

Office of the
Legislative Fiscal Analyst

FY 2001 Budget Recommendations

Joint Appropriations Subcommittee for
Health and Human Services

**Department of Health and
Health Policy Commission**

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1.0 Department of Health/Health Policy Commission-Summary

The Health and Human Services Joint Appropriations Subcommittee reviews the budgets for the Department of Health, the Health Policy Commission, the Medical Education Program, and the Department of Human Services, then approves a budget for each. These recommendations are then presented to the Executive Appropriations Committee for final approval. This section of the report deals with the Department of Health, the Health Policy Commission, and the Medical Education Program.

In preparing for this legislative session, the Analyst has reviewed each budget, visited with the agencies, and analyzed the agency requests and the Governor's recommendations. After reviewing the requests, the Analyst has recommended those budget increase items which seem essential to programs and appear to be the most cost-effective, while considering the available revenues and directions from the Executive Appropriations Committee.

The Legislature approved a funding level of \$916,815,700 for the Department of Health and the Health Policy Commission for Fiscal Year 2000. Of this amount, \$183,773,700 was from the General Fund, the largest other single source was Federal funds, with smaller amounts coming from dedicated credits, restricted accounts, and revenue transfers.

For FY 2001, the Analyst is recommending a total budget of \$972,659,000 to the subcommittee. This recommendation represents a 0.7 percent increase when compared to the FY 2000 estimated level of expenditures. The Analyst's recommendation includes \$182,773,400 from the General Fund, which is a decrease of 0.2 percent compared to the ongoing FY 2000 appropriated General Fund.

The Analyst has maintained salary levels at the FY 2000 levels, leaving any salary consideration to the discretion of the Legislature.

The recommendations, by fund and agency, are found on the following pages. Further details on each budget are found under each tab and will be discussed during the budget hearings.

The Health Department's mission is to protect the public's health through preventing avoidable illness, injury, disability, and premature death; assuring access to affordable, quality health care; and promoting healthy lifestyles.

The Health Policy Commission was established by the 1994 Legislature to bring about needed reform in areas affecting, and affected by, the health care industry.

The Medical Education Program was established in 1997 to secure stabilized funding sources for graduate medical education expenses.

	Analyst FY 2001 Base	Analyst FY 2001 Changes	Analyst FY 2001 Total
Financing			
General Fund	\$182,808,400	(\$35,000)	\$182,773,400
Federal Funds	639,373,800	4,110,100	643,483,900
Dedicated Credits Revenue	87,815,000	102,500	87,917,500
Federal Mineral Lease	600,000		600,000
GFR - Cigarette Tax Restricted Account	250,000		250,000
GFR - Hospital Provider Assessment	5,500,000		5,500,000
GFR - Kurt Oscarson Organ Transplant	100,000		100,000
GFR - Medicaid Restricted Account	4,900,200	1,541,000	6,441,200
GFR - Nursing Facility Account	4,248,500		4,248,500
GFR - State Lab Drug Testing Account	149,400		149,400
Transfers	40,691,000		40,691,000
Beginning Nonlapsing	2,561,100		2,561,100
Total	<u>\$966,940,400</u>	<u>\$5,718,600</u>	<u>\$972,659,000</u>
Programs			
Executive Director's Operations	\$11,690,200		\$11,690,200
Veteran's Nursing Home	2,685,600		2,685,600
Health Systems Improvement	10,940,800		10,940,800
Physician Loan Repayment	554,100		554,100
Nursing Education Financial Assistance	246,400		246,400
Special Population Health Care Provider Financial Assistance and Retention	80,000		80,000
Epidemiology and Laboratory Services	11,551,200		11,551,200
Community and Family Health Services	78,114,300		78,114,300
Health Care Financing	57,041,900		57,041,900
<i>Transfer of 2 FTE Positions</i>		(70,000)	(70,000)
Medical Assistance	770,160,600		770,160,600
<i>Extra Week's Payments</i>		5,788,600	5,788,600
Children's Health Insurance Program	23,441,000		23,441,000
Health Policy Commission	433,300		433,300
Medical Education Program	1,000		1,000
Total	<u>\$966,940,400</u>	<u>\$5,718,600</u>	<u>\$972,659,000</u>
FTE	1,145.8	(2.0)	1,143.8

2.0 Issues: Department of Health/Health Policy Commission

2.1 Transfer of two Division of Health Care Financing Eligibility Workers to the Department of Human Services

The Department of Health and the Department of Human Services have agreed to transfer two eligibility workers from the Department of Health to the Department of Human Services to better reflect the current workload. The Analyst recommends the transfer of the two positions and the funding level of \$70,000, of which \$35,000 is from the General Fund.

General Fund **(\$35,000)**

2.1 Extra Week's Medical Assistance Provider Payment Needed in FY 2001

Regular Medicaid provider payments are made each Saturday. In Fiscal Year 2001, there are 53 Saturdays, so one additional week's payment will be made. This is a one-time cost, which occurs once every five or six years. The Analyst recommends the funding level of \$5,788,600, with the state match coming from the Medicaid Restricted Account, which is a source of one-time funds, which fits well with a one-time expenditure.

4.0 Additional Information: Department of Health and Health Policy Commission

4.1 Funding History

	FY 1997	FY 1998	FY 1999	FY 2000	FY 2001
Financing	Actual	Actual	Actual	Estimated	Analyst
General Fund	\$162,068,800	\$168,774,700	\$174,081,500	\$183,089,900	\$182,773,400
General Fund, One-time		750,000		683,800	
Federal Funds	538,707,878	559,576,190	616,661,003	649,761,901	643,483,900
Dedicated Credits Revenue	37,464,773	48,661,671	73,655,910	74,936,245	87,917,500
Federal Mineral Lease	350,000	551,371	600,000	600,000	600,000
GFR - Cigarette Tax Restricted Account			250,000	250,000	250,000
GFR - Hospital Provider Assessment			5,500,000	5,500,000	5,500,000
GFR - Kurt Oscarson Organ Transplant	200,000	100,000	100,000	100,000	100,000
GFR - Medicaid Hospital Provider Account	7,345,300	6,335,900			
GFR - Medicaid Restricted Account		1,750,000	3,439,000	4,900,200	6,441,200
GFR - Nursing Facility Account	3,611,100	3,713,600	4,276,700	4,244,800	4,248,500
GFR - State Lab Drug Testing Account			150,000	150,000	149,400
Transfers	41,021,269	50,224,984	43,994,938	40,746,054	40,691,000
Beginning Nonlapsing	2,559,134	3,337,664	3,149,400	3,909,367	2,561,100
Closing Nonlapsing	(3,337,692)	(3,145,121)	(3,909,433)	(2,561,067)	(2,057,000)
Lapsing Balance	(9,412,267)	(8,138,459)	(2,463,071)		
Total	\$780,578,295	\$832,492,500	\$919,485,947	\$966,311,200	\$972,659,000
% Change		6.7%	10.4%	5.1%	0.7%
Programs					
Executive Director's Operations	\$11,843,994	\$11,456,399	\$11,548,883	\$12,166,400	\$11,690,200
Veteran's Nursing Home		6,300	1,864,876	2,686,400	2,685,600
Health Systems Improvement	7,617,929	9,939,243	9,158,511	11,231,900	10,940,800
Physician Loan Repayment			227,228	504,400	554,100
Nursing Education Financial Assistance			237,654	246,700	246,400
Special Population Health Care Provider					
Financial Assistance and Retention			22,083	80,000	80,000
Epidemiology and Laboratory Services	8,927,255	9,908,210	10,689,928	12,080,500	11,551,200
Community and Family Health Services	66,111,496	68,343,311	72,598,762	75,647,800	78,114,300
Health Care Financing	43,166,930	50,251,048	50,255,653	63,435,500	56,971,900
Medical Assistance	642,631,321	682,151,837	755,417,063	766,991,700	775,949,200
Children's Health Insurance Program			6,894,197	20,171,600	23,441,000
Health Policy Commission	279,370	399,617	530,438	434,100	433,300
Medical Education Program		36,535	40,671	634,200	1,000
Total	\$780,578,295	\$832,492,500	\$919,485,947	\$966,311,200	\$972,659,000
Expenditures					
Personal Services	\$42,831,972	\$47,469,293	\$51,374,986	\$56,160,616	\$55,602,800
In-State Travel	439,835	503,434	515,066	660,600	635,700
Out of State Travel	309,127	347,453	386,594	631,400	578,200
Current Expense	21,176,962	34,841,600	21,322,484	41,795,753	35,313,100
DP Current Expense	5,178,413	6,085,591	5,030,701	4,717,631	4,643,900
DP Capital Outlay	367,908	200,280	90,769	40,000	
Capital Outlay	302,624	351,063	283,301	472,000	
Other Charges/Pass Thru	709,971,454	742,693,786	840,482,046	861,833,200	875,885,300
Total	\$780,578,295	\$832,492,500	\$919,485,947	\$966,311,200	\$972,659,000
FTE	951.2	988.2	1,170.2	1,148.6	1,143.8

4.1 Additional Information

Budgeting includes the allocation of resources (money) to various programs in State government.

The annual state budgetary process begins in May or June for the fiscal year that will begin 14 months later, with each department of state government determining which items to include in its annual budget request to the Governor. Those requests are submitted in September to the Governor's Office of Planning and Budget (GOPB), which analyzes the requests and results in a recommendation from the Governor to the Legislature. The Office of the Legislative Fiscal Analyst, a non-partisan office that serves both houses of the Legislature in preparing a budget and determining the fiscal impact of proposed legislation, analyzes the Governor's recommendation, then makes independent budgetary recommendations to the Legislature. The Legislature, after reviewing the recommendations, then approves a budget by passing an Appropriation Act, which establishes the spending levels for each program.

The Governor's recommendations may include revenue enhancements, such as tax or fee increases. The Analyst's recommendations are based on revenue estimates approved by, and funding allocated by, the Executive Appropriations Committee. Those revenue estimates do not include the effect of any anticipated legislation. Both the Analyst and the Governor must submit budgets which do not exceed anticipated revenue, but each budget may have its own revenue estimates, and so may have different totals.

The State does not budget on the calendar year, but uses what is termed a Fiscal Year, which is the 12-month period from July 1 to June 30 of the following year. A fiscal year is usually abbreviated FY, with the number which follows designating the year which includes the last six months. The current fiscal year is FY 00, which will end June 30, 2000. The fiscal year for which the Legislature is determining the budget is FY 2001 or FY 01, which will include the period of time from July 1, 2000 through June 30, 2001.

In allocating funds, the Appropriations Subcommittee may use funding from several sources to complete the full appropriation to each. The following sources of funding are available:

- General Fund
- Federal Funds
- Dedicated Credits
- Restricted General Funds
- Revenue Transfers

The following explanations are offered to assist in the understanding of the various funding sources:

General Fund

This is the State's most important source of income. The primary revenue source is the sales tax, although there are other taxes and fees which are deposited into this fund. General Funds may be spent at the discretion of the Legislature, as allowed by the Constitution. Personal income taxes and corporate franchise taxes are not deposited into the General Fund, but into the Uniform School Fund.

Federal Funds

Federal Funds are those funds which come to the State from the Federal government. Generally, federal funds are accompanied by certain requirements. Each grant may have different rules about how the funds may be spent. A common requirement is that which requires some form of state match in order to receive the federal dollars. In such cases, federal funding may be reduced if a state program is reduced. There is also the possibility, that due to outside circumstances, federal funding may be reduced or eliminated. If this happens, most agencies then request state funds to replace the lost federal funds. However, this is generally not recommended. Programs which receive federal funds will have a separate Federal Funds sheet (Section 4.1) which details the federal grant, by program within the line item.

Dedicated Credits

Dedicated Credits are funds which are paid to an agency for specific services and are dedicated to paying for the expense of providing that service. For example, money paid to the State Health Laboratory for the tests and analysis it performs is used to cover the costs of running those tests. By law, these funds must be spent before other appropriated state funds are spent. It should be noted that an agency must estimate the level of its services for the following fiscal year, and thus its level of dedicated credits.

Restricted General Funds

Restricted revenue can only be used for designated purposes. The restricted funds usually receive money from specific sources, with the understanding that those funds will then be used for specific purposes. Within the Department of Health, for example, such restricted funds are used to collect additional funds that are then utilized to match and draw down additional federal funds in the Medical Assistance program.

Revenue Transfers

Occasionally, one agency may contract with another agency to provide funding for specific services.

Lapsing Funds

Funds lapse, or revert back to the State, if the full appropriation is not spent by the end of the fiscal year. Since it is against the law to spend more than the Legislature has appropriated for each line item, all programs will generally either spend all the money or have some left unspent. The unspent funds lapse back to the State, unless specifically exempted. Those exceptions include funds that are set up as non-lapsing. In these cases, unspent funds do not lapse back to the State, but remain with the agency in a special non-lapsing balance, for use in the next fiscal year. In the budgets, the Beginning Non-Lapsing balance is the balance on July 1 of the fiscal year, while the balance on the next June 30 is termed the Closing Non-Lapsing balance. The Closing Non-Lapsing balance from one fiscal year becomes the Beginning Non-Lapsing balance for the following fiscal year. The reason behind non-lapsing funds is that a specific task may take an indeterminate amount of time, or span more than one fiscal year.

Other budgeting terms and concepts which the Legislature will encounter include the following:

Intent Language

Intent Language may be added to an appropriation bill to explain or put conditions on the use of the funds in the line item. Intent language may restrict usage, require reporting, or impose other conditions within the item of appropriation.

Supplemental Appropriation

The current legislative session is determining appropriations for the upcoming fiscal year (FY 01). However, it may be determined that unexpected circumstances have arisen since the past session which require additional funding for the current year. The Appropriations Subcommittee can recommend to the Executive Appropriations Committee that a supplemental appropriation be made for the current year (FY 00).

FTE

FTE is an abbreviation for Full-Time Equivalent. This is a method of standardizing personnel counts. A full-time equivalent is equal to one employee working 40 hours per week. Ten employees each working four hours per week would also count as one FTE.

Line Item

This is a term which applies to an appropriation bill. Each appropriated sum is identified by an item number in the appropriations bill. Generally, each line item appropriation goes to an agency that may have several programs. Once the appropriation becomes law, the money may be moved from program to program within the line item, but cannot be moved to another line item of appropriation. A listing of the line items and the programs within those line items that comprise the Department of Health and the Health Policy Commission and for which the Subcommittee is responsible follows:

Executive Director's Office

Executive Director
Program Operations
Health Care Statistics
Medical Examiner
Center for Health Data

Veterans' Nursing Home

Veterans' Nursing Home

Health Systems Improvement

Director's Office
Emergency Medical Services
Health Facility Licensure
Program Certification and Resident Assessment
Primary Care and Rural Health Systems

Physicians and Physicians Assistants Grant and Scholarship Program

Physicians and Physicians Assistants Grant and Scholarship Program

Nurse Education Financial Assistance Program

Nurse Education Financial Assistance Program

Special Population Health Care Provider Financial Assistance and Retention Program

Special Population Health Care Provider Financial Assistance and Retention Program

Epidemiology and Laboratory Services

Director's Office
Environmental Chemistry and Toxicology
Laboratory Improvement
Microbiology
HIV/AIDS/Tuberculosis/Refugee Health
Food Safety and Environmental Health
Epidemiology

Community and Family Health Services

Director's Office
Division Resources
Health Education
Maternal and Child Health
Chronic Disease
Children with Special Health Care Needs

Health Care Financing

Director's Office
Financial Services
Managed Health Care
Medicaid Operations
Eligibility Services
Coverage and Reimbursement
Contracts
Utah Medical Assistance Program

Medical Assistance

Medicaid Base Program
Title XIX Funding for Human Services
Utah Medical Assistance Program

Children's Health Insurance Program

Children's Health Insurance Program

Health Policy Commission

Health Policy Commission

Medical Education Program

Medical Education Program

4.2 Glossary of Health Terms and Acronyms

Access	Often defined as the potential and actual entry of a population into the healthcare system and by features such as private or public insurance coverage. The probability of entry is also dependent upon the wants, resources, and needs that patients may bring to the care-seeking process. Actual entry into the system is described by utilization rates and subjective evaluations of care. Ability to obtain wanted or needed services may also be influenced by the distance one has to travel, waiting time, total income, and whether one has a regular source of care.
Actual Charge	One of the factors determining a physician's payment for a service under Medicare; equivalent to the billed or submitted charge.
Acute Care	Medical treatment rendered to individuals whose illnesses or health problems are of short-term or episodic nature. Acute care facilities are those hospitals that mainly serve persons with short-term health problems.
Acute Disease	A disease which is characterized by a single episode of a relatively short duration from which the patient returns to his normal or previous state of level of activity. While acute diseases are frequently distinguished from chronic diseases, there is no standard definition or distinction. It is worth noting that an acute episode of a chronic disease (for example, an episode of diabetic coma in a patient with diabetes) is often treated as an acute disease.
AFDC	Aid To Families with Dependent Children. Replaced by federal welfare reform with Temporary Assistance to Needy Families (TANF).
Allowable Costs	Items or elements of an institution's costs which are reimbursable under a payment formula. Both Medicare and Medicaid reimburse hospitals on the basis of only certain costs. Allowable costs may exclude, for example, luxury accommodations, costs which are not reasonable expenditures, which are unnecessary, for the efficient delivery of health services to persons covered under the program in question, or depreciation on a capital expenditure which was disapproved by a health planning agency.
Alternatives to Long-Term Institutional Care	The whole range of health, nutritional, housing, and social services designed to keep persons out of institutions, such as skilled nursing facilities, which Institutional Care provide care on a long-term basis. The goal is to provide the range of services necessary to all to allow the person to continue to function in the home and community environment. Alternatives to long-term care usually focus on the aged, disabled, and retarded, and include: day care centers, foster homes, or homemaker services.
Ambulatory Care	All types of health services which are provided on an outpatient basis, in contrast to services provided in the home or to persons who are inpatients. While many inpatients may be ambulatory, the term ambulatory care usually implies that the patient must travel to a location to receive services which do not require an overnight stay. See also ambulatory setting and outpatient.

Ambulatory Setting	A type of institutional organized health setting in which health services are provided on an outpatient basis. Ambulatory care settings may be either mobile (when the facility is capable of being moved to different locations) or fixed (when the person seeking care must travel to a fixed service site).
Ancillary Services	Supplemental services, including laboratory, radiology, physical therapy, and inhalation therapy, that are provided in conjunction with medical or hospital care.
Appropriateness	Appropriate health care is care for which the expected health benefit exceeds the expected negative consequences by a wide enough margin to justify treatment.
Area Health Education Center (AHEC)	An organization or organized system of health and educational institutions whose purpose is to improve the supply, distribution, quality, use, and efficiency of health care personnel in specific medically underserved areas. An AHEC's objectives are to educate and train the health personnel specifically needed by the underserved areas and to decentralize health workforce education, thereby increasing supply and linking the health and educational institutions in scarcity areas.
Capitation	A method of payment for health services in which an individual or institutional provider is paid a fixed amount for each person served, without regard to the actual number or nature of services provided to each person in a set period of time. Capitation is the characteristic payment method in certain health maintenance organizations. It also refers to a method of Federal support of health professional schools. Under these authorizations, each eligible school receives a fixed payment, called a "capitation grant" from the Federal Government for each student enrolled.
Carve Out	Regarding health insurance, an arrangement whereby an employer eliminates coverage for a specific category of services (e.g., vision care, mental health/psychological services and prescription drugs) and contracts with a separate set of providers for those services according to a predetermined fee schedule or capitation arrangement. Carve out may also refer to a method of coordinating dual coverage for an individual.
Case Management	The monitoring and coordination of treatment rendered to patients with specific diagnosis or requiring high-cost or extensive services.
Case-Mix	A measure of the mix of cases being treated by a particular health care provider that is intended to reflect the patients' difference needs for resources. Case mix is generally established by estimating the relative frequency of various types of patients seen by the provider in question during a given time period and may be measured by factors such as diagnosis, severity of illness, utilization of services, and provider characteristics.

Catastrophic Health Insurance	Health insurance which provides protection against the high cost of treating severe or lengthy illnesses or disability. Generally such policies cover all, or a specified percentage of, medical expenses above an amount that is the responsibility of another insurance policy up to a maximum limit of liability.
Catchment Area	A geographic area defined and served by a health program or institution such as a hospital or community mental health center which is delineated on the basis of such factors as population distribution, natural geographic boundaries, and transportation accessibility. By definition, all residents of the area needing the services of the program are usually eligible for them, although eligibility may also depend on additional criteria.
Centers for Disease Control and Prevention (CDC)	The Centers for Disease Control and Prevention, based in Atlanta, Georgia, is the Federal agency charged with protecting the nations' public health by providing direction in the prevention and control of communicable and other diseases and responding to public health emergencies. CDC is the U.S. Public Health Service agency that led efforts to prevent such diseases as malaria, polio, smallpox, toxic shock syndrome, Legionnaire's disease and, more recently, acquired immunodeficiency syndrome (AIDS) and tuberculosis. CDC's responsibilities as the nation's prevention agency have expanded over the years and will continue to evolve as the agency addresses contemporary threats to health, such as injury, environmental and occupational hazards, behavioral risks, and chronic diseases.
CHEC	Child Health, Evaluation and Care program (see EPSDT)
ChIP	Child Injury Prevention program
Chronic Care	Care and treatment rendered to individuals whose health problems are of a long-term and continuing nature. Rehabilitation facilities, nursing homes, and mental hospitals may be considered chronic care facilities.
Chronic Disease	A disease which has one or more of the following characteristics: is permanent, leaves residual disability; is caused by nonreversible pathological alternation, requires special training of the patient for rehabilitation, or may be expected to require a long period of supervision, observation, or care.
Clinic	A facility, or part of one, devoted to diagnosis and treatment of outpatients. "Clinic" is irregularly defined. It may either include or exclude physicians' offices; may be limited to describing facilities which serve poor or public patients; and may be limited to facilities in which graduate or undergraduate medical education is done.
COB	Coordination of Benefits

Coinsurance	A cost-sharing requirement under a health insurance policy. It provides that the insured party will assume a portion or percentage of the costs of covered services. The health insurance policy provides that the insurer will reimburse a specified percentage of all, or certain specified, covered medical expenses in excess of any deductible amounts payable by the insured. The insured is then liable for the remainder of the costs until their maximum liability is reached.
Community-Based Care	The blend of health and social services provided to an individual or family in their place of residence for the purpose of promoting, maintaining, or restoring health or minimizing the effects of illness and disability.
Community Health Center (CHC)	An ambulatory health care program (defined under section 330 of the Public Health Center Health Service Act) usually serving a catchment area which has scarce or (CHC) nonexistent health services or a population with special health needs; sometimes known as "neighborhood health center." Community health centers attempt to coordinate Federal, State, and local resources in a single organization capable of delivering both health and related social services to a defined population. While such a center may not directly provide all types of health care, it usually takes responsibility to arrange all medical services needed by its patient population.
Community Mental Health Center (CMHC)	An entity which provides comprehensive mental health services (principally Mental Health ambulatory), primarily to individuals residing or employed in a defined Center (CMHC) catchment area.
Community Rating	A method of calculating health plan premiums using the average cost of actual or anticipated health services for all subscribers within a specific geographic area. The premium does not vary for difference groups or subgroups of subscribers on the basis of their specific claims experience.
Continuing Medical Education (CME)	Formal education obtained by a health professional after completing his or her degree and full-time postgraduate training. For physicians, some States require CME (usually 50 hours per year) for continued licensure, as do some specialty boards for certification.
Cost Containment	A set of steps to control or reduce inefficiencies in the consumption, allocation, or production of health care services which contribute to higher than necessary costs. Inefficiencies in consumption can occur when health services are inappropriately utilized; inefficiencies in allocation exist when health services could be delivered in less costly settings without loss of quality; and inefficiencies in production exist when the cost of health services could be reduced by using a different combination of resources.
Cost-Shifting	The situation that occurs when health care providers are not reimbursed or not fully reimbursed for providing health care so charges to those who pay must be increased. Typically results from providing health care to the medically indigent or the Medicare patients.
Covered Services	Health care services covered by an insurance plan.

CTRPN	Counseling, Testing, Referral and Partner Notification (HIV/AIDS)
Customary Charge	One of the factors that determines a physician's payment for a service under Medicare. Calculated as the physician's median charge for that service over a prior 12-month period.
DCP	Diabetes Control Program
Developmental Disability (DD)	A severe, chronic disability which is attributable to a mental or physical impairment or combination of mental and physical impairments; is manifested before the person attains age 22; is likely to continue indefinitely; results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity of independent living, or economic self-sufficiency; and reflects the person's needs for a combination and sequence of special, interdisciplinary, or generic care treatments of services which are of lifelong or extended duration and are individually planned and coordinated.
Diagnosis Related Groups (DRGs)	Group 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 used in Medicare's prospective payment system.
Disability	Any limitation of physical, mental, or social activity of an individual as compared with other individuals of similar age, sex, and occupation. Frequently refers to limitation of a person's usual or major activities, most commonly vocational. There are varying types (functional, vocational, learning), degrees (partial, total), and durations (temporary, permanent) of disability. Public programs often provide benefits for specific disabilities, such as total and permanent.
Disease	May be defined as failure of the adaptive mechanisms of an organism to counteract adequately, normally, or appropriately to stimuli and stresses to which it is subjected, resulting in a disturbance in the function or structure of some part of the organism. This definition emphasizes that disease is multifactorial and may be prevented or treated by changing any or a combination of the factors. Disease is a very elusive and difficult concept to define, being largely socially defined. Thus, criminality and drug dependence are presently seen by some as diseases, when they were previously considered to be moral or legal problems.
DHCF	Division of Health Care Financing (Medical Assistance Administration)
Drug Abuse	Persistent or sporadic drug use inconsistent with or unrelated to acceptable medical or cultural practice. the definition of drug abuse is highly variable, sometimes also requiring excessive use of a drug, unnecessary use (thus incorporating recreational use), dependence, or illegal use.

Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT)	A program mandated by law as part of the Medicaid program. The law requires that all States have in effect a program for eligible children under age 21 to ascertain their physical or mental defects and to provide such health care treatments and other measures to correct or ameliorate defects and chronic conditions discovered. The State programs also have active outreach components to inform eligible persons of the benefits available to them, to provide screening, and if necessary, to assist in obtaining appropriate treatment.
ECF	Extended Care Facility
Emergency Medical Services (EMS)	Services utilized in responding to the perceived individual need for immediate treatment for medical, physiological, or psychological illness or injury.
Employee Retirement Income Security Act (ERISA)	A Federal act, passed in 1974, that established new standards and reporting/disclosure requirements for employer-funded pension and health benefit programs. To date, self-funded health benefit plans operating under ERISA have been held to be exempt from State insurance laws.
Epidemic	A group of cases of a specific disease or illness clearly in excess of what one would normally expect in a particular geographic area. There is no absolute criterion for using the term epidemic; as standards and expectations change, so might the definition of an epidemic, e.g., an epidemic of violence.
Epidemiology	The study of the patterns of determinants and antecedents of disease in human populations. Epidemiology utilizes biology, clinical medicine, and statistics in an effort to understand the etiology (causes) of illness and/or disease. The ultimate goal of the epidemiologist is not merely to identify underlying causes of a disease but to apply findings to disease prevention and health promotion.
ER	Emergency Room
Exclusive Provider Arrangement (EPA)	An indemnity or service plan that provides benefits only if care is rendered by the institutional and professional providers with which it contracts (with some exceptions for emergency and out-of-area services).
Experience Rating	A method of adjusting health plan premiums based on the historical Rating utilization data and distinguishing characteristics of a specific subscriber group.
FACT	Families, Agencies, Communities Together
Favorable Selection	A tendency for utilization of health services in a population group to be lower than expected or estimated.
FDA	Food and Drug Administration

Fee-For-Service	Method of billing for health services under which a physician or other practitioner charges separately for each patient encounter or service rendered; it is the method of billing used by the majority of U.S. country's physicians. Under a fee-for-service payment system, expenditures increase if the fees themselves increase, if more units of service are provided, or if more expensive services are substituted for less expensive ones. This system contrasts with salary, per capita, or other prepayment systems, where the payment to the physician is not changed with the number of services actually used.
Fee Schedule	An exhaustive list of physician services in which each entry is associated with a specific monetary amount that represents the approved payment level for a given insurance plan.
Handicapped	As defined by Section 504 of the Rehabilitation Act of 1973, any person who has a physical or mental impairment which substantially limits one or more major life activity, has a record of such impairment, or is regarded as having such an impairment.
Health	The state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity. It is recognized, however, that health has many dimensions (anatomical, physiological, and mental) and is largely culturally defined. The relative importance of various disabilities will differ depending upon the cultural milieu and the role of the affected individual in that culture. Most attempts at measurement have been assessed in terms or morbidity and mortality.
Health Care Financing Administration (HCFA)	The Government agency within the Department of Health and Human Services which directs the Medicare and Medicaid programs (Titles XVIII and XIX of the Social Security Act) and conducts research to support those programs.
Health Education	Any combination of learning opportunities designed to facilitate voluntary adaptations of behavior (in individuals, groups, or communities) conducive to health.
Health Facilities	Collectively, all physical plants used in the provision of health services; usually limited to facilities which were built for the purpose of providing health care, such as hospitals and nursing homes. They do not include an office building which includes a physician's office. Health facility classifications include: hospitals (both general and specialty), long-term care facilities, kidney dialysis treatment centers, and ambulatory surgical facilities.
Health Insurance	Financial protection against the medical care costs arising from disease or Insurance accidental bodily injury. Such insurance usually covers all or part of the medical costs of treating the disease or injury. Insurance may be obtained on either an individual or a group basis.

Health Maintenance Organization (HMO)	An entity with four essential attributes: (1) An organized system providing health care in a geographic area, which accepts the responsibility to provide or otherwise assure the delivery of; (2) an agreed-upon set of basic and supplemental health maintenance and treatment services to (3) a voluntarily enrolled group of persons; and (4) for which services the entity is reimbursed through a predetermined fixed, periodic prepayment made by, or on behalf of, each person or family unit enrolled. The payment is fixed without regard to the amounts of actual services provided to an individual enrollee. Individual practice associations involving groups or independent physicians can be included under the definition.
Health Manpower Shortage Area (HMSA)	An area or group which the U.S. Department of Health and Human Services designates as having an inadequate supply of health care providers. HMSAs can include: (1) an urban or rural geographic area, (2) a population group for which access barriers can be demonstrated to prevent members of the group from using local providers, or (3) medium and maximum-security correctional institutions and public or non-profit private residential facilities.
Health Personnel	Collectively, all persons working in the provision of health services, whether as individual practitioners or employees of health institutions and programs, whether or not professionally trained, and whether or not subject to public regulation. Facilities and health personnel are the principal health resources used in producing health services.
Health Promotion	Any combination of health education and related organizational, political, and economic interventions designed to facilitate behavioral and environmental adaptations that will improve or protect health.
Health Service Area	Geographic area designated on the basis of such factors as geography, political boundaries, population, and health resources, for the effective planning and development of health services.
Health Status	The state of health of a specified individual, group, or population. It may be measured by obtaining proxies such as people's subjective assessments of their health; by one or more indicators of mortality and morbidity in the population, such as longevity or maternal and infant mortality; or by using the incidence or prevalence of major diseases (communicable, chronic, or nutritional). Conceptually, health status is the proper outcome measure for the effectiveness of a specific population's medical care system, although attempts to relate effects of available medical care to variations in health status have proved difficult.

Home Health Care	Health services rendered in the home to the aged, disabled, sick, or convalescent individuals who do not need institutional care. The services may be provided by a visiting nurse association (VNA) home health agency, county public health department, hospital, or other organized community group and may be specialized or comprehensive. The most common types of home health care are the following: nursing services; speech, physical, occupational and rehabilitation therapy; homemaker services; and social services.
Hospice	A program which provides palliative and supportive care for terminally ill patients and their families, either directly or on a consulting basis with the patient's physician or another community agency. Hospice is used here for an organized program of care for people going through life's "last station." The whole family is considered the unit of care, and care extends through their period of mourning.
Hospital	An institution whose primary function is to provide inpatient diagnostic and therapeutic services for a variety of medical conditions, both surgical and nonsurgical. In addition, most hospitals provide some outpatient services, particularly emergency care. Hospitals may be classified by length of stay (short-term or long-term), as teaching or nonteaching, by major type of service (psychiatric, tuberculosis, general, and other specialties, such as maternity, pediatric, or ear, nose and throat,) and by type of ownership or control (Federal, State, or local government; for profit and nonprofit). The hospital system is dominated by the short-term, general, and nonprofit community hospital, often called a voluntary hospital.
ICU	Intensive Care Unit
ICF/MR	Intermediate Care Facility for the Mentally Retarded
Indemnity	Health insurance benefits provided in the form of cash payments rather than services. An indemnity insurance contract usually defines the maximum amounts which will be paid for the covered services.
Indigent Care	Health services provided to the poor or those unable to pay. Since many indigent patients are not eligible for Federal or State programs, the costs which are covered by Medicaid are generally recorded separately from indigent care costs.
Inpatient	A person who has been admitted at least overnight to a hospital or other health facility (which is therefore responsible for his or her room and board) for the purpose of receiving diagnostic treatment or other health services.
Institutional Health Services	Health services delivered on an inpatient basis in hospitals, nursing homes, or other inpatient institutions. The term may also refer to services delivered on an outpatient basis by departments or other organizational units of, or sponsored by, such institutions.

Intermediate Care Facility (ICF)	An institution which is licensed under State law to provide on a regular basis health-related care and services to individuals who do not require the degree of care or treatment which a hospital or skilled nursing facility is designed to provide. Public institutions for care of the mentally retarded or people with related conditions are also included in the definition. The distinction between "health-related care and services" and "room and board" has often proven difficult to make but is important because ICFs are subject to quite different regulations and coverage requirements than institutions which do not provide health-related care and services.
Intervention or Intervention Strategy	A generic term used in public health to describe a program or policy designed to have an impact on an illness or disease. Hence a mandatory seat belt law is an intervention designed to reduce automobile-related fatalities.
License/Licensure	A permission granted to an individual or organization by a competent authority, usually public, to engage lawfully in practice, occupation, or activity. Licensure is the process by which the license is granted. It is usually granted on the basis of examination and/or proof of education rather than on measures of performance. A license is usually permanent but may be conditioned on annual payment of a fee, proof of continuing education, or proof of competence.
Long-Term Care	A set of health care, personal care and social services required by persons who have lost, or never acquired, some degree of functional capacity (e.g. the chronically ill, aged, disabled, or retarded) in an institution or at home, on a long-term basis. The term is often used more narrowly to refer only to long-term institutional care such as that provided in nursing homes, homes for the retarded and mental hospitals. Ambulatory services such as home health care, which can also be provided on a long-term basis, are seen as alternatives to long-term institutional care.
LPN	License Practical Nurse
Managed Care	Any form of health plan that initiates selective contracting to channel patients to a limited number of providers and that requires utilization review to control unnecessary use of health services.
MCAC	Medical Care Advisory Committee
MCH	Maternal and Child Health
Medical Assistance/Medicaid (Title XIX)	A Federally aided, State-operated and administered program which provides medical benefits for certain indigent or low-income persons in need of health and medical care. The program, authorized by Title XIX of the Social Security Act, is basically for the poor. It does not cover all of the poor, however, but only persons who meet specified eligibility criteria. Subject to broad Federal guidelines, State determine the benefits covered, program eligibility, rates of payment for providers, and methods of administering the program.

Medicaid Notch	The reduction in real income that occurs which increased earnings removes a person from not only public cash-assistance programs, and from Medicaid.
Medically Indigent	People who cannot afford needed health care because of insufficient income and/or lack of adequate health insurance.
Medically Underserved Population	A population group experiencing a shortage of personal health services. A medically underserved population may or may not reside in a particular medically underserved area or be defined by its place of residence. Thus, migrants, American Indians, or the inmates of a prison or mental hospital may constitute such a population. The term is defined and used to give priority for Federal assistance (e.g., the National Health Service Corps).
Medicare (Title XVIII)	A U.S. health insurance program for people aged 65 and over, for persons eligible for social security disability payments for two years or longer, and for certain workers and their dependents who need kidney transplantation or dialysis. Monies from payroll taxes and premiums for beneficiaries are deposited in special trust funds for use in meeting the expenses incurred by the insured. It consists of two separate but coordinated programs: hospital insurance (Part A) and supplementary medical insurance (Part B).
Mental Health	The capacity in an individual to function effectively in society. Mental health is a concept influenced by biological, environmental, emotional, and cultural factors and is highly variable in definition, depending on time and place. It is often defined in practice as the absence of any identifiable or significant mental disorder and sometimes improperly used as a synonym for mental illness.
Mental Health Services	Comprehensive mental health services, as defined under some State laws and Federal statutes, include: inpatient care, outpatient care, day care, and other partial hospitalization and emergency services; specialized services for the mental health of children; specialized services for the mental health of the elderly; consultation and education services; assistance to courts and other public agencies in screening catchment area residents; follow-up care for catchment area residents discharged from mental health facilities or who would require inpatient care without such halfway house services; and specialized programs for the prevention, treatment and rehabilitation of alcohol and drug abusers.
Mental Illness	All forms of illness in which psychological, emotional, or behavioral disturbances are the dominating feature. The term is relative and variable in different cultures, schools of thought, and definitions. It includes a wide range of types and severities.
MMIS	Medicaid Management Information System
Morbidity	The extent of illness, injury, or disability in a defined population. It is usually expressed in general or specific rates of incidence or prevalence.

Mortality	Death. Used to describe the relation of deaths to the population in which they occur. The mortality rate (death rate) expresses the number of deaths in a unit of population within a prescribed time and may be expressed as crude death rates (e.g., total deaths in relation to total population during a year) or as death rates specific for diseases and, sometimes, for age, sex, or other attributes (e.g., number of deaths from cancer in white males in relation to the white male population during a given year).
Need	In health services, need has a normative connotation (i.e., the amount of a good or service which should be consumed). Because of the technical nature of medical care this value judgment is generally made by the health professional, rather than the consumer of the services. In health planning, need is the appropriate amount of health facilities and services required for a given area.
Neighborhood Health Center	An ambulatory health care program usually serving a catchment area which has scarce or nonexistence health services or population with special health needs and is often known as a community health center. Neighborhood health centers attempt to coordinate Federal, State, and local resources in a single organization capable of delivering both health care and related social services to a defined population.
Nurse	An individual trained to care for the sick, aged, or injured. A nurse can be defined as a professional qualified by education and authorized by law to practice nursing. There are many different types, specialties, and grades of nurses.
Nurse Practitioner	A registered nurse qualified and specially trained to provide primary care, including primary health care in homes and in ambulatory care facilities, long-term care facilities, and other health care institutions. Nurse practitioners generally function under the supervision of a physician but not necessarily in his or her presence. They are usually salaried rather than reimbursed on a fee-for-service basis, although the supervising physician may receive fee-for-service reimbursement for their services.
Nursing Home	Includes a wide range of institutions which provide various levels of maintenance and personal or nursing care to people who are unable to care for themselves and who have health problems which range from minimal to very serious. The term includes free-standing institutions, or identifiable components of other health facilities which provide nursing care and related services, personal care, and residential care. Nursing homes include skilled nursing facilities and extended care facilities but not boarding homes.
OBRA	Omnibus Budget Reconciliation Act
Occupancy Rate	A measure of inpatient health facility use, determined by dividing available bed days by patient days. It measures the average percentage of a hospital's beds occupied and may be institution-wide or specific for one department or service.

Occupational Health Services	Health services concerned with the physical, mental, and social well-being of an individual in relation to his or her working environment and with the adjustment of individuals to their work. The term applies to more than the safety of the workplace and includes health and job satisfaction. In the U.S., the principal Federal statute concerned with occupational health is the Occupational Safety and Health Act administered by the Occupational Safety and Health Administration (OSHA) and the National Institute of Occupational Safety and Health (NIOSH).
Open Enrollment	A method for assuring that insurance plans, especially prepaid plans, do not exclusively select good risks. Under an open enrollment requirement, a plan must accept all who apply during specific period each year.
Outpatient	A patient who is receiving ambulatory care at a hospital or other facility without being admitted to the facility. Usually, it does not mean people receiving services from a physician's office or other program which also does not provide inpatient care.
Passive Intervention	Health promotion and disease prevention initiatives which do not require the direct involvement of the individual (e.g., fluoridation programs) are termed "passive". Most often these types of initiatives are Government sponsored.
Peer Review	Generally, the evaluation by practicing physicians or other professionals of the effectiveness and efficiency of services ordered or performed by other members of the profession (peers). Frequently, peer review refers to the activities of the Professional Review Organizations, and also to review of research by other researchers.
Personal Responsibility and Work Opportunity Reconciliation Act of 1996	Conference Agreement for HR 3734: Public Law 104-193. Federal and welfare reform passed by the United State Congress on July 31, 1996 (U.S. House) and August 1, 1996 (U.S. Senate) and signed into law by Pres. Clinton on August 22, 1996. "Ends welfare as we know it."
Physician Assistant (PA)	Also known as a physician extender, a PA is a specially trained and licensed or otherwise credentialed individual who performs tasks, which might otherwise be performed by a physician, under the direction of a supervising physician.
Point of Service	A health insurance benefits program in which subscribers can select between different delivery systems (i.e., HMO, PPO and fee-for-service) when in need of medical services, rather than making the selection between delivery systems at time of open enrollment at place of employment. Typically, the costs associated with receiving care from HMO providers are less than when care is rendered by PPO or noncontracting providers.

Poverty Area	An urban or rural geographic area with a high proportion of low income families. Normally, average income is used to define a poverty area, but other indicators, such as housing conditions, illegitimate birth rates, and incidence of juvenile delinquency, are sometimes added to define geographic areas with poverty conditions.
Preferred Provider Arrangement (PPA)	Selective contracting with a limited number of health care providers, often at reduced or pre-negotiated rates of payment.
Preferred Provider Organization (PPO)	Formally organized entity generally consisting of hospital and physician providers. The PPO provides health care services to purchasers usually at (discounted rates in return for expedited claims payment and a somewhat predictable market share. In this model, consumers have a choice of using PPO or non-PPO providers; however, financial incentives are built in to benefit structures to encourage utilization of PPO providers.
Prevailing Charge	One of the factors determining a physician's payment for a service under Medicare, set at a percentile of customary charges of all physicians in the locality.
Prevalence	The number of cases of disease, infected persons, or persons with some other attribute, present at a particular time and in relation to the size of the population from which drawn. It can be a measurement of morbidity at a moment in time, e.g., the number of cases of hemophilia in the country as of the first of the year.
Preventive Medicine	Care which has the aim of preventing disease or its consequences. It includes health care programs aimed at warding off illnesses (e.g., immunizations), early detection of disease (e.g., Pap smears), and inhibiting further deterioration of the body (e.g., exercise or prophylactic surgery). Preventive medicine developed following discovery of bacterial diseases and was concerned in its early history with specific medical control measures taken against the agents of infectious diseases. Preventive medicine is also concerned with general preventive measures aimed at improving the healthfulness of the environment. In particular, the promotion of health through altering behavior, especially using health education, is gaining prominence as a component of preventive care.
Primary Care	Basic or general health care focused on the point at which a patient ideally first seeks assistance from the medical care system. Primary care is considered comprehensive when the primary provider takes responsibility for the overall coordination of the care of the patient's health problems, be they biological, behavioral, or social. The appropriate use of consultants and community resources is an important part of effective primary care. Such care is generally provided by physicians but is increasingly provided by other personnel such as nurse practitioners or physician assistants.
Primary Prevention	The prevention of an illness or disease before any symptoms manifest themselves.

Provider	Hospital or licensed health care professional or group of hospitals or health care professionals that provide health care services to patients. May also refer to medical supply firms and vendors of durable medical equipment.
Public Good	A good or service whose benefits may be provided to a group at no more cost than that required to provide it for one person. The benefits of the good are indivisible and individuals cannot be excluded. For example, a public health measure that eradicates smallpox protects all, not just those paying for the vaccination.
Public Health	The science dealing with the protection and improvement of community health by organized community effort. Public health activities are generally those which are less amenable to being undertaken by individuals or which are less effective when undertaken on an individual basis and do not typically include direct personal health services. Public health activities include: immunizations; sanitation; preventive medicine, quarantine and other disease control activities; occupational health and safety programs; assurance of the healthfulness of air, water, and food; health education; epidemiology, and others.
QMB	Qualified Medicare Beneficiary
Quality of Care	Can be defined as a measure of the degree to which delivered health services meet established professional standards and judgments of value to the consumer. Quality may also be seen as the degree to which actions taken or not taken maximize the probability of beneficial health outcomes and minimize risk and other untoward outcomes, given the existing state of medical science and art. Quality is frequently described as having three dimensions: quality of input resources (certification and/or training of providers); quality of the process of services delivery (the use of appropriate procedures for a given condition); and quality of outcome of service use (actual improvement in condition or reduction of harmful effects).
Rate	A measure of the intensity of the occurrence of an event. For example, the mortality rate equals the number who die in one year divided by the number at risk of dying. Rates are usually expressed using a standard denominator such as 1,000 or 100,000 persons.
Rehabilitation	The combined and coordinated use of medical, social, educational, and vocational measures for training or retraining individuals disabled by disease or injury to the highest possible level of functional ability. Several different types of rehabilitation are distinguished: vocational, social, psychological, medical, and educational.
Reimbursement	The process by which health care providers receive payment for their services. Because of the nature of the health care environment, providers are often reimbursed by third parties who insure and represent patients.

Reinsurance	The resale of insurance products to a secondary market thereby spreading the costs associated with underwriting.
Screening	The use of quick procedures to differentiate apparently well persons who have a disease or a high risk of disease from those who probably do not have the disease. It is used to identify high risk individuals for more definitive study or follow-up. Multiple screening (or multiphasic screening) is the combination of a battery of screening tests for various diseases performed by technicians under medical direction and applied to large groups of apparently well persons.
Secondary Care	Services provided by medical specialists who generally do not have first contact with patients (e.g., cardiologist, urologists, dermatologists). In the U.S., however, there has been a trend toward self-referral by patients for these services, rather than referral by primary care providers. This is quite different from the practice in England, for example, where all patients must first seek care from primary care providers and are then referred to secondary and/or tertiary providers, as needed.
Secondary Prevention	Early diagnosis, treatment and follow-up. Secondary prevention activities start with the assumption that illness is already present and that primary prevention was not successful and the goal is to diminish the impact of disease or illness through early detection, diagnosis and treatment. For example, blood pressure screening, treatment, and follow up programs.
Service Period	Period of employment that may be required before an employee is eligible to participate in an employer-sponsored health plan, most commonly one to three months.
Severity of Illness	A risk prediction system to correlate the "seriousness" of a disease in a particular patient with the statistically "expected" outcome (e.g., mortality, morbidity, efficiency of care). Most effectively, severity is measured at or soon after admission, before therapy is initiated, giving a measure of pretreatment risk.
Skilled Nursing Facility (SNF)	A nursing care facility participating in the Medicaid and Medicare programs which meets specified requirements for services, staffing and safety.
SLAG	State Legalization Impact Assistance Grant
SLIMB	Special Low-Income Medicare Beneficiary

Sole Community Hospital (SCH)	A hospital which (1) is more than 50 miles from any similar hospital, (2) is Hospital (SCH) 25 to 50 miles from a similar hospital and isolated from it at least one month a year as by snow, is the exclusive provider of services to at least 75 percent of its service area populations, (3) is 15 to 25 miles from any similar hospital and is isolated from it at least one month a year, or (4) has been designated as an SCH under previous rules. The Medicare DRG program makes special optional payment provisions for SCHs, most of which are rural, including providing that their rates are set permanently so that 75 percent of their payment is hospital-specific and only 25 percent is based on regional DRG rates.
Spend Down	The amount of expenditures for health care services, relative to income, that qualifies an individual for Medicaid in States that cover categorically eligible, medically indigent individuals. Eligibility is determined on a case-by-case basis.
STD	Sexually transmitted diseases
Survey	An investigation in which information is systematically collected. A population survey may be conducted by face-to-face inquiry, by self-completed questionnaires, by telephone, by postal service, or in some other way. Each method has its advantages and disadvantages. The generalizability of results depends upon the extent to which those surveyed are representative of the entire population.
Symptomatic	Someone who has symptoms of a disease or illness is symptomatic. Someone who has smoked all his/her life and has a heavy cough is said to be symptomatic. A heavy lifelong smoker who has not yet developed symptoms is said to be pre-symptomatic.
Technology Assessment	A comprehensive form of policy research that examines the technical, economic, and social consequences of technological applications. It is especially concerned with unintended, indirect, or delayed social impacts. In health policy, the term has come to mean any form of policy analysis concerned with medical technology, especially the evaluation of efficacy and safety.
Temporary Assistance for Needy Families (TANF)	The federal block grants to states for assistance payments. Replaces the entitlement program known as Aid to Families with Dependent Children (AFDC).
Tertiary Care	Services provided by highly specialized providers (e.g., neurologists, neurosurgeons, thoracic surgeons, intensive care units). Such services frequently require highly sophisticated equipment and support facilities. The development of these services has largely been a function of diagnostic and therapeutic advances attained through basic and clinical biomedical research.

Tertiary Prevention	Prevention activities which focus on the individual after a disease or illness has manifested itself. The goal is to reduce long-term effects and help individuals better cope with symptoms.
Third-Party Payer	Any organization, public or private, that pays or insures health or medical expenses on behalf of beneficiaries or recipients. An individual pays a premium for such coverage in all private and in some public programs; the payer organization then pays bills on the individual's behalf. Such payments are called third-party payments and are distinguished by the separation among the individual receiving the service (the first party), the individual or institution providing it (the second party), and the organization paying for it (third party).
Title XVIII (Medicare)	The title of the Social Security Act which contains the principal legislative authority for the Medicare program and therefore a common name for the program.
Title XIX (Medicaid)	The title of the Social Security Act which contains the principal legislative authority for the Medicaid program and therefore a common name for the program.
UMAP	Utah Medical Assistance Program
Uncompensated Care	Service provided by physicians and hospitals for which no payment is received from the patient or from third-party payers. Some costs for these services may be covered through cost-shifting. Not all uncompensated care results from charity care. It also includes bad debts from persons who are not classified as charity cases but who are unable or unwilling to pay their bill.
Underinsured	People with public or private insurance policies that do not cover all necessary medical services, resulting in out-of-pocket expenses that exceed their ability to pay.
Uninsured	People who lack public or private health insurance.
Usual, Customary and Reasonable (UCR) Fees	The use of fee screens to determine the lowest value of physician and Reasonable reimbursement based on: (1) the physician's usual charge for a given procedure, (2) the amount customarily charged for the service by other physicians in the area (often defined as a specific percentile of all charges in the community), and (3) the reasonable cost of services for a given patient after medical review of the case.
Utilization	Use; commonly examined in terms of patterns or rates of use of a single service or type of service, e.g., hospital care, physician visits, prescription drugs. Use is also expressed in rates per unit of population at risk for a given period.

Vital Statistics

Statistics relating to births (natality), deaths (mortality), marriages, health, and disease (morbidity). Vital statistics for the United States are published by the National Center for Health Statistics.

WIC

Women, Infant, and Children supplemental food program

Wellness

A dynamic state of physical, mental, and social well-being; a way of life which equips the individual to realize the full potential of his or her capabilities and to overcome and compensate for weaknesses; a lifestyle which recognizes the importance of nutrition, physical fitness, stress reduction, and self-responsibility. Wellness has been viewed as the result of four key factors over which an individual has varying degrees of control: human biology, environment, health care organization (system), and lifestyle.