Managed Care Glossary of Terms

prepared by

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Health Maintenance Organization (HMO)

Initiated in 1973 to address the escalating cost of health care, a **health maintenance organization** (**HMO**) is a type of managed care organization (MCO) that provides health insurance coverage by contracting with a select group of hospitals, doctors, and other providers. Federal laws require choice of insurance products for employees of companies with 25 or more employees, including traditional indemnity healthcare options. The difference between traditional indemnity insurance and HMO coverage is that HMO patients can only receive care from the hospitals, doctors and other professionals who have agreed to treat patients in accordance with the HMO's guidelines, rates and restrictions. In exchange, the "network" of HMO providers receives a steady stream of customers. Enrollment of Medicaid recipients into HMOs was harshly criticized and resisted by advocates in the late 1980's and early 1990's, but managed care coverage for health care is now an accepted practice for Medicaid recipients.

Behavioral Health Organization (BHO)

As HMOs and employers became increasingly concerned about the escalating cost of and demand for behavioral health services, a specialized insurance management tool emerged in the form of **Managed Behavioral Health Organizations (MBHOs**). MBHOs or BHOs emerged to control costs and address the growing demand for behavioral health care services. Like HMOs, BHOs receive per member per month payments and insure that their patients have access to behavioral health treatment through a network of participating hospitals, clinics, doctors and other professionals. The BHO network providers have agreed to the BHO's guidelines, rates and restrictions. In exchange, employers and/or HMOs have gained cost controls and assurances that adequate behavioral health services are available for patients. This insurance industry has grown rapidly. Currently, there are 300 MBHOs covering more than 120 million Americans, mostly through commercial insurance. Coverage for Medicaid recipients by BHOs is a newly emerging practice.

Health Home

A federal initiative under the Accountable Care Act to reduce costs and improve care for extremely hard to serve Medicare and Medicaid recipients, the **Health Home** will be provided a list of eligible patients who need complex care coordination because they are both chronically physically ill and involved with the behavioral health/substance use system or have more than one chronic illness. New York expects to enroll about 500,000 Medicaid recipients into health homes, beginning with those heavily involved in the behavioral health system. The health home theory is that a re-distribution of resources toward prevention, intervention and diversion stages of treatment and away from unnecessary or ineffective acute and restrictive treatment will result in savings.

A **Health Home Lead Agency** will be paid a care coordination fee to ensure that necessary health, mental health, substance use and social service supports are in-place AND being used by individuals enrolled in the Health Home. To do so, the Health Home lead agency will create a network **of Health Home Providers** who they can refer clients to for necessary services. The network providers are not paid by the Lead Health Home agency, they provide the service and bill Medicaid as they would for any other Medicaid eligible patient. Some differences between how providers respond to Health Home recipients and regular Medicaid recipients may include: speed of access to care, the level of case review and accountability that providers will have for this limited number of patients. The Lead Health Home agency CAN subcontract with providers (such as case management providers) to do the care coordination for them – in this instance the TCM provider would be paid a care coordination fee by the Health Home and become **a Health Home Care Coordinator**. It has not yet been determined if the Health Home Networks will become synonymous with the HMO/BHO networks.

Medicaid Redesign Team in NYS

One of the first actions taken by the Cuomo Administration was to establish a Medicaid Redesign Team tasked with

developing cost containment proposals for the state's $53 billion Medicaid program. In Phase I, the MRT developed proposals to meet the immediate state deficit and were enacted as part of the 2011-12 State Budget. These actions included: rate freezes, across –the-board-cuts, utilization caps, expansion of managed care and a Global Medicaid Cap. Most of the cost containment initiatives have been approved for a 2 year period and will remain in place until April 2013.

In Phase II, the MRT is supposed to develop recommendations to the Governor (due December 1, 2011) that will sustain a coordinated plan for multi-year restricted Medicaid spending. The goal is to guide Medicaid service operation so the state remains under a Global Spending Cap, while also addressing the need for improved quality for Medicaid recipients. The expectation is that the recommendations provided to the Governor on December 1, 2011 will be implemented on or before April 1, 2013, when the current Medicaid cost containment initiatives sunset.

Managed Care Terms

Carve In:
this refers to an insurance coverage model which includes physical health and behavioral health benefits in the same health plan. This means that an HMO is contracted under a capitated rate to cover both medical and behavioral health services. It is common for the HMOs to subcontract with a behavioral health organization to manage the specialty benefits and behavioral health services**.**

Carve Out:
This refers to an insurance model under which coverage for Medicaid behavioral health services are separated from the HMO physical health coverage into a separate contract with a specialty or managed behavioral health organization. Services under a BHO can be either paid as fee-for-service or capitated rates or case payments.

Case Rate:
This refers to the amount per enrollee that is paid to the HMO or BHO reimburse network providers for providing treatment to each enrollee. HMOs accept the case rate and then negotiate payment levels with their network providers.

Average Case Rate:
This refers to a high risk method of reimbursement, whereby the case rate is based on a simple average of the cost of all the levels of care provided all the eligible enrollees. The risk is associated with circumstances of a disproportionately high number of enrollees with acute needs presenting at the same time and not having enough low-acuity enrollees to offset the cost of exploding service demands.

Stratified Case Rate:
This refers to a manageable risk method of reimbursement, whereby variable case rates are based upon the acuity level of the enrollees, with higher payments for high acuity enrollees and lower payments for lower acuity enrollees.

Shared Risk:
This refers to when HMOs/BHOs share the risk of loss with their network providers by negotiating case rates for care rather than just negotiating fee for service rates. Providers who consider risk-sharing rates must account for all aspects of their operating costs prior to agreeing to a rate structure.

Network Adequacy:
A key value check for networks developed to serve high need populations will be network adequacy. This requires appropriate standards to measure behavioral health network adequacy in a manner that accounts for network provider quality, ability to accept all eligible enrollees, ability to provide a wide range of services and ability to maintain sufficient capacity in the new environment.

Prior Authorization and Approval:
Shared risk payment models should reduce the need for prior authorization of specialty services, but continuation or approval of services beyond the standard will most likely continue. In behavioral health, the standard of "psychosocial necessity" instead of "medical necessity" might be more appropriate
for the supportive services needed by people with SED and SMI. States
should develop methods to monitor how it is being implemented by MCOs.