

**Decoding Medicaid Care Delivery and Financing Models:  
A Glossary of Widely Used Terms**

May 2012

Medicaid, the nation's public insurance program for low-income Americans, is the largest health care program in the country. In fiscal year (FY) 2009, over 62 million people, or approximately one in five Americans, were enrolled in Medicaid for at least one month during the year.<sup>1</sup> Beginning in 2014, the Affordable Care Act (ACA) will expand Medicaid coverage to nearly all nonelderly individuals with incomes up to 138% of the federal poverty level (\$26,344 for a family of three in 2012).<sup>2</sup> This Medicaid expansion is projected to cover an additional 16 million people by 2019.

Historically, most Medicaid beneficiaries obtained their care on a fee-for-service (FFS) basis, with states directly paying participating physicians, clinics, hospitals, and other providers for each service furnished. However, beginning in the early 1980s, many states began shifting away from FFS and toward managed care strategies aimed at increasing access to care, improving quality, and/or providing greater budgetary predictability or reducing costs. One approach to Medicaid managed care is primary care case management, in which states pay primary care providers regular FFS payments plus a small monthly fee to coordinate, manage, and monitor the primary care delivered to their panel of Medicaid patients. In recent years, the predominant approach in Medicaid has been risk-based managed care, in which states pay managed care organizations (MCOs) a fixed per-member-per-month (PMPM) premium, known as a "capitation" payment, to deliver a defined set of services to enrolled Medicaid beneficiaries. By 2010, 26.7 million Medicaid beneficiaries, or approximately half of all beneficiaries, were enrolled in a risk-based MCO.<sup>3</sup>

Recently, in response to ongoing budget pressures and growing interest in improving care for people with complex health care needs, many states have expanded managed care or pursued other reforms in care delivery and financing. In addition, demonstration, pilot, and state plan authorities provided by the ACA are catalyzing innovation in Medicaid. As a result, the service delivery and payment arrangements in Medicaid programs continue to evolve. What distinguishes most of these arrangements is that they seek to move away from FFS, which pays providers for each covered health care service delivered, and instead structures incentives in ways designed to drive appropriate and high-quality care, improved outcomes, and/or lower costs.

As care delivery and financing models in Medicaid have multiplied, so has the terminology used to refer to them. For the most part, these terms reflect variations on a few common, fundamental concepts. In

one way or another, nearly all refer to models that involve greater coordination, more focused management of care, and/or systems of pre-set payment that place providers at some financial risk.

The following glossary seeks to disentangle and clarify terms that are widely used to describe the diverse approaches that states are currently taking to organize and pay for care for Medicaid beneficiaries. Although some terms are also used in other contexts, including private insurance and Medicare, this glossary confines itself to how they tend to be applied in the context of Medicaid. When possible, the glossary also includes short descriptions of relevant federal legislation or regulation that promotes particular models or defines how they are to be implemented.

The glossary includes the following terms:

[Accountable Care Organization](#)

[Bundled Payments](#)

[Capitation](#)

[Care Coordination](#)

[Care Management](#)

[Case Management](#)

[Disease Management](#)

[Enhanced Medical Home](#)

[Enhanced Primary Care Case Management](#)

[Episode-Based Bundling](#)

[Fee-for-Service](#)

[Global Bundling](#)

[Health Home](#)

[Managed Behavioral Health Organization](#)

[Managed Care Organization](#)

[Managed Long-Term Care](#)

[Medical Home](#)

[Medical Loss Ratio](#)

[Patient-Centered Medical Home](#)

[Pay-for-Performance](#)

[Prepaid Ambulatory Health Plan](#)

[Prepaid Health Plan](#)

[Prepaid Inpatient Health Plan](#)

[Primary Care Case Management](#)

[Risk-based Managed Care](#)

[Targeted Case Management](#)

**Accountable Care Organization (ACO):** There is currently no uniform federal definition of an ACO and the concept continues to evolve. Generally, an ACO is a group of health care providers that agree to share responsibility for the health care delivery and outcomes for a defined group of people. The organizational structure of ACOs may vary, but, in concept, all ACOs would include primary and specialty care physicians and at least one hospital.<sup>4</sup> Individual providers in an ACO are expected to coordinate care for their shared patients to enhance quality and efficiency, and the ACO as an entity is accountable for that care. An ACO that meets quality performance standards that have been set by the payer, and achieves savings relative to a benchmark, can share the savings among the providers. Some states that are pursuing ACOs for Medicaid beneficiaries are building on existing care delivery programs (e.g., [primary care case management](#), [medical homes](#), [managed care organizations](#)) which already involve some degree of coordination among providers and may have developed key infrastructure (e.g., electronic medical records) necessary to facilitate coordination among ACO providers. States may also use different terminology in their Medicaid ACO initiatives, such as Coordinated Care Organizations (CCOs) in Oregon and Regional Care Collaborative Organizations (RCCOs) in Colorado.

*Relevant Federal Legislation or Regulation:*

Pediatric Accountable Care Organization Demonstration Project, ACA §2706. States participating in this new demonstration project would be authorized to allow pediatric medical providers that meet certain requirements to form ACOs for Medicaid and/or Children’s Health Insurance Program (CHIP) beneficiaries and, subject to performance guidelines established by the Health and Human Services (HHS) Secretary and a minimal savings level established by the state Medicaid agency, to receive incentive payments. This demonstration is not currently funded.

While outside the Medicaid context per se, a useful definition of an ACO can be found within the Medicare Shared Savings Program, ACA § 3022, which directs the HHS Secretary to establish a Shared Savings Program that, through ACOs, promotes accountability for a [fee-for-service](#) patient population, coordinates items and services under Medicare Parts A and B, and encourages investment in infrastructure and redesigned care processes for high quality and efficient service delivery.

42 C.F.R. Part 425. CMS regulation regarding the Medicare Shared Savings Program and Accountable Care Organizations.

**Bundled Payments:** Bundled payments compensate providers with a pre-set amount for care provided to patients within a pre-defined time period (e.g., one year) or for the services associated with a given procedure (e.g., knee replacement) or diagnosis (e.g., sinus infection).<sup>5</sup> Frequently, the bundled payment amount is risk-adjusted to take into account demographic characteristics of the patient, such as age and gender, as well as health status. Examples of bundled payment approaches in Medicaid include [global bundling](#) and [episode-based bundling](#).

**Capitation:** Capitation payment refers to the fixed per-member-per-month (PMPM) amount that a state Medicaid agency pays a [managed care organization](#) (MCO) to provide or arrange for services delivered to enrolled beneficiaries. Because the capitation amount is pre-set, MCOs are at financial risk for the services they actually provide. In contrast, in a [fee-for-service](#) system, the Medicaid agency pays providers directly for each service delivered and providers do not bear any financial risk. Capitation payments can be risk-adjusted based on the demographic characteristics of beneficiaries, such as age and gender.

**Care Coordination:** While there is no standard definition, most care coordination programs target high-risk beneficiaries to improve coordination of both medical and social supports provided by different organizations and providers.<sup>6</sup> For example, care coordination may assist beneficiaries with transportation needs, engage them in writing a self-directed and patient-centered plan of care, navigate the boundaries of systems of care on their behalf, or broker medical and social services.<sup>7</sup> [Managed care organizations'](#) (MCOs) approaches to care coordination programs vary, ranging from a centralized team model comprised of nurses and social workers located in the MCO's central offices, to a provider-based model that assigns staff to support specific provider groups. In contrast to care coordination, [case management](#) services tend to apply a medical model that focuses primarily on the beneficiary's health care. Another distinction is that care coordination programs often facilitate the delivery of both covered and non-covered Medicaid services.

**Care Management:** Care management, which is not recognized as a reimbursable service under Medicaid, refers to programs that seek to help patients achieve an optimal level of wellness, improve coordination of care, and engage beneficiaries and their support systems in a collaborative process designed to manage medical, social, and mental health conditions more effectively.<sup>8</sup> Care management programs encompass a broad range of services, that can include distribution of provider and patient educational materials or in-person and telephonic communication between beneficiaries and nurse care managers or social service specialists. As with some [disease management](#) programs, states may target their care management programs to Medicaid beneficiaries with specific diseases or to those considered high-risk or high-cost.<sup>9</sup> Alternatively, they may take a "population-based" approach, implementing care management broadly, but using different strategies for different subgroups based on their needs. States can implement care management programs by contracting with external organizations, administering care management directly using state staff, or adopting a hybrid of the two models. Care management can be implemented in either a [fee-for-service](#) or a risk-based managed care context. Some states link Medicaid care management with a [primary care case management](#) program or a [medical home](#) initiative.

**Case Management:** In Medicaid, case management refers to services that assist eligible enrollees to secure medical and other services necessary for appropriate health care treatment.<sup>10</sup> Case management is not the direct provision of care and services, but a separate and reimbursable class of services under the Medicaid program. The services are an optional Medicaid benefit and can include educational, social, and otherwise non-covered health services. [Targeted case management](#) (TCM) in Medicaid refers to case management services that are provided to specific populations (e.g., individuals diagnosed with HIV/AIDs or living in a particular county).

*Relevant Federal Legislation or Regulation:*

Case Management and Targeted Care Management, Social Security Act § 1915(g). Describes Medicaid case management and TCM services, including assessment of a beneficiary to determine service needs, development of a specific care plan, referral and related activities to help an individual obtain needed services, and monitoring and follow-up activities.

42 C.F.R. § 440.169 and 42 C.F.R. § 441.18. CMS regulations regarding Medicaid case management and targeted case management services.

**Disease Management (DM):** DM attempts to improve the quality of care for beneficiaries with chronic diseases, while slowing the growth of their health care costs.<sup>11</sup> The aim of DM initiatives is to identify chronic conditions more quickly, treat them more effectively, and slow their progression. DM techniques combine the following: enhanced screening, monitoring, and education; coordination of care among providers and settings; and use of best medical practices. Though it is not a recognized reimbursable service under Medicaid, states have increasingly turned to DM to improve care for people with specific conditions, in recognition of the fact that a small share of Medicaid beneficiaries with high levels of need and health care costs accounts for a large share of Medicaid spending. Early DM programs tended to focus narrowly on management of a specific chronic condition (e.g., asthma, diabetes, congestive heart failure), but programs have evolved toward more comprehensive management of the individual's total health care needs.<sup>12</sup> DM can be carried out by risk-based Medicaid [managed care organizations](#) or integrated into states' [primary care case management](#) programs. For the [fee-for-service](#) population, states can operate their own DM programs or contract with Disease Management Organizations.<sup>13</sup>

*Relevant Federal Legislation or Regulation:*

CMS State Medicaid Director Letter regarding disease management for Medicaid beneficiaries with chronic conditions. February 25, 2004. <http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/smd022504.pdf>

**Enhanced Primary Care Case Management (EPCCM):** EPCCM programs build additional features into the standard [primary care case management](#) model, such as [disease management](#), [care coordination](#) or integration of physical and mental health care, [case management](#) for high-cost/high-risk enrollees, and linkages between primary care and community-based services for targeted groups.

**Enhanced Medical Home (EMH):** The EMH approach builds on the [medical home](#) model by placing additional requirements on the primary care provider and the health team, such as: [targeted case management](#) for enrollees at risk for high medical spending, increased access (e.g., 24/7 provider availability), integration of services such as nutrition interventions and mental health services, or coordination of care between subspecialists and the primary care provider team.<sup>14,15,16</sup> An EMH might also emphasize the use of evidence-based protocols of chronic disease management (e.g., for asthma) or require the use of health information technology to improve the quality and coordination of care delivery.<sup>17</sup> No organization currently accredits EMHs like those that provide accreditation for [patient-centered medical homes](#).

**Episode-Based Bundling:** Episode-based bundling pays providers a single pre-set amount for the services involved to treat a patient's health event, or for an episode of care, such as a knee replacement or coronary artery bypass graft.<sup>18</sup> The health event is generally defined by a procedure and/or diagnosis and has an established beginning and end. Payment amounts are set based on established clinical protocols and guidelines, and are typically adjusted to account for the severity of the patient's condition. Compared to [global bundling](#), episode-based bundling is a tool for managing costs incurred over a shorter time period, usually beginning with initial treatment of the health event and ending 30 or 90 days after the procedure or treatment involved. Other terms used to describe the concept of episode-based bundling include episode-based payment and episodic bundling.

Relevant Federal Legislation or Regulation:

Demonstration Project to Evaluate Integrated Care around a Hospitalization, ACA § 2704. Authorizes demonstrations, in up to eight states and over four years, to evaluate the use of bundled payments for the provision of integrated care for a Medicaid beneficiary for an episode of care that includes hospitalization and concurrent physician services. This demonstration is not currently funded.

**Fee-for-Service (FFS):** In a FFS system, the state Medicaid agency establishes the fee levels for covered services and pays providers directly for each service delivered. Providers do not bear any financial risk. Medicaid beneficiaries seeking care in the FFS environment must find providers who participate in Medicaid and accept new patients; there is generally no organized provider network as found in [managed care organizations](#).

**Global Bundling:** Global bundling involves a single pre-set payment to a provider or group of providers for a wide range of services delivered to an individual over a period of time, usually one year.<sup>19</sup> As distinct from [episode-based bundling](#), which involves a payment for a single episode of care, global bundling is often used for patients with conditions that involve a higher likelihood of hospitalizations and potential for readmissions.<sup>20</sup> Global payment amounts are risk-adjusted based on the patient's health and other characteristics that may affect the services needed, such as age or gender, in a manner similar to the risk adjustment of [capitation](#) rates. In addition, global payment may be structured to incorporate outcome or quality measures, to safeguard against under-service, and to reward high performance. Other terms used to describe the concept of global bundling include: risk-adjusted global fees, comprehensive care payment, and global payments.

Relevant Federal Legislation or Regulation:

Medicaid Global Payment System Demonstration Project, ACA § 2705. Authorizes demonstrations, in up to five states for FY2010-FY2012, to shift safety net hospitals from Medicaid FFS payments to a global capitated payment model. This demonstration is not currently funded.

**Health Home:** The Medicaid health home model builds on the traditional [medical home](#) concept.<sup>21</sup> Targeted to individuals with multiple chronic conditions, health homes are designed to be person-centered systems of care that facilitate access to and coordination of the full array of primary and acute physical health services, behavioral health care, and community-based health and social service supports. Health homes establish a care plan for each beneficiary, and coordinate and integrate his or her clinical and non-clinical services. The following health homes services are reimbursable: comprehensive [care management](#), [care coordination](#) and health promotion, transitional care, referrals to community and social services, patient and family support, and use of health information technology.

Relevant Federal Legislation or Regulation:

State Option to Provide Coordinated Care through Health Homes for Individuals with Chronic Conditions, Social Security Act §1945. States may pay for home health services for eligible individuals with chronic conditions who select a designated provider. The Secretary will establish qualification standards for designated home health providers. The federal matching rate for state spending is 90% for the first two years that the initiative is in effect. After two years, the

federal government will match health home spending at the regular rate, which ranges from 50% to 74% across the states.<sup>22</sup>

CMS State Medicaid Director Letter regarding implementation of the ACA provision on health homes for enrollees with chronic conditions. November 16, 2010.

<http://www.cms.gov/smdl/downloads/SMD10024.pdf>

**Managed Behavioral Health Organization (MBHO):** MBHOs are specialty managed care organizations that provide mental health and substance abuse treatment services to individuals.<sup>23</sup> State Medicaid agencies may contract directly with MBHOs to provide and manage behavioral health services to Medicaid beneficiaries, or Medicaid [managed care organizations](#) may subcontract with an MBHO. In either contracting arrangement, the MBHO maintains a distinct provider network, coverage rules, administrative services, and other insurance functions.

**Managed Care Organization (MCO):** MCOs are health plans with [risk-based managed care](#) contracts with states to provide a defined set of benefits to enrolled Medicaid beneficiaries for a set per-member-per-month (PMPM) premium, or [capitation](#) payment.<sup>24</sup> The incentives inherent in capitation payment are distinctly different from the incentives in a [fee-for-service](#) (FFS) system. MCOs that contract with state Medicaid programs include both Medicaid-only plans and plans with a mix of commercially insured and Medicaid members. MCOs must meet extensive federal requirements as well as state-specific standards and requirements that address matters such as: protocols for enrollment and member support; ensuring an adequate provider network; achievement of set benchmarks for access and quality improvement; and collection and reporting of data. Although MCOs are at financial risk for providing the comprehensive Medicaid benefits included within their capitation rates, nearly all states carve certain services out of their MCO contracts, such as prescription drugs or behavioral health services. These carved-out benefits are provided and financed through another contract (e.g., with a non-comprehensive [prepaid health plan](#)) or on a FFS basis.

*Relevant Federal Legislation or Regulation:*

State Option to Use Managed Care, Social Security Act, §1932. States may require Medicaid beneficiaries to enroll in a managed care entity, with some exemptions (e.g., children with special needs, dually eligible Medicare-Medicaid beneficiaries). States and Medicaid managed care organizations must meet certain requirements, including implementing beneficiary protections, developing quality assurance standards, and providing protections against fraud and abuse.

42 C.F.R. Part 438. CMS regulations on Medicaid managed care.

**Managed Long-Term Care (MLTC):** MLTC refers to risk-based arrangements for the delivery of long-term services and supports, including home and community-based care (e.g., adult day care), that permit people to stay in their homes and communities for as long as possible rather than receive care in an institution.<sup>25</sup> Some MLTC programs provide only long-term services and supports, but others also include acute medical care. PACE (Program of All-Inclusive Care for the Elderly) is a comprehensive MLTC model in which states provide Medicare and Medicaid medical and social services to frail older adults who would otherwise need nursing home care, using a multidisciplinary team approach.

Relevant Federal Legislation or Regulation:

Program of All-Inclusive Care for the Elderly or PACE, Social Security Act §1934. If a state chooses to implement PACE, the program must provide health care services to eligible individuals through a comprehensive, multidisciplinary health and social services delivery system that integrates acute and long-term care services. PACE providers are paid on a capitated basis.

**Medical Home:** The medical home concept emerged in the late 1960s, defined by the American Academy of Pediatrics (AAP) *Standards of Child Health Care* as “one central source of a child’s pediatric records to resolve duplication and gaps in services that occur as a result of lack of communication and coordination.”<sup>26</sup> By 2002, the AAP had further developed the medical home definition, to refer to medical care that is “accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective.” The medical home concept continued to evolve in the last decade, when the AAP and other physician groups defined the [patient-centered medical home](#), the [enhanced medical home](#) concept emerged, and the ACA introduced [health home](#) as a model targeted to Medicaid beneficiaries with multiple chronic conditions.

**Medical Loss Ratio (MLR):** The MLR is the share of premium revenues that an insurer or health plan spends on patient care and quality improvement activities, as opposed to administration and profits.<sup>27</sup> The ACA requires that, beginning in 2011, insurers in the large group market meet an MLR standard of 85% annually, and insurers in the small group and individual markets meet an MLR standard of 80%. Health insurers must publicly report the portion of premium dollars they spend on health care and quality improvement in each state in which they operate, and those that fail to meet the applicable MLR standard must pay rebates to consumers. The ACA’s MLR requirements do not apply in Medicaid.<sup>28</sup>

**Patient-Centered Medical Home (PCMH):** The PCMH model evolved in recent years from the early definition of the [medical home](#) concept. In 2007, the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Physicians, and the American Osteopathic Association released key principles that define a PCMH: (1) the personal physician leads a team that is collectively responsible for the patient’s ongoing care; (2) the physician is responsible for the whole person in all stages of life; (3) care is coordinated and/or integrated; (4) quality and safety are hallmarks of a medical home; (5) enhanced access to care is available through all systems; and (6) payment appropriately recognizes the added value to the patient.<sup>29</sup> The National Committee for Quality Assurance (NCQA) is one of a small number of organizations that has issued specific standards that the PCMHs must meet to receive its accreditation.<sup>30</sup>

**Pay-for-Performance (P4P):** P4P is a health care payment model that rewards providers or [managed care organizations](#) (MCOs) financially for achieving or exceeding specified quality benchmarks.<sup>31,32</sup> Some P4P programs pay physicians or hospitals directly based on numerous metrics. P4P payments may be based on structure, process, and/or outcome measures, with providers evaluated against benchmarks or by comparison with other providers. A majority of states contracting with MCOs incorporate a P4P component into their payment methods, such as withholding a portion of the [capitation](#) payment, which the MCO can earn back through demonstrating high performance, or by offering performance-based bonuses in addition to the capitation amount.

**Prepaid Ambulatory Health Plan (PAHP):** A PAHP is a non-comprehensive [prepaid health plan](#) that provides only certain outpatient services, such as dental services or outpatient behavioral health care, and does not cover any inpatient services.<sup>33</sup> PAHPs are paid on a risk, or capitated, basis.

Relevant Federal Legislation or Regulation:

42 C.F.R. § 438.2. CMS regulation regarding prepaid ambulatory health plans.

**Prepaid Health Plan (PHP):** PHPs provide either comprehensive or non-comprehensive benefits to Medicaid beneficiaries through a risk-based contract with a state Medicaid agency.<sup>34</sup> Medicaid [managed care organizations](#) are comprehensive PHPs, while [prepaid inpatient health plans](#) and [prepaid ambulatory health plans](#) are non-comprehensive PHPs. The services most commonly provided by non-comprehensive PHPs are inpatient and outpatient behavioral health care, substance abuse treatment, dental care, nonemergency transportation, and prescription drugs. States may provide some these services through non-comprehensive PHPs, while most other services are provided through MCOs or [primary care case management](#) programs, or on a [fee-for-service](#) basis.

Relevant Federal Legislation or Regulation:

42 C.F.R. Part 438. CMS regulations on Medicaid managed care.

**Prepaid Inpatient Health Plan (PIHP):** A PIHP is a non-comprehensive [prepaid health plan](#) that provides only inpatient hospital or institutional services, such as inpatient behavioral health care, and does not have a comprehensive risk contract.<sup>35</sup> PIHPs are paid on a risk, or capitated, basis.

Relevant Federal Legislation or Regulation:

42 C.F.R. § 438.2. CMS regulation regarding prepaid inpatient health plans.

**Primary Care Case Management (PCCM):** In PCCM programs, which are a form of Medicaid managed care, state Medicaid agencies contract with primary care providers to provide, locate, coordinate, and/or monitor the care of Medicaid beneficiaries who select them or are assigned to them.<sup>36</sup> The provider, in effect, serves as a beneficiary's [medical home](#) for primary and preventive care. States generally set requirements for the participating primary care providers, such as minimum hours of operation at each location, specific credentials or training, and responsibility for referral to specialists. State staff carry out, or sometimes contract out, administrative functions related to PCCM (e.g., network development and credentialing) and generally assume full financial risk. States pay primary care providers a small monthly fee for [case management](#), in addition to regular [fee-for-service](#) payments; some states include a [pay-for-performance](#) element within their payment approaches. The PCCM payment structure stands in contrast to [capitation](#)-based payments to [managed care organizations](#), another form of Medicaid managed care. [Enhanced Primary Care Case Management](#) refers to PCCM programs that include additional services and responsibilities to strengthen coordination of care.

Relevant Federal Legislation or Regulation:

Primary Care Case Management, Social Security Act §1905(t). Defines the content of a PCCM contract between a state and a primary care provider who is responsible for locating, coordinating, and monitoring covered primary care services and for providing for reasonable hours of operation, including 24-hour availability of information, referrals, and treatment for medical emergencies.

42 C.F.R. Part 438. CMS regulations on Medicaid managed care.

CMS State Medicaid Director Letter regarding primary care case management services and section 1905(t) of the Social Security Act. January 1998.

<http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD012198.pdf>

**Risk-Based Managed Care:** Risk-based managed care refers to contracts between a state Medicaid agency and [managed care organizations](#) (MCOs) in which the MCO agrees to provide comprehensive Medicaid benefits to enrolled Medicaid beneficiaries, and the state pays the MCO a fixed per-member-per-month (PMPM) premium, or [capitation](#) payment.<sup>37</sup> MCOs either provide the care directly or arrange for the care through subcontracts.

*Relevant Federal Legislation or Regulation:*

Medicaid Managed Care Organization, Social Security Act §1903(m). Defines the term Medicaid managed care organization and related requirements.

42 C.F.R. Part 438. CMS regulations on Medicaid managed care.

**Targeted Case Management (TCM):** TCM refers to [case management](#) services provided only to specific Medicaid beneficiary groups, defined either by disease or medical condition (e.g., HIV/AIDS, tuberculosis, chronic physical or mental illness) or by geographic regions (e.g., county or city). These services are provided at state option; most state Medicaid programs cover TCM services.<sup>38</sup>

*Relevant Federal Legislation or Regulation:*

Case Management and Targeted Care Management Social Security Act §1915(g). Describes Medicaid case management and TCM services, including assessment of an eligible individual to determine service needs, development of a specific care plan, referral and related activities to help an individual obtain needed services, and monitoring and follow-up activities.

42 C.F.R. § 440.169 and 42 C.F.R. § 441.18. CMS regulations regarding Medicaid case management and targeted case management services.

## Endnotes

---

<sup>1</sup> The Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on data from Medicaid Statistical Information System (MSIS) reports from the Centers for Medicare and Medicaid Services (CMS), 2012. Available at: <http://www.statehealthfacts.org/comparemaptable.jsp?ind=198&cat=4>

<sup>2</sup> The Medicaid eligibility level as set in the ACA is 133% of the Federal Poverty Level (FPL) with a 5% income disregard, making it effectively 138% FPL.

<sup>3</sup> Gifford K, et al., 2011. "A Profile of Medicaid Managed Care Programs in 2010: Findings from a 50-State Survey." Kaiser Commission on Medicaid and the Uninsured. Available at: <http://www.kff.org/medicaid/8220.cfm>

<sup>4</sup> Gold M, 2010. "Accountable Care Organizations: Will They Deliver?" Mathematica Policy Research, Inc. Available at: [http://www.mathematica-mpr.com/publications/pdfs/health/account\\_care\\_orgs\\_brief.pdf](http://www.mathematica-mpr.com/publications/pdfs/health/account_care_orgs_brief.pdf)

<sup>5</sup> Volk G and Pettersson J, 2011. "Global and Episodic Bundling: An Overview and Considerations for Medicaid." AcademyHealth and Robert Wood Johnson's State Coverage Initiatives. Available at: <http://www.rwjf.org/files/research/72272globalbundling201104.pdf>

<sup>6</sup> Rosenbach M and Young C, 2000. "Care Coordination and Medicaid Managed Care: Emerging Issues for States and Managed Care Organizations." Mathematica Policy Research. Available at: <http://www.mathematica-mpr.com/PDFs/caresum.pdf>

<sup>7</sup> Palsbo S and Mastal M F, 2006. "Disability Care Coordination Organizations- The Experience of Medicaid Managed Care Programs for People with Disabilities." Center for Health Care Strategies. Available at: [http://www.chcs.org/usr\\_doc/DCCOs.pdf](http://www.chcs.org/usr_doc/DCCOs.pdf)

<sup>8</sup> Center for Health Care Strategies, Inc., 2007. "Care Management Definition and Framework." Available at: [http://www.chcs.org/usr\\_doc/Care\\_Management\\_Framework.pdf](http://www.chcs.org/usr_doc/Care_Management_Framework.pdf)

<sup>9</sup> Arora R et al., 2008. "Designed and Implementing Medicaid Disease and Care Management Programs: A User's Guide." Agency for Healthcare Research and Quality, Publication Number 07(08)-0063. <http://www.ahrq.gov/qual/medicaidmgmt/medicaidmgmt.pdf>

<sup>10</sup> Rosenbaum S, 2008. "The CMS Medicaid Targeted Case Management Rule: Implications for Special needs Service Providers and Programs." Center for Health Care Strategies, Inc. Available at: [http://www.chcs.org/usr\\_doc/CMS\\_Medicaid\\_Targeted\\_Case\\_Management\\_Rule.pdf](http://www.chcs.org/usr_doc/CMS_Medicaid_Targeted_Case_Management_Rule.pdf)

<sup>11</sup> Congressional Budget Office, 2004. "An Analysis of the Literature on Disease Management Programs." Available at: <http://www.cbo.gov/doc.cfm?index=5909&type=0>

<sup>12</sup> Gifford K, et al., 2011. "A Profile of Medicaid Managed Care Programs in 2010: Findings from a 50-State Survey." Kaiser Commission on Medicaid and the Uninsured. Available at: <http://www.kff.org/medicaid/8220.cfm>

<sup>13</sup> Centers for Medicare & Medicaid Services, Center for Medicaid and State Operations. Letter to State Medicaid Directors regarding disease management. SMDL #04-002. February 25, 2004. <http://www.cms.gov/smdl/downloads/smdl022504.pdf>

<sup>14</sup> Somers S, et al., 2009. "Enhanced Medical Home for Medi-Cal's SPD Population." A report prepared for the California Department of Health Care Services with support from the California HealthCare Foundation. Available at: [http://www.dhcs.ca.gov/provgovpart/Documents/Enhanced%20Medical%20Home%20\(CHCS-posted\).pdf](http://www.dhcs.ca.gov/provgovpart/Documents/Enhanced%20Medical%20Home%20(CHCS-posted).pdf)

- 
- <sup>15</sup> The Children’s Health Fund, 2009. “The Enhanced Medical Home for Medically Underserved Children.” Available at: <http://www.childrenshealthfund.org/sites/default/files/EnhancedMedHomeFinal.pdf>
- <sup>16</sup> Hester J. “Designing Vermont’s Pay-for-Population Health System.” *Preventing Chronic Disease* 7(6):A122. Available at: [http://www.cdc.gov/pcd/issues/2010/nov/10\\_0072.htm](http://www.cdc.gov/pcd/issues/2010/nov/10_0072.htm)
- <sup>17</sup> Brito A, et al., 2008. “The Enhanced Medical Home: The Pediatric Standard of Care for Medically Underserved Children.” *Advances in Pediatrics*, 55: 9-28.
- <sup>18</sup> Volk G and Petterson J, 2011. “Global and Episodic Bundling: An Overview and Considerations for Medicaid.” AcademyHealth and Robert Wood Johnson’s State Coverage Initiatives. Available at: <http://www.rwjf.org/files/research/72272globalbundling201104.pdf>
- <sup>19</sup> Volk G and Petterson J, 2011. “Global and Episodic Bundling: An Overview and Considerations for Medicaid.” AcademyHealth and Robert Wood Johnson’s State Coverage Initiatives. Available at: <http://www.rwjf.org/files/research/72272globalbundling201104.pdf>
- <sup>20</sup> Miller H, 2009. “From Volume to Value: Better Ways to Pay for Health Care.” *Health Affairs*. 28(5): 1418-1428.
- <sup>21</sup> Guidance on implementation of the Patient Protection and Affordable Care Act provision on Health Homes for Enrollees with Chronic Conditions. November 16, 2010. The Centers for Medicare and Medicaid Services. Available at: <http://www.cms.gov/smdl/downloads/SMD10024.pdf>
- <sup>22</sup> Miller V, Schneider A, and Rudowitz R, 2011. “An Overview of Changes to the Federal Medical Assistance Percentages (FMAPs) for Medicaid.” Kaiser Commission on Medicaid and the Uninsured. Available at: <http://www.kff.org/medicaid/8210.cfm>
- <sup>23</sup> Frank RG and Garfield RL, 2007. “Managed Behavioral Health Care Carve-Outs: Past Performance and Future Prospects.” *Annual Review of Public Health*. 28:303-20.
- <sup>24</sup> Gifford K, et al., 2011. “A Profile of Medicaid Managed Care Programs in 2010: Findings from a 50-State Survey.” Kaiser Commission on Medicaid and the Uninsured. Available at: <http://www.kff.org/medicaid/8220.cfm>
- <sup>25</sup> Gifford K, et al., 2011. “A Profile of Medicaid Managed Care Programs in 2010: Findings from a 50-State Survey.” Kaiser Commission on Medicaid and the Uninsured. Available at: <http://www.kff.org/medicaid/8220.cfm>
- <sup>26</sup> Guidance on Implementation of the Patient Protection and Affordable Care Act Provision on Health Homes for Enrollees with Chronic Conditions. 2010. Available at: <http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD10024.pdf>
- <sup>27</sup> Kaiser Family Foundation, 2012. “Explaining Health Care Reform: Medical Loss Ratio (MLR).” Available at: <http://www.kff.org/healthreform/8282.cfm>
- <sup>28</sup> Kaiser Commission on Medicaid the Uninsured. April 2, 2012. “Quick Take: Medicaid MCOs and the Medical Loss Ratio (MLR) Requirements.” Available at: [http://www.kff.org/medicaid/quicktake\\_medicaid\\_mlr.cfm](http://www.kff.org/medicaid/quicktake_medicaid_mlr.cfm)
- <sup>29</sup> Joint Principles of the Patient Centered Medical Home. February 2007. Patient-Centered Primary Care Collaborative. Available at: <http://www.pcpcc.net/joint-principles>

---

<sup>30</sup> National Committee for Quality Assurance. January 31, 2011. "NCQA's Patient-Centered Medical Home (PCMH) 2011." Available at:

<http://www.ncqa.org/LinkClick.aspx?fileticket=ag3nmIPXs5s%3d&tabid=631&mid=2435&forcedownload=true>

<sup>31</sup> Mathematica, Inc. 2009. "Recommendations of the Special Commission on the Health Care Payment System. July 16, 2009. Appendix C: Memos on Basic Payment Models and Complementary Payment-Related Strategies."

Available at: <http://www.mass.gov/eohhs/docs/dhcfp/pc/final-report/appendix-c-payment-models-and-comp-strategies.pdf>

<sup>32</sup> Gifford K, et al., 2011. "A Profile of Medicaid Managed Care Programs in 2010: Findings from a 50-State Survey." Kaiser Commission on Medicaid and the Uninsured. Available at: <http://www.kff.org/medicaid/8220.cfm>

<sup>33</sup> Rosenbaum S and Sonosky C, 2002. "Prepaid Ambulatory Health Plans (PAHPs): Implications for Safety Net Providers." Center for Health Services Research and Policy, School of Public Health and Health Services at George Washington University Medical Center. Available at:

<http://www.gwumc.edu/sphhs/departments/healthpolicy/CHPR/downloads/PAHP.pdf>

<sup>34</sup> Gifford K, et al., 2011. "A Profile of Medicaid Managed Care Programs in 2010: Findings from a 50-State Survey." Kaiser Commission on Medicaid and the Uninsured. Available at: <http://www.kff.org/medicaid/8220.cfm>

<sup>35</sup> Rosenbaum S and Sonosky C, 2002. "Prepaid Ambulatory Health Plans (PAHPs): Implications for Safety Net Providers." Center for Health Services Research and Policy, School of Public Health and Health Services at George Washington University Medical Center. Available at:

<http://www.gwumc.edu/sphhs/departments/healthpolicy/CHPR/downloads/PAHP.pdf>

<sup>36</sup> Gifford K, et al., 2011. "A Profile of Medicaid Managed Care Programs in 2010: Findings from a 50-State Survey." Kaiser Commission on Medicaid and the Uninsured. Available at: <http://www.kff.org/medicaid/8220.cfm>

<sup>37</sup> Kane R, et al., 1996. "Managed Care: Handbook for the Aging Network." University of Minnesota National LTC Resource Center. Available at: <http://aspe.hhs.gov/Progsys/Forum/basics.htm>

<sup>38</sup> Binder C, 2008. "Medicaid Targeted Case Management (TCM) Benefits." Congressional Research Services Report for Congress. Available at: <http://www.pascenter.org/documents/RL34426.pdf>

This publication (#8313) is available on the Kaiser Family Foundation's website at [www.kff.org](http://www.kff.org).