Medicaid Delivery Systems

Kathryn Costanza
Program Principal
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How NCSL Strengthens Legislatures

Policy Research

NCSL provides trusted, nonpartisan policy research and analysis

Connections

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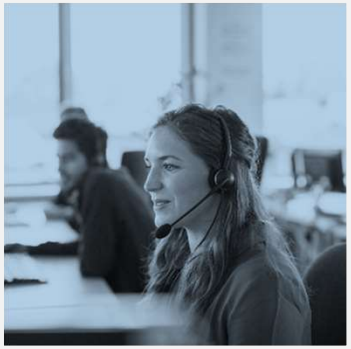

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NCSL delivers training tailored specifically for legislators and staff

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Meetings

NCSL meetings facilitate information exchange and policy discussions

Agenda

- Medicaid Delivery Systems
- State Experiences
- Policy Considerations for Transitions

Medicaid Delivery Systems

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Medicaid Delivery Systems

Legislative Role: Setting Standards, Funding, Oversight

State Operated / Fee-for-Service

State agency ***controls***:

- Costs, Quality, and Access
- Program Operations
- Provider and Beneficiary Stakeholder Relationships
- Program Integrity

Managed Care

State agency ***delegates*** some or all ***responsibility*** for:

- Costs, Quality, and Access
- Program Operations
- Provider and Beneficiary Stakeholder Relationships
- Program Integrity

Medicaid Delivery Systems

State Operated / Fee-For-Service (FFS)

Structure: State administers the program and manages day-to-day operations.

Payment: Providers bill the state. State sets rates, pays providers.

Providers: State enrolls providers. State must accept any willing provider.

Beneficiaries: State determines beneficiary eligibility and enrolls beneficiaries.

Primary Care Case Management (PCCM)

Structure: Similar to FFS. Beneficiary is also assigned a primary care provider that is responsible for coordinating care.

Payment: Same as FFS. State also pays primary care provider an administrative fee plus regular payments for services.

Providers: Same as FFS

Beneficiaries: Same as FFS

Comprehensive Risk-Based Managed Care (MCO)

Structure: State contracts with a private commercial payer (MCO).

Payment: State pays the MCO a per member per month fee for each beneficiary. MCO is "at-risk" for cost of services.

Providers: Providers bill MCO. MCO pays providers. State *and* MCO enroll providers. MCO can limit providers.

Beneficiaries: State *and* MCO enroll beneficiaries.

Limited-Benefit Plan

Structure: MCO manages a subset of benefits:

- Behavioral health
- Non-emergency transportation
- Dental
- Managed long-term services and supports (MLTSS)

Payment: Can be "at risk" or not, depending on if coverage for inpatient services is included.

Providers: Same as MCO

Beneficiaries: Same as MCO

Medicaid Delivery Systems

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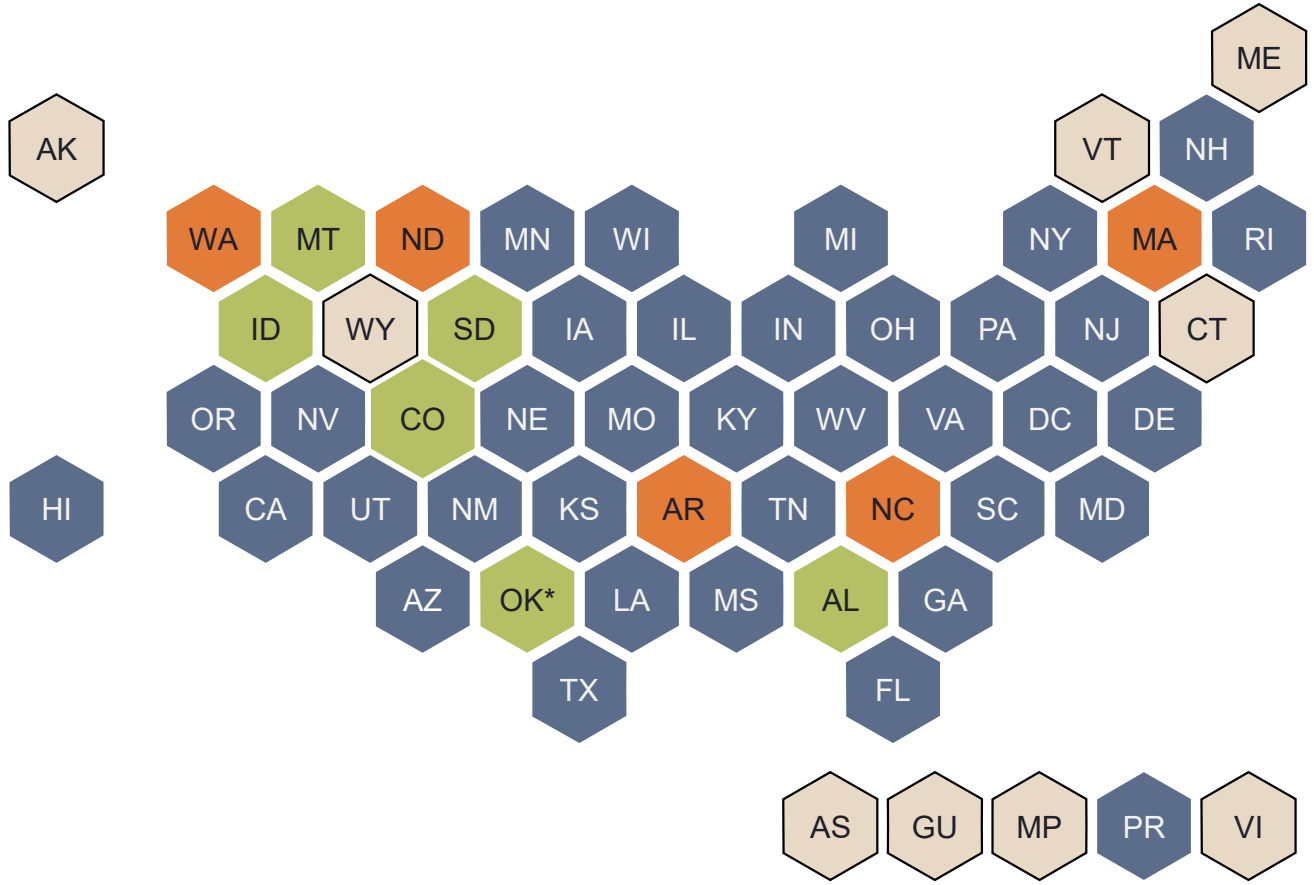
NATIONAL CONFERENCE OF STATE LEGISLATURES

- Comprehensive MCOs
- PCCM
- MCO and PCCM
- State Operated / FFS



Source: Results from an Annual Medicaid Budget Survey For State Fiscal Years 2023 and 2024, KFF (November 14, 2023).
* Oklahoma is currently transitioning from PCCM to MCO

Medicaid Delivery Systems

Value-Based Care

- Paying providers based on quality, outcomes or costs, instead of the volume of services performed.
- Changing how health care providers are organized and incentivized to coordinate across settings and improve care.
- Collecting, analyzing, and managing data to track quality and costs and coordinate care.
- Establishing quality and cost metrics and benchmarks for research and comparison.

Source: Value-Based Care in the States, NCSL Series

Medicaid Delivery Systems

Value-Based Purchasing in MCO Delivery Systems

- Integration of quality measures in MCO quality review process / tied to penalties
- Capitation withholds and incentive payments
- Value-based payment targets

Source: Medicaid Managed Care Brief Series, NCSL Series (*publication on quality in managed care forthcoming in December 2023*)

State Experiences

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“When you’ve seen one Medicaid program . . .

. . . you’ve seen one Medicaid program.”

State Experiences

Comparisons of Medicaid Delivery Systems

- A 2017 study - PCCM model more effective at coordinating care for children.
- A 2021 HMA report - MCOs outperform both PCCM and FFS models on key quality indicators for preventive care, behavioral and women's health.
- A 2009 Missouri comparative analysis of quality of care and access - no significant difference between FFS or MCO performance.
- 2017 analysis, comparing Oregon's MCO Model against Colorado's PCCM Model found similar performance on cost and quality.

Source: Robert Wood Johnson Foundation, Medicaid Managed Care (September 4, 2012); Medicaid Managed Care's Effects on Costs, Access, and Quality: An Update (April 2020); MACPAC, Managed care's effect on outcomes.

Oregon

Source: Mapping Medicaid Managed Care Models & Delivery System and Payment Reform, KFF (2023); Share of Medicaid Population Covered Under Different Delivery Systems, KFF (2022); Limited Benefit Medicaid Managed Care Program Enrollment, KFF (2020).

Delivery System Structure

Delivery System by Percent Enrolled:

- MCO = 91.5%
- PCCM = 0%
- FFS / Other = 8.5%
- Limited Benefit Plans = None

Value-Based Care:

- Accountable Care Organizations
- Primary care payment reform
- Patient-centered medical homes
- Global budgets
- Value-based payment targets and incentives
- All-payer claims database

Oregon

Delivery System Transition and Outcomes

Transition

- $1.9 billion federal investment
- Comprehensive reform, Medicaid expansion, and transition to MCO Model in 2012

Outcomes

- 7% relative reduction in expenditures, reductions in ED visits
- Reduced disparities in primary care visits and access to care, but not in ED use
- Comparable outcomes to Colorado (PCCM)
- Lower cost growth than Washington (MCO) but decline in primary care visits

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Colorado

Source: Mapping Medicaid Managed Care Models & Delivery System and Payment Reform, KFF (2023); Share of Medicaid Population Covered Under Different Delivery Systems, KFF (2022); Limited Benefit Medicaid Managed Care Program Enrollment, KFF (2020).

Delivery System Structure

Delivery System by Percent Enrolled:

- MCO = 11%
- PCCM = 89%
- FFS / Other = 0%
- Limited Benefit Plans = None

Value-Based Care:

- Accountable Care Organizations
- Primary care payment reform
- Patient-centered medical homes
- Bundled payments
- All-payer claims database

Colorado

Delivery System Transition and Outcomes

Transition

- Moved to PCCM model in 2011 and adopted accountable care organizations
- Integrated behavioral health into accountable care organizations in 2018

Outcomes

- Per a 2017 analysis, PCCM model saved $900 per enrollee after 4 years of operations while maintaining quality
- Comparable outcomes to Oregon (MCO)

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Oklahoma

Source: Mapping Medicaid Managed Care Models & Delivery System and Payment Reform, KFF (2023); Share of Medicaid Population Covered Under Different Delivery Systems, KFF (2022); Limited Benefit Medicaid Managed Care Program Enrollment, KFF (2020).

Delivery System Structure

Delivery System by Percent Enrolled:

- MCO = 0%
- PCCM = 66%
- FFS / Other = 34%
- Limited Benefit Plans = Transportation

Value-Based Care:

- Patient-centered medical homes
- Primary care payment reform

Future State

- Moving from PCCM to MCO model in 2024
- Keeping patient-centered medical homes

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Oklahoma

Delivery System Transition and Outcomes

Transition

- Moved from MCO to PCCM model in 2004
- Integrated behavioral health and substance use disorder care between 2005 – 2018.

Outcomes

- 2009 study found increased access to care, decreased hospitalizations, decreased ED visits
- Majority of beneficiaries satisfied with behavioral health

Connecticut

Source: Mapping Medicaid Managed Care Models & Delivery System and Payment Reform, KFF (2023); Share of Medicaid Population Covered Under Different Delivery Systems, KFF (2022); Limited Benefit Medicaid Managed Care Program Enrollment, KFF (2020).

Delivery System Structure

Delivery System by Percent Enrolled:

- MCO = 0%
- PCCM = 0%
- FFS / Other = 100%
- Limited Benefit Plans = None

Value-Based Care:

- Patient-centered medical homes
- All-payer claims database

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Connecticut

Delivery System Transition and Outcomes

Transition

- Transitioned from MCO to FFS in 2012.
- Administrative services organization (ASO).

Outcomes

- Evaluations in 2019 and 2021 found that costs decreased from 2012 to 2018 resulting in estimated savings of $968 million.
- Estimates of the state's administrative costs range from 2.8% - 4.2% but fall below national averages.

Policy Considerations for Transitions

Policy Considerations – Delivery System Transition

1. **Timing** – Staffing, vendor contracting, implementation
2. **Impact to Ongoing Projects and Priorities**
3. **New Agency Functions** – staffing and systems needs
4. **Budget Impact** – staffing, operations, systems updates, transition costs
5. **Communication with Stakeholders and Transition Planning** - beneficiaries, providers, agency, and MCOs

Questions?

Resources

- Medicaid Toolkit, NCSL
- Value-Based Care in the States, NCSL Series
- Medicaid Managed Care, NCSL Series
- Health Costs, Coverage and Delivery State Legislation, NCSL Database

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NCSLFORECAST’24

PREPARING FOR LEGISLATIVE SESSIONS

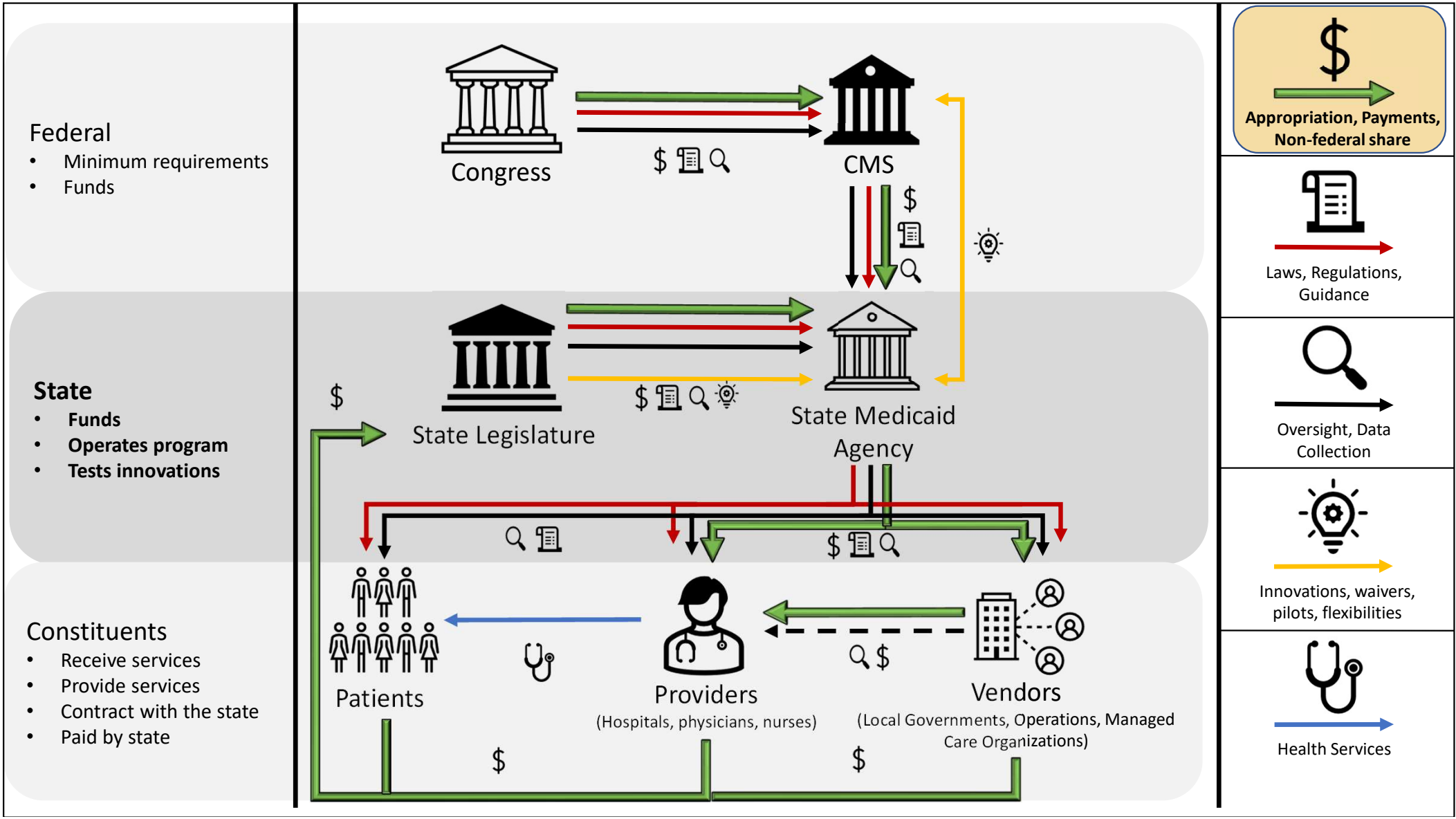
Dec. 4-6, 2023

Reach out anytime!

Kathryn Costanza
Program Principal

Email: Kathryn.Costanza@ncsl.org
Phone: (303)856-1388

Thank you!


Federal
• Minimum requirements
• Funds
State
• Funds
• Operates program
• Tests innovations
Constituents
• Receive services
• Provide services
• Contract with the state
• Paid by state
Congress
CMS
State Legislature
State Medicaid Agency
Patients
Providers
(Hospitals, physicians, nurses)
Vendors
(Local Governments, Operations, Managed Care Organizations)
Appropriation, Payments, Non-federal share
Laws, Regulations, Guidance
Oversight, Data Collection
Innovations, waivers, pilots, flexibilities
Health Services