Managed Care Definitions

A. HMO (Health Maintenance Organization)
An entity that contracts on a prepaid capitated risk basis to provide comprehensive health services to enrollees.

B. PHP (Prepaid Health Plan)
An entity that either contracts on a prepaid capitated risk basis to provide services that are not comprehensive or contracts on a non-risk basis.

C. Managed Care
That body of organizational, financial, and management activities that should be implemented by professionals and organizational entity that is a financial risk for the cost of medical or surgical services they provide.

D. Case Management
A patent-specific process, involving individualized assessments of service need and provision of assistance to individuals in obtaining specific services.

E. Gatekeeping
The form of case management that reduces inappropriate use by controlling patient access to care.

F. Capitation
A managed care payment system under which providers are paid a per patient monthly enrollment fee that also may include a fee for case management. Payments are made regardless of whether services are furnished.

G. Risk
A system for paying managed care providers under which providers are paid a flat fee for one or more services they furnish under their contracts and are at financial risk in the event that patient costs exceed their payment. In the event that payments are greater than the cost of care, the provider can keep the difference.

H. Stop loss
A special financial arrangement that limits the amount of financial losses a managed care contractor (or subcontractor) has to bear if actual expenses exceed revenues from the prospective rate.

I. Reserves
A financial arrangement used to cover expenses that exceed anticipated levels. Sometimes covered through purchase of re-insurance.

J. Incentives

Profit-sharing arrangements offered by HMOs and managed care plans that permit subcontractors and physicians to share in amounts earned from plan saving through reduced hospital and specialty referral usage.

K. Withholds

Amount that a plan holds back from payments to a subcontractor to help cover the cost of specialty referrals.

L. Capacity

The maximum number of patients or patient visits a provider can accommodate as currently figured.

M. Risk Pool

Allocation by a managed care plan of certain amounts of money per member per month into accounts for specialty care, emergency care and in-patient care. Managed care contracts generally specify terms for over-expenditure and under-expenditure of these accounts.

N. Medical Necessity

Medical or surgical treatment which a member requires as determined by one or more participating providers, in accordance with accepted medical and surgical practices and standards prevailing at the time of treatment and in conformity with the criteria and protocols established by the managed care plan.

O. Coordination of Benefits

Those provisions by which the health center or managed care plan, either together or separately, seeks to recover costs of an incident of sickness or accident on the part of the member, which may be covered by another insurer, service plan, government third party payer, or other organization.

P. Primary Care Services

Services (including office visits, injections, immunizations, well-baby care, routine female checkups, periodic health examinations, etc.) to be provided or arranged for by the primary care provider.

Q. Specialty Care Services

The services of a physician qualified in a particular branch of medicine or surgery, including one who, by virtue of advanced training, is certified as being qualified to practice.

R. Fee for Service

A method of reimbursement which is based upon payment to providers for services rendered to members subsequent to, and specifically for, the rendering of those services.