



Managed Care Plans

The term “managed care” in Medicaid is used to refer to a broad spectrum of arrangements. In addition to comprehensive risk-based managed care plans, which are most like private health maintenance organizations (HMOs), CMS also includes primary care case management (PCCM) programs and limited-benefit plans in the agency’s classification of Medicaid managed care. Use of these arrangements varies within and across states, as do the specific service delivery characteristics of each model and the maturity of each state’s program. This variation presents challenges in making comparisons across states and Medicaid managed care arrangements. (See the Annex to this section for descriptions of Medicaid managed care terms used throughout this Report.)

States vary on which benefits they include or exclude from their managed care programs. States often carve out or exclude certain Medicaid services from the set of benefits that a comprehensive risk-based managed care plan is responsible for providing to enrollees. These excluded services tend to be provided under fee-for-service (FFS) arrangements or through limited-benefit plans. While states operate their managed care programs under a broad federal framework (described in greater detail in Section F of this Report), the level of detail of requirements that is included in managed care contracts between the state and the plan also varies considerably.

This section describes:

- ▶ the types of managed care arrangements used by states;
- ▶ the characteristics of managed care plans participating in Medicaid; and
- ▶ benefits that are commonly carved out of comprehensive risk-based managed care plans.

Types of Medicaid Managed Care Arrangements

Three main types of managed care arrangements are used by state Medicaid programs today: comprehensive risk-based managed care, PCCM, and limited-benefit plans.

Comprehensive risk-based managed care. In comprehensive risk-based arrangements, states contract with managed care plans to cover all or most Medicaid-covered services for their Medicaid enrollees. Plans are paid a capitation rate, which is a fixed amount per member per month to cover a defined set of services for a given population. While plans are responsible for providing or arranging for a majority of an enrollee's medical needs, the state's obligation to Medicaid enrollees still exists. Plans are at financial risk if spending on benefits and administration exceeds payments; conversely they are permitted to retain any portion of payments not expended for covered services and other contractually required activities. The level of risk for plans varies from state to state and across covered populations within states (for more on risk arrangements, see Section D of this Report). Sometimes one or more benefits, such as behavioral health services, oral health services, non-emergency transportation, or prescription drugs are "carved out" and provided separately through FFS arrangements or by limited-benefit plans.

PCCM. An alternative to comprehensive risk-based arrangements is PCCM, in which enrollees have a single designated primary care provider (PCP) who is paid a monthly case management fee to assume responsibility for enrollee care management and coordination. Individual providers are not at financial risk in PCCM programs; they continue to be paid on an FFS basis for providing covered services. Several states have enhanced their PCCM programs by adding additional coordinated care management features.

These features provide intensive care management for enrollees with high levels of need, increasing their use of performance and quality measures, and providing practice support for individual providers (Verdier et al. 2009). In some cases, financial incentives for both PCPs and the care management entity have also been added.

Limited-benefit Plans. Some states have contracts to manage a subset of benefits (e.g., transportation, oral health services) or services for a particular subpopulation (e.g., individuals in need of inpatient mental health services). These limited-benefit plans are generally paid on a capitated basis and may be risk-based. They may be used to provide a certain set of services to either FFS enrollees, managed care enrollees or both. For purposes of this Report, Prepaid Inpatient Health Plans (PIHPs) and Prepaid Ambulatory Health Plans (PAHPs) are defined as limited-benefit plans. As defined in federal regulation (42 CFR 438.2):

- ▶ **PIHPs** cover, among other services, inpatient hospital and institutional services. Such plans most frequently focus on providing inpatient mental health or combined mental health and substance abuse inpatient benefits.
- ▶ **PAHPs** are generally very narrow in service scope, typically covering just one type of service. States most commonly use PAHPs to provide only transportation benefits. Other PAHPs may provide oral health services, non-institutional mental health benefits, or disease management.

Table C-1 outlines features associated with various service delivery and payment models, including FFS, comprehensive risk-based managed care, PCCM, and limited-benefit plans.

Seventy-one percent of all Medicaid enrollees received at least some kind of service through managed care, as defined by CMS, in 2009—including comprehensive-risk based managed

TABLE C-1. Overview of Medicaid FFS and Medicaid Managed Care Arrangements¹

Key System Features	FFS	Comprehensive Risk-based Plans	PCCM Programs	Limited-benefit Plans²
Provider participation requirements	Any willing provider licensed by the state who agrees to accept Medicaid rates as payment in full can participate.	Plans must meet network size and location standards. Plans are permitted to limit the number of providers in their network and generally must credential providers before accepting them into the network.	PCCM programs may have to meet additional state requirements and agree to certain service policies.	Plans contract with a network of providers, similar to the process for comprehensive risk-based managed care plans, and may also need to meet network requirements.
Enrollee care-seeking rules	Typically, enrollees may receive care from any participating provider.	Plans set the rules on nonemergency referrals and care management, subject to state requirements and oversight. Services must be received from participating network providers, except in emergencies.	Enrollees may need referral by the PCP to see various kinds of specialists, except in emergencies.	Plans set the rules on nonemergency referrals and care management, subject to state requirements and oversight. Services typically must be received from participating network providers, except in emergencies.
Navigation support for enrollees	Open access; enrollees may or may not have rules or guidance on how or where to seek appropriate available services.	Plans typically must provide enrollees with a member handbook and conduct an initial health assessment to determine enrollee needs. Many also provide disease management and care coordination services.	PCCM programs may provide additional navigation support and ways of identifying appropriate providers.	Depending on the type of services provided, plans may provide navigation support for enrollees similar to comprehensive risk-based plans.
Performance monitoring and quality oversight	Provider accountability for outcomes for individual enrollees is not typically formalized. For example, most states do not require providers to report HEDIS data. ³	Plans must conduct external quality reviews and must report specific performance data (e.g., HEDIS) and undertake specific quality improvement activities. Some states require external accreditation (e.g., NCQA and URAC). ⁴	Same as FFS; potentially specific metrics associated with monitoring PCCM performance.	PIHPs must conduct annual external quality reviews, may be required to report performance data applicable to the services delivered, and undertake specific quality improvement activities. ⁵ External accreditation may be required.

Source: MACPAC analysis

¹ Some states have contracted with vendors to administer elements of their programs. Known as administrative services organizations (ASOs), these vendors are typically paid a non-risk-based fee to provide administrative services. While not defined within federal statute or regulations, depending on how they are structured, ASOs may or may not be classified as a managed care arrangement.

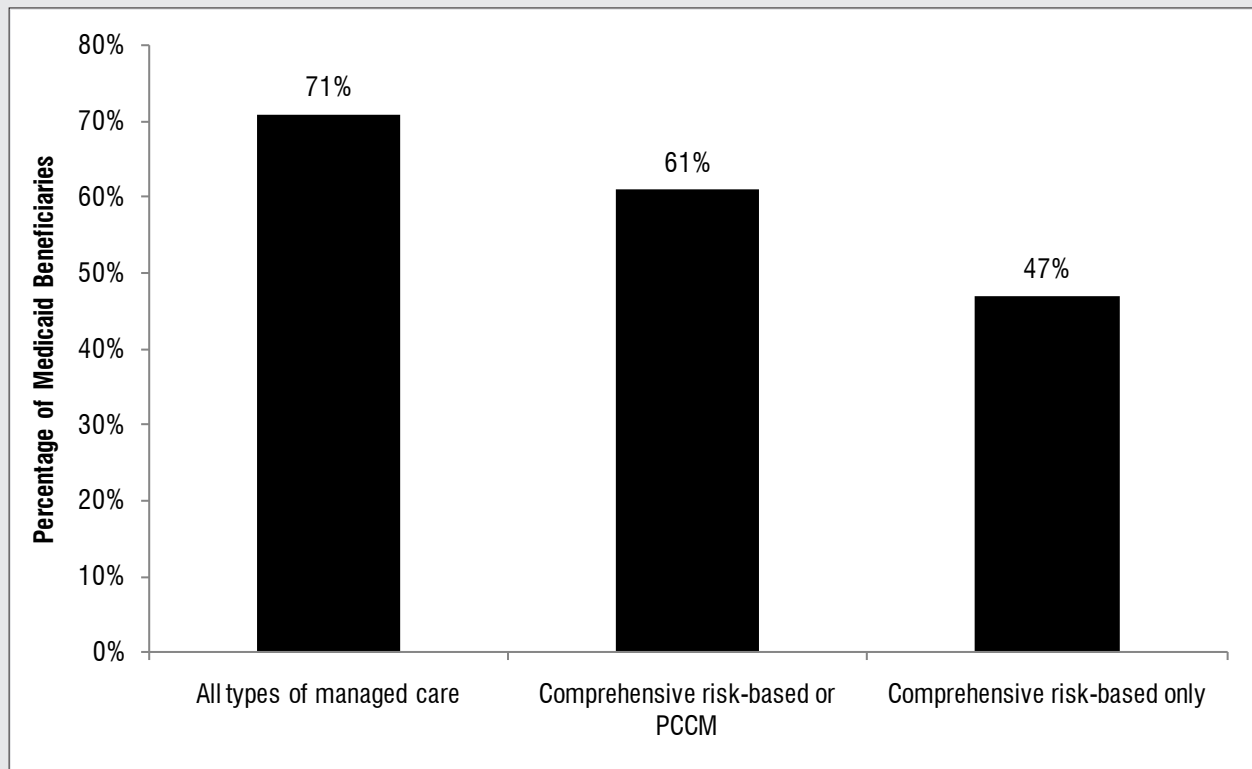
² Limited-benefit plans may have all, some, or none of the elements of the key system features listed above, depending on the benefits covered and type of contracting arrangement with a state. For example, state contracts with limited-benefit plans for providing behavioral health or oral health services may include requirements regarding network development, assistance to enrollees seeking services and development of member materials.

³ HEDIS is Healthcare Effectiveness Data and Information Set.

⁴ NCQA is National Committee for Quality Assurance, and URAC (formerly known as the Utilization Review Accreditation Commission).

⁵ PAHPs are not required to conduct an external quality review.

FIGURE C-1. Percentage of Medicaid Enrollees In Managed Care Arrangements Nationwide, 2009



Notes: Includes CHIP enrollees in Medicaid-expansion programs but not in stand-alone programs. U.S. territories are excluded. MACPAC’s estimate of national managed care enrollment (71 percent) differs from that reported by CMS (72 percent) due to the exclusion of the territories. The comprehensive risk-based or PCCM “unrounded” number is 61.47% and is reported as 61%. Comprehensive risk-based includes plans categorized by CMS as commercial managed care plans, Medicaid-only plans, Health Insuring Organizations (HIOs), and Programs of All-Inclusive Care for the Elderly (PACE). HIOs exist only in California where selected county-authorized health systems serve Medicaid enrollees. PACE programs combine Medicare and Medicaid financing for qualifying frail elderly dual eligibles.

Source: MACStats Table 9

care, PCCM, and limited-benefit plans (Figure C-1, MACStats Table 9).⁶ Excluding the limited-benefit plans results in a nationwide enrollment of 61 percent in either a comprehensive risk-based plan or a PCCM program, with 47 percent of enrollees in a comprehensive risk-based plan only.⁷ There is wide variation in the types of plans offered across states (MACStats Table 10).

Comprehensive Risk-based Plans

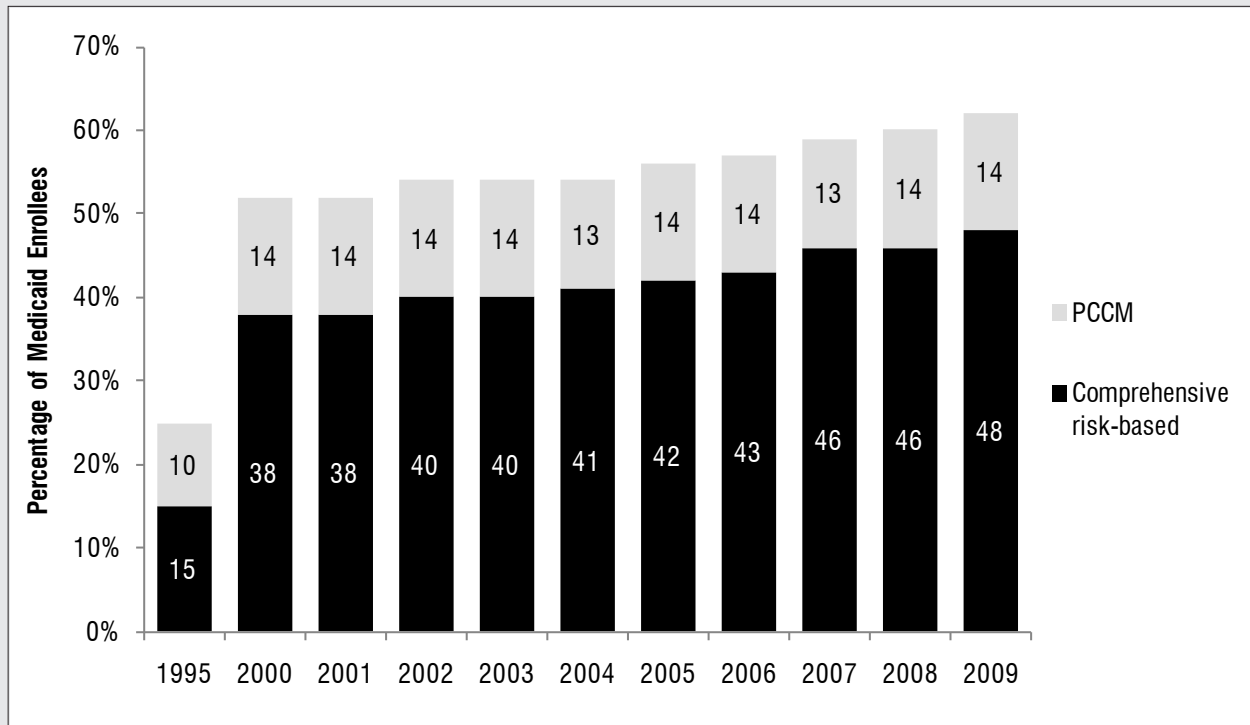
States have increasingly relied upon comprehensive risk-based managed care when delivering care to Medicaid enrollees. As Figure C-2 shows, 15 percent of Medicaid enrollees were in a comprehensive risk-based arrangement in 1995. By 2009 almost half were in a comprehensive risk-based plan.⁸

⁶ Of the U.S. territories and Puerto Rico, managed care data are collected only for Puerto Rico and the U.S. Virgin Islands. Based on these available data, only Puerto Rico includes Medicaid managed care in its benefit design.

⁷ The CMS Medicaid managed care enrollment statistics include CHIP enrollees who are covered through Medicaid-expansion programs but not enrollees in separate, stand-alone CHIP programs. CMS reported a combined enrollment in managed care plans across all states and plan types of 48.8 million. An analysis of the CMS enrollment data by plan type shows an unduplicated count of 35.2 million enrollees in 2009. The duplicated count exceeded the unduplicated count by about 13 million or 38 percent. Some states have particularly high ratios of unduplicated to duplicated counts, indicating that on average Medicaid enrollees are in more than one type of managed care. This seems to reflect the large limited-benefit program enrollments in states that also have other forms of managed care.

⁸ MACPAC’s estimate of comprehensive risk-based enrollment (47 percent) differs from that reported by CMS (48 percent) due to the exclusion of the U.S. territories.

FIGURE C-2. Percentage of Medicaid Enrollees in Medicaid Managed Care by Arrangement Type, 1995 and 2000–2009 (excludes limited-benefit plans)



Notes: Includes CHIP enrollees in Medicaid-expansion programs but not in stand-alone programs. Includes Puerto Rico and the U.S. Virgin Islands. The estimate of comprehensive risk-based and PCCM enrollment in Figure C-1 and throughout this Report (47 percent and 61 percent) differs from the figure shown here (48 percent and 62 percent) due to the exclusion of the U.S. territories. Comprehensive risk-based includes plans categorized by CMS as commercial managed care plans, Medicaid-only plans, Health Insuring Organizations (HIOs), and Programs of All-Inclusive Care for the Elderly (PACE). HIOs exist only in California where selected county-authorized health systems serve Medicaid enrollees. PACE programs combine Medicare and Medicaid financing for qualifying frail elderly dual eligibles.

Source: Calculated from CMS Medicaid Managed Care Enrollment Report Summary Statistics, various years

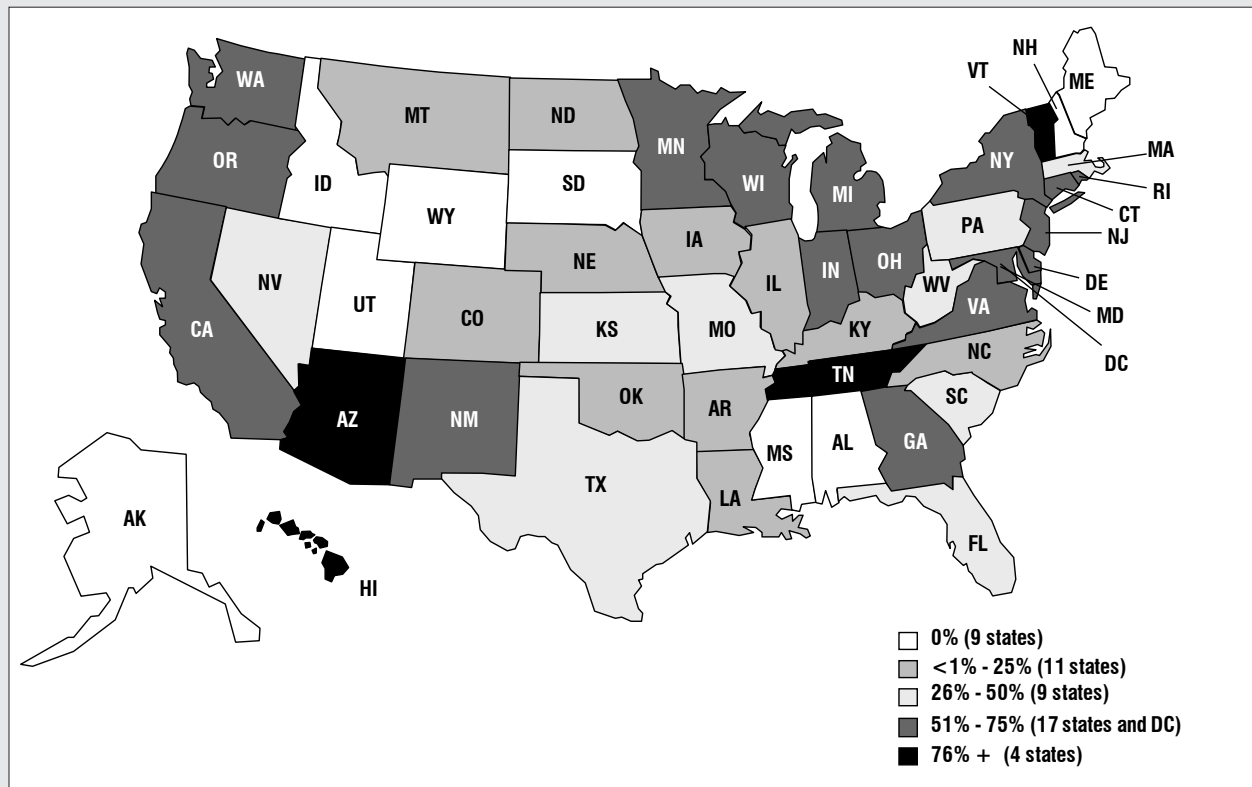
Figure C-3 shows the percentage of Medicaid enrollment in comprehensive risk-based managed care across the states. The 21 states (plus the District of Columbia) with more than half of their Medicaid populations in comprehensive risk-based managed care were mainly concentrated in the East Coast, West Coast, and the upper Midwest. Nine states have no enrollment in comprehensive risk-based managed care.⁹ Several others have only a small share of enrollees in such programs: Colorado (10 percent), Illinois (8 percent), Kentucky (21 percent), and Nebraska (17 percent).

PCCM Programs

As shown in Figure C-4, 30 states operated PCCM programs in 2009, with a total enrollment of 7.3 million. Eleven of those states had no enrollment in comprehensive risk-based plans. Nineteen states with comprehensive risk-based managed care arrangements also had PCCM programs. For example, some states have used PCCM in rural areas when they have had difficulties attracting and retaining comprehensive risk-based plans to serve those areas. The eight states that had more than 50 percent of their

⁹ Seven states (Arkansas, Iowa, Louisiana, Montana, North Carolina, North Dakota, and Oklahoma) have very small PACE programs. Per CMS, Utah has comprehensive risk-based plans that are regulated as PIHPs.

FIGURE C-3. Percentage of Medicaid Enrollment in Comprehensive Risk-based Plans by State, 2009



Note: Includes CHIP enrollees in Medicaid expansion-programs but not in stand-alone programs. Comprehensive risk-based includes plans categorized by CMS as commercial managed care plans, Medicaid-only plans, Health Insuring Organizations (HIOs), and the Program of All-Inclusive Care for the Elderly (PACE). HIOs exist only in California where Medicaid supports selected county-authorized health systems. The PACE program combines Medicare and Medicaid financing for qualifying frail elderly dual eligibles. See MACStats Table 9 for additional information.

Source: MACPAC analysis of CMS 2009 Medicaid Managed Care Enrollment Report Summary Statistics as of June 30, 2009

enrollment in PCCM programs in 2009 had no comprehensive risk-based plan enrollment (MACStats Table 9).

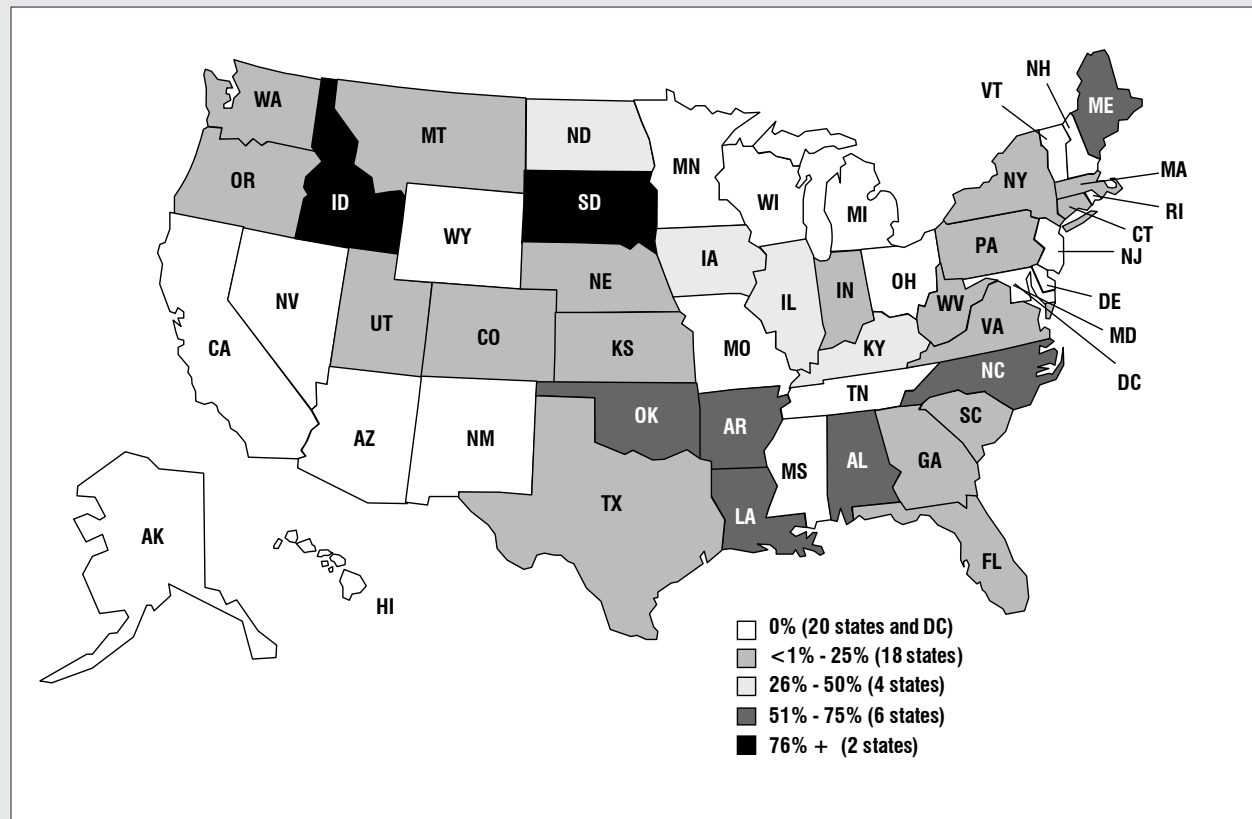
Limited-benefit Plans

Thirty-four states and the District of Columbia have limited-benefit plan arrangements. Creating an unduplicated count of how many enrollees are served by these plans is challenging, because some states use limited-benefit plans to cover more than one service. According to CMS, there are 8.6 million Medicaid enrollees in PIHPs and 7.9 million enrollees in PAHPs. There are 4.3 million enrollees in PIHPs covering inpatient mental health services; 3.1 million enrollees are in

PIHPs that provide combined mental health and substance abuse benefits; 6.1 million are in PAHPs that provided transportation services only; and 1.2 million are in dental PAHPs.

Characteristics of Comprehensive Risk-based Medicaid Managed Care Plans

The evolution in the Medicaid managed care market over the past 20 years has made it difficult to compare policies and plan types across states. However, comprehensive risk-based Medicaid managed care plans can be classified in a number

FIGURE C-4. Percentage of Medicaid Enrollment in PCCM by State, 2009

Note: Includes CHIP enrollees in Medicaid-expansion programs but not in stand-alone programs. See MACStats Table 9 for additional information.

Source: MACPAC analysis of CMS 2009 Medicaid Managed Care Enrollment Report Summary Statistics as of June 30, 2009

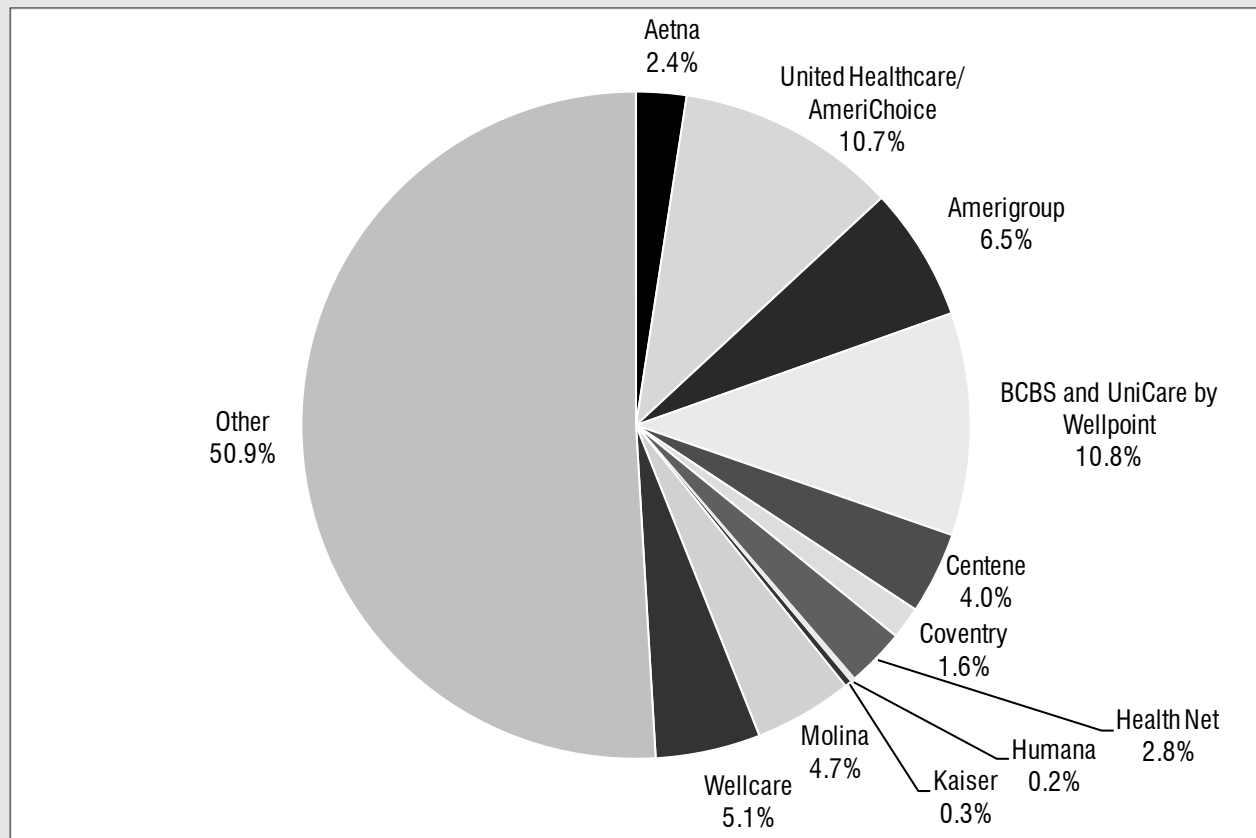
of ways, including whether or not they operate in one or multiple states and how they are sponsored.

Variation among plans includes the extent to which they have enrollees who are insured in the commercial market or Medicare, in addition to Medicaid enrollees.¹⁰ In the mid-to-late 1990s, Medicaid participation by commercial health plans declined, leaving Medicaid more dependent on Medicaid-dominant plans (Felt-Lisk et al. 2001). The Balanced Budget Act of 1997 (BBA, P.L. 105-

33) intensified this trend by eliminating the OBRA 1981 “75/25” rule that required comprehensive risk-based Medicaid managed care plans to have at least 25 percent of their enrollment in the private insurance market. This policy change made it easier for plans to participate in Medicaid. Recent data on the relative performance of different types of Medicaid managed care plans are limited, with many studies dating from the period just after the elimination of the “75/25” rule.

¹⁰ In its 2010 Medicaid Managed Care Enrollment Data Dictionary for the Medicaid Managed Care Data Collection System, CMS uses the term “commercial” to refer to plans that provide comprehensive services to privately insured enrollees and/or Medicare enrollees. CMS uses the term “Medicaid-only” for plans that provide comprehensive services to only Medicaid enrollees, not to commercial or Medicare enrollees. As many Medicaid managed care plans participate in Medicaid as well as CHIP and other public programs, the term “Medicaid-dominant” plans more accurately captures these plans that primarily serve enrollees in these programs.

FIGURE C-5. Medicaid Managed Care Enrollment Market Share by Firm, 2009



Note: "Other" includes Medicaid managed care plans that operate in only one state. Company names for the 11 firms that have Medicaid contracts in more than one state are based on CMS data. BCBS is Blue Cross/Blue Shield.

Source: MACPAC analysis of CMS 2009 Medicaid Managed Care Enrollment Report Summary Statistics as of June 30, 2009

Plans also vary in their geographic scope. About half (49 percent) of enrollees in comprehensive risk-based Medicaid managed care in 2009 were in plans that operated in multiple states. As shown in Figure C-5, these 11 national firms in 2009 included companies active in the commercial insurance market such as Wellpoint and United Healthcare, as well as firms that have historically focused on the Medicaid market, such as Molina and Centene.¹¹

Fifty-one percent of Medicaid enrollees in comprehensive risk-based managed care were enrolled in plans that operated within a single state or region within a state. In addition to commercial plans that operate in a single state or region, these types of plans also include:

- ▶ Provider-sponsored plans that are typically based around providers such as safety-net hospitals or community health centers that tend to have a history of serving low-income populations. Medicaid is an important payer for many of these plans, who also serve as safety net providers for uninsured individuals.

¹¹ Company names are based on CMS Medicaid Managed Care Enrollment data.

- ▶ Government-sponsored plans are created by state and local governments to provide managed care to Medicaid enrollees in a given geographical area. Established as independent health authorities to provide more local control and administration, these plans may constitute a single delivery system for all Medicaid enrollees in the jurisdiction or they may coexist and compete with other health plans in the area.

Carving Out of Comprehensive Risk-based Plan Benefit Packages

In administering their Medicaid managed care programs, states decide which benefits are the responsibility of the managed care plan and which populations are required to enroll, may voluntarily enroll, or are excluded from managed care. States often choose to “carve out” certain services or subpopulations of enrollees from comprehensive risk-based managed care. What services are carved out varies substantially across states depending on how states’ Medicaid benefits are structured and provider systems are organized and financed.

States are increasingly looking to managed care to serve not only low-income children and families, but also enrollees with more complex health needs who have often been carved out of comprehensive risk-based managed care in the past. Issues such as coordination of care and system navigation will be important considerations when determining if certain services or populations should be carved out of managed care. In this section we address service carve outs. In Section B of this Report we address population carve outs.

Considerations for Carving Services Out of Comprehensive Risk-based Managed Care

States can choose to carve out certain Medicaid services from a managed care benefit package and provide the excluded benefits under FFS arrangements or through limited-benefit plans specific to that type of service. When services are carved out of the managed care benefit package, the health plan does not receive payment for, nor does it have the responsibility to provide these services. Behavioral health services tend to be the most commonly carved out services in Medicaid programs. Other common carve outs include oral health services, pharmacy services, and nonemergency transportation benefits.

There are many issues for states to consider with regard to carve outs:

- ▶ **Economies of scale and administration.** Some benefits, such as transportation, may be more economical when provided directly by the state or through a single, competitively bid contract. Using a single pharmacy benefit manager may make it easier for providers to know what the state formulary covers rather than working with the formularies of multiple Medicaid managed care plans. On the other hand, carve outs may lead to inappropriate provision of care, particularly when one of the services which is a substitute for the other is not included in the plan. (Blumenthal and Buntin 1998).
- ▶ **Fiscal considerations.** There may be financial considerations that influence states’ decisions to carve out certain services. For example, the Medicaid Drug Rebate Program, which was established in the Omnibus Budget Reconciliation Act of 1990 (P.L. 101-508), helps lower Medicaid spending on outpatient prescription drugs. Originally, rebates were extended only to drugs provided through

FFS Medicaid, not through managed care. To ensure they got the full benefit of the statutory Medicaid rebate, many states carved out pharmacy benefits from their managed care benefit packages.

Effective March 23, 2010, the Patient Protection and Affordable Care Act (P.L. 111-148) extended the Medicaid Drug Rebate Program to managed care plans in Medicaid. As a result of this legislative change, some states (including Texas and New York) are now considering adding pharmacy benefits into their managed care contracts rather than carving them out (NY 2011, TX 2011).

- ▶ **Quality.** Depending on the structure of the carve out and level of coordination, carve-out arrangements have the potential to improve access to and quality of care by facilitating enrollee access. On the other hand, carve outs have the potential to make it harder to coordinate the services that are carved out with other health services used by enrollees. For example, in some states, behavioral health services are carved out of the plan benefit package but the plan remains responsible for the pharmaceutical costs related to behavioral health. This makes it challenging for plans to coordinate with prescribing providers and to gain a full picture of their enrollees' health needs. Sharing data with comprehensive risk-based plans around carved-out services can assist with care coordination and disease management.

Research on the impact of carve outs on quality and access is limited, and results are mixed. Depending on the service, certain studies have found expanded access after adopting carve outs (Callahan et al. 1995, Goldman et al. 1998) while others found modest declines in the receipt of appropriate care (Ma and McGuire 1998). One study examining carve outs of pharmacy benefits found that including the benefit in the plan (a “carve in”) allowed plans to improve integration of the management of the enrollees' formularies and mix of drugs, resulting in relatively greater use of lower-cost generic drugs and improved care coordination (Joines et al. 2007).

References

- Blumenthal, D., and M.B. Buntin. 1998. Carve outs: Definition, experience, and choice among candidate conditions. *The American Journal of Managed Care* 4, special issue: SP45-SP57.
- Callahan, J.J., D.S. Shepard, R.H. Beinecke, et al. 1995. Mental health/substance abuse treatment in managed care: The Massachusetts Medicaid experience. *Health Affairs* 14, no. 3: 173-184.
- Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services. Medicaid managed care enrollment report, 1998-2010. https://www.cms.gov/MedicaidDataSourcesGenInfo/04_MdManCrEnrllRep.asp.
- Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services. 2009. National summary of state Medicaid managed care programs. <https://www.cms.gov/MedicaidDataSourcesGenInfo/downloads/2009NationalSummaryReport.pdf>.
- Felt-Lisk, S., R. Dodge, and M. McHugh. 2001. *Trends in health plans serving Medicaid—2000 data update. Report to Kaiser Commission on Medicaid and the Uninsured by Mathematica Policy Research*. November. <http://www.kff.org/insurance/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=13885>.
- Goldman, W., J. McCulloch, and R. Sturm. 1998. Costs and utilization of mental health services before and after managed care. *Health Affairs* 17, no. 2: 40-52.
- Joines, W., J. Menges, and J. Tracey. 2007. *Programmatic assessment of carve-in and carve-out arrangements for Medicaid prescription drugs. Report to the Association for Community Affiliated Plans by The Lewin Group*. <http://www.lewin.com/content/publications/AssessmentCarveinCarveOut.pdf>.
- Ma, C.A., and T. McGuire. 1998. Costs and incentives in a behavioral health carve out. *Health Affairs* 17, no. 2: 53-69.
- New York State Department of Health (NY). 2011. *Medicaid redesign initiatives*. Albany, NY: New York State Department of Health. http://www.health.state.ny.us/health_care/managed_care/appextension/mrt_waiver_materials/docs/medicaid_redesign_initiatives.pdf.
- Texas Health and Human Services Commission (TX). 2011. *Medicaid managed care proposals*. Austin, TX: Texas Health and Human Services Commission. <http://www.hhsc.state.tx.us/medicaid/MMC-Proposals.shtml>.
- Verdier, J., V. Byrd, and C. Stone. 2009. *Enhanced primary care case management programs in Medicaid: Issues and options for states. Report to Center for Health Care Strategies and Oklahoma Health Care Authority Center*. Washington, DC: Mathematica Policy Research. September. http://www.chcs.org/usr_doc/EPCCM_Full_Report.pdf.

Section C Annex

Medicaid Managed Care Definitions¹

Managed care entity. A Medicaid managed care organization or primary care case manager (§1932 of the Act).

Comprehensive risk contract. A risk contract that covers inpatient hospital services plus any one of the following services, or at least three of the following services: outpatient hospital, rural health clinic, federally qualified health center, other lab and X-ray, nursing facility, EPSDT, family planning, home health.

Risk contract. A contract under which the managed care contractor assumes risk for the cost of services covered and incurs loss if the cost of furnishing the services exceeds the payments under the contract.

Nonrisk contract. A contract under which the contractor is not at financial risk for changes in utilization or for costs incurred. The contractor may be reimbursed at the end of the contract period on the basis of incurred costs.

Capitation payment. A periodic payment made by a state agency to a contractor on behalf of each enrollee enrolled under a contract for the provision of Medicaid services; payment is made periodically, generally per member per month.

Entities referred to as comprehensive risk-based plans in this Report

- ▶ **Managed care organization.** An entity that has or is seeking a comprehensive risk contract.
- ▶ **Health insuring organization.** A county-operated entity that covers services through payments to or arrangements with providers, in exchange for capitation payments under a comprehensive risk contract. There are only four HIOs, all in California, as described by the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272).

¹ Unless otherwise noted, these terms are defined within 42 CFR 438.2.

Entities referred to as limited-benefit plans in this Report

- ▶ **Prepaid inpatient health plan (PIHP).** An entity that does not have a comprehensive risk contract; provides, arranges, or otherwise has responsibility for inpatient hospital or institutional services for its enrollees; and is paid on the basis of prepaid capitation payments or other payment arrangement that does not use state plan rates. The most common kind of PIHP is for inpatient mental health services.
- ▶ **Prepaid ambulatory health plan (PAHP).** An entity that does not have a comprehensive risk contract; provides services other than inpatient hospital or institutional services for its enrollees; and is paid on the basis of prepaid capitation payments or another payment arrangement that does not use state plan rates. Some common PAHPs are for transportation services and oral health services.

Primary Care Case Management (PCCM) Programs

- ▶ **Primary care case management.** A system under which a primary care case manager (physician, physician group, or entity that employs or arranges with physicians) contracts with a state to furnish case management services, which include location, coordination, and monitoring of primary care. States may also opt to use physician assistants, nurse practitioners, and/or certified nurse midwives.