*.

Current Procedural Terminology, 4th Revision (CPT-4) Coding: A taxonomy of procedures performed by physicians that is used for recording and billing for services rendered. In this taxonomy, each procedure is assigned a unique numerical code.

Customary, prevailing, and reasonable (CPR) method: The method used by some insurers (including Medicare) to determine the allowed charge for certain services of physicians or suppliers 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 the insurer will approve for payment for a particular service provided by a particular physician practice. The insurer 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 an insurer will approve for payment for a particular service provided by any physician practice within a particular peer group and 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 an insurer on a covered medical service or supply. In the absence of unusual medical circumstances, it is the lowest of: 1) the physician's or suppliers's 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) for Medicare, the carrier's private business charge for a comparable service. Also called the *allowed charge*.
- Deductible: In insurance, an aspect of cost sharing in which the insured incurs an initial expense of a specified amount within a given time period (e.g., \$250 per year) before the insurer assumes liability for any additional costs of covered services.
- Delphi technique: A technique used to obtain the most reliable consensus of opinion from a group of experts. Consensus is achieved after an iterative process where group members offer written individual opinions, discuss group opinion, and then revise individual opinions.
- Demonstration (Medicaid): An experiment designed to test alternative health care financing, delivery, and/or coverage mechanisms within the context of a State Medicaid program. States must apply to the Federal Government for special waiver permission if any aspect of the proposed demonstration does not fall within what is allowed under Federal Medicaid law. The demonstration can be population-based (e.g., apply only to certain eligibility categories), geography-based, or statewide.
- Dental care organization: In Oregon, an organization that provides dental services on a prepaid, capitated basis.
- 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). They are also the basis for Oregon's current inpatient hospital payment under Medicaid.
- Disability: A term used to denote the presence of one or more functional limitations. A person with a disability has a limited ability or an inability to perform one or more basic life functions (e.g., walking) at a level considered "typical."
- Disproportionate-share hospital: A hospital that serves a relatively high number of low-income patients. Disproportionate-share hospitals are eligible for special payment bonuses under Medicare and Medicaid. For Medicare, the increased reimbursement takes the form of a percentage adjustment in payment rates under Prospective Payment System (PPS). Under Medicaid, each State must establish its own methodology for adjusting Medicaid reimbursement to disproportionate-share hospitals.
- Doctor of Osteopathy (DO): A physician trained in a system of therapy that utilizes generally accepted physical, medicinal, and surgical methods of diagnosis and therapy, while placing chief emphasis on the importance of normal body mechanics and manipulative methods of detecting and correcting illness and injury. (DOs make up approximately 5 percent of the total physician population in the United States. In general, State licensing boards recognize the DO degree as equivalent to the MD (allopathic) degree.
- Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT): A **State** and federally funded program, administered by the State under the Medicaid program, that is intended to provide screening exams and followup services for illnesses, abnormalities, and treatable conditions to Medicaid-eligible children under age 21. The EPSDT benefit was enacted in 1967.
- Effectiveness: Same as *efficacy* (see below) except that it refers to average conditions of use.
- Efficacy: The probability of benefit to individuals in a defined population from a medical technology applied for a given medical problem under ideal conditions of use.
- Elective procedure: A surgical procedure that may be important to an individual's health but is neither an emergency nor life threatening.
- Eligibility: The quality of meeting specific requirements to qualify for a particular program (e.g., Medicaid) or benefit. Eligible: An individual who qualifies for a program (e.g., Medicaid) or benefit whether or not he or she actually takes advantage of that qualification and participates in the program (see *enrollee*).
- Encounter data: Data describing the content of care and other characteristics of discrete outpatient health care visits. Encounter data usually include provider identification, patient demographics, diagnoses, procedures performed, charges, and date and setting of service.
- Enrollee: An individual who qualifies for (Medicaid) benefits and is "enrolled" in the (Medicaid) program, receiving benefits when needed.

- External validity: A measure of the extent to which study results can be generalized to the population that is represented by individuals in the study, assuming that the characteristics of that population are accurately specified.
- Federal poverty level (FPL): The official U.S. Government definition of poverty based on cash income levels for families of different sizes. In 1992, the FPL for a family of three in the continental United States was \$11,570. (The FPL is slightly higher in Alaska and Hawaii.) Responsibility for changing poverty concepts and definitions rests with the Office of Management and Budget.
- Federally qualified health center (FQHC): A community health center, migrant health center, or health center for the homeless that provides primary care services for uninsured and Medicaid patients. These clinics are funded under sections 329, 330, and/or 340 of the Public Health Services Act.
- Fee-for-service payment:** A method of paying for medical services in which each service performed by an individual provider bears a related charge. This charge (or some related fee) is paid by the individual patient receiving the service or by an insurer on behalf of the patient.
- Fee schedule: A list of covered health care services in which each entry is associated with a specific monetary amount that represents the approved payment level for that service under a given insurance plan.
- Fixed costs: The portion of total costs of a program incurred even when output is negligible—e. g., costs associated with overhead, facilities, and overhead salaries (compare with *variable costs*).
- Freestanding facilities: Facilities that are not physically, administratively, or financially connected to a hospital, such as a freestanding ambulatory surgery center.
- Fully capitated health plan (FCHP): Under the Oregon Medicaid program, FCHPs are prepaid on a per capita basis for all inpatient, outpatient, and ancillary services provided to enrollees, with certain exceptions (e.g., dental and psychiatric care). The FCHP provides these services either directly or through subcontractors. (See *capitated payment*).
- General assistance** (; A): An Oregon State program of limited health care benefits provided (without Federal funding) to medically unemployable adults who would not be disabled long enough to qualify for Social Security benefits.
- Health maintenance organization (HMO): A health care organization that, in return for prospective per capita (cavitation) 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. A Federally qualified HMO is one that has been determined by the Department of Health and *Human Services to meet the standards set forth in Title XIII of the Public Health Service Act*, in such areas as financial and administrative stability, quality, scope of services covered, and rate-setting practices.
- Health Services Commission (HSC): An 11-member committee authorized in the Oregon Basic Health Services Act (Oregon Senate Bill 27) and appointed by the Governor to formulate a list of health services ranked in order of priority.
- Historical controls: See *control group*.
- Human immunodeficiency virus (HIV): The virus that causes acquired immunodeficiency syndrome (AIDS).
- Impetigo herpeticiformis: A rare, redness and inflammation of the pustules of the skin that affects pregnant women and results in fetal death, stillbirth, placental insufficiency, and perinatal death. Steroid treatments and antipsoriatic agents are ineffective and termination of the pregnancy is the only cure.
- Independent practice association (IPA): See *health maintenance organization (HMO)*.
- infant mortality rate:** Number of deaths among children less than 1 year old as a fraction of the total number of live births in a year.
- Inpatient care: Care that includes an overnight stay in a medical facility. Internal validity: A measure of the extent to which study results reflect the true relationship of a ‘risk factor’ (e.g., treatment or technology) to the outcome of interest in study subjects.
- International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) Coding: A two-part system of coding patient medical information used in abstracting systems and for classifying patients into diagnosis-related groups for Medicare. The first part is a comprehensive list of diseases with corresponding codes compatible with the World Health Organization’s list of disease codes. The second part contains procedure codes, which are independent of the disease codes. (Oregon did not use the ICD-9-CM procedure codes in its prioritized list.)
- Joint and several liability: The ability of a plaintiff to sue one or more parties for a tort and the right of a plaintiff to collect the entire compensation from a single entity.
- Length of stay (LOS): The number of days a patient remains in the hospital from admission to discharge.
- Managed health care:** Care provided to enrollees in *case-managed fee-for service plans, health maintenance organizations (HMOs) and preferred provider organizations (PPOs)*. Patients in managed

- health care plans do not have open access to physicians or hospitals and usually must obtain prior approval from a “gatekeeper” primary care provider from the health plan administration before admission to a hospital. HMOs and PPOs may also require that the health provider’s treatment plan be reviewed to ensure that all services are necessary. Patients who do not follow the HMO or PPO guidelines may face larger out-of-pocket costs or be denied payment altogether. Some managed health care plans contain “individual benefits management” programs that allow payment for otherwise uncovered benefits (e.g., home- and community-based services) in order to avoid the utilization of more costly covered services.
- Mandatory benefits (Medicaid):** The core package of Medicaid services that by Federal law (Title XIX of the Social Security Act) must be covered by State Medicaid programs. Includes basic hospital, ambulatory, long-term care, and ancillary services, (Compare with *optional benefits (Medicaid)*).
- Mandatory group (Medicaid):** Refers to Medicaid eligibility groups that must be covered by a State Medicaid program according to Federal law. Includes *Aid to Families with Dependent Children (AFDC)* participants, unemployed parent families, certain pregnant women and young children, foster care children, and some aged, blind, and disabled individuals.
- Matched control group:** See *control group*.
- Medicaid:** A federally aided, State-administered program that provides medical assistance for low-income people meeting specific income and family structure requirements.
- Medical technology:** The drugs, devices, and medical and surgical procedures used in medical care, and the organizational and support systems within which such care is provided.
- Medically needy Medicaid recipients:** People who receive Medicaid under State “medically needy” programs. States have the option to offer Medicaid to medically needy people who would be categorically eligible for Medicaid but whose income and resources lie above the standards for AFDC. Each State sets its own medically needy resource and income standards up to 133 percent of State AFDC income standards.
- 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 at least 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.
- Migrant health center (MHC):** A center that receives Federal funds to provide primary health care to migrant and seasonal farmworkers and their families under section 329 of the Public Health Services Act. See *federally qualified health center*.
- Morbidity:** Sickness or disease; any unhealthful condition.
- Mortality rate:** The death rate, often made explicit for a particular characteristic; e.g., age, sex, or specific cause of death. A mortality rate contains three essential elements: 1) the number of people in a population group exposed to the risk of death (the denominator); 2) a time factor; and 3) the number of deaths occurring in the exposed population during a certain time period (the numerator).
- Myasthenia gravis:** An autoimmune disorder in which the body reacts against a normal substance that communicates between nerve and muscle cells, resulting in muscle weakness and fatigue.
- Negotiated rate:** A payment rate whose final amount is the result of a negotiation between the payer and the health care provider (with negotiations taking place before the service is provided).
- Neonatal:** Pertaining to the first 4 weeks after birth.
- Net benefit:** In this report, a number associated with a given CT pair that reflects both clinicians’ estimates of treatment effects and consumers’ perception of the desirability of experiencing those effects. The Oregon Health Services Commission used net benefit information in its ranking process for the prioritized list.
- New eligible:** In this report, refers to individuals who do not qualify for Medicaid under current rules but would be eligible under the proposal set out in the Oregon waiver application.
- Noncapitated services:** Services not covered under a per capita payment system. Generally, providers are reimbursed on a fee-for-service basis for covered noncapitated services. See *fee-for-service payment* and *capitated payment*.
- Noncategorical eligibles:** Individuals that qualify for Medicaid, but do not fit into one of the “categorically needy” groups. (See *categorically eligible Medicaid beneficiary*.) They include children aged 9 to 21 of 2-parent families whose income meet income eligibility standards, and ‘medically needy’ individuals who “spend down.”
- Non-Hodgkin’s lymphoma:** A cancerous disorder of the lymphoid tissue; also known as lymphocytic lymphoma. Treatment varies according to the grade of the condition but usually includes bone marrow transplantation and/or chemotherapy.
- occupancy rate:** The average percentage of a hospital’s beds occupied at any one time, determined by

- dividing available bed days by patient days.
- Operating margin:** A measure of the financial health and profitability of a hospital, defined as: (total operating revenue minus operating expenses) divided by total operating revenue. A positive operating margin implies a surplus; a negative operating margin implies a loss.
- Optional benefits (Medicaid):** Benefits that States are allowed, but not required, to provide to Medicaid recipients. States may receive Federal finding for up to 32 optional services under the Medicaid program. Among the most common are prescription drugs and dental services. Compare with *mandatory benefits (Medicaid)*.
- optional eligibility group (Medicaid):** **States may** receive Federal funding to provide Medicaid benefits to several optional eligibility groups, including pregnant women and infants under age 1 with incomes between 100 and 133 percent of the Federal poverty level, AFDC children between 18 and 21 years old, and children ages 9 to 21 of two-parent families whose incomes meet Medicaid income eligibility standards, but who are categorically ineligible. Outcome measure: Any measure of an **intermediate** or final outcome experienced by a patient with a given condition. Mortality (deaths within a given time period) is a common outcome measure. Various measures of morbidity (e.g., the ability to walk without assistance) can also be outcome measures.
- outpatient care:** Care provided in a health care facility that does not include an overnight stay.
- Palliative treatment:** Treatment designed to provide relief from a disease or condition (e.g., to provide comfort or reduce pain), but not to cure the disease or condition.
- Partially capitated health plan:** Under the Oregon Medicaid program, partially capitated health plans are prepaid on a per capita basis for certain types of health services (e.g., physician services, laboratory, and X-ray services), which they deliver to enrolled patients either directly or through subcontractors. In addition, partially capitated health plans often coordinate and/or preauthorize noncapitated services (e. g., inpatient care, chiropractic services) for their enrolled patients. See also *physician care organization*. Compare with fully *capitated health plan*.
- Participation (Medicaid):** Acceptance of Medicaid patients by a health care practitioner.
- Participation rate:** The proportion of all active health care practitioners in a given area who accept Medicaid patients in their practice.
- Patient dumping:** Transferring a patient to another hospital for economic reasons alone (e.g., because the patient has no health insurance).
- Per-case payment:** A type of hospital payment system in which the hospital is paid a specific amount for each case treated, regardless of the number and types of services or number of days of care provided. Medicare's DRG payment system for inpatient services is a per-case payment system. See also *prospective payment*.
- Percent-of-cost limit:** A payment *method* wherein a payer reimburses a provider based on a percentage (e.g., 80 percent) of the provider's actual costs for providing a service. Oregon pays most hospitals for outpatient services on a percent-of-cost basis, where costs are determined based on the hospital's Medicare cost reports.
- Physician care organization (PC O):** A group of primary care physicians prepaid to provide a basic package of services that include: physician services, laboratory, radiology, and EPSDT services. PCOs are also required to act as "gatekeepers" to preapprove all nonemergency inpatient and outpatient hospital services.
- Physician Payment Review Commission (PPRC):** A commission, established by the Comprehensive Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272), that makes recommendations to Congress on various issues relating to physician payment under Medicare and Medicaid.
- Poor:** A term defined in relation to the *Federal poverty level (FPL)*, a cash income level which varies with family size and the age of family members. Poor families are families with incomes below 100 percent of the Federal poverty level. In 1992 the Federal poverty level for a family of three in the continental United States was \$11,570.
- Poverty level medical (PLM):** A term used by the Oregon Medicaid program to describe pregnant women and children under 6 years old whose family income is less than 133 percent of the *Federal poverty level (FPL)* and all children up to age 19 born after September 30, 1983, whose income is less than 100 percent of the FPL. This group was mandated Medicaid coverage under the Omnibus Budget Reconciliation Act of 1990 (Public Law 101-239).
- Preexisting condition:** As defined by insurers, a health care condition existing before an insurance policy goes into effect and that would cause an ordinarily prudent person to seek diagnosis, care, or treatment.
- Preferred provider organization (PPO):** A health care delivery arrangement in which an agreement is made between providers and purchasers of medical care that patients who use the "preferred providers" will obtain additional benefits, such as reduced cost sharing. In return for the potential increase in volume of patients, the preferred providers may

- agree to discount their charges or to submit to enhanced utilization review.
- Prenatal care:** Medical services related to fetal, infant, and maternal health, delivered from time of conception to labor.
- Prepaid health plan:** An organized group (e.g., a *health maintenance organization* or group of physicians) that is prepaid on a periodic basis, an amount to cover some or all services provided to its enrollees (see *capitated payment*).
- Preventive medical services:** Clinical services provided to patients to reduce or prevent disease, injury, or disability.
- Primary care:** A basic level of health care, usually provided in an outpatient setting, that emphasizes a patient's general health needs (e.g., preventive services, treatment of minor illnesses and injuries, identification of problems that require referral to specialists).
- Primary care specialty:** One of the medical specialties of family practice, general practice, general pediatrics, general internal medicine, and obstetrics and gynecology.
- Primary condition:** See *primary diagnosis*.
- Primary diagnosis:** The chief diagnosis for which a patient is treated during a given episode of care (e.g., a hospitalization). **Prospective payment:** Payment for medical care on the basis of rates set in advance of the time period in which they apply. The service provider is at least partially at risk for losses and stands to gain from surpluses that accrue in the payment period. The unit of payment may vary from individual medical services to broader categories, such as hospital case, episode of illness, or person (cavitation). See also *cavitation financing method*. Compare *retrospective cost-based reimbursement*.
- Prospective Payment Assessment Commission (ProPAC):** A commission, established by the same law that created the Medicare DRG-based prospective payment system for hospitals (Public Law 98-21), that advises Congress on various issues relating to how Medicare pays hospitals and other health care institutions.
- p value:** In epidemiologic studies, the probability of concluding that a statistical association exists between, for instance, a risk factor and a health endpoint, when, in fact, there is no real association. In other words, the likelihood that an observed association in a study is due to the play of chance. Also called "Type I error," "alpha," or the "level of significance."
- Reasonable charge:** See *customary, prevailing, and reasonable (CPR) method* and *usual, customary and reasonable charges*.
- Recipient (Medicaid):** See *beneficiary*.
- Referral services:** Health care services obtained from a provider to whom the patient was referred by his or her physician. Includes physician specialist care and various ancillary services (e.g., physical therapy services).
- 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.
- 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. Compare *prospective payment*.
- Risk-based provider:** A provider of health care (e.g., a *health maintenance organization*) that accepts prepayment on a per-patient basis for some or all health care services needed by that patient and thus assumes some degree of financial risk for service costs exceeding the prepaid amount. See also *capitated payment*.
- Rural health clinic (RHC):** A clinic certified according to the provisions of Public Law 95-210. These clinics qualify for facility-specific cost-based reimbursement under Medicare and Medicaid.
- Schmidt's syndrome:** A rare hormonal deficiency syndrome that primarily affects females. It is characterized by insufficiency in the adrenal gland, gonads, and/or thyroid. Treatment includes hormone replacement therapy.
- Secondary care:** Services provided by the medical specialists who generally do not have the first contact with patients (e.g., cardiologist, urologist, dermatologist). In the United States, however, there has been a trend toward self-referral by patients for these services, rather than referral by primary care providers.
- Self-limited:** Refers to medical conditions that tend to be limited in duration or course even if untreated.
- Statistical significance:** See *p value*.
- Supplemental Security Income (SSI):** A Federal income support program for low-income disabled, aged, and blind persons which was established by Title XVI of the Social Security Act. Eligibility for the program is based on income and resources.
- Tertiary care:** Services provided by highly specialized providers (e.g., neurologist, neurosurgeon, thoracic surgeon). Such services frequently require highly sophisticated equipment and support facilities. Tertiary care lies at the end of the continuum of type of care (i.e., primary, secondary, tertiary), of which many services overlap, and is difficult to define precisely.

- Third-party payment:** Payment by a private insurer or government program to a medical provider on behalf of a patient for care given to that patient.
- Tort liability:** A legal basis for compensation when property has been damaged or a person has been injured.
- Trigeminal nerve disorder:** The trigeminal nerve supplies sensation to the skin of the face. Patients with disorders of the trigeminal nerve experience pain in the lip, gums, cheek, and chin areas.
- Uncompensated care:** Health care services for which the provider receives no compensation. When reporting uncompensated care costs, providers generally include charity care, bad debt (i.e., unpaid bills), and disparities between providers' billed charges and actual reimbursement for health care services. (Compare with *charity care*.)
- Unrestricted fee-for-service system:** A health care delivery system where patients are free to seek health care services from any willing provider without prior authorization. Services are paid on a fee-for-service basis. (See *fee-for-service*; contrast with *case-managed fee-for-service system*.)
- Uptake rate:** In this report, a measure of how quickly new eligibles under Oregon's proposal would enroll in the Medicaid program.
- Usual, customary, and reasonable charges:** In private health insurance, a basis for determining payment for individual physician services. 'Usual' refers to the individual physician's fee profile, equivalent to Medicare's "customary" charge screen. "Customary," in this context, refers to a percentile of the pattern of charges made by physicians in a given locality (comparable to Medicare's "prevailing" charges). "Reasonable" is the lesser of the usual or customary screens. See *customary, prevailing, and reasonable charges*.
- Variable costs:** The portion of total cost that increases with greater output. g., the costs associated with increasing numbers of persons seen in a health clinic.
- Viral warts:** Skin eruptions resulting from infection of the human papillomavirus (HPV). They can occur on the face, neck, chest, hands, arms, and legs. Of particular interest are anogenital warts (or venereal warts), a very common sexually transmitted disease correlated with cervical and anal cancer. Treatment includes topical application of caustic agents, cryosurgery, and laser surgery.
- Waiver:** States may apply to the Health Care Financing Administration of the Department of Health and Human Services for Federal waivers that would grant the State permission to waive certain provisions of the Medicaid statute, thereby allowing implementation of the proposed demonstration project. See also *demonstration*.