A	
AAAHC (Accreditation Association for Ambulatory Health Care)	The Accreditation Association for Ambulatory Health Care - also known as AAAHC or the Accreditation Association - is a private, non-profit organization formed in 1979 to assist ambulatory health care organizations improve the quality of care provided to patients.
AANA (American Association of Nurse Anesthetists)	Founded in 1931, the American Association of Nurse Anesthetists (AANA) is the professional association for more than 37,000 Certified Registered Nurse Anesthetists (CRNAs) and student nurse anesthetists. CRNAs are advanced practice nurses who are the hands-on providers of 30 million anesthetics given in the United States each year. .
ABMS (American Board of Medical Specialties)	The American Board of Medical Specialties (ABMS), a not-for-profit organization, assists 24 approved medical specialty boards in the development and use of standards in the ongoing evaluation and certification of physicians.
accessibility	The extent to which a member of a managed care organization (MCO) can obtain available services at the time they are needed. Such service refers to both telephone access and ease of scheduling an appointment.
ACCME (Accreditation Council for Continuing Medical Education)	The ACCME is the organization who mission is the identification, development, and promotion of standards for quality continuing medical education (CME) utilized by physicians in their maintenance of competence and incorporation of new knowledge to improve quality medical care for patients and their communities.
Accreditation	A determination by an accrediting body that an eligible healthcare organization complies with applicable Joint Commission standards. See also accreditation decisions.
Accreditation Appeal	The process through which an organization that has been preliminarily denied Joint Commission accreditation exercises its right to a hearing by an Appeals Hearing Panel, followed by a review of the Panel's report and recommendation by The Joint Commission's Board of Commissioners.
Accreditation Cycle	A period of accreditation at the conclusion of which accreditation expires

	unless a full survey is performed.
Accreditation Decisions	Categories of accreditation that an organization can achieve based on a full survey by the accrediting body
Accreditation Report	A report of an organization's survey findings; the report includes organization strengths, requirements for improvement (see definition), and supplemental findings (see definition), as appropriate.
Accreditation Survey Findings	Findings from an on-site evaluation conducted by Joint Commission's surveyors which result in an organization's accreditation decision.
Accreditation Watch	An attribute of an organization's Joint Commission accreditation status. A healthcare organization is placed on Accreditation Watch when a sentinel event has occurred and a thorough and credible root cause analysis of the sentinel event has not been completed within a specified time frame. Although Accreditation Watch status is not an official accreditation category, it can be publicly disclosed by The Joint Commission.
ACGME (Accreditation Council for Graduate Medical Education)	The Accreditation Council for Graduate Medical Education (ACGME) is responsible for the Accreditation of post-MD medical training programs within the United States. Accreditation is accomplished through a peer review process and is based upon established standards and guidelines.
ADA (Americans with Disabilities Act)	The ADA is a wide-ranging civil rights law that prohibits, under certain circumstances, discrimination based on disability.
administration costs	Costs incurred by a carrier, such as an insurance company or HMO, for administrative services like claims processing and overhead expenses. Administration costs are usually expressed as part of premium.
ASO (Administrative Services Only)	A service requiring a third party to deliver administrative services to an employer group and requiring the employer to be at risk for the cost of healthcare services provided. This is a common arrangement when an employer sponsors a self-funded healthcare program.
admissions/1000	The number of hospital admissions per 1,000 health plan members. The formula for this measure is: (# of admissions/member months/ x 1,000 members x # of months.)
ADS (Alternative Delivery System)	A method of providing healthcare benefits that depart from the traditional

	indemnity methods. An HMO, for example, is considered an alternative delivery system.
adverse selection	(1) Describes a plan with a disproportionate share of enrollees who are sicker than the general population, specifically, members who are sicker than anticipated when the medical costs budget was developed. (2) Occurs when a carrier enrolls a poorer risk than the average risk of the group. Fierce competition for the healthiest individuals leaves insurers such as Blue Cross & Blue Shield with members who are more likely to use services because of their existing higher health risk conditions.
age/sex factor	A measurement used in underwriting which represents the age and sex risk of medical costs of one population relative to another. A group with an age/sex factor of 1.00 is average. An age/sex factor above 1.00 indicates a higher than average demographic risk of expected medical claims. An age/sex factor below 1.00 indicates a lower than average demographic risk of expected medical claims.
age/sex rates (ASR)	A set of rates for a given group product in which there is a separate rate for each grouping of age and sex categories. One overall table serves a defined group or product. These rates are used to calculate premiums for group billing purposes. This type of premium structure is often preferred over single and family rating in small groups because it automatically adjusts to demographic changes in the group. Also called table rates.
AHP (Allied Health Practitioner)	Allied health professionals are health care practitioners with formal education and clinical training who are credentialed through certification, registration, and/or licensure. Allied health practitioners work with physicians and other members of the health care team to deliver high-quality patient care services for identifying, preventing, and treating disease and disabilities.
AHP (Accountable Health Plans)	Under the proposed managed competition plans, these would be the insuring delivery systems that would offer a standard federally defined

	benefit plan set by the National Health Board.
AHP (Allied Health Professional)	Specially trained and licensed (when necessary) healthcare workers other than physicians, dentists, optometrists, chiropractors, podiatrists, and nurses.
allowable costs	Charges for services rendered or supplies furnished by a health provider that qualify as covered expenses.
AMA (American Medical Association)	The professional association for physicians.
AOA (American Osteopathic Association)	The accrediting body for osteopathic hospitals.
ANCC (American Nurses Credentialing Center)	The American Nurses Credentialing Center (ANCC) provides individuals and organizations throughout the nursing profession with the tools they need on their journey to excellence. ANCC's internationally renowned credentialing programs certify nurses in specialty practice areas, recognize healthcare organizations for nursing excellence through the Magnet Recognition Program®, and accredit providers of continuing nursing education.
Any Willing Provider Laws	Statutes requiring that managed care networks accept any willing physician who meets a managed care network's established selection criteria. The insurer's viewpoint is that these laws reduce competition and increase administrative costs. Physician's position is that these laws protect them from being shut out of networks. Without these laws, the livelihoods of many physicians may be in jeopardy.
AOA (American Osteopathic Association)	The AOA is a member association representing more than 64,000 osteopathic physicians (D.O.s). The AOA serves as the primary certifying body for D.O.s, and is the accrediting agency for all osteopathic medical colleges and health care facilities.
APG (Ambulatory Patient Group)	A reimbursement methodology developed by 3M Health Information Systems for the HCFA/CMS. APGs are to outpatient visits/services what DRGs are to inpatient hospital days. APGs provide for a fixed reimbursement to an institution for outpatient procedures or visits and

	incorporate data regarding the reason for the visit and other patient data. APGs prevent unbundling of ancillary services.
APIC- (Association of Professionals in Infection Control and Epidemiology)	A multi-disciplinary, voluntary, international organization promoting wellness and prevention of infection world-wide by advancing health care epidemiology **...**
appeal	A formal request by a practitioner or member for reconsideration of a decision, such as a utilization review recommendation, a benefit payment, an administrative action or a quality-of-care or service issue, with the goal of finding a mutually acceptable solution.
application	A form on which the prospective insured states facts requested by the carrier and on the basis of which the carrier decides whether or not to accept the risk, modify the coverage offered or decline the risk. Enrollees in non-insurance health benefits plans also complete enrollment applications.
attestation	A signed statement indicating that a practitioner personally confirmed the validity, correctness, and completeness of his/her credentialing application at the time that he or she applied to the MCO for participation.
attrition rate	Disenrollment expressed as a percentage of total membership. To be meaningful, one must distinguish between open enrollment and off-open enrollment terminations. Off-open enrollment terminations are usually due to subscriber's employment or relocation outside of the HMO's/PPO's service management. Open enrollment terminations may be due to subscriber dissatisfaction and thus may be controllable.
ALOS (average length of stay)	The average number of days in the hospital for each admission. The formula for this measure: total patient days incurred divided by the number of admissions and discharges during the period.
B	
balance billing	The practice of a provider billing a patient for all charges not paid for by the insurance plan, even if those charges are above the plan's UCR (Usual,

	Customary, or Reasonable) or are considered medically unnecessary. Managed care plans and service plans generally prohibit providers from balance billing except for allowed co-pays, coinsurance and deductibles. Such prohibition against balance billing may even extend to the plan's failure to pay at all (e.g., because of bankruptcy).
Bare-Bones Health Plans	These plans have high deductibles, co-payments, low policy limits and may include only several stays of hospitalization. Over half of the states have waived mandated health benefits to allow sales of these plans. Although these no-frills, low cost policies are geared toward small businesses, they are not popular.
base capitation	A stipulated dollar amount to cover the cost of healthcare per covered person less mental health/substance abuse services, pharmacy and administrative charges.
basic health services	Defined as benefits that all federally qualified HMOs must offer, defined under Subpart A. 110.102 of the Federal HMO Regulations.
bed days/1000	The number of inpatient days per 1000 health plan members. The formula is (# of days/member months) x 1000 members x # of months.
benchmark	For a particular indicator or performance goal, the industry measure of best performance. The benchmarking process identifies the best performance in the industry (healthcare or non-healthcare) for a particular process or outcome, determines how that performance is achieved and applies the lessons learned to improve performance.
benefit package	Services an insurer, government agency, or health plan offer to a group or individual under the terms of a contract.
blacklisting	Refusal by insurers to cover high-risk individuals, especially those who could inherit diseases, and those in high-risk industries/professions. The latter is also called redlining or industry screening.
Board Certified Specialist	A doctor who has completed an accredited specialty program and who has passed the proper specialty board examination.

Board Eligible	A term used to describe a physician who is eligible to take the specialty board examination by virtue of having graduated from an approved medical school, completed a specific type and length of training, and practiced for a specified amount of time.
Break-Even Point	The HMO membership level at which total revenues and total costs are equal and therefore produce neither a net gain nor loss from operations.
Bylaws	A governance framework that establishes the roles and responsibilities of a body and its members.
C	
CAMH (Comprehensive Accreditation Manual for Hospitals)	Publishing by TJC, the Comprehensive Accreditation Manual for Hospitals includes guidelines for obtaining, managing, and using information to improve patient outcomes and individual and hospital performance in patient care, governance management, and support process.
Canadian-Style System	(1) Commonly, a term used to describe a single payer system, nationalized healthcare or socialized medicine. (2) Canada's healthcare system is actually none of the above. Canada's national health insurance program is composed of 12 separate single payer systems with global budgets. Patients may choose their doctors who are mainly self-employed and reimbursed under a negotiated fee schedule. Hospitals, about half government owned and half publicly held non-profits, are reimbursed in set lump sums. Each province approves technology and facility investments.
capitation (CAP)	The process of flat rate prepayment for professional services for a given population of health plan (literally "per head"). In practice, a flat fee is paid per-member per-month (PMPM) to a contracting medical group/IPA or Primary Care Physician in return for the provider's assumption of the financial risk required to provide certain professional services to a given population of health plan members. The provider is responsible for delivering or arranging for the delivery of all health services required by

	the covered person under the condition of the provider contract.
carrier	An entity which may underwrite or administer a range of health benefit programs. May refer to an insurer or a managed health plan.
carve out	A decision to purchase separately a service which is typically a part of an indemnity or HMO plan. Example: an HMO may "carve out" the behavioral health benefit and select a specialized vendor to supply these benefits on a stand-alone basis.
case management	The process for identifying covered persons with specific healthcare needs in order to facilitate the development and implementation of a plan that efficiently uses healthcare resources to achieve optimum member outcome.
case manager	An experienced professional (e.g. nurse, doctor or social worker) who works with patients, practitioners, providers, and insurers to coordinate all services deemed necessary to provide the patient with a plan of medically necessary and appropriate healthcare.
Catastrophic Health Insurance	Insurance beyond basic and major medical insurance for severe and prolonged illness that poses the threat of financial ruin to the family.
catchment area	The geographic area from which an HMO draws its patients.
CDC (Centers for Disease Control and Prevention)	an agency of the United States Department of Health and Human Services based near Atlanta Georgia. It works to protect public health and safety by providing information to enhance health decisions, and it promotes health through partnerships with state health departments and other organizations. The CDC focuses national attention on developing and applying disease prevention and control (especially infectious diseases), environmental health, occupational safety and health, health promotion, prevention and education activities designed to improve the health of the people of the United States.
CDS	Controlled Drugs and Substances
CMS (Centers for Medicare & Medicaid	The federal agency of the Department of Health and Human Services that

Services)	administers the Medicare program and oversees states' administration of Medicaid.
CEO (Chief Executive Officer)	One of the highest-ranking corporate officer (executive) or administrator in charge of total management. An individual selected as President and CEO of a corporation, company, organization, or agency, reports to the board of directors.
CPMSM (Certified Professional Medical Services Management)	A medical staff services management practitioner who has successfully completed the examination for certification by the National Association Medical Staff Services.
cherry picking	It is the practice of selling policies only to people who don't need medical care and dropping them once they do. Insurers argue it is an unavoidable practice. Also referred to as cream skimming.
churning	(1) The practice of a provider seeing a patient more often than is medically necessary, primarily to increase revenue through an increased number of services.
Claims (Incurred)	It represents actual carrier liability and includes all claims with dates of service within a specified period, usually called the experience period. Because of the time period between dates of service and claims payments are actually processed, adjustments must be made to a Paid Claims data to determine Incurred Claims.
Claims (Paid)	The amounts paid to providers to satisfy the contractual liability of the benefit plan. These amounts do not include member liability for ineligible charges, deductibles or copayments. If the carrier has preferred payment contracts with providers (e.g. fee schedules, capitation arrangements), lower paid claims liability will usually result. Without such contracts, the total of paid claims plus member liabilities should equal provider billed claims. NOTE: Paid claims for a specific time period do not necessarily reflect the actual liability for medical services delivered during the same period of time. See the definition of Claims (Incurred) for further information.
Claims experience	The claim cost associated with the utilization of healthcare services related

	to the contract between the account and the carrier.
clinic without walls	The concept of a clinic without walls focuses primarily on an organizational structure rather than a physical structure. In so doing, it sidesteps one of the primary barriers to the creation of medical group practices that has existed in the past. Instead of having to buy out the lease and pay to relocate the physicians into a single location, one simply leaves everyone in place while throwing a super PA (professional association) or other entity over the top of their existing PAs to create a combined organization.
Clinical Privileges	Authorization granted by the appropriate authority (for example, a governing body) to a practitioner to provide specific care, treatment, and services in an organization within well-defined limits, based on the following factors, as applicable: license, education, training, experience, competence, health status, and judgment.
closed access	A type of health plan in which covered persons are required to select a primary care physician from the plan's participating providers. The patient is required to see the selected primary care physician for care and referrals to other healthcare providers within the plan. Typically found in a staff, group or network model HMO. Also called closed panel or gatekeeper model.
closed panel	(1) A managed care plan that contracts with physicians on an exclusive basis for services and does not allow those physicians to see patients for another managed care organization. Examples include staff and group model HMOs. It could apply to a large private medical group that contracts with an HMO. (2) Medical services are delivered in the HMO-owned health center or satellite clinic by physicians who belong to a specially formed but legally separate medical group that only serves the HMO. This term usually refers to group and staff HMO models. See also closed access.
CME	Continuing Medical Education **Continuing medical education** (CME) refers to a specific form of

	continuing education (CE) that helps those in the medical field maintain competence and learn about new and developing areas of their field. These activities may take place as live events, written publications, online programs, audio, video, or other electronic media. Content for these programs is developed, reviewed, and delivered by faculty who are experts in their individual clinical areas. Similar to the process used in academic journals, any potentially conflicting financial relationships for faculty members must be both disclosed and resolved in a meaningful way.
CMS	Centers for Medicare & Medicaid Services CMS or the Centers for Medicare & Medicaid Services is the federal agency responsible for administering the Medicare, Medicaid, SCHIP (State Children's Health Insurance), HIPAA (Health Insurance Portability and Accountability Act), CLIA (Clinical Laboratory Improvement Amendments), and several other health-related programs.
COBRA–Consolidated Omnibus Budget Reconciliation Act of 1985	(1) A component of this Act requires employers to offer the opportunity for terminated employees to purchase continuation of healthcare coverage under the group's medical plan (also see conversion). Ex-employees of companies with 20 or more workers are entitled to continue coverage under the group plan for 18 months after leaving. (2) The Act also allows for a Medicare recipient to disenroll from an HMO or CMP with a Medicare risk contract.
Code of Ethics	A systematic set of rules or guidelines to direct appropriate and value-based conduct or behaviors.
Community Care Networks	Local groups of doctors and clinics, organized by hospitals, compete for contracts with group insurers and are responsible for providing care to enrolled individuals. Typically reimbursement is by capitation. Payment schedules are set by an independent regulatory board. Community Care Networks are the centerpiece of the American Hospital Association's reform plan.
Consumer Assessment of Healthcare Providers and Systems –(CAHPS)	a public-private initiative to develop standardized surveys of patients'

	experiences with ambulatory and facility-level care. Health care organizations, public and private purchasers, consumers, and researchers use CAHPS results to: • Assess the patient-centeredness of care; • Compare and report on performance; and • Improve quality of care.
Competency	A determination of an individual's capability to meet defined expectations.
CMP (Competitive Medical Plan)	A federal designation that allows a health plan to obtain eligibility to receive a Medicare risk contract without having to obtain qualification as an HMO. Requirements for eligibility are somewhat less restrictive than for an HMO.
Conditions of Participation	Federal regulations issued by the Healthcare Financing Administration delineating standards for healthcare delivery, similar to standards of The Joint Commission. Hospitals receiving reimbursement for treatment of Medicare patients must meet the Conditions. CMS officially recognizes that Joint Commission hospital accreditation requirements meet or exceed the Medicare Conditions of Participation. As a result, Joint Commission accredited hospitals have "deemed status" and are deemed eligible to participate in the Medicare program.
Confidentiality	Restriction of access to data and information to individuals who have a need, a reason, and permission for such access. An individual's right, within the law, to personal and informational privacy, including his/her healthcare records.
Conflict of Interest	The circumstance of a public official or corporate officer whose personal interests might benefit from his/her official position or actions, especially as it relates to confidential information.
Continuing Education	Education beyond initial professional preparation that is relevant to the type of care delivered in an organization, that provides current knowledge relevant to an individual's field of practice or service responsibilities, and that may be related to findings from performance-improvement activities.

contract	(1) An agreement between two or more persons that creates an obligation to do or not do a particular thing. (2) An HMO agreement executed by a subscriber group (see group contract). The term may be used in place of subscriber when referring to penetration within a given subscriber group. Also used to designate an enrollee's coverage.
contract year	The period of time from the effective date of the contract to the expiration date of the contract.
conversion	The conversion of a member covered under a group master contract to coverage under an individual contract. This is offered to subscribers who lose their group coverage (through job loss, death of a working spouse, etc.).
conversion privilege	This gives an individual insured under a group plan the right to convert from a group health policy to an individual policy in the event the individual leaves the group
COO	Chief Operating Officer
copayment	A cost-sharing arrangement in which a plan member pays a specified charge for a specified service, such as $10 for an office visit. The member is usually responsible for payment at the time the healthcare is rendered. Typical copayments are fixed or variable flat amounts for physician office visits, prescriptions or hospital services.
Core Competencies	Knowledge, skills, values and belief systems required for someone to be able to provide the services of a profession.
cost effective	A term that refers to the allocation of resources in a manner so as to maximize outcome and minimize cost. There is a point at which more cost will not incrementally improve outcome to the extent of the increased cost.
cost shifting	It is the expression that describes the primary method of paying for indigent care in the United States. The "high" cost of private insurance premiums are perceived as the hidden tax to pay for uncompensated

	medical care and medical treatment of the poor. It is viewed as the primary cause of health insurance inflation
cost-benefit Analysis (CBA)	Measures both costs and results of a treatment method in monetary terms, not in physical units.
cost-effectiveness Analysis (CEA)	Measures costs and consequences, with costs measured in dollars, and outcomes calculated in terms of their effectiveness in obtaining a specific objective measured in biological units. CEA is particularly useful for comparing alternative treatments which are very similar and affect similar clinical results or use similar methods.
cost-minimization analysis (CMA)	Measures and compares costs of alternative therapies that have identical clinical effectiveness - including adverse reactions, complications, and duration of therapy.
cost-of-illness analysis	Examines all the costs of a specific disease in a defined population. A macroeconomic analysis, often used to evaluate preventive programs for diseases.
cost-utility analysis (CUA)	Measures costs of alternative treatments in dollars, but evaluates outcomes in terms of the patient's ability to lead a normal satisfying life, their "quality of life." The outcome may be measured in terms of discomfort and pain, changes in functioning, or preference for one intervention over another.
CPR—Customary, Prevailing, and Reasonable	A payment process developed by Medicare. CPR describes the rate physicians charge based on what they have charged in the past (Customary) and what other physicians are charging (Prevailing). The Reasonable charge can be adjusted to the prevailing charge, the customary charge, or the physician's present charge.
CPT	See Physician's Current Procedural Terminology
Credentialing	The process of obtaining, verifying, and assessing the qualifications of a healthcare practitioner to provide patient care services in or for a healthcare organization.

credentialing	(1) The most common use of the term refers to obtaining and reviewing the documentation of professional providers. Such documentation includes licensure, certifications, proof of insurance, evidence of malpractice insurance history, and other documents. Generally includes both reviewing the information provided by the provider and verifying that the information is correct and complete.
Credentials	Documented evidence of licensure, education, training, experience, or other qualifications.
Criteria	Expected level(s) of achievement or specifications against which performance or quality may be compared.
CVO	~~Certification~~? Credentialing Verification Organization
D	
DAW—Dispense As Written	The instruction from a physician to a pharmacist to dispense a brand name pharmaceutical rather than a generic substitution.
decision analysis	A systematic approach to decision-making under uncertain conditions; explicitly analyzing all of the factors in a decision (in a specified order), assessing the probability of the possible outcomes, and selecting the best possible choice.
Deemed Status	Status conferred by the Centers for Medicare and Medicaid Services (CMS) on a healthcare provider when that provider is judged or determined to be in compliance with relevant Medicare Conditions of Participation because it has been accredited by a voluntary organization whose standards and survey process are determined by CMS to be equivalent to those of the Medicare program or other federal laws. Successful completion of a Joint Commission hospital survey can result in deemed status recognition.
delegation	A formal process by which an MCO gives another entity the authority to perform certain functions on its behalf, such as credentialing, utilization management and quality improvement. Although, an MCO can delegate the responsibility for ensuring that the function is performed appropriately.

Delineation of Clinical Privileges	The listing of the specific clinical privileges an organization's staff member is permitted to perform in the organization.
denial	Non-authorization of a request for care or services. NCQA considers non-authorization decision that are based on either medical appropriateness or benefit coverage to be denials. Partial approvals and care terminations are also considered to be denials.
diagnostic related groups (DRGs)	A classification system for inpatient hospital services based on principal and secondary diagnosis, surgical procedures, age, sex and presence of complications; used to determine reimbursement.
differential	The out of pocket difference that an eligible individual may pay when opting for indemnity insurance versus a managed care plan.
discounting	Method used to convert future benefits and costs into equivalent current monetary units, taking into account the general preference for current dollars over future dollars.
divide and dump	Describes separating low-risk workers from the high-risk workers and dumping the latter.
Drug Enforcement Administration (DEA)	The agency that issues certificates to medical providers authorizing them to prescribe controlled substances (i.e. narcotics) and other medications. The DEA registration expires every three years, at which time the physician must register and receive an updated certificate.
drug formulary	A listing of prescription medications which are approved for use and/or coverage by the plan and which will be dispensed through participating pharmacies to a covered person. The list is subject to periodic review and modification by the health plan.
dual choice	(1) A health benefit offered by an employment group that permits those eligible to voluntarily choose among health plans, usually the employers primary insurer and an HMO. (2) The portion of the federal HMO regulations that requires any employer with 25 or more employees residing in an HMO's service area, paying minimum wage, and offering health coverage to offer a federally qualified

	HMO as well. Sometimes referred to as Section 1310 or mandating, the HMO must request it. This provision was "sunsetted" in 1995. (3) Another definition, unrelated to the previous one, pertains to point of service (see POS)
Durable Medical Equipment (DME)	Equipment which can stand repeated use, is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of illness or injury, and is appropriate for use at home. Examples of durable medical equipment include hospital beds, wheelchairs and oxygen equipment.
E	
Economic credentialing	A process that measures and traces cost-effective physician practices used for appointment and reappointment of physicians to medical staff positions.
Educational Commission for Foreign Medical Graduates (ECFMG)	The Educational Commission for Foreign Medical Graduates (ECFMG), through its process of certification, assesses the readiness of graduates of foreign medical schools to enter residency or fellowship training programs in the United States. ECFMG administers an examination on knowledge of basic medical sciences and ability to understand the English language.
Element of Performance (EP)	The specific performance expectations and/or structures or processes that must be in place in order for a hospital to provide safe, high-quality care, treatment, and services. EPs are scored and determine a hospital's overall compliance with a standard. EPs are evaluated on a 3-point scale (with the option of scoring an EP "not applicable"), whereby 0 = Insufficient compliance; 1 = Partial compliance; 2 = Satisfactory compliance.
employer mandate	Under the federal HMO act, federally qualified HMOs can mandate or require an employer to offer at least one federally qualified HMO plan of each type (IPA/network or group/staff). Some state laws have similar provisions.
EMTALA	Emergency Medical Treatment and Active Labor Act The Emergency Medical Treatment and Active Labor Act is a statute

	which governs when and how a patient may be (1) refused treatment or (2) transferred from one hospital to another when he is in an unstable medical condition. EMTALA was passed as part of the Consolidated Omnibus Budget Reconciliation Act of 1986, and it is sometimes referred to as "the COBRA law".
encounter	A contact provided to a patient by a healthcare practitioner or provider. Generally, if the member receives more than one treatment within the same or related department at the same time, it is counted as a single encounter. Encounter claims from Primary Care Providers (PCP) are generally capitated services and do not generate a claim to be paid to the physician.
encounters per member per year	The number of encounters related to each member on a yearly basis. The measurement is calculated as follows: total # of encounters per year/total of members per year.
enrollee	An individual who is enrolled for coverage under a health plan contract and who is eligible on his/her own behalf (not by virtue of being an eligible dependent) to receive the health services provided under the contract.
enrollment	The total number of covered persons in a health plan. The term also refers to the process by which a health plan signs up groups and individuals for membership, or the number of enrollees who sign up in any one group.
ERISA—Employee Retirement Income Security Act	One provision of this Act allows self-funded plans to avoid paying premium taxes, complying with state laws and regulations regarding insurance, even when insurance companies and managed care plans that stand risk for medical costs must do so. Another provision requires that plans and insurance companies provide an explanation of benefits (EOB) statement to a member or covered insured in the event of a denial of a claim, explaining why the claim was denied and informing the individual of his/her right of appeal. It exempts companies that self-insure, or fund

	their own insurance plans, from state regulations. Most large companies began to self-insure in the 80s. Now, 70% of firms with 5,000 or more workers are self-insured. Only Hawaii has an ERISA waiver, allowing it to regulate such plans. The Act is considered to be a major roadblock to state health reform, since it means states cannot require the large companies to provide insurance, pay premium taxes, or cover mandated benefits.
Ethics	The study and philosophy of human conduct, with emphasis on the determination of right and wrong. The principles of right conduct, especially with reference to a specific profession.
Evidence of Standards Compliance (ESC)	A report submitted by a surveyed organization within 90 days of its survey, which details the actions(s) that it took to bring itself into compliance with a standard or that clarifies why the organization believes it was in compliance with the standard for which it received a recommendation. An ESC must address compliance at the element of performance (EP) level and must include a measure of success (MOS) (see definition), if applicable, for all appropriate EP corrections.
Exclusive Provider Organization (EPO)	An EPO is similar to an HMO in that it often uses primary care physicians as gatekeepers, may have capitated providers, has a limited provider panel, and uses an authorization system. An EPO differs from an HMO in that EPO physicians, in most cases, do not receive capitation but instead are reimbursed only for actual services provided. It is referred to as exclusive because the member must remain within the network to receive benefits. EPOs are generally regulated under insurance statutes rather than HMO regulations. Many states do not allow EPOs because they maintain that EPOs are really HMOs. If the patient goes outside the EPO network for care, they are required to pay the entire cost of the care.
expected claims	The projected claim level of a covered person or group for a defined contract period. This level also becomes known as a desired loss ratio or break even point in relationship to projected premium. See also experience rating.
experience rating	The process of setting rates based partially or in whole on evaluating previous claims experience and then projecting required revenues for a

	future policy year for a specific group or pool of groups. See also expected claims.
F	
FACIS	Fraud and Abuse Control Information System **FACIS®** is the database designed to to assist healthcare industry personnel search a single database containing information on healthcare individuals and entities that have been excluded from federal healthcare programs as well as adverse actions taken by licensing boards of State governments .
FCVS	Federation Credentials Verification Service a national non-profit organization that provides services for state medical and osteopathic licensing authorities. FCVS was developed to provide a centralized, uniform process for medical licensing authorities—as well as private, governmental and commercial entities—to obtain a verified, primary source record of a physician's "core" medical credentials. This Subsequent Request Packet is specifically designed for physicians who have previously
FDA	Food and Drug Administration
federal qualification	A designation made by HCFA/CMS after conducting an extensive evaluation process of the HMO's entire method of doing business: documents, contracts, systems, facilities, etc. An organization must be federally qualified or a designated CMP (competitive medical plan) to be eligible to participate in certain Medicare cost and risk contracts. All HMOs are not federally qualified - many are state licensed only.
Federation of State Medical Boards (FSMB)	Organization to which all state licensing boards, the armed forces, and the federal Medicare Program report disciplinary actions taken against physicians.

fee schedule	A comprehensive listing of fee maximums used to reimburse a physician and/or other provider on a fee-for-service basis.
fee-for-service equivalency	A quantitative measure of the difference between the amount a physician and/or other provider receives from an alternative reimbursement system, e.g., capitation, compared to fee-for-service reimbursement.
Fee-For-Service reimbursement (FFS)	The traditional healthcare payment system under which physicians and other providers receive a payment that does not exceed their billed charge for each unit of service provided.
FFS—Fee-for-Services	(1) A form of payment to providers where the provider receives payment on a per service basis (2) Refers to a group that charges the patient according to a fee schedule set for each service and/or procedure to be provided and the patient's total bill will vary by the number of services/procedures actually received.
Field Underwriting	The process performed by sales personnel for screening prospective buyers of the carrier's products. The purpose is to ensure profitable contracting with groups and to screen out those prospects that are not in the carrier's best interests.
First-Dollar Coverage	A policy that, like an HMO, has no deductibles and covers the first dollar of an insured's expenses.
FMLA	Family and Medical Leave Act
Focused Survey	A survey conducted during The Joint Commission accreditation cycle to assess the degree to which an organization has improved its level of compliance relating to specific recommendations. The subject matter of the survey is typically an area(s) of identified deficiency in compliance; however, other performance areas may also be assessed by a surveyor(s), even though they may not have been previously identified as deficiencies. See also compliance; recommendation.
frequency	The number of times a service was provided.

FSMB	Federation of State Medical Boards The Federation of State Medical Boards (FSMB) is a national non-profit organization representing the 70 medical boards of the United States and its territories. The FSMB's mission is to continuously improve the quality, safety and integrity of health care through developing and promoting high standards for physician licensure and practice.
FTE	Full Time Equivalent
Funding Level	The level of funding required to finance a medical care program. Under an insured program, it is usually the insurance or HMO premium. Under a self-funded program, the amount is usually set by the employer designee.
Funding Method	Refers to the method by which funding a medical care program occurs. Under an HMO plan, the funding method is usually a prospective rate only. Under insurance plans there are many variations of payment methods or liabilities to employers, both prospective and retrospective.
G	
Gatekeeper	A primary care physician in an HMO who makes referrals. His/her function is to reduce healthcare utilization and costs.
gatekeeper model	An informal, though widely used term that refers to a primary care case management model health plan. In this model, all care from providers other that the primary care physician, except for emergencies, must be authorized by the primary care physician before care is rendered. The gatekeeper is a predominant feature of almost all HMOs.
GME	Graduate Medical Education
Governing Body	The individual(s), group, or agency that has ultimate authority and responsibility for establishing policy, maintaining care quality, and providing for organization management and planning; other names for this group include the board, board of trustees, board of governors, board of commissioners, and partners (networks).

group model HMO	There are two kinds of group model HMOs. The first type of group model is called the closed panel, in which medical services are delivered in the HMO-owned health center or satellite clinic by physicians who belong to a specially formed but legally separate medical group that only serves the HMO. The group is paid a negotiated monthly capitation fee by the HMO, and the physicians in turn are salaried and generally prohibited from carrying on any fee-for-service practice. In the second type of group model, the HMO contracts with an existing, independent group of physicians to deliver medical care. Usually, an existing multi-specialty group practice adds a prepaid component to its fee-for-service mode and affiliates with or forms an HMO. Medical services are delivered at the group's clinic facilities (both to fee-for-services patients and to prepaid HMO members). The group may contract with more than one HMO.
Group Practice	The American Medical Association defines group practice as three or more physicians who deliver patient care, make joint use of equipment and personnel, and divide income by a prearranged formula.
GSA - General Services Administration	GSA is the centralized procurement for the federal government offering products, services and facilities that federal agencies need to serve the public. GSA offers businesses the opportunity to sell billions of dollars worth of products and services to federal agencies
H	
HA—Health Alliances	Regional alliances may be nonprofit corporations, independent state agencies or agencies of state governments, appointed by statewide councils composed of representatives of employer and consumer organizations. If the individual does not choose a health plan within 30 days, the alliance assigns the individual to the lowest-cost plan available.
HCFA Common Procedural Coding System (HCPCS)	A listing of services, procedures and supplies provided by physicians and other providers. HCPCS includes CPT (Current Procedural Terminology) codes, national alpha-numeric codes and local alpha-numeric codes. The national codes are developed by HCFA/CMS in order to supplement CPT codes. They include physician services not included in CPT as well as

	non-physician services such as ambulance, physical therapy and durable medical equipment. The local codes are developed by local Medicare carriers in order to supplement the national codes. HCPCS codes are digit codes with the first digit being a letter followed by four numbers. HCPCS codes beginning with A through V are national and those beginning with W through Z are local.
HCQIA - Health Care Quality Improvement Act	Passed by Congress in 1986 with the expectation that it would help protect hospitals and individual's participating on medical peer review committees from potential liability in the form of money damages after the revocation of a physician's hospital privileges. The Act has established standards for the hospital peer review committees, provides immunity for those involved in peer review, and has created the National Practitioner Data Bank, a system for reporting physicians whose competency has been questioned or when the physician has been sanctioned.
Health Maintenance Organization (HMO)	(1) Originally, an HMO was defined as a prepaid organization that provided healthcare to a voluntarily enrolled member in return for a preset amount of money on a PMPM basis. With the increase in self-insured business, or with financial arrangements that do not rely on prepayment, that definition is no longer accurate. Now the definition encompasses two possibilities: a health plan that places at least some of the providers at risk for medical expenses, and utilizes primary care physicians as gatekeepers (although there are some HMOs that do not). (2) An organization of healthcare personnel and facilities that provides a comprehensive range of health services to an enrolled population for a fixed sum of money paid in advance. These health services include a wide variety of medical treatments and counsel, inpatient and outpatient hospitalization, home health service, ambulance service, and sometimes dental and pharmacy services. The HMO may be organized as a group model, an individual practice association (IPA), a network model or a staff model.
Health Plan Employer Data and Information Set (HEDIS 3.0)	A core set of performance measures to assist employer and other health purchasers to compare and understand the actual performance of health

	plans. This is the so-called “report card on healthcare.” The system is currently in its second generation of evolution. 21 managed care plans are now participating in a one-year project in which HEDIS will be utilized to compare performance among plans. It is projected to become a critical marketing tool for health plans.
Healthcare Delivery System	The system of practitioners, facilities, institutions and programs that deliver health services. This term may also apply to a specific delivery system such as one offered by a health maintenance organization.
Healthcare Financing Administration (HCFA)	The federal agency formerly responsible for administering Medicare and overseeing states’ administration of Medicaid. On June 14, 2001, the Healthcare Financing Administration (HCFA) announced that it has changed its name to the Centers for Medicare and Medicaid Services. The official acronym is CMS
Healthcare Integrity and Protection Data Bank (HIPDB)	Data bank created by the Health Insurance Portability and Accountability Act of 1996, HIPDB is a national healthcare fraud and abuse data collection program for reporting and disclosure of certain final adverse actions taken against healthcare providers, suppliers or practitioners. It was established to combat fraud and abuse in health insurance and healthcare delivery. It contains information related to delivery of healthcare items or service on healthcare providers, suppliers, or practitioners as follows: civil judgments in federal or state courts; federal or state criminal convictions; actions by federal or state agencies responsible for licensing and certification of healthcare providers, suppliers or practitioners; exclusion from participation in federal or state healthcare programs; and any other adjudicated actions or decisions that the Secretary establishes by regulations. Information from the HIPDB is available to federal and state government agencies, health plans, and via self-query for healthcare providers, suppliers and practitioners. Currently there are no mandatory querying requirements. HIPDB information is not available to the general public or to hospitals.
Healthcare Quality Improvement Act (HCQIA)	Federal legislation passed in 1986 for the purpose of restricting the ability of incompetent physicians to move from state to state without disclosure or

	discovery of their prior damaging or incompetent performances. The Act established the National Practitioner Data Bank (NPDB) to which medical and healthcare organizations must report disciplinary actions taken against a practitioner. All healthcare organizations are required to query the NPDB at initial appointment and at reappointment.
HEDIS	Healthcare Employers Data Information Set
HFAP	Healthcare Facilities Accreditation Program – the accrediting organization for AOA
HIPAA	Health Insurance Portability and Accountability Act
HIPDB	Healthcare Integrity & Protection Data Bank
HMO	Health Maintenance Organization
Hold Harmless	A clause frequently found in managed care contracts, whereby the HMO and the physician hold each other to not be liable for malpractice or corporate malfeasance if either of the parties is found to be liable. This language does not preclude a managed care company from being sued if one of its physicians is sued. It may also refer to language that prohibits the provider from billing patients in the event a managed care company becomes insolvent. State and federal regulations may require this language.
I	
incremental cost	The additional cost of a service or program (over time, or serving a larger population) compared with another program.
incurred but not reported (IBNR)	The amount of money that the plan should accrue for medical expenses not yet known, that is, medical expenses that the authorization system has not captured and for which claims have not yet been received. Unexpected IBNRs have caused more problems for managed care plans than any other issue.
incurred claims	A term that refers to the actual carrier liability for a specified period and includes all claims with dates of service within a specified period, usually

	called the experience period. Due to the time lag between dates of service and the dates claims payments are actually processed, adjustments must be made to any paid claims data to determine incurred claims.
incurred claims loss ratio	The result of incurred claims divided by premiums. A defined time period is usually specified.
indemnity	A benefit paid by an insurance company for an insured loss.
Independent Practice Association (IPA)	(1) Under this structure physicians practicing in their own office participate in a prepaid healthcare plan. The physicians agree upon rates to enroll patients and bill the IPA on a fee-for-services basis. (2) An organization that has a contract with a managed care plan to deliver services in return for a single capitation rate. The IPA, in turn, contracts with individual providers to provide the services either on a capitation basis or on a fee-for-services basis.
Independent Practice Association (IPM)	A group of independent private practice physicians who have created an incorporated entity for the purpose of contracting with one or more HMOs to provide services to their members. Also known as an independent practice association.
Indicator	A measure used to determine, over time, an organization's performance of functions, processes, and outcomes.
Individual Practice Association (IPA) model HMO	A healthcare model that contracts with an individual practice association entity to provide healthcare services in return for a negotiated fee. The individual practice association in turn contracts with physicians who continue in their existing individual or group practices. The individual practice association may compensate the physicians on a per capita, fee schedule, or fee-for-service basis.
individual stop-loss coverage	A practice in experience rating which isolates claim amounts per individual over a defined level (e.g. #30,000). These isolated or pooled amounts are charged to a pool funded by the pool charges of all groups who share this same pooling level. Pooling large claim amounts helps stabilize significant premium fluctuations more prominent with small group sizes. Smaller groups generally will have lower pooling points and

	larger groups will have larger pooling points.
Infection Control Program or Process	An organization-wide program or process, including policies and procedures, for the surveillance, prevention, and control of infection.
inpatient	An individual who has been admitted to a hospital as a registered bed patient and is receiving services under the direction of a physician for at least 24 hours.
Institutional Review Board	An Institutional Review Board (IRB) is required by the Food and Drug Administration (FDA) for any hospital conducting investigations on human subjects or drugs or medical devices regulated by the FDA.
integrated delivery system	A generic term referring to a joint effort/joint venture of physician/hospital integration for a variety of purposes. Models include physician-hospital organizations, group practice without walls, management service organizations and medical foundations.
Intent of Standard	A scorable, brief explanation of a standard's rationale, meaning, and significance.
International Classification of Diseases, 9th Edition (ICD-9-Cpmsm)	A listing of diagnoses and identifying codes for reporting diagnosis of health plan enrollees identified by physicians. The coding and terminology provide a uniform language that will accurately designate primary and secondary diagnosis and provide for reliable, consistent communication on claim forms.
J	
Job lock	Staying in a job out of fear of losing health insurance coverage. Pre-existing condition waiting periods, high rates and denials plague individuals applying for new policies. Job lock represents a major hidden cost of the current system.
Joint Commission (officially referred to as The Joint Commision or TJC	An independent, not-for-profit organization dedicated to improving the quality of care in organized healthcare settings. Founded in 1951, its members are the American College of Physicians, the American College of Surgeons, the American Dental Association, the American Hospital Association, and the American Medical Association. The major functions of The Joint Commission include developing accreditation standards,

	awarding accreditation decisions, and providing education and consultation to healthcare organizations.
L	
Lag study	A report that tells managers how old the claims being processed are and how much money is paid out monthly (both for the current month and for any earlier months). These items are then compared to the amount of money being accrued for expenses each month. This powerful tool is used to determine whether the plan's reserves are adequate to meet all expenses.
Laundry List	An exhaustive listing of individual procedures or conditions that a practitioner may request to perform in a healthcare organization.
Leaders (Joint Commission)	The leaders described in the leadership function include at least the leaders of the governing body, the chief executive officer and other senior managers; department leaders; the elected and the appointed leaders of the medical staff and the clinical departments and other medical staff members in organizational administrative positions; and the nurse executive and other senior nursing leaders.
Length of Stay (LOS)	The number of days that a member stayed in an inpatient facility.
Liability	As it relates to damages, an obligation one has incurred or might incur through a negligent act.
Licensed Independent Practitioner (LIP)	Any individual permitted by law and by the organization to provide care and services, without direction or supervision, within the scope of the individual's license and consistent with individually granted clinical privileges.
Licensure	A legal right that is granted by a government agency in compliance with a statute governing an occupation (such as medicine or nursing) or the operation of an activity (such as in a hospital).
line of business	Refers to source of membership. Members under the age of 64 enrolled through an employer are known as commercial members. Members over age 64 who are Medicare beneficiaries are known as Medicare members.
LIP	Licensed Independent Practitioner
Locum Tenens	One practitioner temporarily taking the place of another practitioner.

LOS/ELOS/ALOS	Length of Stay/Estimated Length of Stay/Average Length of Stay. The terms all make reference to the number of hospital days.
loss ratio	The result of paid claims and incurred claims plus expenses divided by the paid premiums. See also incurred claims loss ratio, net loss ratio, paid claims loss ratio and medical loss ratio.
M	
Malpractice	Professional misconduct, improper discharge of professional duties, or failure to meet the standard of care of a professional that results in harm to another. The negligence or carelessness of a professional person, such as a nurse, pharmacist, physician or accountant.
Managed Care	(1) Use of a planned and coordinated approach to providing healthcare with the goal of quality care at a lower cost. Usually emphasizes preventive care and often associated with an HMO. (2) An all encompassing term. At the very least, a system of healthcare delivery that tries to manage the cost of healthcare, the quality of healthcare, and access to care. Common denominators include a panel of contracted providers that are less than the entire universe of available providers, some type of limitations of benefits to subscribers who use non-contracted providers (unless authorized to do so), and some type of authorization system. Managed healthcare may be described as a spectrum of systems, including so-called managed indemnity, PPOs, POS, open panel HMOs, and closed panel HMOs. (3) The term may also apply to indemnity insurers with utilization review. Managed care uses financial incentives to persuade providers not to order unnecessary services, urges patients to use providers in the system and encourages the organization to keep patients as healthy as possible. (4) A method of healthcare cost containment through control of utilization and reimbursement while continuously monitoring quality. In this system, healthcare providers agree to discount their services in exchange for increased patient volume through directed care within a limited provider network.

managed healthcare plan	One or more products which integrate financing and management with the delivery of healthcare services to an enrolled population; employs or contracts with an organized provider network which delivers services and which (as a network or individual provider) either share financial risk or has some incentive to deliver quality, cost-effective services; uses an information system capable of monitoring and evaluating patterns of members' use of medical services and the cost of those services.
Management Service Organization (MSO)	A legal entity that provides practice management, administrative and support services to individual or group practices. MSOs may be a subsidiary of a hospital, or privately/publicly owned by investors. When a physician sells a private practice to a hospital or for-profit medical services company, he/she is usually selling practice assets to an MSO.
mandated benefits	Those benefits which health plans are required by state or federal law to provide to policy holder and eligible dependents.
mandated providers	Providers of medical care, such as psychologists, optometrist, podiatrists and chiropractors, whose licensed services must, under state or federal law, be included in coverage offered by a health plan.
marginal cost	The additional cost of producing one more unit of outcome. Usually not the same as the average cost. If the marginal benefits are less than the marginal costs, additional treatment represents an inefficient use of resources.
market share	That part of the total healthcare market potential that a managed care company has captured.
MCO	Managed Care Organization
MCO— Managed Care Organization	A generic term applied to a managed care plan. Some people prefer it to the term HMO because it encompasses plans that do not conform exactly to the strict definition of an HMO. It may also apply to a PPO, EPO, or OWA.
Measure of Success (MOS)	A numerical or quantifiable measure usually related to an audit that

	determines if an action was effective and sustained. An MOS report is due four months after Evidence of Standards Compliance (ESC). See definition for approval.
MEC	Medical Executive Committee
Medicaid	A federal program administered and operated individually by participating state and territorial governments which provides medical benefits to eligible low income persons needing healthcare. The costs of the program are shared by the federal and state governments.
Medical Director	Physician responsible for bridging healthcare delivery with management and administration. Major responsibilities include maintaining a provider network, utilization review, and quality assurance.
medical foundation	A not-for-profit entity associated with a physician group that provides medical services under a professional services contract. The foundation acquires the business and clinical assets of the group practice, holds the provider number, and manages the business for both parties.
medical loss ratio	The cost ratio of health benefits used compared to revenue received. Calculated as: total medical expenses/total revenue.
Medical Record Review	The process of measuring, assessing, and improving the quality of medical record documentation—that is, the degree to which medical record documentation is accurate, complete, and performed in a timely manner. This process is carried out with the cooperation of relevant departments or services.
Medical Staff	A body that has the overall responsibility for the quality of the professional services provided by individuals with clinical privileges and also the responsibility of accounting, therefore, to the governing body. The medical staff includes fully licensed physicians and may include other licensed individuals permitted by law and by the organization to provide patient care services independently (that is, without clinical direction or supervision) within the organization. Members have delineated clinical privileges that allow them to provide patient care services independently within the scope of their clinical privileges. See also clinical privileges;

	licensed independent practitioner.
Medical Staff Bylaws	A document that describes the organization, roles, and responsibilities of the medical staff. The bylaws are developed, adopted, and periodically reviewed by the medical staff and approved by the governing body.
Medical Staff Executive Committee	A group of medical staff members, a majority of whom are licensed physician members of the medical staff practicing in the organization, selected by the medical staff or appointed in accordance with governing body bylaws. This group is responsible for making specific recommendations directly to the organization's governing body for approval, as well as receiving and acting on reports and recommendations from medical staff committees, clinical departments or services, and assigned activity groups.
Medicare	Title XVIII of the Social Security Act, Health Insurance for the Aged. A federal insurance program for persons over 65 years of age.
Medicare	A nationwide, federally administered health insurance program which covers the cost of hospitalization, medical care, and some related services for eligible persons. Medicare has two parts: Part A covers inpatient costs (currently reimbursed prospectively using the DRG system). Medicare pays for pharmaceuticals provided in hospitals, but not for those provided in outpatient settings. Also called Supplementary Medical Insurance Program. Part B covers outpatient costs for Medicare patients (currently reimbursed retrospectively).
Medicare beneficiary	A person who has been designated by the Social Security Administration as entitled to receive Medicare benefits.
Medicare Provider Analysis and Review (MedPar) Data	Data which are collected by the Centers for Medicare and Medicaid Services (CMS) from hospitals in order for hospitals to receive reimbursement for performed services and procedures.
member	A participant in a health plan (subscriber/enrollee or eligible dependent) who makes up the plan's enrollment. Also used to describe an individual specified within a subscriber contract who may or may not receive

	healthcare services according to the terms of the subscriber policy.
member category	A group of members classified (usually based on age and used in a capitation environment) to determine physician reimbursement levels. At a minimum, the categories are pediatrics, adults and Medicare. Also called member type.
member month	A unit of volume measurement. A member month is equal to one member enrolled in an HMO for one month, whether or not the member actually receives any services during the period. Two member months are equal to one member enrolled for two months or two members enrolled one month. Many internal operating statistics for HMOs are expressed in terms of members months.
member months	The total of all months that each member is covered. For example, if a plan had 10,000 members in January and 12,000 members in February, the total member months for the year to date as of March 1st would be 22,000.
members per year	The number of members effective in the health plan on a yearly basis. Calculation is: member months/12
MESH	Medical staff-hospital organization. (See PHO)
MIS— Management Information System	The common term for the computer hardware and software that provides the support for managing the plan.
Mixed Model	A managed care plan that mixes two or more types of delivery systems. This has traditionally been used to describe an HMO that has both closed and open panel delivery systems.
MLP— Mid-level Practitioner	Non-physicians who deliver medical care, generally under the supervision of a physician but for less cost. Physician's assistants, clinical nurse practitioners, and nurse midwives are included in this group.
Modified Community Rating	A separate rating of medical service usage in a given geographic area (community) using age, sex, data, etc.
modified fee-for-service	A system in which providers are paid on a fee-for-service basis, with

	certain fee maximums for each procedure.
Morbidity Rate	An actuarial term that measures the likelihood of medical care expenses occurring.
Mortality Rate	An actuarial term that measures the probability of death occurring.
MSO—Managed Service Organization	An MSO is an entity that is legally separate from the hospital or physician entity and, in some circumstances, from the PHO. The MSO functions in some situations simply as a practice site, including supplies, personnel, and administrative services. The nature of services provided by the MSO are comprehensive. Although the MSO provides certain advantages concerning physician practice autonomy, greater access to managed care plans, and a form of joint practice acquisition, the MSO is perceived as a temporary solution— a mere step towards full integration.
MSP	Medical Services Professional
N	
National Association Medical Staff Services (NAMSS)	The professional association for medical and professional staff services practitioners.
National Committee for Quality Assurance (NCQA)	the major accreditation body for managed care organizations (MCO). It is an independent organization that works with the managed care industry, healthcare purchasers, healthcare researchers, and consumers to develop standards that measure the structure and function of MCO quality improvement programs.
National Committee for Quality Assurance (NCQA)	A not-for-profit organization that performs quality-oriented accreditation reviews on HMOs and similar types of managed care plans.
National Council on Graduate Medical Education (NCGME)	Rations number of medical students specializing in certain fields “based on the national need for new physicians in specific specialties.”
National Practitioner Data Bank (NPDB)	A data bank created by the Healthcare Quality Improvement Act which is a central repository of information on physicians, dentists, and in some cases, other healthcare practitioners. It contains reports on medical malpractice payments, adverse licensure actions, adverse clinical privilege

	actions, and adverse professional society membership actions.
National Privacy Panel (NPP)	Responsible for ensuring "privacy protection as applied to health information." The board establishes national, unique identifier numbers for plans, providers and patients.
NCQA	National Committee for Quality Assurance
net loss ratio	The result of total claims liability and all expenses divided by premiums. This is the carrier's loss ratio after accounting for all expenses.
network model HMO	A healthcare model in which the HMO contracts with more than one physician medical groups, IPAs and may contract with single and multi-specialty groups. The physician works out of his/her own office. Physician may share in utilization savings, but does not necessarily provide care exclusively for HMO members.
non-participating provider (nonpar)	A term used to describe a provider that has not contracted with the carrier or health plan to be a participating provider of healthcare.
Not Accredited	An accreditation decision that results when an organization has been denied accreditation, when its accreditation is withdrawn by The Joint Commission, or when it withdraws from the accreditation process. This designation also describes any organization that has never applied for accreditation.
NPDB	National Practitioner Data Bank
NPI	National Practitioner Identifier
NTIS	National Technical Information Services
O	
OBRA—Omnibus Reconciliation Act	The tax and budget reconciliation acts passed by Congress. Much of the Act contains language important to managed care, especially with respect to the Medicare market segment.
office visit	Physician services provided in an office setting.

OIG	Office of Inspector General
open access	A term describing a member's ability to self-refer for specialty care. Open access arrangements allow a member to see a participating provider without a referral from another doctor. Also called open panel.
open enrollment period	A period during which subscribers in a health benefit program have an opportunity to select an alternate health plan being offered to them, usually without evidence of insurability or waiting periods.
Operative and Other Procedures	Includes operative, other invasive, and noninvasive procedures such as radiotherapy, hyperbaric treatment, CAT scan, and MRI, that place the patient at risk. The focus is on procedures and is not meant to include medications that place the patient at risk.
ORYX	The Joint Commission indicator monitoring initiative for quality of patient care in hospitals.
OSHA	Occupational Safety and Health Administration
outcome audit	A type of patient/medical care evaluation study in which criteria are designed to focus upon desired patient outcome or results of treatment, as distinguished from a process audit in which criteria focus upon the components of appropriate clinical intervention.
outcomes measurement	A process of systematically tracking a patient's clinical treatment and responses to that treatment, including measures of morbidity and functional status.
out-of-pocket costs	The portion of payments for health services required to be paid by the enrollee, including copayments, coinsurance and deductibles.
out-of-pocket limit	The total payments toward eligible expenses that a covered person funds for him/herself of dependents: i.e., deductibles, co-pays and coinsurance—as defined per the contract.
OWA—Other Weird Arrangement	A general acronym applying to any new and unusual managed care plan that demonstrates a new and unique characteristic.
P	

PCN	See primary care network
Peer Review	Evaluation of the clinical work or behavior of an individual by another individual or group of individuals with like credentials whose training and/or skills are similar. For example, physician to physician, podiatrist to podiatrist, dentist to dentist.
per contract per month (PC/PM)	The amount of dollars related to each effective contract holder, subscriber or member for each month (PS/PM - per subscriber per month), (PM/PM - per member per month).
Per Diem	A total payment per day regardless of what the billed charges are.
Per Diem Reimbursement	Reimbursement to an institution, usually a hospital, based on a set rate per day rather than on charges. Per diem reimbursement can vary by service (e.g., medical/ surgical, obstetrics, mental health, and intensive care) or can be uniform regardless of the intensity of services.
per member per month (PMPM)	The unit of measure related to each effective member for each month the member was effective. The calculation is: # of units/member months (MM).
Performance Improvement	The continuous study and adaptation of a healthcare organization's functions and processes to increase the probability of achieving desired outcomes and to better meet the needs of individuals and other users of services. This is the third segment of a performance measurement, assessment, and improvement system.
PHO	See Physician-Hospital Organization
physician	Any doctor of Medicine (M.D.) or doctor of osteopathy (D.O.) who is duly licensed and qualified under the law of jurisdiction in which treatment is received, or is defined in the summary plan description.
Physician Contingency Reserve (PCR)	The "at-risk" portion of a claim or capitation that is deducted and withheld by the MCO (usually an IPA) before payment is made to a participating physician as an incentive for appropriate utilization and quality of care. This amount - for example, 20% of the claim - remains within the MCO and is credited to the doctors's account. The PCR or "withhold" can be

	used in instances where the MCO needs additional funds to pay for specialty or subspecialty care, hospitalization or pharmaceutical utilization. The withhold is returned to the physician based on achievement of budgeted goals or his/her performance or productivity compared against his/her peers, or a combination of both. Also called "withhold."
physician extender	A nurse practitioner or physician assistant who has the authority to act as a principal provider, within certain defined limitations, in the specialty area where they are most commonly employed.
Physician Member of the Medical Staff	A doctor of medicine or doctor of osteopathy who, by virtue of education, training, and demonstrated competence, is granted medical staff membership and clinical privileges by the organization to perform specified diagnostic or therapeutic procedures.
Physician, Qualified	A doctor of medicine or doctor of osteopathy who, by virtue of education, training, and demonstrated competence, is granted clinical privileges by the organization to perform specific diagnostic or therapeutic procedure(s) and who is fully licensed to practice medicine.
Physician's Current Procedural Terminology (CPT)	A list of medical services and procedures performed by physicians and other providers. Each service and/or procedure is identified by its own unique five digit code. CPT has become the healthcare industry's standard for reporting of physician procedures and services, thereby providing an effective method of nationwide communication.
Physician-Hospital Organization (PHO)	These are legal (or perhaps informal) organizations that bond hospitals and the attending medical staff. PHOs are frequently developed for the purpose of contracting with managed care plans. They are sometimes called MESH.
Plan of action	A plan detailing the action(s) that an organization will take to come into compliance with a Joint Commission standard. A plan of action must be completed at the element of performance (EP) (see definition) level, and for some IPs, a measure of success (MOS) (see definition) must also be completed.
Podiatrist	An individual who has received the degree of doctor of podiatry medicine

	and who is licensed to practice podiatry.
point-of-service plan	A type of health plan allowing the covered person to choose to receive a service from a participating or a non-participating provider, with different benefit levels associated with the use of participating providers. Point-of-service can be provided in several ways: ▪ An HMO may allow members to obtain limited services from non-participating providers ▪ An HMO may provide non-participating benefits through a supplemental major medical policy ▪ A PPO may be used to provide both participating and non-participating levels of coverage and access ▪ Various combinations of the above may be used
Policies and Procedures	The formal, approved description of how a governance, management, or clinical care process is defined, organized, and carried out.
pool (risk pool)	A defined account (e.g. defined by size, geographic location, claim dollars that exceed "x" level per individual, etc.) to which revenue and expenses are posted. A risk pool attempts to define expected claim liabilities of a given defined account as well as required funding to support the claim liability.
PPA	See Preferred Provider Arrangement
PPO	See Preferred Provider Organization
practice guidelines	Systematically developed statements on medical practice that assist a practitioner in making decisions about the appropriate healthcare for specific medical organizations. Managed care organizations use these guidelines to evaluate appropriateness and medical necessity of care. Synonyms include practice parameters, standard treatment protocols and clinical practice guideline.
Preferred Provider Arrangement (PPA)	It is the same as a PPO but sometimes refers to a somewhat looser type of plan in which the payer (i.e., the employer) makes the arrangement rather

	than the providers.
Preferred Provider Organization (PPO)	(1) A group of physicians and/or hospitals who contract with an employer to provide services to their employees. In a PPO the patient may go to the physician of his/her choice, even if that physician does not participate in the PPO. (2) A plan that contracts with independent providers at a discount for services. The panel is limited in size and usually has some type of utilization review system associated with it. A PPO may be risk bearing, like an insurance company, or may be non-risk bearing, like a physician sponsored PPO that markets itself to insurance companies or self-insured companies via an access fee.
preferred providers	Physicians, hospitals, and other healthcare providers who contract to provide health services to persons covered by a particular health plan. See also preferred provider organization.
Primary Care Network (PCN)	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 (PCP)	The term generally applying to internists, pediatricians, family physicians, general practitioners and occasionally to obstetrician/gynecologists.
Primary Care Provider	The physician of an enrollee chooses to be his/her personal healthcare manager, coordinating the delivery of all healthcare services. See gatekeeper.
Primary Source	The original source of a specific credential that can verify the accuracy of a qualification reported by an individual healthcare practitioner. Examples include medical school, graduate medical education program, and state medical board.
Priority Focus Areas (PFA)	Process, systems, or structures in a healthcare organization that can significantly impact the provision of safe, high-quality care and can create great risk for negative outcomes should the processes, systems, or structures not function properly.

Priority Focus Process (PFP)	The process for standardizing the priorities for sampling during an organization's survey based on information collected about the organization prior to survey. The process also helps to focus the survey on areas that are critical to that organization's patient safety and quality of care processes. Examples of such information may include, but are not limited to, data from the organization's e-app (see definition); the organization's plan of action prepared as part of the Periodic Performance Review (PPR) (see definition) process; complaint and sentinel event information; data collected from external sources, such as Medicare Provider Analysis and Review (Med-Par) (see definition) data; performance measurement data; and previous survey results.
Privileging	The process whereby a specific scope and content of patient care services (that is, clinical privileges) are authorized for a healthcare practitioner by a healthcare organization based on evaluation of the individual's credentials and performance.
PRO	See Professional Review Organization
Proctoring	Actual observance of the performance of one practitioner by another practitioner who has previously been deemed qualified to act in this capacity.
Professional Association	An organization made up of members of a profession for the purpose of defining itself, identifying core competencies and translating them into a core curriculum; developing standards of practice, developing a code of ethics, designing and implementing mechanisms for self-regulation including certification from basic to advanced; and promoting professional development of its membership.
Professional Development	The life long process of growing, evolving and advancing in an area of work.
Professional Review Organization (PRO)	A physician-sponsored organization charged with reviewing the services provided to patients. The purpose of the review is to determine if the services rendered are medically necessary; provided in accordance with professional criteria, norms and standards, and provided in the appropriate setting.

profile analysis	Analysis of statistical profiles of physicians, patients, diseases, operations, etc., which displays trends (patterns) over time so that problems can be identified and changes enacted. Such patterns might not be evident from the review of single cases.
prospective reimbursement	Any method of paying hospitals or other healthcare providers for a defined period (usually one year) according to amounts or rates of payment established in advance (i.e., capitation).
provider	A physician, hospital, group practice, nursing home, pharmacy of any individual or group of individuals that provides a healthcare service.
Q	
Qualified Individual	An individual or staff member who is qualified to participate in one or all of the mechanisms outlined in Joint Commission standards by virtue of the following: education; training; experience; competence; registration; certification; or applicable licensure, law or regulation.
Quality Adjusted Life Years (QALYs)	Years of life, adjusted for their lesser quality due to illness. For example, if a treatment prolongs life for three years, but the patient is in pain and spends most of that time in a skilled nursing facility, we might say their health status is only 25% of normal health. In that case, the additional three years is only worth 3 x .25, or .75 QALYS.
quality assurance	A formal set of activities to review and affect the quality of services provided. Quality assurance includes quality assessment and corrective actions to remedy any deficiencies identified in the quality of direct patient, administrative and support services.
quality improvement	A continuous process that identifies problems in healthcare delivery, tests solutions to those problems and constantly monitors the solutions for improvement.
Quality of Life (QOL)	The patient's ability to lead a normal satisfying life, often measured in terms of functional status, the ability to perform activities of daily living; health status, which includes ability to function, as well as improvement in the physical signs or symptoms of the disease, or the health related quality

	of life, which includes functional status, plus improved health status, plus the ability to experience greater general satisfaction with life.
R	
rate	The amount of money per enrollment classification paid to a carrier for medical coverage. Rates are usually charged on a monthly basis.
rating process	The process of evaluating a group or individual to determine a premium rate in regard to the type of risk it presents. Key components of the rating formula are the age/sex factor, location, type of industry, base capitation factor, plan design, average family size, demographics and the administration costs.
RBRVS	See Resource Based Relative Value Scale
recidivism	The frequency of the same patient returning to the hospital for the same problems. Refers to inpatient hospitalization.
recipient	A person who has been designated by the Medicaid agency as eligible to receive Medicaid benefits
reciprocity	A contractual arrangement among plans whereby participating plans agree to exchange claim data and transfer claim payments, in accordance with agreed upon rules, when a provider in one plan territory renders services to a member from another plan. This encourages providers to accept member identification cards from participating plans.
Recommendation	A citation requiring corrective action based on the nature, severity, or number of compliance problems which is accompanied by appropriate follow-up monitoring.
reconsideration	Appeal mechanism requesting consideration of an adverse determination made by a physician advisor in carrying out review responsibilities regarding a claim affecting the rights of the beneficiary, attending physician or institutional provider within a required time unit.
referral	The recommendation by a physician and/or health plan for a member to

	receive care from a different physician or facility.
referral provider	A provider that renders a service to a patient who has been sent to him/her by a participating provider in the health plan.
Regulatory Agency	The arm of government that enforces legislation regulating an act or activity in a particular area, for example, the federal Food and Drug Administration.
reinsurance	(1) A type of protection purchased by HMOs from insurance companies specializing in underwriting specific risks for a stipulated premium. This becomes a cost of doing business for HMOs. Typical reinsurance risk coverages are: (A) individual stop-loss (B) aggregate stop-loss (C) out of area (D) insolvency protection As HMOs grow in membership, they usually reduce their reinsurance coverage (and related direct costs) as they reach a financial position to assume such risks themselves. (2) Insurance purchased by a health plan to protect it against extremely high cost cases. See also stop-loss.
Requirement for improvement	A recommendation that was not sufficiently addressed in an organization's Evidence of Standards Compliance (ESC) and needs to be addressed in order for the organization to retain its accreditation decision. Failure to address a requirement for improvement after two opportunities will result in a recommendation to place the organization in Conditional Accreditation.
Resource Based Relative Value Scale (RBRVS)	This classification system is used as a financing mechanism to reimburse physicians and other types of providers by a classification system which measures training and skill required to perform a given healthcare service. Adjusting for overhead costs, geographical differences and services

	rendered, RBRVS is intended to redress Medicare's tendency to overcompensate for such services as surgery and diagnostic tests and to underpay for primary care services that involve examining and talking with patients. The new RBRVS became effective January 1992 and represents a significant change in the way physicians are compensated for Medicare services.
retention	That portion of the cost of a medical benefit program which is kept by the insurance company or health plan to cover internal costs or to return a profit. Can also be referred to as administrative costs.
retrospective review	A method of determining medical necessity and/or appropriate billing practice for services which have already been rendered.
risk contract	An agreement between HCFA/CMS and an HMO or competitive medical plan requiring the HMO to furnish at a minimum all Medicare covered services to Medicare eligible enrollees for an annually determined, fixed monthly payment rate from the government and a monthly premium paid by the enrollee. The HMO is then liable for services regardless of their extent, expense of degree.
Risk Management	An organized approach to identifying, assessing and planning for potential problems that may be encountered during the project.
risk pool	A pool of money that is at risk for being used for defined expenses. Whatever funds (if any) are left at the end of a designated risk period are commonly returned to those who manage the risk.
S	
sanction	A reprimand, for any number of reasons, of a participating provider.
self-funding self-insurance	A healthcare program in which employers fund benefit plans from their own resources without purchasing insurance. Self-funded plans may be self-administered, or the employer may contract with an outside administrator for an administrative services only (ASO) arrangement. Employers who self-fund can limit their liability via stop-loss insurance on

	an aggregate and/or individual basis.
self-referrals	Arrangements for care beyond primary care made by the patient rather than the provider. HMOs generally specify to which in-house departments or services a patient may self-refer. For example, patients may be allowed to self-refer to optometry or mental health services. For non-HMO services, patients are not allowed to self-refer if the care is to be paid by the HMO, except in emergencies.
sensitivity analysis	A "what if" analysis, in which several alternative estimates of uncertain variables are used to test the robustness of conclusions.
Sentinel Event	An unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome.
service area	The territory within certain boundaries that an HMO designates for providing service to members. Since easy access into the health delivery system is a primary HMO tenet, it is generally believed that a member should not have to drive longer than 30 minutes in order to gain access to the system. Some HMOs establish a mileage radius from their medical delivery sites, some rely on zip codes and others use county boundaries to define service areas.
service plan	A health insurance plan that has direct contracts with providers but is not necessarily a managed care plan. The archetypal (and virtually only) service plans are Blue Cross and Blue Shield plans. The contract applies to direct billing of the plan by providers (rather than billing of the member), a provision for direct payment (rather than reimbursement of the member), a requirement that the provider accept the plan's determination of UCR and not balance bill the member in excess of that amount, and a range of other terms. It may or may not address issues of utilization and quality.
shared risk	In the context of an HMO, an arrangement in which financial liabilities are apportioned among two or more entities. For example, the HMO and the

	medical group may each agree to share the risk of excessive hospital cost over budgeted amounts on a 50-50 basis.
Shared Visions–New Pathways	An initiative to progressively sharpen the focus of the accreditation process on care systems critical to the safety and quality of patient care.
Sherman Anti-trust Act	Federal law that makes illegal contracts, conspiracy, and monopolies to restrain trade. Areas of concern for healthcare organizations include reduced market competition, price fixing, preferred provider organizations and exclusive contracts.
single carrier replacement	The process by which a purchaser of group healthcare coverage covers all eligibles through one carrier and drops all other carriers already in the account.
staff model HMO	(1) The staff model consists of a group of physicians who are either: salaried employees of a specially formed professional group practice, which is an integral part of the HMO plan, or salaried employees of the HMO. Medical services in staff models are delivered at HMO owned health centers and generally only to HMO members. The physicians in either form of staff model are usually limited in their fee-for-service activities. (2) An HMO that employs providers directly, and those providers see members in the HMO's own facilities. A form of closed panel HMO.
Standard of Care	Description of the conduct that is expected of an individual in a given situation. It is a measure against which a defendant's conduct is compared.
Standards	Authoritative statements enunciated and made known by the profession by which the quality of practice, administration or education can be judged.
Stark Act	Legislation that prohibits a physician who has a financial relationship with an entity from referring Medicare or Medicaid patients to that entity for the provision of a designated health service.
stop-loss insurance	Insurance coverage taken out by a MCO or self-funded employer to provide protection from losses resulting from claims over a specific dollar amount per member per year (calendar year or illness to illness).

	Types of stop-loss insurance: 1. Specific or individual - reimbursement is given for claims on any covered individual which exceed a predetermined deductible, such as $25,000 or $50,000. 2. Aggregate - reimbursement is given for claims which in total exceed a predetermined level, such as 125% of the amount expected in an average year.
subscriber	The person responsible for payment of premiums or whose employment is the basis for eligibility for membership in an HMO or other health plan.
sub-specialist	Someone who is recognized to have expertise in a specialty of medicine or surgery. Within HMOs it usually refers to physicians who are able to receive referrals from primary care physicians.
supplemental services	Optional services that a health plan may cover or provide in addition to its basic health services. For example, many HMOs offer a chiropractic benefit plan for an additional $4-$6 premium PM/PM that allows HMO members to self-refer themselves to chiropractic plan providers for treatment.
Survey Team	The group of healthcare professionals who work together to perform a Joint Commission accreditation survey.
T	
Third Party Administrator (TPA)	An independent person or corporate entity (third party) who administers group benefits, claims and administration for a self-insured company group. A TPA does not underwrite healthcare risk.
third party payer (payor)	An organization that acts as a fiscal intermediary between the provider and consumer of care. Examples include HMOs, insurance carriers, HCFA/CMS.
TPA	See third party administrator
Tracer Methodology	A process surveyors use during the on-site survey to analyze an organization's systems, with particular attention to identified priority focus

	areas, by following individual patients through the organization's healthcare process in the sequence experienced by the patients. Depending on the healthcare setting, this process may require surveyors to visit multiple care units, departments, or areas within an organization or within a single care unit to "trace" the care, treatment, and services rendered to a patient.
trend factor	The rate at which medical costs are changing due to such factors as prices charged by medical care providers, changes in the frequency and pattern of utilizing various medical service, cost shifting and use of expensive medical technology.
triple option	A type of health plan in which employees may choose from an HMO, PPO or indemnity plan, depending on how much they are willing to contribute to cost. See also multiple option plan.
U	
UB-92	The common claim form used by hospitals to bill for services. Some managed care plans demand greater detail than is available on the UB-92, requiring hospitals to send additional itemized bills.
UCR	See Usual, Customary, or Reasonable
unbundling	The practice of a provider billing for multiple components of service that were previously included in a single fee. For example, if dressings and instruments were included in a fee for a minor procedure, the fee for the procedure remains the same, but there are now additional charges for the dressings and instruments.
underwriting	A review of prospective and renewing cases for appropriate pricing, risk assessment and administrative feasibility.
upcoding	The practice of a provider billing for a procedure that pays better than the service actually performed. For example, an office visit that would normally be reimbursed at $45 is coded as one that is reimbursed at $53.
UPIN	Unique Physician Identification Number

URAC	Utilization Review Accreditation Commission
USMLE	United States Medical Licensing Exam
Usual, Customary, or Reasonable (UCR)	(1) A method of profiling prevailing fees in an area and reimbursing providers on the basis of that profile. One common methodology is to average all fees and choose the 80th or 90th percentile, although a plan may use other methodologies to determine what is reasonable. Sometimes the term is used synonymously with a fee allowance schedule when the schedule is set relatively high. (2) The allowance measured and determined by comparing actual provider charges with the charges customarily made for similar services and supplies to individuals with similar medical conditions. When covered charges are based on the UCR allowance, the medical plan will pay the UCR allowance or billed charges, whichever is less.
utilization	The frequency with which a benefit is used. For example, utilization may be reported as 3,200 doctors's office visits per 1,000 HMO members per year. Utilization experience multiplied by the average cost per unit of service delivered equals capitated costs.
Utilization Management	The examination and evaluation of the appropriateness of the utilization of an organization's resources. Also referred to as utilization review.
Utilization management	A process that measures use of available resources (including professional staff, facilities, and services) to determine medical necessity, cost effectiveness, and conformity to criteria for optimal use.
Utilization review	The review of services delivered by a healthcare provider to determine whether, according to preestablished standards, the services were medically necessary.
Utilization Review Coordinator	A hospital employee, typically a medical record professional or a nurse, who coordinates the hospital's utilization review activities, gathers data from medical records and elsewhere for the use of the utilization review committee, and assists the committee in its work.

W	
withhold	A percentage of payment to the provider held back by the HMO until total cost of referral or hospital services has been determined. Physicians exceeding the amount determined as appropriate by the HMO lose the amount held back. The amount of withhold returned depends on individual utilization by the gatekeeper, financial indicators for the overall capitated plan and referral patterns through the year by the gatekeeper, groups of physicians or the overall plan pool.