# **Managed Care in Oregon**

The experiment, the journey, the future

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November 18, 2011



#### What we will cover

- Oregon snapshot
- The basics what, why and how
- History and evolution of managed care in Oregon
- Managed care today in Oregon
  - Enrollment requirements and exemptions
  - Benefits and carve outs
  - Federal requirements and state contract requirements
  - Capitation payments
  - State infrastructure
  - State oversight, including performance and quality of care
- Summary and conclusions
- The future, including 2011 supporting legislation



# Oregon snapshot (2009)

- Population: 3.8 million
  - Medicaid participants:16.5% (630,000)
  - Medicare beneficiaries:16% (608,000)
- Median annual income: \$50,900
- Unemployment rate: 9.6%
- Health spending per capita: \$4,880

- Medicaid spending: \$4 billion (14.3%)
- Medicaid spending per enrollee: \$5,960
- Medicaid enrollment by eligibility group:
  - Children 54%
  - Adults 20%
  - Disabled 13%
  - Aged 6%
  - Other programs 7%
- Oregon's FMAP: 62.9% (2011)

# The basics – What is managed care?

- HMO Act of 1973 spurred growth in managed care, a system of financing and delivery of health care through MCOs.
- MCOs use a network of providers to furnish health services.
- With an estimated 30% of costs that are unnecessary or don't lead to improved health, organized around programs to reduce costs:
  - Preventive care
  - Medically necessary and outcomes-based care
  - Better care management through disease management, exceptional needs care coordination
  - Patient education and provider incentives
- Federal/state agencies provide the policy framework and oversight, moving the responsibility and accountability to MCOs for care delivery focused on local needs and resources.

# The basics - Why managed care?

- Nearly all states are experiencing a fiscal crisis, with medical costs outpacing nearly all other expenditures.
- Everyone is facing the same challenges:
  - Costs are too high, care is fragmented and outcomes are unsatisfactory.
  - Access issues result in increased costs.
  - Fragmented care leads to poorer health outcomes and higher costs.
- To improve health care quality and access, we need:
  - The right care in the right place at the right time.
  - Universal application of outcome based treatment standards and measurements.



# The basics - Important considerations

- Paying MCOs does not permit states to shift to plans the federally mandated responsibility to ensure appropriate payment, access, and quality as required under federal law and regulation.
- The use of managed care brings some additional responsibilities to the states.
- State's ability to find savings through managed care varies, depending on:
  - The availability of providers,
  - Existing practice patterns of those providers,
  - Patterns of service use by Medicaid enrollees,
  - Current FFS levels, and
  - The managed care model.



# The basics – How is managed care structured?

- Three primary types of Medicaid managed care arrangements:
  - Comprehensive risk-based plans cover all or most Medicaid covered services.
  - Limited benefit plans:
    - Contract to manage a subset of benefits (e.g., transportation and oral health services), or
    - Contract to manage services for a particular subpopulation (e.g., medically fragile adults or children in foster care).
  - Primary Care Case Managers (PCCMs):
    - Contract to manage care as a client's single designated primary care provider, and
    - Are paid a monthly case management fee for care management and coordination.

History and evolution

# Managed care in Oregon



# Oregon's managed care history

- 1989: Legislation passed to support OHP Demonstration Project Waiver.
  - Reliance on managed care to ensure access and constrain costs, building on Oregon's history of experience in both commercial market and Medicaid
- 1994 PCOs were phased out in favor of FCHPs.
  - PCOs were directly accountable for most services and did not provide coverage for prescription drugs and hospital costs.
  - FCHPs would be responsible for all medical benefits with few carveouts.
  - Commercial HMOs such as Regence, Kaiser and Providence expanded rapidly into new service areas.
  - These HMOs began serving Medicaid populations as FCHPs while thousands of new enrollees became eligible for the OHP.
- In many cases, Medicaid expansion by HMOs was followed by commercial market managed care expansion.

# Oregon's managed care history

- 1994, continued:
  - Phase 1:
    - Introduced FCHPs with payments based on costs of care;
    - Included traditional Medicaid populations, except seniors, people with disabilities and children in state care or adoption assistance; and
    - Included new expansion adult population under the Federal Poverty Level.
  - FFS payments remained lower than FCHP payments as an incentive for FCHP geographic expansion.



# Oregon's managed care evolution

#### 1995:

- Phase 2 expanded to include seniors, people with disabilities, and children in state care or adoption assistance.
- For these populations, FCHPs would:
  - Address the different needs, such as specialty care and specialized supplies and equipment;
  - Provide more cost-effective care management; and
  - Resolve negative impacts based on location, access or provider panels.



# Oregon's managed care evolution

#### 1997:

- All but three Oregon counties had at least one FCHP.
- Oregon released a Request for Applications to provide capitated mental health services on a statewide basis.

#### 1998:

- Large "mainstream" health plans could not sustain their expansions into areas outside the major population areas.
- During the same period, smaller FCHPs were being created in service areas where large plans were withdrawing.



# Oregon's managed care evolution

#### 2000:

- Smaller FCHPs supplanted the original FCHPs in many counties.
- In some communities, FCHP presence had shrunk to a single FCHP or disappeared entirely.
- Smaller plans usually formed around an IPA or hospital.
- Smaller plans designed their care for the community and its needs, fostering local control and local accountability.



How it works today

# Managed care in Oregon



### Managed care enrollment

- Physical Health FCHPs and PCOs – 83% enrollment
  - 14 FCHPs
  - 2 PCOs
- PCMs 1% enrollment
  - Available in areas with little or no FCHP/PCO capacity
  - PCMs are paid FFS rates for patient care and receive an additional case management fee of \$6 per member per month.

- Dental Care Organizations –
   95% enrollment
  - 8 DCOs
- Mental Health Organizations –
   90% enrollment
  - 9 MHOs



### **Enrollment requirements**

- The primary person in a household group selects an FCHP/PCO and DCO on behalf of all members.
  - All household members must be enrolled in the same plan(s) unless otherwise exempt from enrollment.
  - If no FCHP/PCO is available, clients in the same household group may select different PCCMs.
- Each week, clients in mandatory service areas\* are automatically enrolled into an FCHP/PCO and/or DCO, unless exempt.
- MHO enrollment is based on the household's FCHP/PCO.
- \* Mandatory Service Areas have adequate managed care capacity and enrollment is mandatory. Voluntary Service Areas lack adequate managed care capacity and enrollment is voluntary. In voluntary areas, PCM enrollment is an option.



### **Enrollment exemptions**

- OHP populations exempt from managed care enrollment include:
  - Alaska Natives/American Indians (upon request);
  - Children in state custody for less than 30 days;
  - Pregnant clients in third trimester, if practitioner isn't on the provider panel for area FCHPs;
  - Individuals with End Stage Renal Disease;
  - Women eligible through the Breast and Cervical Cancer Program;
  - Individuals in Voluntary Service Areas (areas without adequate plan capacity);
  - Medicare/Medicaid dually eligible individuals, if there is only one FCHP in their area and they choose not to enroll in that FCHP's affiliated Medicare Advantage Plan; and
  - Others as determined by the state.



#### OHP services provided through two main benefit packages\*

OHP Plus	Who receives this benefit package?	People eligible for traditional Medicaid and Children's Health Insurance Program (CHIP) receive these benefits.  • Children (ages 0 through 18) and pregnant women cannot have their benefits reduced except by federal waiver.
	What are the benefits?	Comprehensive medical, dental, vision, prescription drug and behavioral health benefits.  Non-pregnant adults have reduced dental and vision benefits.
OHP Standard	Who receives this benefit package?	People not otherwise eligible for traditional Medicaid receive this benefit.
	What are the benefits?	<ul> <li>Basic medical care (<i>e.g.</i>, doctor's visits), prescription drug and behavioral health benefits;</li> <li>Limited hospital, dental, vision and durable medical equipment benefits;</li> <li>Medical transportation covered for emergencies only;</li> <li>No coverage for hearing aids and exams, home health, private duty nursing, or therapies (physical, occupational, speech), glasses/contact lenses.</li> </ul>

<sup>\*</sup>There are also other benefit packages that cover a small portion of program clients.



### Oregon's contracted managed care services

- Capitated services: What is included?
  - The same benefits as covered by OHP, except those excluded from contracts as "carve outs"
  - OHP pays for the excluded services on FFS basis
  - Contracted services are specific to the type of managed care plan – FCHP, PCO, DCO, MHO

- Managed care carve outs: What is excluded?
  - Family planning services
  - Physician assisted suicide under the Oregon Death with Dignity Act
  - Therapeutic abortions
  - Non-emergency medical transportation
  - Residential chemical dependency services
  - Mental health drugs



# Federal managed care requirements\*

- General provisions:
  - Non-discrimination
  - Covered services
  - Inspection and audit
  - Care management and coordination
  - Provider requirements and networks
- Enrollment, disenrollment and re-enrollment:
  - Choice and limitations on changes of PCPs
  - Disenrollment
  - Automatic re-enrollment

- Enrollee rights and protections:
  - Dignity and privacy
  - Customer service and member education
  - Information about services and how to contact the plan (e.g., toll free hotlines and ombudsman programs)
  - Marketing activities
  - Liability for payment
  - Emergency services



<sup>\*</sup> Source: CMS Checklist for Managed Care Contract Approval

# Federal managed care requirements\*

- Quality assessment and performance improvement:
  - Access
  - Structure and operation
  - Measurement and improvement
  - Reporting
- Grievance system:
  - Service authorizations and notices of actions
  - Appeals and expedited appeals processes
  - Access to fair hearings

- Certification and program integrity (includes fraud and abuse)
- Sanctions:
  - Closing enrollment
  - Financial sanctions
  - Temporary management
  - Termination
- Finance and payments, including financial solvency

<sup>-</sup>Health

<sup>\*</sup> Source: CMS Checklist for Managed Care Contract Approval

### Oregon's managed care contract requirements

- Federal requirements
- Additional state requirements, such as:
  - Geographic service area
  - Enrollment limits
  - Services included and excluded
  - Benefit limitations through the Prioritized List of Health Services
  - Participation in All Payers All Claims (APAC) reporting program
  - Payment rates
  - Mandatory reports
  - Insurance requirements
- Contracts are supported in rules, policies and procedures.



#### Federal requirements\* - managed care capitation rates

#### **Basic requirements**

- All payments must be actuarially sound.
- Rates must be developed in accordance with generally accepted actuarial principles and practices.
- The managed care contract must specify:
  - The payment rates;
  - Any risk sharing mechanisms; and
  - The actuarial basis for computation of those rates and mechanisms.

#### Rate development requirements

- Base utilization and cost data derived from (or comparable to) the Medicaid population
- Adjustments for such factors as medical trend inflation, incomplete data, plan administration, and utilization
- Specific rates appropriate for each enrolled population
- Payment mechanisms and assumptions, and risk-sharing mechanisms appropriate for high-risk groups





### States' approaches to capitation rate setting

- Multiple methods used nationwide:
  - Administered pricing: State sets rates, usually at the lower end of an actuarially sound range
  - Competitive bidding: Using Request for Proposals process, state selects plans based on proposed rates and services
  - Hybrid approaches:
    - State sets a range of rates and plans bid competitively within that range, or
    - State negotiates with plans based on administered pricing or their competitive bid.
- Some states identify a specific percentage for administrative costs included in capitation rates; others set administrative costs on a per member per month (PMPM) basis.

# OHP's approach to capitation rate setting

- Oregon:
  - Uses both internal and external actuaries;
  - Sets a specific percentage for administrative costs;
  - Uses administered pricing based on actuarially sound rates;
  - Uses a Request for Applications process in areas with inadequate plan coverage; and
  - Conducts a Rates Advisory Panel to communicate with plans about rate setting and policies.
- MCOs are paid at levels necessary to cover the costs of providing contracted services.
- MCO financial reports are used to analyze administrative costs that are included in capitation rates.

# OHP's approach to capitation rate setting

- Per capita (or PMPM) costs are:
  - Calculated for each eligibility category and service delivery arrangement, and
  - Paid based on estimated enrollment for each plan.
- Risk adjustment includes factors such as eligibility category and age to account for individuals with higher health costs.
- Plans assume the risk of providing required services and must obtain risk protection through the purchase of catastrophic expense stop-loss coverage or re-insurance.



#### **OHP** capitation rates (October 2011)

Eligibility category	FCHP	PCO	DCO	МНО
Temporary Assistance to Needy Families (Adults Only)	\$467.90	\$266.26	\$26.64	\$24.63
Poverty Level Medical Adults	\$1,466.46	\$230.21	\$24.41	\$10.66
PLM, TANF, and CHIP Children < 1	\$580.86	\$110.69	\$0.25	\$0.57
PLM, TANF, and CHIP Children 1 – 5	\$104.61	\$74.55	\$17.43	\$4.56
PLM, TANF, and CHIP Children 6 – 18	\$96.99	\$66.36	\$22.65	\$27.23
Aid to the Blind/Aid to the Disabled with Medicare	\$133.74	\$132.54	\$22.58	\$72.73
Aid to the Blind/Aid to the Disabled without Medicare	\$943.76	\$545.89	\$19.92	\$120.15
Old Age Assistance with Medicare	\$155.12	\$146.75	\$13.04	\$8.15
Old Age Assistance without Medicare	\$715.30	\$581.19	\$21.45	\$14.23
Children in state custody or adoption assistance	\$184.30	\$101.08	\$20.97	\$245.69
OHP Families	\$294.52	\$339.94	\$5.08	\$15.36
OHP Adults & Couples	\$502.56	\$529.21	\$5.10	\$38.58
Weighted Average*	\$304.17	\$152.36	\$18.26	\$37.59

<sup>\*</sup>Weighted average capitation rates are based on Jan. 2011 enrollment distributions.



# Managed care oversight - external

- A contracted External Quality Review Organization (EQRO), Acumentra Health, conducts an annual External Quality Review (EQR) of the MCOs as required by CMS.
- An EQR includes the analysis and evaluation of aggregated information on quality, timeliness, and access to the health care services that an MCO furnishes to Medicaid recipients.
- The EQRO reviews and reports plan compliance in three areas:
  - Compliance with state and federal standards (e.g., service authorization, access to specialists);
  - Validation of performance measures for access and preventive care;
     and
  - Validation of performance improvement projects that must improve member health and satisfaction.



#### Primary internal managed care administration and oversight

- Delivery System Management
  - Provide support and maintenance
  - Monitor contract compliance and financial solvency
  - Approve plan educational materials
  - Resolve client issues related to managed care enrollment
  - Develop and update contracts
- Quality Assurance and Improvement
  - Monitor compliance with federal quality assurance requirements and EQRO recommendations
  - Oversee quality improvement work plans
  - Manage Oregon EQRO contract
  - Grievance system and fraud and abuse oversight
- Organization around, and coordination between, both the managed care and FFS delivery systems is essential.



# State infrastructure for MCO administration

Federal requirements

State rules and contracts

#### Internal workgroups

- Executive Steering
- MCO Collaborative

Contractor forums and workgroups

Direct agency oversight (AMH for MHOs, DMAP for FCHP/PCOs and DCOS)

AMH Medicaid Policy

DMAP Delivery Systems

DMAP QA/QI Unit

Administers EQRO contract

### Other agency supports

Actuarial Services Operations:

- Claims
- Provider enrollment
- Call centers

Research and Analysis

- Surveys
- ReportsDatavalidation

Hearings

Units serving all delivery systems

- Policy
- Medical Mgt.



Summary and conclusions

# Managed care in Oregon



# The good:

- A consistently high level of satisfaction with the managed care system among Medicaid recipients (83%), a ten-year trend.
- Improvement in access to health care, care coordination and care integration:
  - An increase in the number of physicians participating in Medicaid through the managed care delivery system;
  - Reductions in emergency room utilization and in unnecessary or duplicative services;
  - Improved health outcomes through disease and care management programs; and
  - Continual quality improvement through a focus on evidence based care and performance improvement projects.
- Involvement of all interested parties in planning, implementation and ongoing operations contributing to community buy-in and identification of best practices

#### The bad:

- Because of how plans are paid per capita, they don't always have motivation for good health policy.
- Plans continue to express concerns regarding payment levels and financial risk.
- Physical, dental and behavioral health care are not integrated leading to poorer health outcomes and higher costs.
- With the continued fiscal crisis, although there has been significant progress, we are still facing the challenges – costs are too high, care is fragmented and outcomes are unsatisfactory.



### The challenges:

- Competition for state general fund dollars;
- Resistance to change in the way health care is financed and delivered;
- Increases in the cost of technologies, including diagnostics and prescription drugs;
- Increasing diversity of patient populations; and
- Changes in available physician and hospital capacity.



The future

# Managed care in Oregon



# Change agents for Oregon health system transformation

- 2011Oregon Legislation:
  - Moves to new managed care model Coordinated Care Organizations (CCOs), with Patient Centered Primary Care Homes (PCPCH) as the core;
  - Supports recent federal provisions that will ease implementation of the new managed care model; and
  - Enacts budget reductions that make these changes imperative and encourage closer cooperation between plans and the state.
- The Affordable Care Act:
  - Supports Oregon's health system transformation efforts; and
  - Includes many provisions and funding opportunities to promote better coordination of care through grants, technical assistance and enhanced matching rates.

### How CCOs will change managed care in Oregon

#### For plans

- CCOs will manage physical, dental and behavioral health care coordination
- Greater flexibility and accountability (metrics)
- New systems of governance
- Greater attention to health equity and community engagement
- Global budget methodology
- Incentives for optimal health outcomes
- Quality standards and incentives will align with industry standards

#### For clients

- Coordinated, patient-centered care that recognizes individual needs
- Care for members with highrisk or chronic health care needs a priority
- Help accessing health care, community and social support services at multiple levels
- Improved transition planning (e.g., inpatient to outpatient care)



#### **Barriers to reform**

#### **Federal**

- Ability to blend of Medicaid, Medicare and other funding streams
- Differences between Medicare and Medicaid managed care rules
- The culture of CMS oversight doesn't foster innovation (restricts path to pursue demonstrations)
- Lack of mechanisms to use non-traditional health care professionals

#### **State**

- Still-developing health information technology
- Complicated and entrenched enrollment procedures
- Coordinating the new CCO system with the new Health Insurance Exchange
- Financial and political obstacles



### **Next steps**

- Four health transformation work groups have been meeting since August 2011 \*:
  - CCO Criteria Workgroup
  - Global Budget Methodology Workgroup
  - Outcomes, Quality and Efficiency Metrics Workgroup
  - Medicare-Medicaid Integration of Care and Services Workgroup
- Their work will inform the plan for CCOs that will be submitted to the 2012 Oregon legislature in February
- The goal is to launch the first CCO in July 2012.

**Contact Information:** 

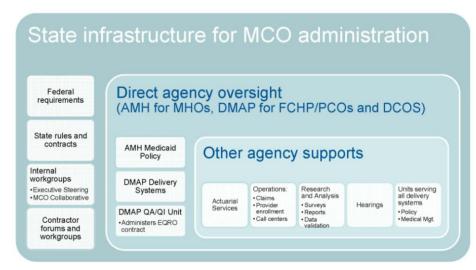
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#### Internal workgroups and forums

Discuss and resolve issues on an agency-wide basis:

- Executive Steering
- MCO Collaborative

#### **Contractors forums and workgroups**

Discuss and resolve issues cooperatively with contracted plans

- Actuarial Services Advisory Panel
- Dental Contractors
- Encounter Data Workgroup
- Education and Marketing Workgroup
- Financial Solvency Workgroup
- Medical Directors
- Mental Health Code Workgroup
- Mental Health Contractors
- Mental Health Quality and Improvement Workgroup
- Mental Health Rates and Finance Workgroup
- Rules and Contracts Workgroups
- OHP Contractors
- Policy Advisory Panel
- Quality and Performance Improvement Workgroup

#### **Direct agency oversight**

DMAP has two units dedicated to oversight of 16 physical health plans and 8 dental plans.

- DMAP Delivery Systems Unit (17 staff)
- DMAP Quality Assurance and Improvement Unit (5 staff)

The Addictions and Mental Health Division (AMH) has 5 staff dedicated to oversight of 9 Mental Health Organizations.

#### Other agency supports

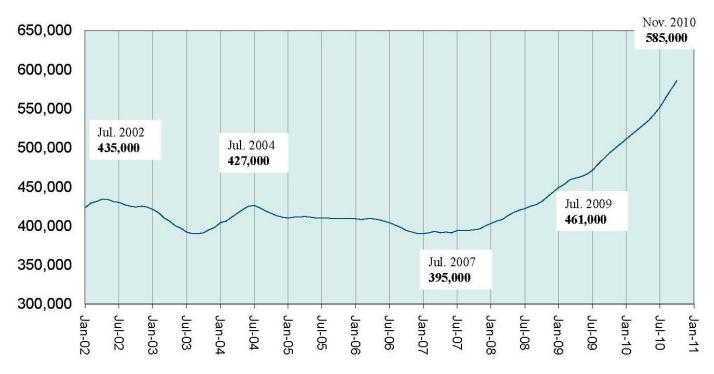
Other units vary in the amount of time dedicated to managed care work.

Time another					
Formation	01-55	Time spent on			
Function	Staff	managed care work			
Actuarial Services Unit	13	85% of total work			
Rate development		time			
Reporting					
Claims Unit	21	5 staff spend 100%			
Review and validate plan claim		of their time			
data					
Resolve electronic data		4 staff spend 25% of			
interchange issues		their time (misc.			
Provider enrollment to support		issues)			
plan claim data					
Client Call Center	10	47 hours weekly			
Provider Call Center	8	20-25 hours weekly			
Research and Analysis	6	4 positions, as-			
<ul><li>CAHPS survey</li></ul>		needed (CAHPS an			
<ul><li>Performance measure validation</li></ul>		annual requirement			
Reporting		starting in 2012)			
Hearings	5	85% of total work			
Coordinate and conduct State		time			
Fair Hearings					
Medical Management	21	45 hours weekly			
Prior authorizations		-			
<ul><li>Consultation, coordination</li></ul>					
Prevention activities					
Policy and Planning	27	6% of unit work time			

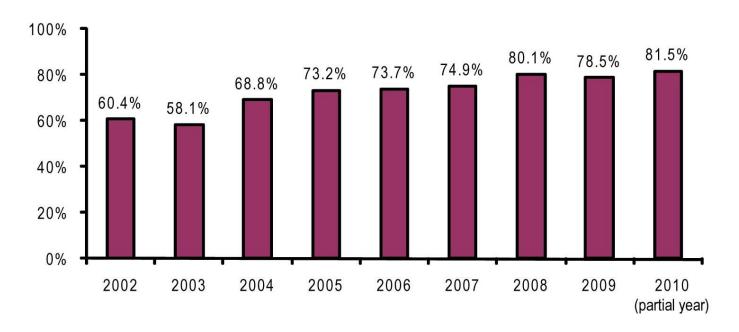


#### Oregon Health Plan Eligibility and Enrollment, 2002-2010

#### **OHP** eligibles over time



#### FCHP/PCO enrollees over time





#### Glossary of common managed care terminology

**Actuarial soundness** –The requirement that the development of capitation rates meet common actuarial principles and rules. In general, Medicaid managed care rates are actuarially sound for a specific state and period for which they're prepared, if projected payments provide for all reasonable costs.

**Capitation** – a set dollar payment per patient per unit of time (usually per month) that is paid to cover a specified set of services and administrative costs without regard to the actual number of services provided.

**Care coordination** – A process and technique to manage the care of an individual's specific health care needs (often multiple) in a way that is designed to achieve the optimum patient outcome in the most cost-effective manner

**Carve out** – One or more services excluded from those required to be provided under a managed care contract. These services may be paid on a fee-for-service or other basis.

**Comprehensive Risk Contract** – A risk contract that covers comprehensive services, that is, inpatient hospital services and any of the following services, or any three or more of the following services:

- 1) Outpatient hospital services
- 2) Rural health clinic services
- 3) FQHC services
- 4) Other laboratory and X-ray services
- 5) Nursing facility (NF) services
- 6) Early and periodic screening, diagnosis, and treatment (EPSDT) services
- 7) Family planning services
- 8) Physician services
- 9) Home health services

**Dental Care Organization (DCO)** – a prepaid dental plan that provides dental services to qualified medical assistance clients. The state pays the DCO a monthly capitation fee to provide comprehensive services and to manage each enrolled client's dental care.

**EQRO (External Quality Review Organization)** – States are required to contract with an entity that is external to and independent of the State and its HMO and HIO contractors to perform an annual review of the quality of services furnished by each HMO or HIO contractor.

Federally qualified Health Maintenance Organization (HMO) – An HMO that CMS has determined is a qualified HMO under section 1310(d) of the Public Health Service Act (Title 42 United States Code).

**Fee-For-Service (FFS)** – A payment system by which doctors, hospitals and other providers are paid a specific amount for each service performed as identified by a claim for payment.

**Fiscal Solvency** – The requirement that managed care organizations have sufficient operating funds, on hand or available in reserve, to cover all expenses associated with services for which they have assumed financial risk.

**Fully Capitated Health Plan (FCHP)** – The state pays the Fully Capitated Health Plan (FCHP) a monthly capitation payment to provide comprehensive services and to manage each enrollee's health care. FCHPs provide medical services ranging from physician and hospital inpatient care to physical therapy and many medications. FCHPs provide an Exceptional Needs Care Coordinator (ENCC) for clients with special needs.

**Health insuring organization (HIO)** – A county-operated entity that, in exchange for capitation payments, covers services for recipients:

- 1) Through payments to, or arrangements with, providers;
- 2) Under a comprehensive risk contract with the State; and
- 3) Meets the following criteria –
- (i) First became operational prior to January 1, 1986; or
- (ii) Is described in section 9517(e)(3) of the Omnibus Budget Reconciliation Act of 1985 (as amended by section 4734 of the Omnibus Budget Reconciliation Act of 1990).

**Independent Practice Association (IPA)** – An organization providing health care by providers who maintain their own offices and continue to see their own patients but may agree to treat enrolled members of an MCO for a negotiated lump sum payment or a capitated amount per member. An IPA may also serve as a PCM, and/or it's participating practitioners may serve as PCMs.

**Insolvency** – A legal determination occurring when a managed care plan no longer has the financial reserves or other arrangements to meet its contractual obligations to patients and subcontractors.

**Mandatory service area** – In areas of the state where there is adequate managed care capacity and choice for consumers, managed care enrollment is mandatory (except for exempt populations or individuals).

**Managed Care** – A system of health care that combines delivery and payment; and influences utilization of services, by employing management techniques designed to promote the delivery of cost-effective health care.

**Managed Care Organization (MCO)** – An entity that has, or is seeking to qualify for, a comprehensive risk contract under this part, and that is –

- 1) A Federally qualified HMO that meets the advance directives requirements of subpart I of part 489; or
- 2) Any public or private entity that meets the advance directives requirements and is determined to also meet the following conditions:
- (i) Makes the services it provides to its Medicaid enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid recipients within the area served by the entity; and
- (ii) Meets the solvency standards of 42 CFR 438.116.

**Mental Health Organization (MHO)** – Provides mental health services to qualified medical assistance clients. A client's MHO enrollment is determined by the medical plan the client chooses. The state pays the MHO a monthly capitation fee to provide comprehensive mental health services and to manage each enrolled client's mental health care. An MHO may be an FCHP, community mental health program, or private mental health organization. Services

provided by MHOs include: evaluation; case management; consultation; mental health related medication and medication management; individual, family, and group therapy; local acute inpatient care; 24 hour urgent and emergency response; and for adults only: rehabilitation services; skills training; supported housing and residential care.

#### Prepaid ambulatory health plan (PAHP) – An entity that:

- 1) Provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State plan payment rates;
- 2) Does not provide or arrange for, or is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees; and
- 3) Does not have a comprehensive risk contract

**Physician Care Organization (PCO)** – The state pays the Physician Care Organization (PCO) a monthly capitation payment to provide most comprehensive services and to manage each enrolled client's health care. Clients enrolled in a PCO receive inpatient hospital services and post-hospital extended care services on a fee-for-service basis

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

#### Prepaid Inpatient Health Plan (PIHP) - An entity that:

- 1) Provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State plan payment rates;
- 2) Provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and
- 3) Does not have a comprehensive risk contract

**Preferred Provider Organization (PPO)** – A health care delivery system that contracts with providers of medical care to provide services at discounted fees to members. Members may seek care form non-participating providers but generally are financially penalized for doing so by the loss of the discount and subjection to copayments and deductibles.

Practitioner Incentive Plan (PIP) – any compensation arrangement at any contracting level between Contractor and a physician or Physician Group that may directly or indirectly have the effect of reducing or limiting services furnished to Members. Contractor must report on Practitioner Incentive Plans between the Contractor itself and individual physicians and groups and also between groups or Intermediate contracting Entities (e.g., certain IPAs, Physician-Hospital Organizations) and individual physicians and groups.

**Preferred Providers** – Physicians, hospitals, and other health care providers who contract to provide health services to persons covered by a particular health plan.

Primary Care Management (PCM) – (also known as Primary Care Case Management, PCCM) – The state contracts directly with primary care providers who agree to be responsible for the provision and/or coordination of medical services to Medicaid recipients under their care. They are paid a monthly case management fee in addition to their fee-for-services payments. PCMs may be physicians, physician assistants, nurse practitioners with a physician back-up, or naturopathic physicians with a physician back-up. PCMs may also be rural health clinics, migrant and community health clinics, federally qualified health centers, county health departments, Indian health service clinics, or tribal health clinics.

PCMs can refer clients to specialty services. PCMs are usually utilized when an FCHP is either not available or is closed to new enrollment.

**Primary Care Provider (PCP)** – The provider that serves as the initial interface between the member and the medical care system. The PCP is usually a physician, selected by the member upon enrollment, who is trained in one of the primary care specialties who treats and is responsible for coordinating the treatment of members assigned to his/her plan. (also called "Gatekeeper").

**Referral Services** – any specialty, inpatient, outpatient or laboratory services that are ordered or arranged, but not furnished directly.

**Reinsurance** – An insurance arrangement whereby the MCO or provider is reimbursed by a third party for costs exceeding a pre-set limit, usually an annual maximum.

**Risk Contract** – A contract under which the contractor:

- 1) Assumes risk for the cost of the services covered under the contract; and
- 2) Incurs loss if the cost of furnishing the services exceeds the payments under the contract

**Shared Savings** – A provision of most prepaid health care plans where at least part of the providers' income is directly linked to the financial performance of the plan. If costs are lower than projections, a percentage of these savings are referred to the providers.

**Utilization Management** – The process of evaluating the necessity, appropriateness and efficiency of health care services against established guidelines and criteria.

**Utilization Review (UR)** – A formal review of utilization for appropriateness of health care services delivered to a member on a prospective, concurrent or retrospective basis.

**Voluntary service area** – In areas of the state that lack adequate managed care capacity and choice for consumers, enrollment in available managed care plans is voluntary.