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TABLE OF CONTENTS

EMSC and Managed Care: A Developing Relationship	4
Facts About Managed Care	5
Health Care Financing	5
The History of Managed Care	5
Managed Care Plan Descriptions	5
How Managed Care Plans Manage Care	6
Continuous Quality Improvement	7
Quality Improvement in EMSC	8
Medicaid Managed Care Developments	9
State Child Health Insurance Program	9
Policy Issues in EMSC and Managed Care	10
Prudent Layperson Definition of Emergency Medical Condition	10
Emergency Medical Treatment and Labor Act	10
Mastering Managed Care: Effective Collaboration Tips for EMSC	11
Strategies for Working with Managed Care Organizations	11
Top Five Areas for EMSC Discussion and Collaboration with Managed Care	12
Appendices	15
Appendix A: Health Care Financing Methods	15
Appendix B: Glossary of Health Care Financing and Managed Care Terms	17
Appendix C: National Managed Care Resources	21
Appendix D: Recommendations and Priorities of the EMSC Managed Care Task Force	24
Appendix E: Bibliography	27

Managed Care and EMSC:

A PRACTICAL GUIDE TO RESOURCES IN MANAGED CARE

“Managed care organization: An umbrella term for health maintenance organizations and health plans that provide health care under pre-set payment arrangements and coordinate care through a defined network of primary care physicians and hospitals.”

EMSC and Managed Care: A Developing Relationship

Health plans now provide care for more than 85% of all employed families. States now require managed care enrollment for most Medicaid beneficiaries. As managed care increasingly penetrates the health care environment, your Emergency Medical Services for Children (EMSC) project can use this opportunity to collaborate with managed care organizations (MCO) to assure that high quality care in children's health services is a major part of public and private sector efforts. Moreover, you can help focus these strategies to ensure children's access to the entire spectrum of emergency services, including primary prevention of illness and injury, acute care, and rehabilitation.

The Health Resources and Services Administration's (HRSA), Maternal and Child Health Bureau (MCHB) and the National Highway Traffic Safety Administration (NHTSA) jointly administer the federal EMSC Program. This collaboration has resulted in:

- ◆ an increase in the number of ambulances with child-size equipment;
- ◆ protocols and treatment guidelines designed especially for children;
- ◆ transport and triage guidelines and interfacility agreements that enable children to be treated at places best equipped for their needs; and
- ◆ facility categorization to improve children's access to appropriate care.

Continuing concerns exist that market-based health care reform changes may negate many of these improvements to the emergency medical services (EMS) system and/or delay further improvements. Access to care and quality of care are particularly critical issues. For instance, in the EMS arena, some MCOs place restrictions on individuals' direct contact with pre-hospital providers (e.g., ambulance services, emergency medical technicians, paramedics) to reduce health care costs. In some cases, the health plan may require the enrollee to contact the primary care physician or a designee of the plan prior to calling an emergency number such as 9-1-1. This procedure could delay access to care in a true emergency. Many MCOs have established procedures to re-

direct patients with acute problems, including children, to sites other than emergency departments (EDs), and the triage protocols used for determining the appropriate treatment setting may not be pediatric specific.

Facilities designated as “participating providers” by MCOs also may not have adequate equipment or training to manage children's emergencies. Additionally, many primary care physicians are not adequately prepared to manage the increased acuity of the child who has been diverted from the EMS system.

MCOs and EMS providers can strive to reach the common goals of quality, appropriate, and cost-effective health care for all populations. The EMSC Program supports and promotes the concept of accessible, quality primary care and a “medical home” for every child. To the extent that MCOs are able to provide such primary care, these plans offer opportunities for excellent care for some groups that have not had access to it in the past. However, it is equally important that a quality emergency system be available and that reducing inappropriate use of emergency care not lead to restrictions in appropriate and necessary use. Currently, methods to control visits to EDs vary among MCOs, and in many cases consumers are confused as to what process to follow in an actual emergency.

Another EMS concern in the managed care environment is the public safety-net aspect of emergency services. Historically, third party payers have assisted in subsidizing basic health care for the poor in the emergency department. Thus, in the absence of an explicit national policy to guarantee health care to all, we have been paying for indigent care through cost shifting. Yet the advent of MCOs is rapidly changing this implicit guarantee of health care since MCOs do not share the cost of uncompensated care. Consequently, both primary and emergency care for the poor is at risk. This is a special problem for children since children's access to private insurance has declined steadily over the last 15 years. As noted by the American Hospital Association in 1999, more than 11 million children were uninsured due to their parents' unemployment or to reductions in their parents' employer-sponsored coverage. Co-payments and deductibles further limit access for some children. At this point, it is unclear what the impact of welfare reform will be on children's health care.

Facts About Managed Care

Health Care Financing

Health care is paid for through many different mechanisms. Funding sources are often not integrated, making it very confusing for the average consumer to determine the best way to access funds. The financing of health care can generally be divided into the following categories (see Appendix A for a definition of each):

- ◆ Self-Pay/Uninsured
- ◆ Employer Sponsored Plan
- ◆ Indemnity Plan
- ◆ Managed Care Plan
- ◆ Government Sponsored Plans
- ◆ Medicare
- ◆ Medicaid
- ◆ State Child Health Insurance Program
- ◆ Department of Defense TRICARE Program
- ◆ Public Health Service
- ◆ Other (Crippled Children's Fund, Children's Miracle Network, March of Dimes)

This guide focuses primarily on health care financed through a managed care plan. Medicaid will also be included in this discussion, as more than 54% of all Medicaid beneficiaries and most State Child Health Insurance Program (SCHIP) participants are enrolled in some type of managed care plan.

The History of Managed Care

While more people have recently turned to managed care to control rising health care costs, managed care is not new. Kaiser Permanente, one of the largest MCOs in the world, can trace its roots back to 1933. That year, California surgeon Sidney R. Garfield, MD, had a 10-bed hospital that was having difficulty surviving in the fee-for-service environment. In the face of his financial difficulties, Dr. Garfield negotiated with Industrial Indemnity Company, a contractor's insurance firm sponsored by industrialist Henry J. Kaiser, to prepay five cents a day per employee for work-related medical care that he would provide. He also negotiated with a group of construction companies completing the Grand Coulee Dam in Washington state to provide a voluntary five cents a day payroll deduction for non work-related care.

Later, Kaiser called on Dr. Garfield to establish similar group practice prepayment plans for workers at his shipyards in San Francisco and other company worksites. Dr. Garfield reproduced this organization in other states, eventually building more hospitals but still having funds available for teaching, training, and research. Many other types of private managed care arrangements have been successfully implemented throughout the years using this prepayment arrangement, known as capitation.

Managed care entered the public arena in 1971 when California launched a major initiative to enroll Medicaid beneficiaries in managed care plans. The HMO Act of 1973 also stimulated the

growth of health maintenance organization (HMOs). The Act included a mandate for federal grants, loans, and loan guarantees for developing HMOs and provided for equal contributions for the employer for either an HMO or basic medical plan. The Act also made provisions for an HMO to require an employer with 25 or more employees to provide an HMO option with both employee and employer contributions for benefits if health insurance was a company benefit. HMOs had a pricing advantage over basic medical plans because they could use community rating versus individual employer ratings when determining capitation rates, causing them to grow rapidly in the marketplace. This advantage was later leveled in the HMO Act of 1988.

California began to experience difficulty in the operation of its Medicaid managed care program due to questionable marketing activities by participating plans and many default enrollments. This activity prompted a 1976 federal HMO amendment that included stringent requirements for HMO operations. Many of the prepaid Medicaid activities stopped because HMOs were reluctant to enter agreements. Private sector enrollment continued to grow and many different types of managed care plans began to develop as employers attempted to find ways to control the rising cost of health care for their employees. Public sector managed care activities were stimulated again in 1993 when Congress made changes to the process of requesting waivers to the Social Security Act.

Managed Care Plan Descriptions

Managed care plans have evolved significantly from the early Kaiser years. More than 150 million people currently receive their health care through managed care. While many group practice plans still exist, a "hybrid" of managed care plans operates in the market today.

Many of the various plan designs have been created in response to employer and consumer demands for choice in selecting their health insurance plans. Most managed care plans are formed from a network of purchasers of care and, in many cases, providers of care. The network may consist of physicians, clinics, hospitals, health centers, home care providers, and others that the health plan has selected to participate in the delivery of care. Following are descriptions of the common basic managed care models.

- ◆ **Staff Model.** In the staff model, physicians and other medical professionals are salaried employees of the HMO. The clinics, health centers, and, in some cases, hospitals in which they practice are owned by the HMO. Usually only services delivered by the HMO are covered.
- ◆ **Group Model.** The group model HMO is very similar to the staff model, with the exception that the multi-specialty physicians group practice is not owned by the HMO. The group operates as an independent partnership or professional cooperative that usually has an exclusive contract with the HMO. The plan pays the

group at a negotiated rate and each group is responsible for paying its physicians, staff, and other expenses.

- ◆ **Independent Practice Association (IPA) Model.** The most predominant of structures, the IPA contracts with a large number of individual private practice physicians who may operate a solo practice or a small group. The physician agrees to accept some financial risk in exchange for accepting the plan's patients. The physicians are paid on a fee-for-service basis or at a fixed amount to provide care for the IPA's members.
- ◆ **Preferred Provider Organization (PPO).** A PPO is a network of physicians and hospitals that agree to provide care on a discounted fee-for-service basis in exchange for a plan's patients. Usually, the PPO is not at risk for care. Plan members who use the PPO network receive more health care coverage when using a network physician, and they pay a higher out-of-pocket cost when they seek care outside the PPO network.
- ◆ **Physician Hospital Organization (PHO).** A PHO is typically composed of a network of non-profit organizations that have traditionally served the community. Physicians contract directly with a hospital to provide inpatient and outpatient care.
- ◆ **Physician Practice Management (PPM).** A PPM is usually a for-profit organization. It is made up of physician-managers who are responsible for developing contractual arrangements between medical practices and various hospitals.
- ◆ **Point-of-Service (POS).** The POS plan was designed to accommodate enrollees who desire more choice in selecting their providers of care. In this type of managed care plan, the provider's reimbursement and enrollee's out-of-pocket expenses are determined each time the enrollee receives care. Different benefit levels are associated with providers who participate or who do not participate as a network provider. For example, if an enrollee chooses to seek care from a participating physician, the plan may cover all charges except a predetermined co-payment amount. If the person chooses a non-participating provider, only a percentage of cost may be covered, and the enrollee will be responsible for the remainder of the cost.
- ◆ **Mixed Model.** Many health plans have found it beneficial to diversify and offer various types of plans. This model is particularly useful in areas with both metropolitan and rural populations. A mixed model

plan includes more than one form of HMO within a single plan. A staff model HMO may also contract with independent physician groups or with individual, private practice physicians. Any number of combinations are possible.

The design of a managed care plan often depends on the origin of the network. While many managed care plans have been driven by the payer, more hospitals and physicians are banding together to negotiate with MCOs or are creating managed care-like entities to compete directly in the health care market.

How Managed Care Plans Manage Care

The goal of a good managed care plan is to provide high quality, integrated care in the most cost-effective manner. Managed care administrators use a number of management tools to achieve this goal, including:

Negotiated Payment Rates. One key element of any successful managed care plan is its ability to negotiate payment rates with providers of care. In most instances, the rates are negotiated on a capitation basis where the provider is paid a fixed amount for each enrollee per month. The provider must then provide or make arrangements for all the necessary care as agreed on in the contract. The provider is usually at risk for a portion of the expenses for care that exceeds the prepayment amount. Likewise, the provider is entitled to the profits for care that is under the capitation rate. Providers must balance between under- and over-utilization to be effective managers of care.

EMS providers are just beginning to explore new payment arrangements with MCOs. For example, in March 1999 Kaiser Permanente implemented a precedent-setting program with American Medical Response (AMR) to manage and provide medical transportation for their members across the county. Kaiser Permanente will pay AMR a monthly fee that will cover all costs of the services provided. Prior to this time, medical transportation was covered on a fee-for-service basis. AMR has agreed to provide medical transportation services in compliance with nationally certified, computer-aided, triage protocols.

Gatekeeping. Most plans assign the enrollee to a "gatekeeper," usually the primary care physician (PCP), who typically serves as the initial contact for all of the enrollee's needs. Family practice, pediatric, and internal medicine physicians generally provide primary care. The PCP is responsible for making any referrals to specialists and usually is at risk for all or part of the cost of the specialist's care. Because of this role, the PCP is very important in managing the patient's care, including ensuring that the patient is linked to other resources that may be required.

Preventive Health Education/Services. Managed care plans were built on the philosophy that it is better to prevent an illness or identify it early than incur the high cost of treatments at advanced

stages of illness. Many plans offer prevention programs such as smoking cessation and weight and stress reduction classes. Until recently, however, the preventive models have focused on illness prevention with little emphasis on injury prevention, which is gaining increased importance. EMSC projects throughout the country have been actively involved in both illness and injury prevention programs for a number of years and can offer a great deal in the way of data and resources to the managed care industry.

Utilization Management. Utilization management is essential in any managed care plan because it analyzes the cost-effectiveness of the chosen course of treatment and the overall practice patterns of a particular provider or group. A health plan may carry out utilization management by requiring an enrollee to have certain procedures, emergency department visits, inpatient admissions, and any other number of services approved prior to the occurrence. Often this prior authorization occurs via telephone with an exchange of information occurring between qualified medical professionals. Reimbursement is authorized if the care meets established guidelines or is in line with prudent clinical judgment.

Criticism of prior authorization programs occurs when the party requesting approval has to wait a long period of time to be connected to or receive authorization from the approving body or if the provider or enrollee feels that the person providing the authorization is not qualified to do so. Many managed care members have also become concerned if the authorization is not binding. Many states are pushing to require payment for any service that has been prior authorized based on legitimate information. In the case of authorizing emergency care, many states are advocating for “prudent layperson” legislation, which is described on page 8 and in the Glossary.

Other utilization management tools include concurrent review, which occurs when the patient’s care is reviewed for medical necessity and appropriateness during the actual performance of services. For example, once a hospital admission is approved, the managed care plan may contact the hospital while the patient is still in the hospital to determine how the patient is progressing and what the plans are for discharge. Retrospective review may occur after the services have been rendered. In this instance, the medical record is usually reviewed to make a determination about the care provided. A retrospective review can be conducted before any payment is made in the case of fee-for-service care or money can be recouped if prepayment has occurred.

All reputable utilization plans include an appeals mechanism by which a decision can be reconsidered on request of the affected parties. Usually a second physician reviews the clinical and other information to make a final decision.

Case Management. Case management is a process of coordinating a variety of health services for a patient to assure that he or she receives the most appropriate care, in the best setting, and in a cost-effective manner. Case managers may be employed by the provider of care, insurers, or local and state public agencies. A

case manager usually becomes involved in high-cost, complex cases that require someone to remain abreast of the patient’s condition as a whole. The case manager then attempts to integrate the wishes of the patient and family with the most appropriate clinical course of treatment, available resources, existing insurance coverage, and available health care financing alternatives. The case manager works closely with the primary care physician and is usually considered a link to needed services throughout the health care continuum.

Demand Management. Demand management refers to programs that attempt to influence and empower patients to use medical care appropriately by having an impact on the factors that influence their decision to seek medical care. Some proponents would argue that demand management should not be considered a tool of managed care because MCOs attempt to manage the supply of services, whereas demand management influences the actual demand for services.

For example, many demand management programs are telephone-based and use nurse counselors to provide medical information to patients to support their decision-making processes regarding when to seek care and what type of care to seek. Other approaches include self-help groups that assist the patient in self-care issues and health promotion/disease prevention programs similar to those sponsored by employers.

Continuous Quality Improvement

Quality improvement is also an integral component of an MCO’s management plan. Consumers and purchasers are beginning to rely as much on quality as price when determining the most appropriate health plan.

As in other health care settings, effective quality improvement programs are going through an evolving process in managed care. MCOs are moving away from focusing all efforts on the few instances of extreme variations in care and instead are emphasizing moving care to an optimal level. They are using more scientific approaches, applying reliable data and well-researched protocols to benchmark treatment and access to care. Because many of these quality initiatives are driven by processes known to affect health outcomes, more MCOs are also participating in the development of clinical pathways and outcomes measures (see Appendix B for a definition of each). EMSC can offer much in this area as plans attempt to standardize clinical protocols for accessing emergency care.

Some MCOs have attempted to influence quality by using financial incentives for providers. Studies on the effectiveness of this approach are underway. Member satisfaction is also gaining interest as a gauge of an MCO’s quality of care. Consumer groups and employers are also promoting the use of member surveys and report cards as a way to help them choose health plans. Many other activities to assess quality are currently under development. A partial list of organizations undertaking such activities follows:

The National Committee for Quality Assurance (NCQA). NCQA is a national accrediting body for MCOs. Their evaluation process examines how a health plan manages all components of its delivery system. It is conducted by a team of physicians and managed care experts and includes both on- and off-site evaluations. A national oversight committee of physicians analyzes the team's findings and assigns an accreditation level based on the MCO's performance.

NCQA also developed the **Health Plan Employer Data and Information Set (HEDIS)**, a set of performance measures designed by employers, consumers, and HMOs to standardize the reporting of health plan performance. The aim is for employers and consumers to use HEDIS as a tool to evaluate and purchase health plans. Specifically, HEDIS collects information on such things as a health plan's rates per enrollee for childhood immunizations, cholesterol screening, breast cancer, cervical cancer, first trimester perinatal care visits, major affective disorders, coronary artery bypass graphs, and cesarean sections. Member satisfaction is evaluated by soliciting input from enrollees regarding access to medical care, thoroughness of medical examinations, ease of seeing their physician of choice, satisfaction with health outcomes, and their intent to switch plans. NCQA provides a report to purchasers and consumers on participating plans.

Foundation for Accountability (FAcct). FAcct represents public and private purchasers of health care, consumers, researchers, and health care evaluators. The group was formed to increase the accountability of health care organizations and will evaluate, endorse, and promote a common set of patient-oriented measures of health care quality that focuses on the outcomes of care. FAcct developed a quality measurement framework that includes information about consumers' health status, satisfaction, and risk factors, along with measures for specific conditions.

Health Care Financing Administration (HCFA). As part of its Quality Assurance Reform Initiative, HCFA's Office of Prepaid Health Care has developed a set of guidelines to assess quality of care in health plans. These guidelines are currently being tested in Ohio, Minnesota, and Washington. HCFA has attempted to provide these guidelines to plans rather than issue punitive regulations in an attempt to promote quality improvement. HCFA has a number of other quality initiatives under development to monitor the quality of care rendered to beneficiaries.

Health Resources and Services Administration (HRSA). HRSA recently established a Center for Managed Care to coordinate collaborative efforts with managed care organizations. The Center works to improve the quality of services rendered and to ensure that existing systems are not dismantled without adequate safety nets to assure coverage for required services.

The Joint Commission on the Accreditation of Health Care Organizations (JCAHCO). JCAHCO also accredits health care

Quality Improvement in EMSC

Quality in pediatric emergency medical care is the sum of all activities undertaken within an EMS system to develop and maintain a standard of excellence in emergency care for children. Improvement of the system should be continuous, customer-centered, data driven, and offer a scientific approach to improvement based on quantitative methods, evidence-based practices, and organizational development principles. Improvement involves decreased dependence on changing behavior through deterrence. Rather than searching for errors, problems, or deficiencies, the focus should be on improving the process or system so that problems are less likely to occur from the outset.

Quality improvement in EMSC assures that children:

- ♦ obtain illness and injury prevention services;
- ♦ receive family-centered and culturally competent care;
- ♦ receive the appropriate pre-hospital care by educated bystanders, first responders, and/or EMTs;
- ♦ are transported, when required, in an emergency vehicle furnished with child-size equipment;
- ♦ receive care at the best facility to meet their pediatric emergency and critical care needs; and
- ♦ have a medical home that promotes recovery and continued wellness.

Quality improvement in EMSC requires:

- ♦ strong leadership at all levels to articulate a vision and inspire a lasting commitment;
- ♦ a focus on the customer – children, families, and communities;
- ♦ collaborative efforts between partners that can improve the process and outcomes of emergency care of children;
- ♦ links to strategic planning goals, education and training, and program development;
- ♦ data and information that are reliable, rapidly accessible, standardized, and timely;
- ♦ pediatric clinical guidelines and measures of performance that assist in guiding, evaluating, and improving EMSC; and
- ♦ a commitment to research that contributes evidence for changes in practice.

Quality improvement in EMSC presents many complex challenges and opportunities. MCOs and EMS providers can combine efforts and data sources to make improvements a reality.

networks. Its accreditation process largely addresses issues of network integration, coordination, and accountability. JCAHCO has also developed outcome indicators for managed care, which focus on health status; clinical performance; consumer and purchaser satisfaction; and data validity, reliability, and worthiness.

Medicaid Managed Care Developments

Many of the changes occurring in today's health care market can be attributed in part to Medicaid activity. Approximately 50% of the Medicaid beneficiaries are children, although they account for only 15% of the total expenditures. The federal HMO amendment passed in 1976 imposed stringent requirements on HMOs receiving federal funds as a result of questionable activities that occurred in California. In response, nearly all Medicaid managed care activities stopped because HMOs had a difficult time meeting the new requirements. To encourage continued growth of public sector HMOs, Congress, through the Omnibus Budget Reconciliation Act of 1981, gave states more flexibility in administering managed care programs. States were then given authority to request waivers to the Social Security Act in an attempt to develop alternative models of care delivery.

However, the waiver process was very complex, and only a few states had successfully completed the process in 1983. When Congress simplified the waiver process in 1993 and again in 1997, a dramatic change ensued. Many states began seeking waivers to offer innovative approaches for delivering care to Medicaid beneficiaries. States were able to offer MCOs more competitive purchasing arrangements. Currently, all but five states (Alaska, Idaho, Montana, Vermont, and Wyoming) have Medicaid managed care plans. Following are descriptions of the processes and plans in a few states:

Arizona. Arizona was one of the first states to apply for a waiver in the early 80s. Most other states did not attempt to develop a managed care program of the magnitude of Arizona's until 10 years later when the waiver regulations were relaxed. The latest U.S. General Accounting Office report noted that the annual cost per patient in Arizona dropped 11% in 1995 without appearing to compromise care. Arizona continues to serve as a model for other states.

California. The state of California has had considerable experience with MCOs and has converted its Medicaid program, called Medi-Cal, to managed care. Many counties have or are in the process of developing a type of purchasing cooperative that integrates public and private sector services. Participants from within a county, such as the hospital, clinics, Maternal and Child Health, and immigrant programs, unite to become a public HMO.

Maryland. The Medicaid program in Maryland received approval for its waiver to enroll all Medicaid recipients in managed care on October 30, 1996, and began enrollment on June 2, 1997. The

program currently covers acute and ambulatory care and intends to phase in long-term care. Children with special health care needs are also included in the program. The state attempted to assure that all parties had the opportunity to give input into the redesign of the system and held a number of public meetings with consumers, providers, and advocates. A steering committee, assisted by technical advisory groups, was appointed following the public meetings. Consumer response forums were also held.

Oregon. The Oregon Health Plan (OHP) is known for its efforts to overhaul health care delivery for the state's entire population. The original OHP included goals to redesign the Medicaid program, mandate employer-provided health insurance, set up a medical pool for high risk individuals, and create an incentive for small businesses to offer health insurance.

All of the components have yet to be started, however great strides have been made in the indigent care program. Oregon's experience in the area of managed care led to the successful implementation of its current program. Oregon was able to expand coverage to all state residents below the poverty level with savings generated by the design of the benefit package. Coverage is provided for approximately 70% of the plan members by Fully Capitated Health Plans in most counties. The remainder of the coverage comes from physician care organizations or primary care case managers.

Tennessee. One of the well-known statewide managed care plans is TennCare, which covers the indigent population of Tennessee. TennCare was developed using 12 MCOs that assumed full risk with the intent of covering 1.8 million Medicaid eligible and uninsured people. The state used a strategy of pooling federal, state, and local indigent care for a total of \$2.9 billion in the first year alone. Beneficiaries receive a standard benefit package adapted from the state group insurance plan.

However, the Tennessee plan was very aggressive, and there was little time for the initial implementation phase. The waiver was approved on November 18, 1993, with implementation set for January 1, 1994. The quick implementation period led to a number of problems with enrollment, education, and access. Now that the plan has been in operation for several years, it serves as a model for many other states. A number of operational issues have yet to be resolved, including frequent turnover in the program's leadership. However, state officials report that the project has been successful in holding down costs and providing benefits to people who have never had access to health insurance in the past.

State Child Health Insurance Program

The Balanced Budget Act of 1997 included a child health block grant that offered states \$20.3 billion in new federal funding over a five-year period to initiate and expand child health assistance to uninsured, low-income children. The law allows the states to provide coverage by either designing a unique program, expanding eligibility for children under the state's Medicaid program, or some

combination of the two. To be eligible for funds, the Secretary of the Department of Health and Human Services must approve the state plan.

States have taken advantage of SCHIP's flexibility to design programs that suit the needs of children in their own state. Florida, New York, and Colorado are building on existing programs. Others, like Massachusetts, New Jersey, and Connecticut, have designed new programs that either subsidize employer-based coverage, create seamless Medicaid and grant programs through joint applications, or provide special benefit packages for children with special needs.

Many of the children who enter the EMS system are uninsured or underinsured. EMS providers and emergency department staff can serve a critical role in helping children obtain affordable health insurance and access to primary care, as well as a "medical home," through SCHIP. When the child's condition is not life threatening, the EMS and emergency department encounter may be the perfect opportunity to assist families in completing medical eligibility paperwork and identifying local resources for primary care providers.

EMSC program participants should work with their state SCHIP representatives to identify opportunities to participate in program development and outreach. Many states have enhanced education about the health insurance programs and simplified the application and enrollment processes. The federal government has advocated for public-private efforts to increase Medicaid enrollment. Lawmakers also have called for legislation to provide states with additional funding and flexibility to conduct aggressive, effective outreach through SCHIP.

The EMSC program currently is supporting a demonstration project in Oregon designed to increase the number of children enrolled in SCHIP. The EMS agency is collaborating with the Oregon Medical Assistance Program, which administers the Medicaid portion of the Oregon Health Plan, and local health departments to utilize EMS providers to help enroll uninsured children in SCHIP. EMS providers will provide information and assistance to parents in enrolling uninsured children, promote enrollment information at fairs and other community events, and integrate enrollment information in home inspection and safety presentations.

Policy Issues in EMSC and Managed Care

Health care reform activities related to managed care have resulted in the passage of a number of laws and regulations at the federal and state levels. Two issues that have generated considerable attention in the area of public policy are the "prudent layperson" definition of emergency medical care and the Emergency Medical Treatment and Labor Act (EMTALA). Each is described in more detail below:

"Prudent Layperson" Definition of Emergency Medical Condition

The Balanced Budget Act of 1997 required all health plans that participate in Medicare or Medicaid to adopt the "reasonable or

prudent layperson" standard, and many states also have accepted this standard. The essence of this standard is defined as:

"An emergency medical condition means a condition with acute symptoms of sufficient severity (including pain) such that a prudent layperson, one who has an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the health of the individual, serious impairment to bodily functions, and/or serious dysfunction of any bodily organ or part."

A number of efforts exist at the federal level to enact a "prudent layperson" standard for all insured individuals. This standard, as originally introduced in the Access to Emergency Medical Services Act of 1999 (H.R. 904), was included in several bills introduced in Congress during its 1999 session. The "prudent layperson" language included in most bills conforms to the definition included in the Medicare and Medicaid portions of the Budget Reconciliation Bill.

Attempts are being made to pass the "prudent layperson" bill to guarantee coverage of emergency services based on a patient's presenting symptoms, rather than the final diagnosis. Plans would also be prohibited from requiring, as a condition for coverage, that patients obtain prior authorization from the health plan before seeking emergency care. Proponents of the "prudent layperson" standard also state that it will promote quality, cost-effective care by establishing a process in which the emergency physician and health plan work together to coordinate appropriate post-stabilization and follow-up care.

Emergency Medical Treatment and Labor Act

EMTALA enforcement guidelines require that all hospitals that have an emergency department and accept Medicare reimbursement:

- ♦ provide an appropriate medical screening examination to determine if the patient has a medical emergency;
- ♦ provide, within their capability, whatever treatment is necessary to stabilize the emergency condition; and
- ♦ prevent transfer of a patient who has not been stabilized, unless the patient requests the transfer or a physician certifies that the benefits of the transfer outweigh the risk.

Issues related to EMTALA have moved to the forefront of emergency medicine over the past several years due to varying interpretation and enforcement of the guidelines and increasing managed care requirements. In 1998, HCFA convened a work group composed of federal and state policy makers and hospital, physician, consumer, and health plan representatives to develop recommendations for revisions to the EMTALA guidelines. The revised guidelines provide a definition of a medical screening examination and stabilization. They clarify that a medical screening

examination and stabilization applies to any individual who is on hospital property. This property includes parking lots, sidewalks, driveways, and ambulances owned and operated by the hospital, even if the ambulance is not on hospital grounds.

The guidelines also state that medical screening examinations may occur in places other than the emergency department, as long as the patient is sent to a hospital-owned facility that is contiguous or is part of the hospital "campus". The guidelines further state that it is not appropriate for a hospital to request, or a health plan to require, prior authorization before the patient has received a medical screening examination or has been stabilized. Additionally, the determination of whether an emergency medical condition exists should be made by the examining physician actually caring for the patient in the treating facility.

Many questions still arise when discussing EMTALA because it creates a mandate for emergency providers to treat the patient, but does not require a managed care plan to pay for the care provided.

Mastering Managed Care: Effective Collaboration Tips for EMSC

Strategies for Working with Managed Care Organizations

Know the managed care organizations in your community. Familiarize yourself with the organizations in your community, including the model they represent, the populations they serve, and their policies and procedures related to emergency services. To obtain a list of MCOs in your state, check with the state insurance commission or public health department. While many MCOs offer coverage nationally, they generally have a local administrative office in the community they serve. It is best to work with the MCO's state or local office since practices may vary from state to state. See Appendix C for a list of national organizations that may serve as resources.

Learn the managed care language. It is important to know the terms commonly used in provider negotiations and their impact on health care (see the Glossary at the back of this guide for definitions of commonly used managed care terms).

Clearly define your objectives and search for areas of collaboration. Because many groups are attempting to approach managed care organizations with their concerns, it may be difficult to find representatives willing to have a discussion. To increase your chances of success in arranging a meeting, clearly identify your objectives and common goals. Use data whenever possible to define a specific issue. In considering EMS for children in a managed care environment, the following issues should be addressed:

- ♦ Children should have access to emergency care 24 hours a day.

- ♦ Financial and procedural barriers should not delay necessary emergency services.
- ♦ Children should receive care in the most appropriate facility.
- ♦ Providers should be well trained in the special needs of children.
- ♦ Follow-up care should be provided by the most appropriate health care professional.

To effectively address these issues, consider working with MCOs on the following activities:

- ♦ developing pre-hospital triage criteria and destination guidelines for children;
- ♦ enhancing 9-1-1 communications systems;
- ♦ identifying quality improvement measures for emergency services for children;
- ♦ establishing emergency plans for children with special health care needs.
- ♦ developing well-coordinated plans for disasters.
- ♦ educating and training primary and emergency care providers to enhance their knowledge of, understanding of, and skills in caring for children.
- ♦ developing emergency care and transportation protocols for use in the pre-hospital, outpatient, and acute care settings.
- ♦ implementing injury prevention programs based on analysis of emergency utilization data.
- ♦ distributing public awareness materials.

In addition to working with MCOs, it is equally important to develop a relationship with government agencies and local employer groups. Many state Medicaid programs, SCHIP, and employers have moved to managed care arrangements to control costs and expand access. Pay close attention to the Medicaid program in your state since it provides coverage for at least 17% of all children in the country. Many Medicaid programs are all-inclusive, while others carve out certain services or populations. Contact your state Medicaid director to discuss the emergency services language in the managed care contracts. A list of Medicaid directors by state can be found on the American Public Human Services Association's web site at www.aphsa.org.

Many employers have organized to ensure that they purchase high quality care for their employees. They are very interested in objective information that may impact their purchasing decisions. Employers are key to making change in the managed care system.

The opportunity exists with both public and private purchasers to explore what provisions have been made to ensure access to emergency services and specialty care. Question whether their contracts include a definition of an emergency and allow for direct access to 9-1-1 or the local emergency number. Explore the scope of benefits and the type of quality measures used to monitor performance.

The legislation that governs managed care activities for many private employers within the state may be regulated by the state insurance commissioner. As such, the insurance commissioner is yet another important contact for your EMSC project. To identify your state's insurance commissioner(s), access the National Association of Insurance Commissioners web site at www.naic.org. Also available at this site is model legislation for many managed care activities, including the provision of emergency services.

Top Five Areas for EMSC Discussion and Collaboration with Managed Care Organizations

Your EMSC program staff can help establish an EMS foothold in the managed care arena by working with providers in your state—as well as with purchasers, health plans, consumers, and community organizations—on a variety of EMS/EMSC-related issues. Managed care will have an impact on all areas of the system, making the list of activities that states can address endless. Listed below are five issues considered to have the greatest impact on EMSC. Additional assistance on how to address these issues is available through the EMSC National Resource Center at (202) 884-4927.

Issue 1: The First Emergency Call. To control unnecessary visits to EDs, many MCOs have established procedures to redirect patients to places other than EDs for acute problems. For example, an enrollee may be required to contact the primary care physician or a designee of the plan prior to calling an emergency number such as 9-1-1. If this situation sounds all too familiar in your area, consider working with MCOs to address the following questions:

- ♦ *What education is needed to help consumers distinguish a true emergency for children from a less urgent health problem?*
- ♦ *What other issues should be considered for consumers trying to receive emergency care through emergency access numbers?*

Issue 2: Pre-hospital Care. Some local EMS systems (emergency communications systems, ambulance services, EMTs, paramedics) are exploring methods for integrating services with MCOs to assure continuity of care throughout the system. Several prehospital providers are discussing the possibility of contracting directly with managed care plans to respond to emergency calls from their plan members. Services that may be provided include telephone or face-to-face triaging to decide both the need for emergency transport or other methods of transportation.

In the future, prehospital providers may also determine what facility the patient should be transported to based on the resources of EDs, patient acuity, and provider participation. The same transportation systems may also be involved with transporting patients between facilities for acute care, rehabilitation, or convalescence. If such a system is implemented...

- ♦ *How can your EMSC program and MCOs collaborate to develop prehospital triage criteria and destination guidelines for children?*
- ♦ *What process is in place to assure that children who are covered by MCOs get optimal emergency care if the EMS system is activated by the fire department, police, or a bystander?*

Issue 3: Authorization for Acute Care. Providers have expressed concern regarding the possibility of having payment for emergency care services denied because of lack of authorization from the MCO. Often at issue is the length of time it takes to receive prior authorization. Many providers also question the potential conflict between prior authorization and EMTALA, which requires physicians and hospitals to render emergency services immediately for an injury or sudden illness.

Some providers have made efforts at the federal and state levels to address access issues related to emergency services. Bills have been introduced in both the House and Senate recommending that:

- ♦ Emergency services be exempt from prior authorization.
- ♦ Managed care plans provide 24-hours-a-day, 7-days-a-week access to the Prior Authorization Program for services (other than an emergency) which are promptly needed by the enrollee.
- ♦ Referrals be automatically deemed as approved if a participating physician or other authorized person refers the patient to the emergency department.
- ♦ Payment be made for any service that has been prior authorized based on legitimate information.

When addressing this issue, consider these questions:

- ♦ *How can the EMSC program work with MCOs to resolve conflicts that may arise between the prior authorization process, retrospective payment denials, and the federal law that requires emergency care to be rendered regardless of the insurance status?*
- ♦ *How can the EMS system work with MCOs to educate families of children who typically seek routine care in an emergency department to contact their primary care provider for future episodes of non-urgent care?*
- ♦ *What other access issues should be considered for children needing emergency services?*

Issue 4: Quality Improvement. Continuous quality improvement must be the goal of all parties involved in delivering health care. While there are a number of quality improvement initiatives underway by MCOs; purchasers of care; and various federal, state, and local governments, such efforts must include an assessment of emergency medical services for children. With this in mind. . .

- ◆ *How can EMSC systems best collaborate with managed care plans and other private and government organizations to assure that quality improvement programs include measures for emergency services for children?*
- ◆ *What kinds of pediatric measures, throughout the continuum of care, are important for consideration in quality improvement programs?*

Issue 5: EMSC System Integration. During the last 14 years, substantial effort has been made to improve existing EMS systems to meet the needs of children. Many states have:

- ◆ Developed pediatric equipment guidelines for ambulances and EDs;
- ◆ Adopted pediatric treatment protocols and appropriate transport guidelines;
- ◆ Designated certain hospitals as pediatric specialty facilities;
- ◆ Integrated rehabilitation planning and services in the acute care phase;
- ◆ Trained and educated prehospital and hospital personnel in the specifics of emergency care for children; and
- ◆ Developed innovative educational materials.

The EMSC program wants to build on these improvements so that children are well-served by the EMS system. In so doing, . . .

- ◆ *How can the EMSC program and MCOs collaborate to assure that the progress made to date in enhancing EMS to meet the unique emergency needs of children continues in a managed care environment?*
- ◆ *How can EMS systems and MCOs collaborate to develop common facility category criteria for children who require trauma care, critical care services, and other special care?*

Other Issues. Many other issues exist that merit attention, including: ensuring access to emergency medical services 24 hours a day; reducing financial and procedural barriers that may delay necessary emergency services; and ensuring the most appropriate health care professional provides follow-up care. In addition, your EMSC project should educate managed care providers on the following EMS topics:

Primary Care Preparedness

Managed care arrangements present new considerations for primary care providers who may not be prepared for the increased acuity of patients that present for urgent care. In discussions with MCO representatives, suggest that they offer additional training to primary care physicians to prepare them to assume more responsibilities through managed care's gatekeeping functions.

Injury Prevention

Injuries are the leading cause of death in the U.S. for children and young adults. For every child who dies, there are hundreds more who are treated and then released from EDs and acute care facilities. Many injuries can be prevented through coordinated efforts of EMS providers, managed care contractors, schools, and child care providers. Prevention efforts are cost-effective because they decrease health care consumption. The National EMSC Managed Care Task Force and the Injury Prevention White Paper Panel recommend that EMSC projects work with MCOs on the following:

- ◆ Designate individuals within an MCO with the responsibility and authority for injury prevention activities.
- ◆ Integrate injury prevention into quality improvement activities. Develop performance indicators to quantify the progress of injury prevention. Organizations with an interest in injury prevention should collaborate with MCOs to establish working groups for developing HEDIS and other performance measures related to injury prevention.
- ◆ Use data to recognize and solve injury problems. Data should be used as an aid to partnership and public policy efforts and the prioritization, planning, and evaluation of safety efforts within the MCO.
- ◆ Facilitate provider education in injury prevention and control. Health plans can help providers explore methods to overcome barriers that exist in implementing a program by providing technical assistance on incorporating injury prevention methods into routine office practices.
- ◆ Promote parent education in injury prevention and control.
- ◆ Create member safety incentives. Even when people are educated about the hazards of risky behavior, they may need incentives to avoid taking familiar risks.
- ◆ Support public and private emergency medical services efforts.
- ◆ Work with other safety partners to promote injury prevention advocacy.

Children with Special Health Care Needs

Focus discussion on a "seamless system" of care for children with special health care needs, regardless of the source of payment. This can include:

- ◆ Early referral to rehabilitation services after an acute illness or injury.
- ◆ Development of linkages with specialized and primary care services.
- ◆ Prehospital provider training about the needs of children with special health care needs in an emergency.
- ◆ Assurance of a smooth transition when the child and family leave the acute care facility.

Cultural Competency

EMSC is committed to providing culturally competent emergency care to all children in a manner that demonstrates sensitivity to and respect and understanding of the unique cultural differences within, among, and between groups. MCOs are also required by most payers to provide culturally competent care. Search for opportunities to collaborate on programs that improve the cultural competency of both EMS and managed care providers.

Family-centered Care

Point out the important role family members play in the care of children during the emergency and rehabilitation stages. The EMSC Program provides technical assistance to states to help integrate family-centered care concepts into educational programs, protocols, and community linkages.

Disaster Preparedness

The need to remain constantly prepared for natural and man-made disasters has unfortunately become a reality of daily life. Medical

care of mass casualties requires full assessment of the event, comprehensive medical capabilities, and disaster organization skills. Look for ways to include the unique needs of children in any disaster preparedness effort. Work in concert with health care plans, as many of them have also recognized the need to be prepared for disasters.

Research

Research is the key to future improvements in all medical care, including EMSC. Note in your discussions with MCOs how these improvements should result in better prevention of childhood emergencies and better outcomes for children who experience illness or injury.

For additional information about EMSC managed care priorities, see Appendix D.

Appendix A: Health Care Financing Methods

Self-Pay/Uninsured:

More than 40 million people in the United States are without health insurance of any kind. The rate is especially alarming for children. It is estimated that in 1994 alone, 10 million children were uninsured. Moreover, the number of children without employment-related insurance continues to grow. The lack of insurance limits access to necessary primary and acute care for millions of children in this country. Challenged to find ways to provide healthcare to the uninsured population, many states are developing innovative approaches to provide coverage at little or no cost to the uninsured population who qualify at an established percent of the poverty level. Still, EDs across the country continue to serve as a primary care provider for many uninsured people.

Employer Sponsored Plan:

Many employers choose to develop their own health insurance pool and are considered self-insured. Under a self-insured arrangement, the employer reviews its own past health care experience to determine the average cost of providing care for its employees. Funds are set aside to cover employees' health care expenses rather than paying a premium to an insurance carrier. In most instances, the employer will contract with a third party administrator (TPA), such as an insurance company, to carry out many of the administrative tasks associated with processing and paying health care claims. The employer usually protects itself from unexpected high cost care by purchasing a "stop-loss" or re-insurance policy. This type of insurance protects a company against all or part of the losses that may be incurred, while honoring the claims of its participating providers, policy holders, or employees and covered dependents.

Indemnity Plan:

In the indemnity plan the purchaser pays a monthly premium for health insurance coverage for its employees. Providers are reimbursed for services on a fee-for-service basis. The fee does not usually equate to the charge. Providers are most often paid a usual and customary fee. The fee is considered reasonable if it falls within the parameters of the average or commonly charged fee for a particular service within that specific community.

Managed Care Plan:

A managed care plan is an organized system of care usually structured with contracted arrangements with purchasers, providers, and insurers of care. The care is coordinated through a defined network of primary care physicians, acute care providers, rehabilitation and home care providers, and other members of the delivery team. The services are usually covered under a pre-set monthly

payment. Managed care organizations now enroll more than 149 million Americans.

Medicare:

Medicare is the common name for Title XVIII of the Social Security Act, entitled "Health Insurance for the Aged and Disabled". The Medicare legislation established a health insurance program for aged persons to complement retirement, survivors, and disability insurance benefits under other titles of the Social Security Act. The program started in 1965. As of fiscal year 1998, approximately 38.8 million people had enrolled in the program. The program is designed to cover the costs of hospitalization, medical care, and some related services for the elderly and disabled population. Medicare Part A covers eligible inpatient hospital, skilled nursing facility, home health, and hospice services. Medicare Part B coverage is optional, and must be paid through a monthly premium. Part B covers eligible physician services, outpatient clinical laboratory services, durable medical equipment, ambulance services, and certain other health care services.

Medicaid:

Medicaid is a national public financing program for providing health and long-term care coverage to millions of low income people. Authorized under Title XIX of the Social Security Act, Medicaid is a joint federal-state program administered by the states under federal guidelines. Beneficiaries are means-tested for coverage. Currently, Medicaid is a major public financing program that provides health and long-term care coverage to 18 million children. It is considered the health care safety net for children's services. Care for the indigent will increasingly be delivered through managed care arrangements.

State Child Health Insurance Program:

The Balanced Budget Act of 1997 included a child health block grant that offered states \$20.3 billion in new federal funding over a five-year period. The purpose of the grant was to enable states to initiate and expand child health assistance to uninsured, low-income children. The law allows the states to provide coverage by either designing a unique program or expanding eligibility for children under the state's Medicaid program, or some combination of the two. To be eligible for funds, a state plan must be approved by the Secretary of the Department of Health and Human Services.

TRICARE:

The Department of Defense's (DoD's) TRICARE system is a nationwide, managed health care program intended to ensure high quality consistent health care benefits, preserve choice of health

Appendix A: Health Care Financing Methods

care providers for beneficiaries, improve access to care, and contain health care costs. The HMO option of TRICARE uses regional managed care support contracts to augment the capabilities of military hospitals. Contractors perform managed care responsibilities such as developing networks of civilian providers, locating providers for beneficiaries, performing utilization management functions, processing claims, and providing beneficiary support functions. Resources are also shared between the contractor and DoD. Active duty military personnel are automatically enrolled in the TRICARE HMO option. Other eligible beneficiaries must enroll in the program on a space available basis. More than 5.5 million people are eligible for TRICARE benefits.

Public Health Service:

Other than Medicare and Medicaid, a significant amount of funding for health care needs comes from the Public Health

Service. One example of a funding source is the Maternal and Child Health (MCHB) through the "Title V" program. Through this block grant, states can provide services to eligible mothers and children who otherwise would have limited access to care.

Other Funding Sources:

Other health care funding sources make up approximately five percent of total health care spending. Many of the sources are benevolent organizations that fund special needs of the population such as the Crippled Children's Fund, Children's Miracle Network, March of Dimes, and many other similar sources. Funding may also be received from individuals, foundations, or corporations in the form of contributions.

Appendix B: Glossary of Health Care Financing and Managed Care Terms

Capitation: A negotiated rate in which the provider is paid a fixed amount for each enrollee per month. The provider must then provide or make arrangements for the provision of all necessary care as agreed upon in the contract. The provider is usually at risk for a portion of the expenses for care that exceeds the prepaid amount. Likewise, the provider is entitled to the profits for care that falls below the capitation rate. Providers must balance their medical decision-making between under- and over-utilization of resources, services, tests, and consultants.

Carve Out: Benefits or certain services for specific populations that are excluded from the health plan and provided separately from the plan. Typical “carve outs” may include behavioral health or children with special needs services. Coverage is then purchased separately from specialized providers. MCOs or the purchaser of care can make arrangements for specialized coverage.

Case Management: A process of coordinating a variety of health services for a person with identified health care needs to assure that the patient receives the most appropriate care, in the best setting, and in a cost-effective manner.

Case Manager: A case manager may be employed by the provider of care, insurer, or a local or state public agency. The case manager usually becomes involved in high-cost, complex cases that require someone to remain abreast of the patient's condition as a whole. The case manager then attempts to integrate the wishes of the patient and family with the most appropriate clinical course of treatment, available resources, existing insurance coverage, and available health care financing alternatives. The case manager works closely with the primary care physician and is usually considered a link to needed services throughout the health care continuum.

Case Mix: The type of population that a provider serves while taking into consideration the number and type of services provided and the severity of the illnesses or injuries of the patients usually treated.

Clinical Pathways: Evidence-based guidelines that suggest the sequence of clinical care given certain physiological, psychological, or social parameters.

Concurrent Review: The practice of reviewing the patient's care for medical necessity and appropriateness during the actual performance of services. For example, once a hospital admission is approved, the managed care plan may contact the hospital while the patient is still in the hospital to determine how the patient is progressing.

Diagnosis Related Groups (DRGs): A classification system that assigns a numerical code to categories of diagnoses based on the patient's principal diagnosis, secondary diagnosis, surgical procedures, age, sex, pre-existing conditions, and complications. Reimbursement is determined based on the assigned category.

Emergency Medical Services (EMS): A range of services that includes prevention, out-of-hospital care, acute care, and linkage to rehabilitation services.

Employee Retirement Income Security Act of 1974, Public Law 93-406 (ERISA): A federal law that regulates employee benefit plans, including health benefit plans. This law mandates reporting and disclosure requirements for group life and health plans. Self-insured companies may be exempt from many of the benefits, cost-sharing, or quality standards established by ERISA or other health care regulations.

Employer Mandate: A provision of the federal HMO Act that allows federally qualified HMOs to mandate or require an employer with at least 25 employees to offer at least one federally qualified HMO plan of each type (IPA/network or group/staff) as a benefit, if health insurance is a benefit. Some state laws have similar provisions.

Encounter: A face-to-face meeting between a person and a health care provider for the purpose of providing some type of health care.

Enrollee: A person who has coverage under the health plan contract, excluding eligible dependents

Enrollment: The process of signing up for a particular health plan. Enrollment also refers to the total number of covered persons in a health plan.

Episode of Care: Treatment rendered in a defined time frame for a specific disease. Episodes may be made up of many encounters.

Experience Rating: The process of reviewing prior health insurance claims for a defined group of people for the purpose of projecting the cost of future health care coverage.

Fee-for-Service Reimbursement: A method of reimbursement that pays for the unit(s) of care after services have been rendered. The fee does not usually equate to the charge. Providers are most often paid a usual and customary fee. The fee is considered reasonable if it falls within the parameters of the average or commonly charged fee for the particular service within that specific community.

Appendix B: Glossary of Health Care Financing and Managed Care Terms

Fee Schedule: The listing of payment amounts that have been pre-established based on a particular procedure or diagnosis code. The provider of service is usually paid the amount listed or a percentage of the amount, depending on contractual arrangements.

Formulary: A listing of prescription medications and durable medical equipment that is preferred for use by the health plan and which will be dispensed through participating vendors to covered persons.

Free-Standing Emergency Medical Service Centers: Health care facilities that are physically, organizationally, and financially separate from a hospital and have the primary purpose of providing immediate, short-term medical care for minor but urgent medical conditions.

Gatekeeper: Usually defined as the patient's primary care physician (PCP). Primary care is generally provided by family practice, pediatric, and internal medicine physicians. The PCP usually serves as the initial contact for all of the enrollee's needs. The PCP is responsible for making any referrals to a specialist and usually is at risk for all or part of the cost of the specialist's care.

Group Model HMO: An HMO that is very similar to the Staff Model HMO, with the exception that the multi-specialty physician's group practice is not owned by the HMO. The group operates as an independent partnership or professional cooperative. The group usually has an exclusive contract with the HMO. The plan pays the group at a negotiated rate and each group is responsible for paying its physicians and other staff.

Group Practice Without Walls: Typically a network of physicians who have formed a single legal entity but maintain their individual practices. The assets of individual practices may be acquired by the larger entity, but some autonomy is retained at each site. The central management provides administrative support.

Health Care Financing Administration (HCFA): The federal agency with primary responsibility for administering Medicare, including formulation of policy and guidelines, contract oversight and operation, maintenance and review of utilization records, and general financing of Medicare. HCFA also oversees the states' administration of Medicaid by providing broad national guidelines.

Health Maintenance Organization (HMO): The entity that provides or arranges for coverage of designated health services needed by plan members for a fixed, prepaid premium.

Health Plan Employer Data and Information Set (HEDIS): A set of standardized measures, developed by NCOA, to rate a managed care plan's performance.

Independent Practice Association (IPA) Model HMO: A plan that contracts with a large number of individual private practice physicians who may have a solo practice or operate as a small group. The physician agrees to accept some risk in exchange for receiving the plan's patients. The physicians are paid on a fee-for-service basis or a fixed amount to provide care for the IPA's members.

Managed Care Organization: An umbrella term for HMOs and all health plans that provide health care in return for pre-set monthly payments and coordinate care through a defined network of primary care physicians and hospitals.

Management Service Organization (MSO): A legal entity that provides practice management and administrative and support services to individual physicians or group practices. An MSO may be a direct subsidiary of a hospital or may be owned by investors.

Mandated Benefits: Benefits that health plans are required by federal or state law to provide to policyholders and eligible dependents.

Member Category: A group of health plan members who are classified to determine physician reimbursement levels. At a minimum, the categories are pediatrics, adults, and Medicare. Another often-used term is "member type".

Mixed Model HMO: A health plan that includes more than one form of HMO within a single plan. For example: a staff model HMO may also contract with independent physician groups or with individual private practice physicians. Any number of combinations are possible.

Network Model HMO: An HMO that contracts with more than one physician group and may contract with single and multi-specialty groups. The physician works out of his or her own office. The physician may share in utilization savings, but does not necessarily provide care exclusively to HMO members.

Outcomes Management: A process where health system administrators and clinicians work to systematically improve health care results, typically by modifying physician practices in response to data gleaned through outcomes measurement. These data are then "remeasured" and "remodified" often in a formal program of continuous quality improvement.

Appendix B: Glossary of Health Care Financing and Managed Care Terms

Outcome Measures:

Performance indicators that assess how well a patient responds to a particular service or treatment. Measurement usually centers around survival rates, complications from disease or therapy, severity of illness, mortality, ultimate recovery, return to the community, and quality of life.

Physician-Hospital Organization (PHO): A legal entity formed and owned by one or more hospitals and physician groups to obtain payer contracts and to further mutual interests. Physicians maintain ownership of their practices while agreeing to accept managed care patients under the terms of the PHO agreement. The PHO serves as a negotiating, contracting, and marketing unit.

Physician's Current Procedural Terminology (CPT): The coding scheme developed by physicians to identify health care services and medical procedures. Each service or procedure has been assigned a 5-digit code that is internationally recognized. This code is often used for billing and data collection purposes.

Point-of-Service (POS) Plan: A plan designed to accommodate enrollees who desire a larger choice in selecting their providers of care. In this type of plan, the provider's reimbursement and enrollee's out-of-pocket expenses are determined each time the enrollee receives care. There are different benefit levels associated with participating or non-participating providers.

Practice Guidelines: Carefully developed materials offering clinicians diagnosis and treatment information for specific medical conditions. Practice guidelines are usually well-researched and developed with expert input.

Preferred Provider Organization (PPO): A network of physicians and hospitals that provides care at a discounted fee for service. The fee is usually lower than through traditional insurance. Usually the PPO is not at risk for care. Plan members who use the PPO receive more coverage when using a network physician. They pay higher out-of-pocket costs when they receive care outside the PPO network.

Primary Care Physician (PCP): A provider of comprehensive health care to meet the general health care needs of patients. Primary care is traditionally provided by family practice, pediatric, and internal medicine physicians. The physician is trained to recognize and treat most common health problems and provides a wide array of services from preventive care to treatment of acute illnesses.

Primary Care Network: A group of primary care physicians who have joined together to share the risk of providing care to their patients who are covered by a given health plan.

Principal Diagnosis: A condition established after study that is mainly responsible for the patient seeking health care services from a provider. The principal diagnosis commonly refers to the condition most responsible for a patient's admission to the hospital.

Prior Authorization: A process that requires the covered person to have certain procedures, emergency room visits, inpatient admissions, and any other number of services approved prior to the occurrence. Often this prior authorization occurs via telephone with an exchange of information occurring between qualified medical professionals.

Prospective Payment: A payment method based on a predetermined amount for services over a defined period of time.

"Prudent Layperson" Definition of Medical Emergency:" Expansion of the definition of "emergency" from a strictly medical designation to the average citizen's understanding of an emergency. This indication is important when determining when to seek emergency care and when it should be reimbursed. An emergency in this instance may be defined as those health care procedures, treatments, or services provided after the onset of what reasonably appears to be a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in:

- ◆ Placing the patient's health in serious jeopardy.
- ◆ Serious impairment to bodily functions.
- ◆ Serious dysfunction of any bodily organ or part.
- ◆ Disfigurement of the patient.

Physician Hospital Organization (PHO): Typically a network of non-profit organizations that have traditionally served the community. Physicians contract directly with a hospital to provide inpatient and outpatient care.

Physician Practice Management (PPM): Typically a for-profit organization. It is made up of physician-managers who are responsible for developing contractual arrangements between medical practices and various hospitals.

Appendix B: Glossary of Health Care Financing and Managed Care Terms

Quality Improvement: A continuous process that identifies problems in health care delivery, tests solutions to those problems, and constantly monitors the solutions for improvement.

Reasonable and Customary: The commonly charged or prevailing fees for health services within a geographic area. A fee is considered reasonable if it falls within the parameters of the average or commonly charged fee for the particular service within that specific community.

Reinsurance: Insurance purchased by an HMO, insurance company, or self-funded employer from another insurance company to protect itself against all or part of the losses that may be incurred in the process of honoring the claims of its participating providers, policy holders, or employees and covered dependents.

Risk Analysis: The process of evaluating expected medical

care costs for a prospective group and determining what product, benefit level, and price to offer in order to best meet the needs of the group and the carrier.

Staff Model HMO: A plan where the physicians and other medical professionals are salaried employees of the HMO. The clinics and health centers in which they practice are owned by the HMO. Care is usually covered only for care delivered by the HMO.

Third Party Administrator (TPA): An independent person or corporate entity (third party) that provides group benefits, claims processing, and administrative services for a self-insured company/group. A TPA does not underwrite the risk.

Utilization Management (UM): A process that integrates review and case management of services in a cooperative effort with other parties, including patients, employers, providers, and payers.

Appendix C: National Managed Care Resources

The EMSC National Resource Center (NRC) provides a number of managed care-related resources. For additional information, please contact the EMSC NRC by calling (202) 884-4927; faxing (202) 884-6845; or writing to 111 Michigan Avenue NW, Washington DC 20010. The following organizations also have useful information on managed care.

Agency for Healthcare Research and Quality (AHRQ)

Executive Office Center - Suite 502
2101 East Jefferson Street
Rockville, MD 20852
(301) 594-1349
(301) 594-2155 FAX
www.ahrq.gov

Alliance of Community Health Plans (ACHP)

100 Albany Street - Suite 130
New Brunswick, NJ 08901-1227
(732) 220-1388
(732) 220-0298 FAX
www.hmogroup.com

American Academy of Pediatrics (AAP)

141 Northwest Point Boulevard; P.O. Box 927
Elk Grove Village, IL 60009-0927
(847) 228-5005 or (800) 433-9016
(847) 228-5097 or (847) 228-6432 FAX
www.aap.org

American Association of Health Plans (AAHP)

1129 20th Street, NW - Suite 600
Washington, DC 20036
(202) 778-3200
(202) 331-7487 FAX
www.aahp.org

American College of Emergency Physicians (ACEP)

1111 19 Street, NW, Suite 650
Washington, DC 20036
(202) 728-0610
(202) 728-0617 FAX
www.acep.org

American Managed Behavioral Healthcare Association (AMBHA)

700 13th Street, NW - Suite 950
Washington, DC 20005
(202) 434-4565
(202) 434-4564 FAX
www.ambha.org

American Public Health Association (APHA)

800 Eye Street, NW
Washington, DC 20001-3710
(202) 777-APHA
(202) 777-2534 FAX
www.apha.org

Association of Maternal and Child Health Programs (AMCHP)

1220 19th Street, NW
Washington, DC 20036
(202) 775-0436
(202) 775-0061 FAX

Association of State and Territorial Health Officials (ASTHO)

1275 K Street, NW - Suite 800
Washington, DC 20005-4006
(202) 371-9090
(202) 371-9797 FAX
www.astho.org

Center for Health Services, Research, and Policy (CHSRP)

George Washington University
2021 K Street, NW - Suite 800
Washington, DC 20052
(202) 296-6922
(202) 296-0025 FAX
www.gwu.edu/~chsrp

Center on Disability and Health (CDH)

1522 K Street, NW - Suite 800
Washington, DC 20005
(202) 842-4408
(202) 842-2402 FAX
e-mail: bgrisscdh@aol.com

Child Welfare League of America (CWLA)

440 First Street, NW - Suite 310
Washington, DC 20001-2085
(202) 638-2952
(202) 638-4004 FAX
www.cwla.org

Appendix C: National Managed Care Resources

Children's Defense Fund (CDF)

25 E Street, NW
Washington, DC 20001
(202) 628-8787
(202) 662-3510 FAX
www.childrensdefense.org

Consumer Coalition for Quality Health Care (CCQHC)

1275 K Street, NW - Suite 602
Washington, DC 20005
(202) 789-3606
(202) 898-2389 FAX

Employee Benefit Research Institute (EBRI)

2121 K Street, NW - Suite 600
Washington, DC 20037
(202) 659-0670
(202) 775-6312 FAX
www.ebri.org

Families USA Foundation

1334 G Street, NW
Washington, DC 20005
(202) 628-3030
(202) 347-2417 FAX
www.familiesusa.org

Family Voices

P.O. Box 769
Algodones, NM 87001
(505) 867-3159
(505) 867-6517 FAX
www.familyvoices.org

Foundation for Accountability (FACct)

520 SW 6th Avenue - Suite 700
Portland, OR 97204
(503) 223-2228
(503) 223-4336 FAX
www.facct.org

Health Care Financing Administration (HCFA)

7500 Security Blvd.
Baltimore, MD 21244
(410) 786-3000
www.hcfa.gov

Health Resources and Services Administration (HRSA)

Center for Managed Care
5600 Fishers Lane
Rockville, MD 20857
(301) 443-8041
(301) 443-4842 FAX
www.hrsa.gov/cmcc

Kaiser Commission on the Future of Medicaid

1450 G Street, NW - Suite 250
Washington, DC 20005
(202) 347-5270
(202) 347-5274 FAX
Publications Request Line: 1-800-656-4533
www.kff.org

Mathematica Policy Research Inc.

600 Maryland Avenue, SW
Washington, DC 20024
(202) 484-9220
(202) 863-1763 FAX
www.mathematica-mpr.com

National Association of Children's Hospitals and Related Institutions (NACHRI)

401 Wythe Street
Alexandria, VA 22314
(703) 684-1355
(703) 684-1589 FAX
www.childrenshospitals.net

National Association of County and City Health Officials (NACCHO)

440 First Street, NW - Suite 500
Washington, DC 20001
(202) 783-5550
(202) 783-1583 FAX
www.naccho.org

National Center for Education in Maternal and Child Health (NCEMCH)

2000 15th Street, North - Suite 701
Arlington, VA 22201-2617
(703) 524-7802
(703) 524-9335 FAX
www.ncemch.org

Appendix C: National Managed Care Resources

National Committee for Quality Assurance (NCQA)

2000 L Street, NW - Suite 500
Washington, DC 20036
(202) 955-6428
(202) 955-3599 FAX
www.ncqa.org

National Conference of State Legislatures (NCSL)

444 North Capitol Street, NW - Suite 515
Washington, DC 20001
(202) 624-5400
(202) 737-1069 FAX
www.ncsl.org

National Consumer League/Consumer Health Care Education Center

c/o National Consumer League
1701 K Street, NW - Suite 1200
Washington, DC 20006
(202) 835-3323
(202) 835-0747 FAX

National Governors' Association (NGA)

Hall of the States
444 North Capitol Street
Washington, DC 20001-1512
(202) 624-5300
(202) 624-5313 FAX
www.nga.org

National Health Law Program

2639 South LaCienega Boulevard
Los Angeles, CA 90034
(310) 204-6010
(310) 204-0891 FAX
www.healthlaw.org

Women's and Children's Health Policy Center (WCHPC)

Department of Population and Family Health Services
Johns Hopkins School of Public Health
615 North Wolfe Street
Baltimore, MD 21205
(410) 502-5443
(410) 955-2303 FAX
www.med.jhu.edu/wchpc

Zero to Three

734 15th Street, NW
Washington, DC 20005
(202) 638-1144
(202) 638-0851 FAX
e-mail: zerotothree@aol.com or
dcnccip@gteens.com

Appendix D: Recommendations and Priorities of the EMSC Managed Care Task Force

In collaboration with the Health Resources and Services Administration's Maternal and Child Health Bureau, the National Highway Traffic Safety Administration, and the Robert Wood Johnson Foundation, the EMSC Managed Care Task Force developed more than 60 different recommendations designed to ensure children access to quality emergency services. The recommendations were prioritized and assigned action steps. Following are a list of the most critical recommendations for consideration by managed care organization; providers of care; professional associations; and federal, state, and local policy makers.

A. Ensure access to emergency medical services for children in the evolving health care delivery system.

1. Identify best practice models that facilitate access to emergency care, (i.e., Medicaid demonstration projects, CHIP enrollment projects, immunization programs, and others).
2. Help states implement best practices (i.e. use Managed Care Task Force group to provide assistance).
3. Continue to monitor and analyze health care reform activities. Help shape changes in policies that affect access to care.

B. Encourage the development, dissemination, and evaluation of nationally recognized pediatric emergency care guidelines.

1. Collect, evaluate, and disseminate available pediatric emergency care guidelines.
2. Work with AAP, ACEP, ENA, NAEMSP, and other groups to develop uniform guidelines.
3. Work with AHCPR to encourage funding for research, development, piloting, and dissemination of pediatric emergency care guidelines.
4. Facilitate discussions on the effectiveness of certain guidelines.
5. Encourage physicians and EMTs to collaborate on the development of guidelines used in a pre-hospital setting.
6. Assist in distinguishing between guidelines used for purposes of triage and guidelines used for clinical care. Encourage health plan organizations and EMS providers to include pediatrics and family-centered care into triage guidelines. Monitor alternative transport arrangements.

C. Encourage the development of nationally recognized performance measures (process, structure, and outcome).

1. Work with groups that are already developing measures such as the Foundation for Accountability, National Committee for Quality Assurance (HEDIS measures), Health Care Financing Administration, and others.
2. Identify the specific domains for measures (i.e. injury prevention, child abuse and neglect, coordinating information with the PCP, and other). Develop indicators, evaluate for validity and reliability, and disseminate.

D. Coordinate care with the "medical home" to assure continuity in care.

1. Recognize that the "medical home" is evolving into a "virtual medical home" where immediate access to patient information is essential for the primary care provider responsible for coordinating care and all other providers rendering care. Work with AAP, ACEP, ENA, AAFP, medical informatics groups, and others to assure the "virtual medical home meets the needs of children.

E. Ensure reimbursement for emergency medical services for children.

1. Promote reimbursement for all pediatric pre-hospital and emergency department visits (consistent with EMTALA/COBRA). Work with HCFA and other purchasers to set and enforce payment.
2. Examine "Utility Model" for reimbursement of EMS.
3. Encourage and support EMS provider participation in the development of reimbursement policies at the federal, state, and local level.
4. Make the case that emergency care is preparedness-

Appendix D: Recommendations and Priorities of the EMSC Managed Care Task Force

based and serves as the public safety net. Emergency care is less expensive than many perceive when these factors are considered.

F. Explore issues around the definition of medical necessity.

1. Work with AAP, ACEP, NAEMSP, and AAFP to encourage public and private health insurers to clarify standards for the determination of medical necessity. Specifically,
 - Does a “prudent layperson” standard apply to coverage for the initiation of services or does the determination rest with the provider or plan?
 - Are diagnostic tests to determine the presence of an emergency covered?
 - What role does final diagnosis play in determining whether the emergency service is covered?
 - Should prior authorization be permitted or prohibited for coverage of emergency services and under what circumstances?
 - Under what circumstances are non-network providers covered?
 - Whose determination governs in the event of a conflict between the treating physician and the plan physician?
 - What provisions for follow-up care are required as a result of a medical emergency?
2. Assure that the above is linked to triage guidelines.
3. Work with ACEP, NAEMSP, AAP and AAFP to develop answers to above.
4. Monitor state legislative initiatives concerning medical necessity issues.

G. Develop pediatric-specific information to communicate to parents about when and how to access emergency care for children.

1. Develop model EMSC guidelines for consumers that can be distributed directly or by health plans, providers, purchasers, and other national organizations.
2. Assure that educational materials and programs created by the NRC are culturally and linguistically appropriate.

3. Promote EMSC consumer education as a performance measure.
4. Tap into media markets to sell concepts and products that improve care for children.

H. Promote pediatric emergency preparedness at alternative care sites such as freestanding urgent care facilities.

1. Assess the freestanding urgent care center’s role in providing emergency medical services for children. Identify the number and type of facilities in the U.S., the number of children using the facilities, and how EMSC can assist urgent care centers in issues related to preparedness and staffing.
2. Based on assessment, determine what resources and guidelines are need.
3. Assess the potential interaction between prehospital providers and freestanding urgent care centers in the growing urgent care market.
4. Inform the public about what they should expect from urgent care.

I. Encourage public and private health insurers to promote high quality emergency services rather than limiting services or altering clinical decisions to contain costs.

1. Explore alternative methods of achieving cost containment and quality in emergency care other than capitation.
2. Encourage MCOs to invest in illness and injury prevention efforts. Articulate that cost savings may be a long-term achievement but short-term measurable achievements can be made in the area of public relations, partnership building, and public education. Highlight plans that are successful (i.e. asthma, prenatal care, and others).

J. Integrate injury prevention into quality improvement processes (data-driven) used by purchasers and health plans.

Appendix D: Recommendations and Priorities of the EMSC Managed Care Task Force

1. Encourage the collection of injury prevention data. Data should be presented and analyzed in a meaningful fashion (e.g., small area analysis) to encourage health plan usage.
 2. Encourage public and private insurers to reimburse a provider for data collection activities.
 3. Encourage purchasers and health plans to develop incentives for consumers who comply with prevention recommendations.
 4. Encourage purchasers and health plan organizations to collaborate with local health departments.
- K. Incorporate the help of professional case managers in the emergency care process to ensure discharge planning and long-term follow-up care as needed.**
1. Develop relationships with professional case manager organizations.
 2. Identify the difference between hospital case managers and managed care case managers and compile and disseminate resources for each group.
 3. Encourage pharmaceutical companies that are promoting disease management programs to address pediatric emergency care services, particularly for children with special health care needs.
 4. Promote discharge planning as a performance measure for EMS.

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