



ACCESS: The patient's ability to get medical care determined by factors such as the availability of medical services, their acceptability to the patient, the location of health care facilities, transportation, hours of operation, and the cost of care.

ACCOUNTABILITY: A procedure based on outcomes through which the process of care, service provider, or network is evaluated.

ACCREDITATION: Formal approval of a provider organization by an official agency using a set of industry-derived standards.

ACTIVITIES OF DAILY LIVING [ADLs]: Self-care activities a person performs daily like bathing, dressing, toileting and eating.

ACTUARY: A person in the insurance field who conducts statistical studies and decides policy rates.

ACUTE CARE: Medical services provided after an accident or for intensive treatment of a disease or disorder, usually for a short time.

ADMINISTRATIVE COSTS: The expenses incurred to operate a health plan, such as claims processing, billing, enrollment, and other overhead costs.

ADVERSE SELECTION: Occurs when those joining a health plan have higher medical costs than the general population; if too many enrollees have higher than average medical costs, the health plan experiences adverse selection.

AFTERCARE: Services that are administered following hospitalization or rehabilitation that are individualized for each patient's needs.

ALLIANCE: A group of providers who join together to increase their savings by sharing resources and developing group purchasing arrangements.

ALLOWABLE COSTS: Charges for services that are reimbursable under a given health plan.

ALTERNATIVE DELIVERY SYSTEMS (ADS): A general term referring to any organized method of providing health care other than private practice, fee-for-service reimbursement.

AMBULATORY CARE: Outpatient medical services (not provided in a hospital). If the patient makes the trip to the doctor's office of surgical center without an overnight stay, it is considered ambulatory care, but if he or she is treated at home, it is not.

AMBULATORY SETTING: A type of health care settings at which health services are provided on an outpatient basis. Ambulatory settings usually include clinics and surgery centers.

ANCILLARY CARE: Additional health care services performed, such as lab work and X-rays.

AT-RISK CONTRACTING: A contract arrangement between a payer and service provider that sets a limit on money spent for services provided based on the assumption that some populations may or may not use the services more than others.

AUTHORIZATION: As it applies to managed care, authorization is the approval of care, such as hospitalization. Preauthorization may be required before a patient is admitted or care is given by (or reimbursed to) non-HMO providers.

AVERAGE LENGTH OF STAY: The average number of days that an episode of care lasts, determined by the total number of days a treatment was necessary divided by the total number of episodes.

BEHAVIOR HEALTH CARE: Provided for the treatment of mental and/or substance abuse disorders.

BENEFITS: Health and related services guaranteed to be provided in a health plan.

BENEFICIARY: The person enrolled in the health plan.

CAPACITY: Ability of a health organization to provide necessary health services.

CAPITATION: A way of pre-paying a health plan, provider, or hospital for health services based on a fixed monthly or yearly amount per person, no matter how few or many services a consumer uses.

CARVE OUT: A program delivery and financing arrangement by which certain health care services, often for certain populations, are administered and funded separate from general health care services.

CASE MANAGEMENT: A process by which the services provided to a specific enrollee are coordinated and managed to achieve the best outcome in the most cost-effective manner.

CASE MIX: The number and frequency of hospital admissions or managed care services utilized, reflecting the assorted needs and uses of a hospital's or managed care organization's resources.

CATEGORICAL ELIGIBILITY: This refers to persons who qualify for coverage due to their membership in a given class or population, as opposed to income.

CERTIFICATION: Certification is the official authorization for use of services.

CLAIMS: Information submitted by a provider or covered person to establish that medical services were provided to a covered person, from which processing for payment to the provider or covered person is made.

CLAIMS REVIEW: The method by which an enrollee's health care service claims are reviewed before reimbursement is made. The purpose of this monitoring system is to validate the medical appropriateness of the provided services and to

be sure the cost of the service is not excessive.

COINSURANCE: The percentage of the costs of medical services paid by the patient. This is a characteristic of indemnity insurance plans and PPO plans. The coinsurance usually is about 20% of the cost of medical services after the deductible is paid.

COMMUNITY-BASED: Care that responds to the needs identified by the community and draws from that community to address those needs. Services are provided as near to the home as possible.

COMMUNITY-RATING: A method of setting premiums according to the expected use of the population as a whole, rather than the use of specific groups.

COMPREHENSIVE CARE: A system of care that covers primary (including prevention), secondary, and tertiary care and addresses physical health, mental health, nutrition, and oral health. The system integrates health and health related services with education, social services, and family support systems.

CONCURRENT REVIEW: An assessment of the medical necessary or appropriateness of services that occurs while they are being completed.

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA): A law that requires employers to offer continued health insurance coverage to employees who have had their health insurance coverage terminated.

CONSUMER: A person who receives and/or purchases services while also advocating for service quality and appropriateness.

CONSUMER SATISFACTION: The evaluation by a person concerning how well they liked the services they received and/or the manner in which they were provided.

CONTINUITY OF CARE: Comprehensive care that is provided during all transition, such as hospital to home, home to hospital, etc. Planning ensures linkages with education, health, and community resources.

CONTINUOUS QUALITY (CQI): A management principle that emphasizes the improvement, of the process of service delivery through the use of creative approaches, monitoring, feedback, and organizational learning.

CONTINUUM OF CARE: An array of services that meets the needs of the covered population in an appropriate and cost-effective manner.

COORDINATED CARE: The system that has services which are coordinated to assure timeliness, appropriateness, continuity, and completeness of care.

CO-PAYMENT: What a consumer pays for each health visit or services received, usually under \$10.00.

COST EFFECTIVENESS: The degree to which a service meets its intended goal at an acceptable cost.

COST SHARING: Financing arrangements such as deductibles, co-payments and coinsurance that shift some of the cost of services to the covered person.

COVERAGE: Agreed upon set of health services that a plan will pay for and/or provide.

CREDENTIALING: Examination of a physician or other health care provider's credentials to determine whether they should be entitled to clinical privileges at a hospital or managed care organization.

CUSTOMER: A person who receives and/or purchases services.

DECISION TREE: The decision tree, the basic rational means for decision review, is a way of showing the concrete and reasonable steps of a clinical decision problem. Its form highlights three structural components: the options that are available to the decision maker; the probable events that follow from and affect these actions, such as clinical information obtained or the clinical consequences revealed; and the outcomes for the patient that are associated with each possible scenario of actions and consequences.

DEDUCTIBLE: Annual amount that consumer agrees to pay for health services before insurance plan pays.

DELIVERY SYSTEM: An organized array of service providers coordinated to deliver a set package of services.

DEMAND REDUCTION: A strategy for reducing health care costs by reducing the demand for services.

DEMAND RISK: The risk that enrollees may demand different levels of service than what was projected.

DENIAL OF CARE: The determination that a request for service is inappropriate or not medically necessary.

DEPENDENT: An individual who receives health insurance through a spouse, parent, or other family member.

DESIGNATED PROVIDER: An organization or individual with which a health plan contracts with to provide services.

DIAGNOSTIC RELATED GROUPS: A classification system for service payments based on a person's primary and secondary diagnoses, demographics and complicating factors.

DIRECT COSTS: Direct costs are those that are entirely attributable to the service in question, for example, the services of professional and paraprofessional personnel, equipment, and materials.

DISABILITY MANAGEMENT: A strategy to control the cost of disabilities by preventing their occurrence, achieving optimal functional recovery for those that do occur, and facilitating an eventual return to work or school.

DISEASE MANAGEMENT: An approach that coordinates services around a specific diagnosis in order to minimize the negative effect of the illness.

DISENGAGEMENT: The termination or ending of enrollment for an individual or group by a health plan.

DRUG MAINTENANCE LIST: Also called an additional drug benefit list, it is a catalog of a limited number of prescription medications, as designated by a managed health care organization, commonly prescribed by health care providers for long-term patient use. This list is usually modified on a regular basis.

DUAL-ELIGIBLES: People who have both private insurance and Medicaid.

DUMPING: Generic term referring to obtaining care for an enrollee at the expense of another party.

DURABLE MEDICAL EQUIPMENT: Necessary medical equipment that is not disposable, (*e.g.*, wheelchairs, walkers, ventilators, etc.)

EARLY INTERVENTION: Providing services to prevent further deterioration, delay, or increased need.

EMPLOYEE RETIREMENT INCOME SECURITY ACT of 1974 (ERISA): A law that mandates reporting and disclosure requirements for group life and health plans.

ENCOUNTER: When a covered person receives services from a health care provider.

ENROLLED POPULATION: The entire group of persons covered by a particular health plan; defined in terms of specific lives covered; person enrolled are referred to as enrollees.

ENROLLEE: Member of an enrolled population.

EPISODE OF CARE: The treatment provided for a specific condition over a continuous, defined period of time.

ESSENTIAL PROVIDERS: Types of providers or provider organizations (e.g., physicians, psychologists, pediatricians) whose services are required to be included in benefit plans by state or federal statute.

EXCLUSIVE PROVIDER ORGANIZATION [EPO]: A health plan in which only treatment provided by participating providers is reimbursable.

EXPECTED CLAIMS: The expected claim amount for services over a specific time period.

EXPLANATION OF BENEFITS: Written, formal statement sent to enrollees that lists the services provided and costs billed by their health plan.

EXTENDED CARE FACILITY: A nursing home-type setting that offers skilled, intermediate, or custodial care.

FAMILY CENTERED: The system of care that recognized and builds upon the importance of the family and reflects this in the way services are planned and delivered. It facilitates family/professional collaboration and responds to family identified needs, builds upon family strength, and respects the diversity of families.

FEDERAL FINANCIAL PARTICIPATION (FFP): Payment paid by the federal government to a state as its share of Medicaid costs.

FEE-FOR-SERVICE REIMBURSEMENT: A payment system that pays providers for each unit of service delivered.

FEE MAXIMUM: The highest amount a provider can be paid for a specific health care service delivered within the terms of a contract.

FEE SCHEDULE: A listing that defines a pre-established payment amount for services to be delivered.

FLEXIBLE BENEFIT PLAN: A program that annually provides enrollees with plan options from which they can choose their benefits for the next year to meet their specific needs.

FORMULARY: List of approved prescription medications which health plan pays for; medicines not listed in the formulary will not be covered.

FREEDOM OF CHOICE WAIVER: Section 1915(b) Waiver.

FUNDING AUTHORITY: The agency authorized to pay and oversee contracts with all service providers within a defined geographic area.

FUNDING METHOD: The mechanism through which a payer (e.g., Medicaid, employer,) pays for the health care of its covered persons.

GATE KEEPING: The use of primary care clinicians, case managers or some other mechanism as the initial contact for care in order to ensure that only appropriate and cost-effective care is utilized.

GRIEVANCE PROCEDURE: Defined process in a health plan for consumers or providers to use when there is a disagreement about a plan's services, billings, or general procedures.

HEALTH CARE FINANCING ADMINISTRATION (HCFA): The federal agency that administers Medicare and oversees the states' administration of Medicaid.

HCFA WAIVERS: Agreements with the federal government that allow states that hold them specific flexibility in the administration of their state's Medicaid plan.

HEALTH MAINTENANCE ORGANIZATION (HMO): A health care organization that meets the following characteristics (1) it offers an organized system for providing health care within a specific geographic area; (2) it provides a set of basic and supplemental health maintenance and treatment services; and (3) it provides care to an enrolled group of people; there are four basic models of HMO's: group model, individual practice association model, network model and staff model.

HEDIS: System for determining the quality of a health plan's services and outcomes, based on certain health providers and hospitals, usually those within its own network.

HOSPICE: A health care facility that provides supportive care for the terminally ill.

HOSPITAL ALLIANCE: A group of hospitals that have joined together to improve competitive positions and reduce costs by sharing common services and developing group purchasing programs.

HUMAN RISK MANAGEMENT: The reduction of treatment demand by identifying and managing the health risks covered persons prior to the development of treatment needs.

INCURRED BUT NOT REPORTED (EBNR): Service cost incurred but not yet reported to the entity at-risk.

INCURRED CLAIMS: The total actual liability for covered services incurred over a specified period by the entity at-risk for services; this includes both claims paid and those owed (IIBNR) for services occurring within the specified time period.

INDEMNITY: An insurance program in which the payer reimburses providers (either directly or through the covered person) for covered services received.

INDIRECT COSTS: Indirect costs are usually termed overhead costs, as they are the costs that are shared by many services concurrently, for example, maintenance, administration, equipment, electricity, water.

INFORMATION MANAGEMENT: The identification, collection, analysis and use of various types of data within a system to further the organizations mission and goals.

INPATIENT: A patient admitted to a hospital and who is receiving services under the direction of a physician for at least 24 hours.

INTEGRATED BEHAVIOR HEALTH NETWORK: A carved out health plan that combines various manage behavioral health care services in a single, coordinated delivery system.

INTEGRATED DELIVERY SYSTEM: A generic term that refers to any of a variety of types of joint efforts between clinicians and service providers.

JOINT COMMISSION ON ACCREDITATION OF HEALTH CARE ORGANIZATIONS (JCAHO): A private, non-profit organization that sets standard, evaluates, and accredits hospitals, health care organizations and networks.

LEAD AGENCY: An organization that serves as a single clinical and fiscal authority that provides and/or subcontracts for services toward a desired outcome.

LENGTH OF STAY (LOS): The duration of a period of care for a covered person.

LIABILITY RISK: The risk of change in the likelihood of a lawsuit.

LOCAL MENTAL HEALTH: Local organizational entity (usually with some statutory authority) that centrally maintains administrative, clinical and fiscal authority for an organized system of behavioral health care.

LONG-TERM CARE: Services ordinarily provided in a skilled nursing, intermediate-care, personal-care, supervisory-care, or elder-care facility.

LONG-TERM OUTCOME: The result of care over time, as opposed to more immediate effects.

MANAGED ACCESS: A strategy for controlling health care costs by restricting or otherwise limiting access to services.

MANAGED BENEFITS: A strategy for controlling health care costs by manipulating the structure of the benefits package.

MANAGED CARE ORGANIZATION (MCO): Various strategies that seek to optimize the value of provided services by controlling their cost and utilization, promoting their quality and measuring performance to ensure cost-effectiveness. An organization that provides a managed health care plan.

MANAGED HEALTH CARE PLAN: A single service product that integrates the financing, administration and delivery of health care services for an enrolled population.

MANAGED SERVICE ORGANIZATION (MSO): An organization that provides management and administrative support services to individual clinicians and group practices.

MANDATED BENEFITS: Health plan benefits that are required by state or federal law.

MANDATORY ENROLLMENT: Requirements that certain groups of people must enroll in a program, (*e.g.*, Medicaid managed care).

MAXIMUM ALLOWABLE FEE SCHEDULE: A payment system that reimburses services up to a specified amount.

MEDICAID: A federal program administered individually by participating states that share in the program's costs to provide medical benefits to specific groups of low income and/or categorically eligible persons.

MEDICARE: Title XX of the Social Security Act which pays for health care for the elderly and adults who are disabled.

MEDICAL NECESSITY: A specific health care service that is medically appropriate, necessary to meet the person's health needs, consistent with the person's diagnosis, and consistent with established standards of care.

MEDICAL PROTOCOLS: Medical protocols are the guidelines that physicians in the future may be required to follow in order to have an acceptable clinical outcome. The protocol would provide the care giver with specific treatment options or steps when faced with a particular set of clinical symptoms or signs or laboratory data. Medical protocols would be designed through an accumulated database of clinical outcomes.

MEDICARE: An entitlement program run by the Health Care Financing Administration of the federal government by which people aged 65 years or older receive health care insurance. Medicare part A covers hospitalization and is a compulsory benefit. Medicare part B covers outpatient services and is a voluntary service.

MEDIGAP: Insurance provided by carriers to supplement the monies reimbursed by Medicare for medical services. Since Medicare pays physicians for services according to their own fee schedule, regardless what the physician charges, the individual may be required to pay the physician the difference between Medicare's reimbursable charge and the physician's fee. Medigap is meant to fill this gap in reimbursement, so that the Medicare beneficiary is not at risk for the difference.

MEMBER: A participant in a health plan who makes up the plan's enrollment.

MEMBER ASSISTANCE PROGRAM (MAP): A type of risk management that tries to lower health care costs by lowering treatment demand through preventive interventions;

MEMBERS PER YEAR: A way of counting enrollees over time; one unit is counted for every twelve member months.

MORBIDITY: The incidence and severity of situations requiring treatment (e.g., illness, accidents) within a specific group of persons.

MORTALITY: The rate of death for persons within a specific group for each age represented in the group.

MULTIPLE FUNDING STREAMS: A method where funding flows to a service provider in independent streams from different funding sources.

MULTIPLE OPTION PLAN: A health care plan which allows enrollees to choose from several models of care.

NON-PARTICIPATORY PROVIDER: A provider that has not contracted with a given health plan.

OPEN ACCESS: Open access arrangements allow members to see participating providers, usually a specialist, without a referral from the health plan's gatekeeper.

OPEN ENROLLMENT PERIOD: Specific time during which members of a health benefit program are allowed to change health plans without restriction.

ORGANIZED DELIVERY SYSTEMS: Networks of providers and payors that provide care in competition with other networks in their region.

OUT-OF-PLANS BENEFITS: Coverage for providers not under contract with the health plan on an indemnity basis, generally with high deductibles and/or co-pays.

OUTCOME MEASURES: Indicators used to gauge the effectiveness of treatment for a specific disease or medical condition.

OUTCOMES: The results of a specific health care service or benefit package.

OUTCOMES MANAGEMENT: Efforts to improve the results of health care services through the use of feedback on the effectiveness of services provided.

OUT-OF-AREA CARE (OOA): Term referring to care delivered to a person outside the geographic area covered by their health plan.

OUT-OF-POCKET-COSTS: The share of health services payments paid by the enrollee.

OUTPATIENT: A patient who receives health care services without being admitted to a hospital.

PAID CLAIMS: The actual amount paid to providers by a health plan.

PARTIAL CAPITATION: Term that refers to payment system in which some services included in the benefit package are funded according to an at-risk contracting arrangement and some are funded through fee-for-service or other traditional form of reimbursement.

PARTICIPATING PROVIDER: A provider who has contracted with a health plan to provide specific services.

PAYER/PAYOR: The public or private organization that is responsible for the payment of health care expenses.

PEER REVIEW: The evaluation of services by outside persons with similar training and experiences as the staff providing the service.

PEER REVIEW ORGANIZATION (PRO): Organizations originally established by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) to review the quality and appropriateness of care provided under Medicaid or Medicare funding.

PHYSICIAN-HOSPITAL ORGANIZATION(PHO): An organization owned by one or more hospitals and physician groups through which negotiation, contracting and marketing is conducted.

POINT-OF-SERVICE (POS): A health plan which allows enrollees to receive services from a participating or non-participating provider at differing benefit levels.

POOLING: The process of combining risk for all or several groups of person.

PRACTICE GUIDELINES: Descriptions of sound medical practice that assist clinicians in making appropriate decisions regarding health care provided for specific medical conditions.

PRE-ADMISSION CERTIFICATION (PAC): A review of the need for a specific health care service according to specific criteria.

PRE-EXISTING CONDITION: Any medical condition that has been diagnosed or treated within a specified period before the member's effective date of health coverage under the group contract.

PREFERRED PROVIDER ORGANIZATION (PPO): An organization which contracts with specific providers to provide health care services to enrollees and has a benefit package that provides incentives for the use of these contracted providers.

PREMIUM: The amount of money paid to a health plan to provide coverage over a specific time period.

PREPAID HEALTH PLAN (PHP): A contract between the payer and the plan that prepays the health plan a flat amount per month to provide services to enrollees.

PREVENTATIVE CARE: Health care emphasizing priorities for prevention, early detection, and early treatment of conditions, generally including routine physical examination, immunization, and well person care.

PRIMARY CARE GATEKEEPER MODEL: A management strategy that uses primary care clinicians or staff as the covered person's initial contact for health care and referrals to ensure that only appropriate care is delivered (gate keeping).

PRIMARY CARE NETWORK: A group of primary care physicians who have joined together to share the risk of providing care to their patients who are members of a given health plan.

PRIMARY CARE PHYSICIAN: A physician or clinician whose practice focuses upon internal medicine, family/general practice, pediatrics and obstetrics/gynecology.

PRIVATIZATION: Generic term referring to efforts to move functions formerly carried out by governmental entities to private non profit or private for profit status.

PROSPECTIVE REIMBURSEMENT: Payment to service providers over a period of time period prior to the provision of services.

PROVIDER: An organization or individual that provides and is reimbursed for a health care service.

PUBLIC LAW 99-660: Federal legislation that mandates that public funds for mental health services be targeted to the adults and children most in need of service and that requires each state to develop a plan.

PUBLIC-PRIVATE PARTNERSHIP: Partnerships between public and private organizations that combine private expertise in managed care models with public sector experts in models of care for seriously impaired or low income populations.

QUALITY ASSURANCE: Efforts to review and improve the quality of services provided.

RATING: The method that is used to determine the cost of premiums to the members of a managed health care or indemnity insurance plan.

REINSURANCE: Insurance purchased by a health plan to protect itself against certain specific types of losses.

REPORT CARD: A way to rate and compare the performance of health plans in terms of quality, cost-effectiveness, utilization of services, consumer satisfaction, administrative efficiency and financial stability.

RESOURCE MANAGEMENT: Efforts to improve the use of resources to achieve the best, cost-effective care.

RETROSPECTIVE REVIEW: A manner of judging medical necessity and appropriate billing practices for services that have already been rendered.

RISK: The chance a health plan or provider takes when they agree to deliver health services to a group of people for a certain payment rate, even if costs for the services exceed the payments.

RISK ADJUSTMENTS: The higher capitation rate paid to providers or health plans for services to a group of enrollees whose medical care is known to be more costly than average.

RISK ANALYSIS: Evaluation of the expected service needs of a potential group of enrollees and the cost of providing them appropriate services.

RISK LIMITATION ARRANGEMENT: When an MCO promises that costs will not exceed a given amount.

RISK POOL: A grouping of enrollees or contracts by some common factor (e.g., contract size, geographic location, service utilization pattern) that allows all dollars received or spent for that group to be kept together.

RISK SHARING: Occurs when two parties agree through a formula to share any losses that result when medical costs exceed payments.

RISK SHIFT: The transfer of risk for the costs of services from one responsible party to another.

SECTION 1115 WAIVER: A federal option that allows a state to operate its system of care for Medicaid enrollees in a

manner different from that ordered by HCFA to demonstrate the effectiveness and cost.

SECTION 1915 (b) WAIVER: A federal option that allows a state to partially limit the choice of providers for Medicaid enrollees; for example, under the waiver a state can limit the choice of enrollees to disenroll from an HMO on more than a yearly basis.

SELF-INSURANCE: Where an organization provides care for its members or employees rather than purchasing insurance through a third-party.

SERVICE PROVIDER: One who provides services, can be a school, doctor, therapist, etc.

SCREENING: The method by which managed care organizations limit access to health care for unnecessary reasons. In most HMOs, a phone call to the physician or his or her medical office staff is required before an office visit can be arranged. "Gatekeepers" and concurrent review are other methods of screening patients.

SELF-FUNDING: Often confused with self-insurance, a self-funded health care plan is funded entirely by the employer. Self-funded plans may be self-administered, or the employer may contract with an outside administrator for an administrative services only arrangement. Self-funded plans obtain stop loss insurance to cover catastrophic illness.

SELF-INSURANCE: A self-insured company provides its own insurance to its employees, without the use of an outside vendor. The self-insured company is exempt federal ERISA rules.

SHARED UTILIZATION RISK: Agreement where the payer and service provider share the responsibility for the potential rewards and costs of service use according to a specific, pre-set formula (also known as a Risk Corridor Arrangement).

SINGLE-PAYER SYSTEM: All funds flow through a single source (usually governmental) who takes on the responsibility of financing and administering the health care.

SINGLE-POINT ACCOUNTABILITY: Responsibility for the treatment of an individual or the outcome of a treatment system is on a single service provider.

SKILLED-NURSING FACILITY (SNF): Typically an institution for convalescence or a nursing home, the skilled nursing facility provides a high level of specialized care for long-term or acute illness. It is an alternative to extended hospital stays or difficult home care.

SMALL GROUP POOLING: Putting together the revenue and expenses for the coverage of several small enrollee groups in order to reduce risk or loss.

SSA: Social Security Administration that oversees SSI and SSDI

SSDI: Social Security Disability Income, set a dollar amount paid to eligible persons and their dependents when they have lost their jobs due to a disability.

SSI: Supplemental Security Income: Federal program for children who are poor and have severe disabilities that provides monthly cash benefits and in most states, Medicaid.

STAFF MODEL HMO: A type of HMO that employs clinicians to provide health care to its members, reimbursing them through salaries and other incentives.

STAKEHOLDERS: Groups of persons with a special interest in the design and functioning of a service or product; stakeholders include consumers, family members of consumers, service providers, and legislators.

STANDARD BENEFIT PACKAGE: A set of health care benefits required for all health plans.

STATE MENTAL HEALTH AUTHORITY OR AGENCY: State government agencies charged with administering and funding their state's public mental health services.

STOP-LOSS INSURANCE: Separate insurance purchased by a health plan to protect itself against claims greater than the expected amount per covered person per year.

SUBCAPITATION: An arrangement where a capitated health plan pays its contracted providers on a set fee basis.

SUBCONTRACT: The act of appointing through a second contract with a third party obligations between the two original parties.

SUBSCRIBER CONTRACT: A written agreement that defines an enrollee's health care policy.

SSI: Supplemental Security Income

TAX EQUITY and FISCAL RESPONSIBILITY ACT of 1982 (TEFRA): The federal law that created the current risk- and cost-contract provisions under which health plans contract with HCFA and the Medicare program.

TERTIARY CARE: Tertiary care is administered at a highly specialized medical center. It is associated with the utilization of high-cost technology resources.

THIRD-PARTY ADMINISTRATOR (TPA): An external organization that handles administrative duties and sometimes utilization review. Third-party administrators are used by organizations that actually fund the health benefits but find it not cost-effective to administrate the plan themselves.

THIRD PARTY PAYER: A public or private organization which is responsible for another's health care expenses.

TITLE V (5): Maternal and child health program that focuses on health issues of women and children.

TITLE XVIII (18): Section of Social Security Act that focuses on Medicare.

TITLE XIX (19): Section of the Social Security Act that focuses on Medicaid.

TOTAL QUALITY MANAGEMENT (TQM): Organizational systems that promote quality at all levels based on indicators and outcomes.

TREND FACTOR: The rate at which medical costs change over time.

TRENDING: Analysis used to predict future service use costs.

TRIAGE: The evaluation of patient conditions for urgency and seriousness, and establishment of a priority list for multiple patients. In the setting of managed care, triage is often performed after office hours on the telephone by a nurse or other health professional to screen patients for emergency treatment.

UNDERWRITING: The review of the cases to determine the risk they pose and their potential costs.

UNDERUTILIZATION: The determination that a specific service is used below the level suggested as appropriate.

UNIFIED FUNDING STREAM: Funding arrangement in which money flows to a service provider in single stream combined by the payer from several different funding sources.

UPCODING: The practice of billing a service by a code that pays more than its correct code.

URGENT CARE CENTER: A medical facility where ambulatory patients can be treated without an appointment, and receive immediate, non-emergency care. The urgent care center may be open 24 hours a day; patients calling an HMO after hours with urgent, but not emergent, clinical problems, are often, referred to these facilities.

UTILIZATION: The level of use of a service over time.

UTILIZATION GATEKEEPER: The agency or agencies responsible for managing service use.

UTILIZATION MANAGEMENT: A system designed to ensure that the services provided to a client are cost-effective, appropriate and least restrictive.

UTILIZATION REVIEW: Examination of the patterns of service usage in order to determine means for keeping cost down while maintaining quality.

UTILIZATION RISK: The risk that actual service use might differ from use projections.

VALUE ASSURANCE MANAGEMENT: Efforts within an organization to deliver services that are responsive to needs, achieves specific outcomes, and is sensitive to consumer needs.

WITHHOLD FUND: The portion of the monthly capitation payment to physicians withheld by the managed care plan until end of the year or other time period to create an incentive for efficient care, if the physician exceeds utilization norms for other members of his group or geographic region, he or she loses the fund or part of it. The principle of the withhold fund may be applied to hospital services, specialty referrals, laboratory usage, etc.

WORKERS' COMPENSATION: A state-governed system that addresses work-related injuries. Under this system, employers assume the cost of medical treatment and wage losses stemming from a workers' job-related injury. In return, employees give up the right to sue employers.

WORK-UP: The total patient evaluation, which may include laboratory assessments, radiologic series, medical history, and diagnostic procedures.

WRAP-AROUND: Benefits organized around an individual enrollee's needs and has a no-eject, no-reject policy with services continued as long as beneficial and necessary with a special focus on outcomes not cost.