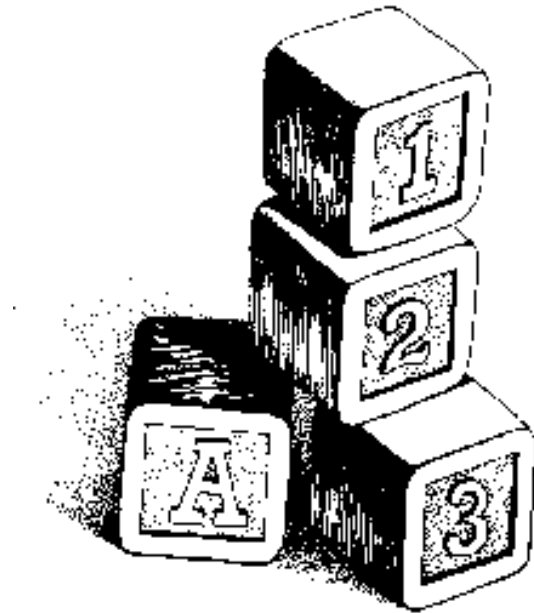


# The ABCs of Health Care in Oregon



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## ***GLOSSARY OF TERMS***

### ***USED IN OREGON AND U.S. HEALTH POLICY***

**Access** – Term commonly used to describe the ability to obtain health care services. Access to health care may be compromised by inability to pay, lack of available providers/resources or social/cultural factors.

**Acute Care** – Health care received in response to a particular episode of illness or injury, as opposed to chronic or preventive care.

**Administrative Costs** – Used in the context of third party payers, includes those monies *not* disbursed in the form of paid claims, i.e., general overhead expenses like payroll, facility costs, equipment, printing and mailing, professional fees, etc. For publicly funded programs, this term refers to costs incurred for other than direct services.

**Admitting Privileges** – Status granted to a health care practitioner by the governing board of a health care facility, usually upon recommendation of the professional staff. Based on provider's license, education, training, and level of experience.

**Adult and Family Services (AFS)** – A division of the Oregon Department of Human Resources. The branch of state government that provides cash grants, food stamps, job services and child care to low income families in Oregon.

**Advance Directives** – Legal documents that instruct caregivers regarding a patient's wishes for medical treatment under specified conditions, generally anticipating a time when the patient will be unable to consent. See *Living Wills*.

**Ambulatory** – Health care services that do not require overnight or in-patient care. Also called outpatient care.

**Ambulatory Care Sensitive Conditions (ACSC)** – Hospital admissions that can be largely avoided if sufficient and timely outpatient care is received. ACSC admissions are a subset of medical problems that are said to evidence failures of the ambulatory care system.

**Ancillary** – Support services in hospitals or outpatient settings, including x-rays and laboratory services.

**Area Agency on Aging (AAA)** – Local councils set up to conduct planning and review of aging services. Usually operated by a county or Council of Government

(COG)

**Area Health Education Center (AHEC)** – A private, non-profit organization whose primary goals are to improve the distribution, supply, quality, utilization, and efficiency of health personnel in rural and medically underserved areas. AHEC programs in Oregon are administered by the School of Medicine, Oregon Health Sciences University and represent a partnership between the state and federal governments. The individual centers are used to identify local health care needs, augment existing health care systems, support current practitioners, provide information to the public and educate and train personnel.

**Balanced Budget Act of 1997 (BBA)** – A comprehensive set of laws passed by Congress in August 1997 primarily intended to balance the federal budget by the year 2002. In doing so, the BBA cuts Medicare spending by \$100 billion over five years and makes significant changes to the way Medicare and Medicaid programs are funded and organized.

**Bed Days** – A commonly used formula among health services analysts, which expresses number of hospital inpatient days per 1000 population. The formula is usually computed for a defined population, such as enrollees in a health plan.

**Beneficiary** – The person who is entitled to services under a third party payment plan; employees and their dependents may also be beneficiaries. Also called subscriber, member or enrollee.

**Benefits** – The specific services members are entitled to use in their health plan. May be flexible benefits from which employees choose the types of coverage they want or can be standard benefit packages that employers buy and offer to their employees

**Block Grant** – Type of federal grant that delegates broad responsibility for federal programs to individual states which then have substantial discretion as to the use of the federal grant dollars. Under the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35), seven block grant programs were established, including a primary care block grant. At the option of each state, the state may apply for a primary care block grant, which includes Community Health Center and the Primary Care Research and Demonstration programs.

**Blue Cross/Blue Shield** – Types of insurance called service plans that were formed in the 1930s and exempted from federal taxes. Most Blue Cross plans were initially physician-owned and controlled, and covered physician costs, while Blue Shield organizations covered hospital costs. Found in every state, they are not one national organization and have different benefits, premiums and policies, although they have only recently begun offering HMO products.

**Board Certified** – A health care practitioner who has passed the national examinations in a particular field of specialty. Boards, e.g., the American Academy of Family Practice, are private, nonprofit organizations that are not government affiliated.

**Board Eligible** – A health care practitioner who has completed the training necessary to take examinations for board certification.

**Bureau of Primary Health Care (BPHC)** – (formerly Bureau of Health Care Delivery and Assistance – BHCDA) – The federal government agency within the Health Resources and Services Administration, Public Health Service, Department of Health and Human Services, responsible for administering several community health programs, including the Community Health Center program, the Migrant Health Program and the Maternal and Child Health program. BPHC also administers the National Health Service Corps and Health Services Scholarships programs.

**Capitation** – Third party payment system in which providers are paid a contracted amount in advance (usually monthly) per enrolled person regardless of the volume of services provided.

**Case Management** – Process of having a patient's varied health care needs coordinated by using an ongoing individualized plan. Professional case managers may work for health plans, large providers or be independent contractors.

**Centers for Medicare & Medicaid Services (CMS)** – The federal agency responsible for administering the Medicaid and Medicare programs.

**Certificate of Need (CON or CN)** – Designed to control health care costs by eliminating duplication of services or unnecessary new technologies, CON laws were first passed by Congress in 1974 and administered by the states. In 1987, Congress repealed the CON law, but many states, including Oregon, retained the program in a modified form. The Oregon Health Division must currently approve significant new health services, including new hospital beds, major medical equipment and nursing home beds.

**Childrens Health Insurance Program (CHIP)** – A federal program passed in 1997 allocating approximately \$24 billion over five years to provide health insurance coverage to low income children who are not already eligible for Medicaid. CHIP offers states an enhanced matching rate and provides states with considerable flexibility in designing their programs, which may consist of simple Medicaid expansion or separate insurance-based models. Also referred to as **SCHIP**.

**Chronic Illness** – A medical condition of a continuing nature that may result in life-long care needs.

**Claims** – Bills for services sent by health care providers to third party payers.

**Clinician** – A health care professional directly involved with patient care. Primarily used to describe practicing physicians, nurses or physician assistants as opposed to researchers and administrators.

**Co-insurance** – The share of health care premiums paid by the insured person.

**Co-payment** – A flat fee (e.g., \$5 per visit or \$10 per prescription) collected from the patient at the time of service, usually under a managed care health plan like an HMO.

**Coalition of Local Health Officials:** A private, nonprofit group comprised primarily of officials from local health departments and established for the purpose of advocating for locally delivered public health needs in Oregon.

**Commercial Insurers** – Generally refers to for-profit insurance companies that typically offer products that pay for health care on a fee-for-service basis. Also called "indemnity" plans.

**Common Procedural Terminology (CPT)** – A set of codes commonly used by health care providers to bill for patient services. The codes identify what services were provided and are used to determine the amount of payment.

**Community and Migrant Health Centers** – Offering primary care health care services for the underserved, uninsured and special populations, these clinics exist with the support of donations, grants and fundraising. They are also referred to as Federally Qualified Health Centers (FQHCs), and their federal support is authorized under Sections 329 and 330 of the Public Health Services Act.

**Community Mental Health Center (CMHC)** – A publicly funded or private non-profit entity, which provides ambulatory mental health, services to individuals within a geographic catchments area. Services are generally available to the public on a sliding fee scale.

**CONET:** A network of hospitals in Central/Eastern Oregon formed to address regional rural hospital concerns. Includes hospitals in Bend, Redmond, Madras, Prineville, Lakeview, John Day and Burns.

**Conference of Local Health Officials (CLHO)** – An organization of county health department officials charged by Oregon statute with advising the Health Division on matters relating to local public health needs.

**Cost-based reimbursement** – A payment method whereby the provider of services

is paid based on costs incurred to provide the service. Prior to 1983, Medicare paid all hospitals on a cost-based formula and in Oregon; eligible rural hospitals receive cost-based Medicaid reimbursement. Federally-qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) also receive a type of cost-based reimbursement. See *FQHC, RHC*.

**Council of Government (COG)** – A regional grouping of county governments to coordinate planning, specific services and other regional activities.

**Credentialing** – The process of reviewing a health care practitioner's licensure, certification, experience and history before granting employment or hospital medical staff privileges.

**Critical Access Hospital (CAH)** – A limited service rural hospital made possible by the Medicare Rural Hospital Flexibility Program (MRHFP), passed by Congress in 1997. CAH's have 15 or fewer beds, maximum 96-hour lengths of stay and a network relationship with a larger hospital. They are paid by HCFA on a reasonable cost basis for both inpatient and outpatient services.

**Custodial Care** – Basic ongoing personal or nursing care for an incapacitated patient with a terminal or chronic illness.

**Deductible** – The amount of medical expense an individual or family must incur from their own funds before insurance starts to cover their medical expenses.

**U.S. Department of Health and Human Services (DHHS)** – Formerly called the Department of Health, Education and Welfare, this is the federal agency responsible for administering most health-related programs.

**Department of Human Resources (DHR)** – The Oregon "umbrella" agency which contains divisions covering the range of health and social services, e.g., the Health Division, the Senior and Disabled Services Division and Children's Services Division.

**Diagnosis Related Group (DRG)** – A prospective hospital payment system utilized by Medicare (and in a modified form, by Medicaid) beginning in 1983 and replacing cost-based reimbursement. Hospitals are paid a flat fee based on a formula of expected costs.

**Disproportionate Share Hospital (DSH)** – A federal designation given to a hospital that provides services to a relatively large number of low-income patients. This designation allows for a higher rate of reimbursement.

**Durable Medical Equipment (DME)** – Equipment that serves a specific medical purpose, such as wheelchairs, artificial limbs, and other non-disposable

equipment.

**Durable Power of Attorney for Health Care** – an advance directive authorized by Oregon law that allows a competent person to designate a willing "surrogate" to make health care decisions in the absence of ability to consent to treatment. *See Living Wills, Advance Directives.*

**Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT)** – A long-standing pediatric Medicaid program which stresses preventive medicine for children, consists of a specified set of services and is reimbursed separately from general primary care.

**Elective** – Health care procedure that is not an emergency and that the patient and practitioner plan in advance.

**Emergency Medical Services (EMS)** – Systems that provide emergency medical care to a specific population. The Health Division coordinates Oregon's EMS systems.

**Emergency Medical Technician (EMT)** – A paramedical professional trained in emergency medical care. There are three levels of EMTs, varying by the amount and sophistication of training received.

**Employer Contribution** – The amount a company pays for its employees' health care premiums. The amount and method of the contribution varies widely and may be a function of collective bargaining agreements.

**Employer Mandate** – One of several methods proposed, on the state and federal levels, to finance and expand health insurance coverage. Employers would be required to pay part or all of their employees' health insurance premiums. In Oregon, an employer mandate is scheduled to take effect in 1997 and affect all employees who work more than 17.5 hours per week.

**Essential Access Community Hospital (EACH)** – A full service rural hospital, which is, affiliated with one or more smaller Rural Primary Care Hospitals (RPCBs) under the federal EACH/RPCH demonstration program. The RPCH serves fundamentally as a referral and transfer facility, and the EACH as the receiving facility.

**Family Health Insurance Assistance Program (FHIAP)** – An Oregon program passed by the 1997 legislature that subsidizes insurance premiums for uninsured and underinsured low income families who are not eligible for Medicaid.

**Federally Qualified Health Center (FQHC)** – A clinic supported by the US Public Health Service that is either in a federally-designated medically underserved area (MUA) or serving a medically underserved population (MUP). FQHCs receive cost-based Medicare and Medicaid reimbursement (except that, under the Oregon

Health Plan, the Medicaid payment methodology is waived) and may be classified as Community Health Centers (CHCs), Migrant Health Centers (MHCs) or FQHC "look-alikes," which receive no grant funds.

**Fee-for-Service (FFS)** – The historically dominant system of paying for health care services in the U.S. Under this system, providers simply send a bill to the patient and/or insurance company for services rendered and is paid their usual and customary fee.

**Fee Schedule** – A list of services and the negotiated amount health plans or insurers will pay for those specific services.

**Flexible Benefits** – Also called "cafeteria style" benefits, this is an employee benefit plan under which employees are allocated a specific amount of "benefit dollars" and are then allowed to choose from a "menu" of health care and other benefits according to their own needs.

**Frontier Area** – An area with six or fewer people per square mile. Oregon has 10 frontier counties.

**Geographic Classification Review Board (GCRB)** – The board within HCFA that determines which hospitals can be reclassified for purposes of Medicare reimbursement. Reclassified hospitals generally receive higher payments from Medicare.

**Graduate Medical Education (GME)** – Medical education undertaken after conferral of the M.D. or D.O., including internship, residency, fellowships, and continuing education.

**Health and Human Services, United States Department of** – the U.S. government's principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves. HHS works closely with state, local, and tribal governments, and many HHS-funded services are provided at the local level by state, county or tribal agencies, or through private sector grantees. In addition to the services they deliver, the HHS programs provide for equitable treatment of beneficiaries nationwide, and they enable the collection of national health and other data.

**Health Care Coalition of Southern Oregon (HCCSO):** a coalition of public and private health care providers in Jackson, Josephine and Douglas counties that serve low income patients.

**Healthcare Experts for Rural Oregon (HERO)** – Recruitment and retention services coordinated by Scott Ekblad from the Office of Rural Health.

**Health Care Financing Administration (HCFA)** – Former name of Centers for Medicare and Medicaid Services (CMS)

**Health Care Reform** – refers to changes to the health care delivery system, how it is structured, how it is financed, and how people obtain access to care.

**Health Insurance Portability and Accountability Act of 1996 (HIPAA)** – Written by the federal Health and Human Services agency (HHS) to provide specific direction regarding the security and confidentiality of health information, as well as the standardization of transaction standards and code sets, and how health care information is billed and identified.

**Health Maintenance Organization (HMO)** – A system of coordinated care, which delivers a basic set of health, services to a group of enrollees. The HMO generally receives capitated payments from individuals, employers or the government.

**Health Professional Shortage Area (HPSA)** – An area designated by the Secretary of DHHS as having an acute shortage of health care providers and therefore eligible for various federal benefits. Designations are originated on the state level; in Oregon, the Health Division's Primary Care Program coordinates this activity.

**Health Resources and Services Administration** – Part of DHHS.

**Home Health Agency (HHA)** – An agency that provides skilled nursing care and some therapeutic services in the home to the aged, disabled, sick, or convalescent.

**Home Health Care** – Services provided to people in their own homes. Third party payers cover some services, but other services may not be covered because they are not deemed medically necessary. In order to be eligible for Medicare reimbursement, home health services must be delivered by a certified HHA.

**Hospice** – Facilities or programs for terminally ill people. Hospice programs focus on helping the patients and families through the death and dying process rather than prolonging life with additional medical interventions.

**Indemnity** – Once the most common type of health insurance in the United States, where the insurer pays for billed services after the services have been provided, as long as the service is covered. See *Fee-for-Service*.

**Infant Mortality Rate (IMR)** – The number of infants who die in their first year of life per 1,000 live births.

**Inpatient** – Services provided to a patient who has been admitted to a hospital and

has occupied a hospital bed for at least 24 hours.

**Joint Commission on the Accreditation of Healthcare Organizations (JCAHO)** – A private, nonprofit organization that accredits health care organizations and agencies. Used to be called Joint Commission on Accreditation of Hospitals. Accreditation is not usually required for licensure, but is increasingly required for third party reimbursement.

**Licensed Facilities** – Usually a function reserved for states, licensing is usually required for hospitals, outpatient surgical facilities, hospices and long term care facilities. The federal government licenses Veterans Administration hospitals and Indian health centers.

**Living Will** – A legal document people use to instruct their health care providers regarding the level of care they desire in the event of incapacitation. See *Advance Directives*.

**Loan Repayment Program** – Term used to describe benefits, either state or federal, which offer total or partial repayment of educational loans to health care practitioners who agree to meet specified conditions, e.g., practice in a medically underserved or rural area. Oregon's Rural Services Program offers benefits to physicians, nurse practitioners and physician assistants and is administered by the Oregon Student Assistance Commission.

**Long Term Care (LTC)** – Non-acute care provided to persons with chronic illnesses in non-hospital settings, e.g., nursing homes, adult foster care or home care.

**Malpractice Insurance** – Insurance that physicians and other health care providers purchase to protect themselves from lawsuits in the event they are sued by a patient.

**Managed Care** – An organized system of health care services, which may take a variety of forms. Usually features a full range of integrated health care services, facilities, and products and the patient's access to services is coordinated and managed by a primary care provider. Health maintenance organizations are the most conspicuous examples of managed care systems.

**Managed Care Plans** – Health insurance products characterized by managed care, i.e., organized and integrated health care delivery systems that can be HMOs or arrangements in which the plan and the practitioners share risk or have other financial incentives for efficient and appropriate patient care.

**Managed Competition** – A reform proposal designed to blend government regulation with marketplace competition, presumably incorporating managed care delivery systems.

**Mandated Benefits** – Specific health services enumerated in state statute which all health insurance plans issued in the state must offer, e.g., neonatal care, chiropractic care, substance abuse treatment and mental health services.

**Maternal and Child Health (MCH)** – Organized health services for mothers and their children. MCH programs take into account the risks of this group and work to provide preventive care, usually through a public health organization. Federal funds for MCH are made available through Title V of the Social Security Act.

**Medical Assistance Facility (MAF)** – A new category of hospital facility designed in Montana for the frontier areas of that state. Similar to the RPCH in the EACH/PCH program, the MAF offers a limited range of services. The program received a waiver from HCFA in 1991 to obtain Type A Medicare payment as a hospital. Served as a model for the Medicare Rural Hospital Flexibility Program (CAH).

**Medicaid** – Authorized by Title XIX of the Social Security Act, Medicaid is a health care program jointly administered by the states and the federal government which provides medical benefits for eligible low-income persons in one of five categories: (1) mothers and dependent children (AFDC); (2) aged; (3) blind; (4) disabled; (4) children in foster care. Oregon's Medicaid program is atypical because it has received a waiver to extend care to all persons under the federal poverty level.

**Medically Underserved Area (MUA)** – A geographic location, which has insufficient health resources (personnel and/or facilities) to meet the medical needs of the resident population. Health status of the resident population is also important in this federal designation. Obtaining designation as an MUA is a precondition to receiving community health center federal grant monies. There is sometimes a difference between state and federal criteria for designating medically underserved areas. See *HPSA*.

**Medicare** – Title XVIII of the Social Security Act of 1965 which helps pay for medical and health services for persons age 65 and over and persons who are disabled. This program is financed through Social Security deductions from employee/employer payrolls and is handled through national trust funds.

**Medicare Risk Contracts** – Arrangements between health plans and the Health Care Financing Administration in which the plan acts like an HMO and assumes the financial risk of providing Medicare benefits and supplemental benefits. The health plan is paid a flat fee per person per month. Beneficiaries in risk contracts must use only member providers.

**Medicare Rural Hospital Flexibility Program** – Federal program included in the 1997 Balanced Budget Act designed to preserve rural hospitals. In order to

participate in this program, states must have their state Rural Health Plan approved by HCFA. *See Critical Access Hospital.*

**Medicare Secondary Payer (MSP)** – An instance when Medicare acts as the secondary payer for medical services. For example, a private insurance plan acts as the primary payer, while Medicare pays the remainder of the bill.

**Medicare supplements or Medigap** – Individually purchased insurance policies that cover costs of health care services not covered by Medicare.

**Metropolitan Statistical Area (MSA)** – A federal designation referring to a geographic area with at least one city with a population of 50,000, an urbanized area with an equivalent population, and a total population of at least 100,000. Generally involves an entire county. Oregon's MSAs include Multnomah, Washington, Clackamas, Columbia, Yamhill, Polk, Marion, Lane and Jackson counties.

**Mid-level Practitioners** – Term sometimes used to describe advanced practice nurses, nurse practitioners and physician assistants

**Migrant Health Center (MHC)** – A type of FQHC funded under Section 329 of the Public Health Service Act. These centers provide health services to migrant workers and their families. *See FQHC, Community Health Center.*

**Morbidity** – A measure of the frequency, level of intensity and loss of function from accidents, illness or injury within a specific age, geographic, occupational or other specifically defined group. Morbidity measures describe the rate of illness or accidents, such as breast cancer in women or diabetes in Native Americans.

**Mortality** – Measures the death rate based on past statistical measures. Usually measured by sex and age and is expressed as a rate per 100,000 population.

**National Health Service Corps (NHSC)** – A federal program which offers incentives to physicians, nurse practitioners, physician assistants and dentists to practice in Health Professional Shortage Areas (HPSAs). In Oregon, NHSC programs are administered through a Primary Care Cooperative Agreement between the Health Division and the federal Bureau of Primary Care.

**National Rural Health Association** – A national membership organization whose mission is to improve the health and health care of rural Americans.

**Office for Health Plan Policy and Research (OHPPR)** – The Oregon agency that is the policy arm of the Oregon Health Plan and additionally addresses more comprehensive health policy issues.

**Office of Medical Assistance Programs (OMAP)** – The agency in Oregon that administers the federal/state Medicaid program and the Medicaid portion of the Oregon Health Plan.

**Office of Rural Health** – Oregon’s Office of Rural Health is one of 50 in the nation and was established by the state legislature in 1979. It is advised by the Oregon Rural Health Coordinating Council.

**Oregon Association of Hospitals and Health Systems** – A statewide organization working to enhance and promote community health and develop Oregon’s innovative healthcare industry.

**Oregon Health & Science University** – OHSU educates health and high–technology professionals, scientists, environmental engineers, and it undertakes the functions of patient care, community service and biomedical research. As the sole medical school in Oregon, OHSU affects the entire state.

**Oregon Health Plan** – first passed by the legislature in 1989 and authored by Senate President John Kitzhaber, this effort to offer universal health care to all Oregonians consists of three parts: (1) an expansion/reform of Medicaid to include all Oregonians whose income is less than the federal poverty level regardless of eligibility "category"; a risk pool that offers insurance coverage to Oregonians whose medical conditions have rendered them uninsurable; and (3) a mandate that all Oregon employers make health insurance available to their employees who work more than 17.5 hours per month. A unique feature of the plan is the ranking of condition–treatment pairs in numerical order based on cost–effectiveness and potential for successful outcome. Depending upon available funds, conditions "below the line" are not covered. Parts one and two of the plan have been implemented; part three has been repealed by the legislature. See *Medicaid, OMAP*.

**Oregon Medical Association** – The OMA promotes and provides leadership in the science of medicine, and improves and preserves the health of Oregon citizens.

**OMPRO** – A nonprofit organization dedicated to improving the quality and effectiveness of healthcare. Medicare has appointed OMPRO to ensure Medicare beneficiaries’ rights to good healthcare.

**Oregon Nurses Association** – A professional association and labor union, ONA represents registered nurses.

**Oregon Primary Care Association (OPCA)** – A nonprofit membership organization with members representing community based primary care clinics, and federally

supported community and migrant health centers.

**Oregon Revised Statutes (ORS)** – The compendium of state law in Oregon.

**Oregon Rural Health Association (ORHA)** – A nonprofit organization whose primary goal is to improve the health of rural Oregonians.

**Oregon Society of Physician Assistants** – The society promotes quality, cost effective and accessible health care, and to promote the professional and personal development of Physician Assistants.

**Oregon State Paramedics Association** – OSPA provides information, promotes communication, shared ideas, and encourages and assists First Responders and Emergency Medical Technicians at providing high quality EMS.

**Payer (Payor)** – Also called "third party payer." Any agency, insurer or health plan that pays for health care services in an organized fashion. Payers include the government (Medicare and Medicaid); commercial insurance such as Aetna and Travelers; employers' self-insured plans and nonprofit plans like Blue Cross/Blue Shield. See *Third Party Payer*.

**Peer Review** – The evaluation of specific health care services and procedures conducted by professionals who have similar training and background. Peer review is used to analyze quality of care, individual competency and the effectiveness of certain procedures. Practitioners who participate in peer review are protected by law from liability and peer review proceedings are confidential, i.e., not subject to discovery by plaintiff attorneys in a malpractice action.

**Physician** – generally used to describe doctors who have a Doctor of Medicine (MD) or a doctor of osteopathy (DO) degree. Oregon statute also allows naturopaths and chiropractors to refer to themselves as physicians.

**Physician Payment Review Commission (PPRC)** – A congressional commission created to find a more rational, cost-effective approach to Medicare physician payment. See *RBRVS*.

**Pre-existing Condition** – Insurance term used to describe a medical condition that has been discovered or treated prior to an individual applying for insurance coverage. Most insurers decline to cover pre-existing conditions for a specified length of time (six months to two years) or not at all. Serious pre-existing conditions may render an individual uninsurable and thereby eligible for Oregon's high risk pool.

**Preferred Provider Organization (PPO)** – An organized group of providers that contracts with a health plan or directly with employers to provide services at a

favorable rate. Enrollees are then offered financial incentives to use these providers exclusively, e.g., services from preferred providers are covered more generously.

**Preventive Care**– Health care services that stress regular testing, screenings and early intervention. Annual physicals and other preventive measures were traditionally not covered by insurance under a fee-for-service or indemnity system. Managed care generally stresses preventive care and rewards enrollees for seeking such care.

**Primary Care** – Basic level of health care usually rendered by general practitioners, family physicians, internists, pediatricians, and more recently, mid-level practitioners. This entry-level care emphasizes caring for the patient's comprehensive health needs as opposed to a more specialized or fragmented approach to medical care. Obstetricians and gynecologists are sometimes designated as primary care physicians.

**Prior Authorization** – A cost-control procedure which requires a medical service or medication to be approved in advance by the doctor and/or the insurer. Without prior authorization, the health plan or insurer usually will not pay for the service.

**Prospective Payment System (PPS)** – Medicare's system of paying hospitals by setting rates prior to the provision of the service, based on the patient's diagnosis. See *Diagnosis Related Groups*.

**Professional Standards and Review Organization (PRO)** – Local private, nonprofit organizations that contract with the federal government to review and monitor the quality and effectiveness of health services that are paid for with federal funds, e.g., Medicare and Medicaid.

**ProPAC** – A commission established by Congress to maintain and update the prospective payment system of Medicare. The Commission works to assure access to health care and encourages productivity and cost-effectiveness within the industry. See *Diagnosis Related Groups, Medicare*.

**Provider** – Describes people and/or institutions that give health care services and includes physicians, hospitals, nurses, chiropractors, social workers or any other licensed health care practitioner or entity.

**Public Health Service, U.S. (PHS)** – A principal operating component of DHHS concerned with administering public health programs, including the Indian Health Service, biomedical research, health professionals training, family planning, emergency medical services, health maintenance organizations, community health programs, and health planning.

**Qualified Medicare Beneficiary** – Someone who qualifies for Medicare, but whose income is at or below the poverty level. The state must pay for the person's Part B payment as well as their co-payments and deductibles.

**Quality Assurance** – Term used by health care industry to describe method by which quality patient care is provided and maintained. May include peer review, employee performance reviews, patient satisfaction surveys, hospital tissue committee, morbidity and mortality conferences and other measures.

**Referral** – May refer to (1) an informal suggestion from one provider for the patient to see another provider or (2) a more formal process within managed care plans by the primary care doctor to specialists, hospitals, or other services. Within the context of managed care, primary care physicians may be financially at risk for the cost of referrals and thereby have an incentive to minimize unnecessary referrals.

**Resource-Based, Relative Value System (RBRVS)** – An index that assigns relative values to each medical service provided by a physician. The values represent the relative amount of resources, including time and overhead, involved in providing each service. The Medicare fee schedule for physician compensation utilizes RBRVS. See *Physician Payment Review Commission, Medicare*.

**Rural Health Clinic (RHC)** – A type of payment system for clinics located in a rural HPSA or MUA, created by Congress with two goals in mind: (1) to encourage the utilization of mid-level practitioners by providing full reimbursement for their services to Medicare and Medicaid patients, even in the absence of a full time physician; and (2) to create a cost-based reimbursement mechanism for rural primary care practices that will allow them to operate in an area that would not otherwise financially support a clinic. The Oregon Health Plan waives cost-based reimbursement for Medicaid patients served by Rural Health Clinics. In Oregon, the Health Division certifies RHCs.

**Rural Health Coordinating Council (RHCC)** – An 18-member, five are governor-appointed, group created by the 1979 Oregon Legislature and staffed by the Office of Rural Health. The RHCC's responsibilities include advising the Office of Rural Health, assisting in distribution of community grant funds and rural health policy development.

**Rural Information Center (RIC/RICHS)** – A national clearinghouse for those seeking information about rural health issues. Joint project of the federal Office of Rural Health Policy and the USDA's National Agricultural Library.

**Rural Primary Care Hospital (RPCH)** – A new type of limited service health care facility with no more than six beds which may use non-physician personnel to provide limited inpatient care for up to 72 hours and emergency services 24

hours/day. Currently authorized in only seven states as federally funded pilot project. See *Essential Access Community Hospital (EACH), Medical Assistance Facility and Critical Access Hospital*.

**Rural–Urban Commuting Area Codes (RUCA)** – a Census tract–based classification scheme that utilizes the standard Bureau of Census urban area and place definitions in combination with commuting information to characterize all of the nation's Census tracts regarding their rural and urban status and relationships. A collaborative project between Health Resources and Service Administration's (HRSA's) Federal Office of Rural Health Policy (FORHP), the Department of Agriculture's Economic Research Service (ERS), and the WWAMI Rural Health Research Center.

**Section 329** – The section of the Public Health Service Act, which authorizes the Migrant Health Program.

**Section 330** – The section of the Public Health Service Act, which authorizes the Community Health Center Program.

**Section 501 (c)(3) of the IRS Code:** The section of the Internal Revenue Services (IRS) code that defines the federal income tax exempt status of non–profit organizations that are organized and operated exclusively for charitable, religious, educational, scientific and/or literary purposes. To qualify as a Section 501 (c)(3) organization, no part of the organization's net earnings can be used to the benefit of private shareholders or individuals, nor can the organizations engage in activities to influence legislation. All donations to such organizations are deductible as charitable contributions. Other requirements presented in Section 501 (c)(3) may be reviewed by checking the IRS code.

**Self–funded/Self–insured** – Term used to describe large employers who contract with providers directly to render health services to their employees in lieu of traditional insurance products. To protect themselves against catastrophic losses, self–insured employers usually purchase a product called "reinsurance" that provides coverage beyond a certain limit, e.g., \$50,000.

**Service Area** – A rational geographical area for the provision of health care services. The Health Division and the Office of Rural Health define "service area" as the following:

1. Health resources are generally located within 30–40 minutes travel time.
2. Defined areas are not smaller than a single zip code and zip codes are geographically contiguous.
3. Defined area contains a population of more than 1,000 people.

4. Area constitutes a "rational" medical trade or market area considering topography, social and political boundaries and travel patterns. Additional considerations for service areas are boundaries that:
  - a. Are congruent with any existing special taxing districts (e.g., hospital or health districts);
  - b. Include a population that has local perception that it constitutes a "community of need" for primary health services or demonstrates demographic, socioeconomic or ethnic homogeneity. The population should be large enough (800 to 1000 people) to be financially capable of supporting at least a mid-level medical provider.

**Sliding Fee Scale** – A schedule of discounts in charges for services that is based on the consumer's ability to pay, according to income and family size. Bureau of Primary Health Care programs, such as the Community Health Center program, require that projects have sliding fee scales based upon the federal government poverty guidelines.

**Single Payer System** – A reform proposal that advocates paying for health care through one payer (usually proposed to be the government) rather than a multitude of existing payers, e.g., insurance companies, Medicare, Medicaid, etc.) Based on the Canadian model of health care delivery, this system would substitute tax levies for current insurance premiums and supplement those funds from other tax revenues to provide universal coverage.

**Socialized Medicine** – Health care system similar to the British model in which the government owns all facilities, professional staff and all citizens are guaranteed access to health care.

**Sole Community Hospital (SCH)** – A hospital designated as the sole provider of hospital services in a defined service area, thereby entitled to increased Medicare and Medicaid reimbursement.

**State Office of Rural Health (SORH)** – Entities under this name exist in all 50 states and all receive funds under a grant from the federal Office of Rural Health Policy, which must be supplemented, by state funds in a ratio of 3:1. SORHs work to improve access, recruit professionals, provide technical assistance, and call attention to the needs of the rural residents of their state. They may be housed in universities, state health departments, state hospital associations or freestanding.

**Tertiary Care** – Term used to describe the most specialized and highly technical health care, performed in a hospital setting.

**Third Party Payer (or Payor)** – An insurance company or government agency, such as Blue Cross/Blue Shield service plans or Medicare, that pays for hospital and

doctor bills and certain other health care services for subscribers. (First party = patient; second party = provider of service). Payment from these payers is commonly referred to as third party reimbursement. See *Payer/Payor*.

**Title XVIII** – Part of the Social Security Act, which authorizes the Medicare Program.

**Title XIX** – Part of the Social Security Act, which authorizes the Medicaid Program.

**Uncompensated Care** – Care a provider gives without being paid. Includes free care or charity care for people who have no insurance and cannot afford services, as well as bad debt.

**Underinsured** – People who have some type of health care insurance, but not enough insurance to cover all their health care costs such as co-payments and deductibles.

**Underwriting** – The process that analyzes the health status, claims experience, age, and general health risks of the individual or group seeking insurance coverage. This review determines the monthly premium for most groups or individuals and whether or not pre-existing condition clauses will be included. Underwriting may be done strictly on an experience basis or community-wide rating.

**Universal Coverage** – Term used to describe system under which all individuals would have some form of insurance coverage, financed through a combination of private and public funds.

**Utilization Management/Review** – The process health plans and insurers use to confirm that appropriate and cost effective patient care is being delivered. Utilization reviewers are usually specially trained health professionals, such as nurses.

**Veterans Administration** – An independent division of the federal government that offers health care services to veterans who have been injured in action during wars or have injuries that are a result of combat. Includes hospitals as well as outpatient care and nursing home care.

**Waiver** – Used in the health care context, refers to an exception to a particular law or regulation, usually federal. Not all federal laws relating to health care can be waived, but the Medicaid and Medicare laws are occasionally waived by HCFA for

the purposes of conducting a demonstration project such as the Oregon Health Plan.

**Women, Infants, and Children Program (WIC)** – A federally funded nutrition program for women, infants and young children that consists of nutrition supplements and counseling.

**Workers Compensation** – An insurance program paid by employers that covers injuries and work-related health problems of employees. The administration and efficacy of workers compensation programs is overseen by a state agency in Oregon, the Workers Compensation Division of the Department of Insurance and Finance.

## HEALTH CARE ACRONYMS

AAA	Area Agencies on Aging
ACSC	Ambulatory Care Sensitive Conditions
AFDC	Aid to Families with Dependent Children
AFS	Adult and Family Services
AHEC	Area Health Education Centers
AMA	American Medical Association
ANA	American Nurses Association
ANP	Adult Nurse Practitioner
BBA	Balanced Budget Act of 1997
BHCDA	Bureau of Health Care Delivery and Assistance (now BPHC)
BME	Board of Medical Examiners
BPHC	Bureau of Primary Health Care
CAH	Critical Access Hospital
CHC	Community Health Center
CHIP	Childrens Health Insurance Program
CMHC	Community Mental Health Center
CMS	Centers for Medicare and Medicaid Services
CNM	Certified Nurse Midwife
CLHO	Conference of Local Health Officials
COG	Council of Government
CON, CN	Certificate of Need
CNM	Certified Nurse Midwife
CPT	Common Procedural Terminology
DC	Doctor of Chiropractic
DHHS	U.S. Department of Health and Human Services
DHR	Department of Human Resources
DHS	Oregon Department of Human Services
DME	Durable Medical Equipment
DO	Doctor of Osteopathy
DPM	Doctor of Podiatric Medicine
DRG	Diagnosis Related Group
DSH	Disproportionate Share Hospital
EACH	Essential Access Community Hospital
EMS	Emergency Medical Services
EMT	Emergency Medical Technician
EPSDT	Early Periodic Screening, Diagnosis, and Treatment Program.
FHIAP	Family Health Insurance Assistance Program
FFS	Fee For Service
FNP	Family Nurse Practitioner
FP	Family Physician
FQHC	Federally Qualified Health Center
FTE	Full Time Equivalent

GCRB	Geographic Classification Review Board
GME	Graduate Medical Education
HCFA	Health Care Finance Administration
HERO	Healthcare Experts for Rural Oregon
HHA	Home Health Agency
HIPAA	Health Insurance Portability and Accountability Act of 1996
HMO	Health Maintenance Organization
HPSA	Health Professional Shortage Area
HRSA	Health Resources and Services Administration, part of DHHS
HHS	Health and Human Services
IM	Internal Medicine
IMR	Infant Mortality Rate
IPA	Independent Practice Association
JCAHO	Joint Commission on the Accreditation of Healthcare Organizations
LTC	Long Term Care
MAF	Medical Assistance Facility
MCH	Maternal and Child Health
MD	Medical Doctor
MHC	Migrant Health Center
MRHFP	Medicare Rural Hospital Flexibility Program
MSA	Metropolitan Statistical Area
MSFW	Migrant/Seasonal Farm Workers
MSP	Medicare Secondary Payor
MUA	Medically Underserved Area
MUP	Medically Underserved Population
ND	Doctor of Naturopathic Medicine
NHSC	National Health Service Corps
NP	Nurse Practitioner
NRHA	National Rural Health Association
OAHHS	Oregon Association of Hospitals and Health Systems
OB	Obstetrics
OBYN	Obstetrics/Gynecology
OHSU	Oregon Health & Science University
OMA	Oregon Medical Association
OMAP	Oregon Medical Assistance Program
OMPRO	Oregon Medical Professional Review Organization
ONA	Oregon Nurses Association
OPCA	Oregon Primary Care Association
ORH	Office of Rural Health
ORS	Oregon Revised Statutes
OSPA	Oregon Society of Physician Assistants
PA	Physician Assistant
PA-C	Physician Assistant, Certified
PA-S	Physician Assistant, Student
PCCM	Primary Care Case Manager

PCP	Primary Care Practitioner
PHS	Public Health Service
PNP	Pediatric Nurse Practitioner
PPO	Preferred Provider Organization
PPRC	Physician Payment Review Commission
PPS	Prospective Payment System
PRO	Professional Standards and Review Organization
RBRVS	Resource-Based, Relative Value System
RHC	Rural Health Clinic
RHCC	Rural Health Coordinating Council
RIC/RICHs	Rural Information Center/ Health Services
RNO	Rural Nurses' Organization
RPCH	Rural Primary Care Hospital
RUCA	Rural Urban Commuting Area Codes
SCH	Sole Community Hospital
SORH	State Office of Rural Health
SORHN	Southeastern Oregon Rural Health Network
VA	Veterans Administration
WHCNP	Women's Health Care Nurse Practitioner
WIC	Women, Infants, and Children Program

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