

Definition of Health Maintenance Organization's (HMOs) and Prepaid Health Plans (PHPs)

For the purposes of risk contracting to serve the Medicaid population, an HMO is defined as an entity which:

- A. Is organized primarily for the purpose of providing health care services;
- B. Makes the services provided to Medicaid enrollees as accessible as those services are to non-enrolled Medicaid recipients in their service areas;
- C. Makes provision against the risk of insolvency and assures that Medicaid enrollees will not be liable for the HMO's debts if it becomes insolvent;
- D. Meets the definition of HMO set forth in Ohio Revised Code Section 1742.01 "Health maintenance organization" means a public or private organization which is organized under the laws of this state or another and which:
 - 1. Provides or otherwise makes available to enrolled participants health care services, including at a minimum basic health care services;
 - 2. Is compensated for the provision of basic health care services and supplemental health care services to enrolled participants primarily on a pre-determined periodic rate basis;
 - 3. Provides physicians' services primarily through either:
 - a. Physicians who are either employees or partners of such organization;
 - b. Arrangements with physicians in individual or group practice under which all such physicians and groups are provided effective incentives to avoid unnecessary or unduly costly utilization, regardless of whether any physician is individually compensated primarily on a fee-for-service basis, or otherwise;
 - 4. Assures the availability, accessibility, quality and, to the extent possible, effective utilization of the health care services which it provides or makes available, through clearly identifiable focal points of legal and administrative responsibility.
- E. Complies with Ohio Administrative rules, including, but not limited to 5101:3-26.

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For the purposes of risk contracting to serve the Medicaid population, PHPs are defined as entities which:

- A. Provide or arrange provision for a defined scope of medical services to enrolled recipients on a prepaid, capitated basis, but do not qualify as an HMO;
- B. Exist as preferred provider organizations, health insuring organizations, or other entities organized primarily for the purpose of providing health care services;
- C. Make the services provided to Medicaid enrollees as accessible as those services are to non-enrolled Medicaid recipients in their service areas;
- D. Make provisions against the risk of insolvency and assures that Medicaid enrollees will not be liable for the organizations debts if it becomes insolvent; and
- E. Comply with Ohio Administrative rules, including, but not limited to 5101:3-26.

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