# White Paper Appendix C: Managed Care Delivery System: Incentives and Implications for Population Health

## OVERVIEW

As noted in the body of the White Paper, we are distinguishing between two major types of delivery systems—fee-for-service (FFS) and managed care—even though many additional types have evolved in recent years. The type of delivery system used by a state for its Medicaid population has important implications for population health.

In a FFS environment, the state is the key decision-maker about the settings where services are provided, the type of providers who can deliver services and the range of services offered. Traditional FFS delivery systems that pay for each service provided do not easily allow states to focus on the non-medical, social support services. Primary Care Case Management (PCCM) is another type of delivery system in which providers are paid a small case management fee in addition to regular FFS payments for each service provided. The White Paper groups FFS and PCCM into one category—FFS—since the underlying payment model is the same for both.

In a managed care delivery system using capitation, however, the leadership of the managed care organization (MCO) makes these decisions though the state still has a role. The MCO can choose to deliver preventive services in many different settings and through non-licensed but otherwise qualified providers. An MCO also has the flexibility to offer its Medicaid enrollees additional "value added" services (e.g., non-medical, social support services) and can support population health strategies that are not covered in their state's Medicaid plan. MCOs also can substitute services or settings "in lieu of" services or settings that are covered in the State Plan. These critical decisions—the setting in which a service is delivered, the type of provider who delivers the service and the type of "value added" or "in lieu of" service that can be offered—are made by the MCO rather than the state Medicaid agency. It is important to note that the costs of "value added" services may be reported as administrative expenditures except if the service is an activity that improves health care quality under 45 CFR Section 158.150. In this case, it may be included as a "medical" cost rather than an administrative cost.[1] "In lieu of" services are counted as medical costs in MCO capitation rates.

As states adopt delivery systems and payment models that reward outcomes over volume, these types of systems will facilitate the ability of payers to invest in non-medical interventions that improve health.

## BACKGROUND ON MEDICAID DELIVERY SYSTEMS

In FFS delivery systems, participating physicians, clinics, hospitals and other providers are paid a fee for each service they provide. Historically, most state Medicaid programs delivered and paid for services for Medicaid beneficiaries on a FFS basis.[2]

Primary Care Case Management (PCCM) is another type of delivery system in which state Medicaid agencies contract with primary care providers to provide, locate, coordinate and monitor primary care services for Medicaid beneficiaries who select them. In essence, they serve as a "medical home" for primary and preventive care. States pay them a small monthly case management fee in addition to regular FFS payments for each service provided.[3] As previously mentioned, the White Paper groups FFS and PCCM into one category—FFS—since the underlying payment model is the same for both.

Most states have adopted or are expanding their use of managed care delivery systems. Comprehensive risk-based MCOs are health plans that contract with states to provide comprehensive Medicaid benefits to enrolled

Medicaid beneficiaries for a pre-set per member per month capitation payment.[4] Under these contracts, MCOs are at financial risk for the Medicaid services specified in their contracts. Many states "carve out" certain services from their MCO contracts (e.g., prescription drugs or behavioral health services) and these services are financed under a separate contract with a prepaid health plan or on a FFS basis.

***According to a state survey in 2015, there were 22 states that operate a FFS, PCCM or a combination of these two delivery system models for a sizeable share of their enrollees.***[5] In these 22 states where a portion of enrollees are covered through FFS or PCCM, the Medicaid agency makes the decision about whether to pursue coverage of optional or additional preventive services and population health strategies. In many cases, covering additional preventive services and population health strategies will require approval by the Centers for Medicare and Medicaid Services for a state plan amendment or waiver.

***The remaining 29 states (including DC) have contracts to cover most or all Medicaid beneficiaries through comprehensive risk-based MCOs.*** (Roughly 60 percent of Medicaid lives are covered through MCOs; almost 90 percent of children enrolled in Medicaid and CHIP receive health care through managed care arrangements.[6])

In addition to the FFS and managed care delivery systems described above, three additional models have emerged in recent years—the Patient-Centered Medical Home (PCMH), the Health Home (HH) and accountable care organizations (ACOs). The PCMH and HH models include a group of providers who are responsible for coordinating the patient's ongoing care. They facilitate access to the full range of services and integrate clinical and non-clinical services. In the PCMH model, the team is led by a physician with a primary care focus. Health Homes offer team-based care coordination with a strong focus on behavioral health care and social supports and services.[7] Health Homes are specifically targeted to individuals with multiple chronic conditions.[8]

An ACO is a group of health care providers or a regional entity that contracts with providers and/or health plans to share responsibility for the health care delivery and outcomes of a defined population.[9] An ACO that meets quality performance standards can share in the savings. States use different terms for ACOs including Coordinated Care Organizations (CCOs) in Oregon and Regional Care Collaborative Organizations (RCCOs) in Colorado.

The Affordable Care Act provides states with new options for testing innovative payment and delivery system reforms. Medicaid ACOs are seen by many as an opportunity to integrate population health and payment and delivery system reforms in a coordinated way.[10] States are finding that ACOs offer a model to reward good outcomes instead of volume and allow providers to use non-medical interventions that improve health.

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1. Milbank Memorial Fund. "Medicaid Cover of Social Interventions: A Road Map for States." Issue Brief: July 2016.
2. Kaiser Commission on Medicaid and the Uninsured. "Medicaid Delivery System and Payment Reform: A Guide to Key Terms and Concepts." June 2015.
3. Ibid.
4. Ibid.
5. Kaiser Family Foundation and National Association of Medicaid Directors. "Medicaid Reforms to Expand Coverage, Control Costs and Improve Care: Results from a 50-State Medicaid and Budget Survey for State Fiscal Years 2015 and 2016." October 2015.
6. Center for Children and Families. "Looking at the New Medicaid/CHIP Regulations through a Children's Lens." Kelly Whitener. June 2016.
7. Medicaid Health Homes: An Overview. Centers for Medicaid and Medicaid Services. Fact Sheet – September 2016.
8. Kaiser Commission on Medicaid and the Uninsured. "Medicaid Delivery System and Payment Reform: A Guide to Key Terms and Concepts." June 2015.
9. Ibid.
10. Milbank Memorial Fund. "Population Health in Medicaid Delivery System Reforms." Issue Brief: March 2015.