A Glossary of Managed Care Terms

Capitation
A reimbursement system that pays a specified monthly amount for each assigned member (patient).

Carve-out
When an employer group excludes a category of care from its benefit package with a managed care organization, and contracts with another provider or group of providers for these services. An eye care carve-out offers primary, secondary and tertiary care provided by general ophthalmologists and/or optometrists, and surgical and medical ophthalmic specialists.

Disenrollment
When a patient withdraws from a managed care plan. This often occurs when an employer changes its managed care affiliation. A high disenrollment rate probably indicates patient/employer dissatisfaction with that plan.

Enrollment
The total number of patients participating in a managed care plan. The size of enrollment often is important in determining whether you should become a plan provider.

Fee-for-service
A reimbursement system that pays a certain dollar amount for each service provided. This is the traditional way health care has been reimbursed in the United States.

Gatekeeper
The health care provider, usually a primary care physician, who coordinates and manages a patient’s care. The gatekeeper may either treat the patient or refer the patient to a specialist for secondary or tertiary care. The gatekeeper is responsible for ensuring that preventative care is provided.

HEDIS
A reporting mechanism developed by employers and managed care plans that provides comprehensive information about a health organization’s performance. HEDIS studies are important indicators of the quality of care being delivered.

Managed care
A health care plan that is designed to eliminate redundancy and oversuse of the health care system, thus reducing or lending more predictability to costs. Managed care has institutionalized quality control of health care through physician peer review and other mechanisms like HEDIS.

Managed care organization
The administrative arm of managed care that organizes provider panels, markets managed care products to employer groups and oversees patient use and referral within the provider panels.

Medical director
A physician who coordinates and supervises the delivery of health care by a managed care plan.

NCQA accreditation
The National Committee on Quality Assurance, an independent, non-profit group that reviews and accredits health maintenance and managed care organizations. NCQA says its accreditation is based on a series of standards that stress the importance of achieving and maintaining quality care.

Provider
The person or entity providing health care services. It may be an individual ophthalmologist, general physician or other health care professional, a practice, a clinic or hospital, or another facility.

Provider panel
The health care providers who contract with a managed care organization to deliver care to enrolled patients. Usually refers to individual professionals or practices.

Quality review committee
A peer review system within the managed care organization. The QRC periodically reviews patient records to determine if care is provided efficiently and effectively.

Roster of physicians
The actual list of providers who have been approved to deliver care for enrolled patients. This roster is given to patients, who then select a primary care physician. When deciding whether to join a provider panel, ask for the roster of physicians and review it.

Specialist referral
Referral from the primary care physician (or gatekeeper) to a surgeon or other specialist. This may be done by letter, form, telephone or computer interface.

Utilization rate
The rate at which a given group of patients uses the health care system. Patients who over-utilize or under-utilize the system drive up costs. The managed care organization strives for the most efficient and effective utilization of this system.

—By Judith Lu, Contributing Editor