Overview of Medicaid Delivery Systems

- General Overview
- Medicaid Managed Care

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Who is AHIP?

America's Health Insurance Plans (AHIP) is the national association whose members provide coverage and health-related services that **improve and protect the health and financial security of consumers, families, businesses, communities and the nation**.

Our Mission

America's Health Insurance Plans and its members **create and accelerate positive change and innovation across the health care system for consumers** through market-based solutions and public-private partnerships that advance affordability, value, access, and well-being.

Our Values

We shape and drive market-based solutions and public policy strategies to improve health, affordability and financial security by:

Promoting consumer choice and market competition

Simplifying the health care experience for individuals and families

Supporting constructive partnerships with all levels of government

Partnering with health care providers on the journey from volume to value

Pursuing the promise of clinical innovations while ensuring value

Addressing the burden of chronic disease and social factors that impact health

Harnessing data and technology to drive quality, efficiency and consumer satisfaction

Agenda

- Snapshot of Medicaid program enrollment by state
- Medicaid Managed Care Authorities
- State and Enrollee Participation by Managed Care Type
- Medicaid Managed Care Enrollment in the Context of Total Medicaid Enrollment
- Overview of Medicaid Managed Care
- Overview of Medicaid ACOs
- Comparison of Model Types
- Medicaid Health Plan Quality
- Value Based Payment in Medicaid
- Supplemental Payments in Medicaid Managed Care

Medicaid Managed Care Enrollment

June 2019 Medicaid & CHIP Enrollment

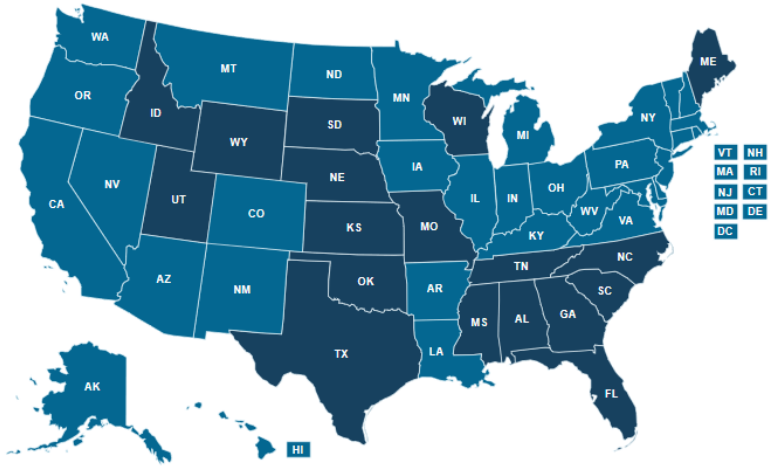
72,227,695 individuals were enrolled in Medicaid and CHIP in the **51 states** that reported enrollment data for June 2019.

- **65,614,176 individuals** were enrolled in Medicaid.
- **6,613,519 individuals** were enrolled in CHIP.

34,722,035 individuals were enrolled in CHIP or were children enrolled in the Medicaid program in the **48 states** that reported child enrollment data for June 2019 representing **50.5%** of total Medicaid and CHIP program enrollment.

List | Map

Show Medicaid Expansion Status **33** expansion states **18** non-expansion states



https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html

Last updated August 29, 2019
View the complete monthly enrollment dataset on Data.Medicaid.gov

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Medicaid Managed Care Authorities

- State Plan Authority – Section 1932 (a)
  - Submitted by the state without needing a waiver
  - No authority to make the program mandatory for American Indians, children with special healthcare needs or people eligible for both Medicare and Medicaid
- Medicaid Waiver Authority – Section 1115
  - Authority to approve experimental, pilot or demonstration projects
  - Must be budget neutral (e.g. may not cost the federal government more than the FFS program)
  - Often used in combination with a DSRIP program to transform Medicaid delivery systems
  - Allows states to cover services not typically covered by Medicaid in certain circumstances
- Medicaid Waiver Authority – Sections 1915 (a) and (b)
  - 1915(a) – Voluntary Medicaid managed care procured using a competitive procurement process
  - 1915(b)
    - 1915(b)(1) - Allows states to restrict enrollees to managed care networks
    - 1915(b)(2) – Allows states to use a central enrollment broker
    - 1915(b)(3) – Allows states to invest savings in additional services for beneficiaries
    - 1915(b)(4) - Allows states to restrict the provider networks

Four Federally Recognized Types of Managed Care Entities

- **Managed Care Organizations (MCOs)**
  - Comprehensive benefit package
  - Payment is risk-based/capitation
  - Annual rate setting process provides states with budget predictability
- **Primary Care Case Management (PCCM)**
  - Primary care case managers contract with the state to furnish case management (location, coordination, and monitoring) services
  - Generally, paid fee-for-service for medical services rendered plus a monthly case management fee
- **Prepaid Inpatient Health Plan (PIHP)**
  - Limited benefit package that includes inpatient hospital or institutional services (example: mental health)
  - Payment may be risk based or non-risk
- **Prepaid Ambulatory Health Plan (PAHP)**
  - Limited benefit package that does not include inpatient hospital or institutional services (examples: dental and transportation)
  - Payment may be risk based or non-risk

Continuum of Medicaid Managed Care Options

	Fee for Service	Primary Care Case Management (PCCM)	Accountable Care Organizations (ACOs)	Risk-Based Capitation (MCOs)
Overview	Non-capitated, non-risk model with no care coordination or case management, limited quality incentives, no budget predictability, strong incentives for over utilization and inappropriate use, few reporting obligations, few fraud waste and abuse protections	Primary Care Providers (PCPs) receive a fee, usually per- member-per-month (PMPM), to coordinate care for its panel of patients. PCPs do not share risk with the state. SoonerCare is a PCCM model. Limited quality incentives, no budget predictability, strong incentives for over utilization and inappropriate use, limited reporting obligations, few fraud waste and abuse protections	ACOs are groups of hospitals, doctors, and other health care providers who come together voluntarily to give coordinated care for their patients, limited risk sharing with the state, quality and value incentives, large up front infrastructure costs, no budget predictability, limited control over utilization and inappropriate use due to open provider networks, strict reporting requirements, few fraud, waste and abuse obligations	Capitated, risk-based contracting with a single organization for all covered services. Quality and value incentives, no infrastructure outlay, budget predictability, control over utilization and inappropriate, strong oversight of network adequacy, strict reporting requirements, extensive fraud, waste and abuse obligations

Medicaid Implementation Models by State 2017

Covered Populations	Comprehensive MCO with or without MLTSS - Mandatory	Comprehensive MCO with or without MLTSS - Voluntary	PCCM – Mandatory	PCCM Voluntary	PCCM Entity - Mandatory	PCCM Entity - Voluntary	MLTSS - Mandatory	MLTSS - Voluntary	Other PHP - Mandatory	Other PHP Voluntary
Low-income Adults	39	5	6	2	1	1	1	0	0	2
Aged, Blind or Disabled Children or Adults	41	14	9	4	0	2	2	2	1	1
Non-Disabled Children	41	3	10	2	1	1	1	0	1	2
Individuals receiving Limited Benefits	12	1	3	0	0	1	0	0	1	2
Low-income adults not otherwise eligible and covered prior to 2014	35	5	5	1	0	1	0	0	0	1
Full Duals	22	26	0	2	0	2	3	2	0	1
Partial Duals	6	5	0	1	0	0	0	1	0	1
Children with Special Health Care Needs	29	14	4	2	0	2	1	0	1	2
Native American/Alaskan Natives	20	45	4	7	0	2	1	3	0	5
Kids in Foster Care	30	18	2	5	0	2	1	0	1	4
Exempt populations	NA/AN 12	FC/AA 26	NA/AN 3	FC/AA 5	NA/AN 0	FC/AA 0	NA/AN 1	FC/AA 4	NA/AN 2	FC/AA 2

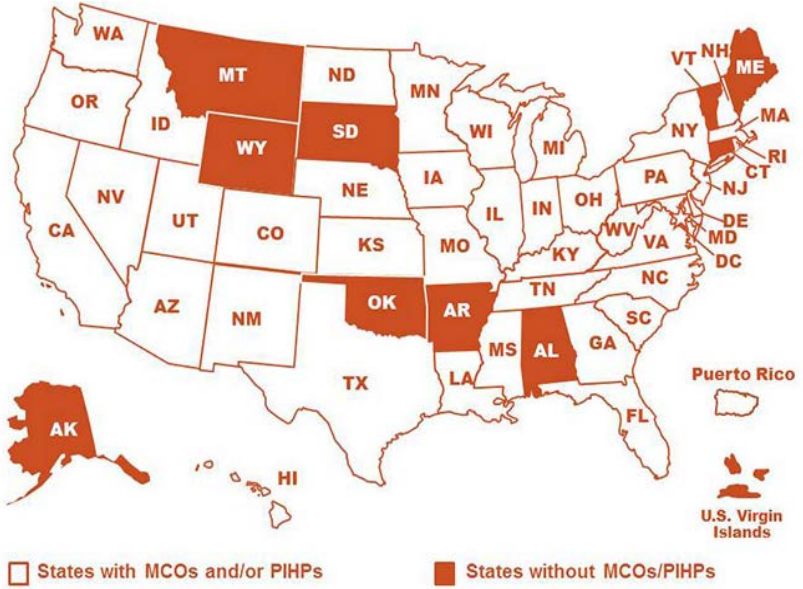
Source: https://data.medicaid.gov/Uncategorized/2017-Managed-Care-Features-By-Enrollment-Populatio/bf45-9uyk

Exclues plans solely for dual éligible bénéficiaires (DSNP, MMP, PACE) and limite bene fit plans (dental, transportation)

Certain federal statutory authorities do not allow enrollment of American Indians/Alaska Natives or Foster Care Children. Where states use these authorities to operate Medicaid managed care, American Indians/Alaska Natives or Foster Care Children are considered "exempt."

Overview of the Use of Comprehensive Medicaid Managed Care Delivered Via MCOs

- As of June 2019, more than 72.2 million people were enrolled in Medicaid and CHIP (65.6 in Medicaid, 6.6 in CHIP
- As of 2017 (the most recent data available from CMS) more than 55 million Medicaid beneficiaries received care through Comprehensive MCOs[2]
- 41 states utilize MCOs to deliver care on a mandatory basis for some or all of their Medicaid population[3]



Jurisdiction[2]	2017 Total Medicaid Enrollees	2017 Comprehensive MCO with or without MLTSS	2017 PCCM	2017 MLTSS only	2017 BHO (PIHP and/or PAHP)	2017 Dental
USA	80,242,585	55,558,073	2,914,483	367,600	10,727,803	6,974,762
Oklahoma	808,267	--	538,738	--	--	--

[1] Source: https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html

[2] Source: https://data.medicaid.gov/Enrollment/2017-Managed-Care-Enrollment-by-Program-and-Popula/vcjc-yq9z/data

[3] Source: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/index.html

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Overview of Medicaid MCOs

- **Medicaid MCOs Save Money:** Facts show that Medicaid MCOs saved states about $7 billion in 2016
- **Medicaid MCOs Adhere to Strict Oversight and Accountability Standards:** Medicaid MCOs are subject to strict oversight and accountability via CMS guidance, state regulation and contract
  - Strict standards cover all aspects of care delivery including network sufficiency, provider access, quality, reporting, and fraud, waste and abuse oversight
- **Medicaid MCOs facilitate access to non-medical services:** By connecting members to non-medical services Medicaid MCOs reduce the barriers many Medicaid beneficiaries face due to social determinants of health (food, housing, transportation, employment, educational resources)

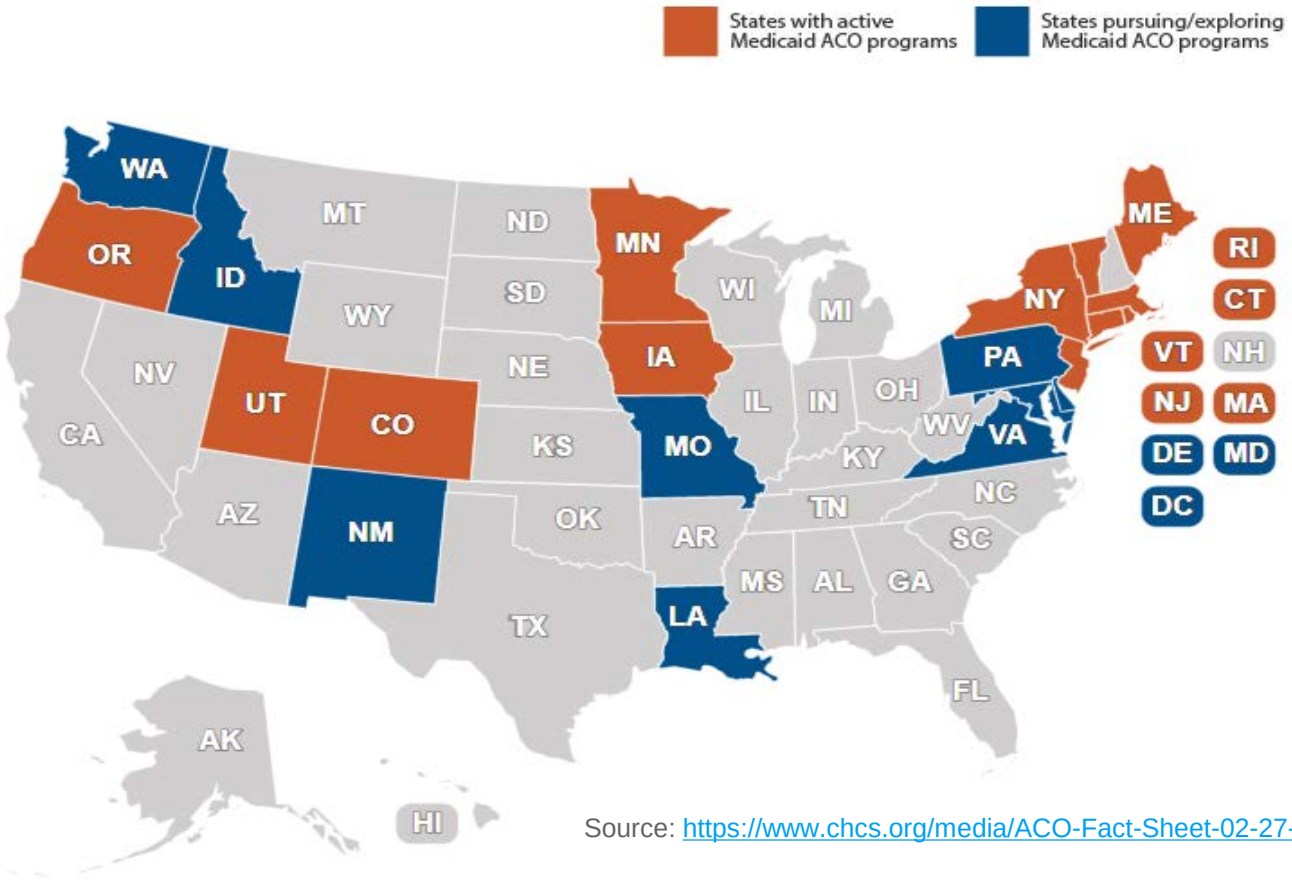
Key Advantages to Leveraging Medicaid MCOs

- **Budget Predictability:** States pay MCOs a set amount per member per month and the MCO is at full risk, helping the state achieve budget predictability for these services
- **Established Member Outreach and Education Programs**: MCOs have long experience finding and engaging members
- **Sophisticated Analytical Capacity:** MCOs leverage their large data sets and sophisticated analytical capacity to support quality improvement and member engagement at the individual and population level
- **Risk Management:** MCOs are held to strict reserve and financial solvency requirements by states

Key Advantages to Leveraging Medicaid MCOs

- **Access to a Continuum of Care:** MCOs create and manage extensive provider networks that include medical, behavioral health and social services over large geographical areas
- **Sophisticated Administrative Functions:** MCOs can deliver on the state's administrative requirements leveraging resources and experience already in house and without the need for seed funding from the state
- **Coordination:** MCOs deliver care coordination that emphasizes primary care and use of cost-effective
- **Alignment of Care Delivery, Outcomes, and Payment**: MCOs emphasize high value services which translate to improvements in health outcomes in a cost effective manner

Overview of ACOs in Medicaid



Source: https://www.chcs.org/media/ACO-Fact-Sheet-02-27-2018-1.pdf

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Overview of ACOs in Medicaid

- ACOs are designed to improve care coordination and delivery by holding providers financially accountable for the health of the patient population they serve. This accountability is achieved through three key activities:
  - Implementing a value-based payment structure;
  - Measuring quality improvement; and
  - Collecting and analyzing data
- To establish a financial incentive for providers to deliver value instead of volume within Medicaid ACO programs, states typically use one of the following models:
  - Shared Savings Arrangement
  - Global Budget Model

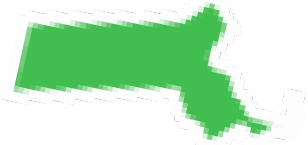
Overview of ACOs in Medicaid

- Quality metrics are tied to payment, and providers typically will not receive a portion of shared savings if they do not meet or exceed their quality benchmarks
- States implementing ACOs must establish and maintain their own data infrastructure to adequately support ACOs
- States Implementing ACOs typically have to provide providers with significant financial resources to facilitate the implementation of health information technology and staff expertise necessary to support ACO analytic and data management requirements

Medicaid Quality Requirements

- Since 2013 Federal Law has required each state to submit a Core Set of measures of child health quality.
- Since 2012 CMS has promulgated a Core Set of adult quality measures to states may voluntarily measure and submit.
- 42 CFR 438.204 requires states utilizing managed care to promulgate a quality strategies which must include:
    - Procedures that assess the quality and appropriateness of care and services furnished to all Medicaid enrollees and to individuals with special health care needs;
    - Procedures that identify the race, ethnicity, and primary language spoken of each Medicaid enrollee;
    - Procedures that regularly monitor and evaluate compliance with the quality measurement requirement
    - Arrangements for annual, external independent reviews of the quality outcomes and timeliness of, and access to, the services covered under each MCO and PIHP contract;
    - For MCOs, appropriate use of intermediate sanctions
    - An information system that supports initial and ongoing operation and review of the State's quality strategy; and
    - Standards for access to care, structure and operations, and quality measurement and improvement

Medicaid FFS vs. Managed Care Quality



A study of the results of the HEDIS quality measures showed that Massachusetts Medicaid health plans exceeded national benchmarks 83% of the time compared to only 43% in the state's PCCM program

Source: Jeremy D. Palmer, FSA, MAA and Sheamus K. Parkes, FSA, MAAA, Comparison of HEDIS® Results: MassHealth PCC Program and Managed Care, Milliman, February 11, 2013.

A study in Minnesota found that Medicaid Health Plans outperformed FFS on 19 HEDIS metrics concluding "it would appear that managed care is able to deliver stronger health outcomes and therefore stronger potential value than can be expected from the FFS system"

Source: Public Consulting Group, Report on the Value of Minnesota Health Care Programs (MHCP) Managed Care as Compared to Fee-for-Service, September 24, 2013.

A study in Georgia found that children in Medicaid Health Plans are more than twice as likely to experience 6 or more well-child visits during the first 15 months of life than beneficiaries in the state's FFS program and children age 12-19 were more likely to visit primary care providers

Janice Carson, MD, Georgia Department of Community Health, PQO Update: Performance Measurement, Presentation to the Georgia Department of Community Health Board, October 11, 2012.

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Medicaid Managed Care Quality

- Of the 15 Child Core Measures, 14 improved each year from 2016-2018, the remaining one improved in 2016 and 2017 and remained level in 2018, none declined
- In 2016, 59% of children in Medicaid health plans received 6 or more well-child visits in the first 15 months of life, whereas 23.5% of children in FFS met this metric (similar results were seen in 2015)
- In 2016, 69.7% of children in Medicaid health plans received well child visits at ages 3,4,5 & 6 while on 35.9 % of children in FFS met this metric (similar results were seen in 2015)

Source: https://oahp.org/wp-content/uploads/2019/02/OAHP-Value-Report-02252019.pdf

- Among the state's non-specialty Medicaid MCOs, of the 76 quality measures calculated each year from 2015-2017: 39 improved in each year, 28 remained stable and only 12 declined.
- Of the 30 measures of adult health: 20 went up, 4 remained level and 6 went down over the 3 year period
- Of the 19 measures of child and adolescent health: 12 went up, 5 remained level and only 2 went down over the 3 year period

Source: https://www.health.ny.gov/health_care/managed_care/reports/docs/executive_summary/executive_summary.pdf

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The Quality of Medicaid Health Plans is Comparable to Commercial Coverage

NCQA Health Insurance Plan Ratings 2018-2019 - Summary Report (Medicaid)

Search for a health insurance plan by state, plan name or plan type (private, Medicaid, Medicare). Click a plan name for a detailed analysis.

In 2018, NCQA rated more than 1,000 health insurance plans based on clinical quality, member satisfaction and NCQA Accreditation Survey results. This way of rating plans emphasizes care outcomes (the results of care people receive) and what patients say about their care.

Note: The overall rating score is the weighted average of all measures, not an average of the three composites (Consumer Satisfaction, Prevention, Treatment). For more information about the ratings, including how they are calculated, visit our 2018 ratings page.

Medicaid | Ohio | Enter Plan Name | Search

Lower Performance ≤1.0 1.5 2.0 2.5 3.0 3.5 4.0 4.5 5.0 Higher Performance

Rating	Plan Name	States	Type	NCQA Accreditation	Consumer Satisfaction	Prevention	Treatment
3.5	Buckeye Health Plan	OH	HMO	Yes	3.5	2.5	3.0
3.5	CareSource	OH	HMO	Yes	4.5	2.5	3.0
3.5	Molina Healthcare of Ohio, Inc.	OH	HMO	Yes	3.5	2.5	3.0
3.5	Paramount Advantage	OH	HMO	Yes	3.5	2.5	3.0
3.5	UnitedHealthcare Community Plan of Ohio, Inc.	OH	HMO	Yes	3.5	2.5	2.5

- NCQA Accreditation as of June 30, 2018
- **I** = Insufficient data; **NC** = No Credit; **NA** = Not Applicable; **NP** = Not Publicly Reported
- Specific plan demographic data are supplied by the AIS Directory of Health Plans, Atlantic Services, Inc. (www.aishealth.com)
- † Indicates Special Needs Plan (SNP), according to CMS
- * Indicates a Massachusetts Medicaid plan using CAHPS 2017 data due to changes in state regulations
- Contact us at my.ncqa.org to ask about licensing the ratings data for research or display

http://healthinsuranceratings.ncqa.org/2018/search/Medicaid/OH

The Quality of Medicaid Health Plans is Comparable to Commercial Coverage

Private(Commercial) ▾ | Ohio ▾ | Enter Plan Name | Search

Lower Performance ≤1.0 1.5 2.0 2.5 3.0 3.5 4.0 4.5 5.0 Higher Performance

Rating	Plan Name	States	Type	NCQA Accreditation	Consumer Satisfaction	Prevention	Treatment
4.5	AultCare Insurance Company	OH	HMO	Yes	5.0	I	4.0
3.5	Aetna Life Insurance Company (Ohio)	OH	PPO/EPO	Yes	3.0	2.5	3.0
3.5	AultCare Corporation	OH	PPO	Yes	4.0	2.5	3.0
3.5	Community Insurance Company dba Anthem Blue Cross and Blue Shield in Ohio	OH	PPO/EPO	Yes	3.5	3.0	3.0
3.5	Humana Health Plan of Ohio, Inc.	OH	HMO/POS	Yes	3.0	3.0	3.0
3.5	Medical Mutual of Ohio	OH	HMO/POS/PPO	Yes	4.5	2.5	2.5
3.5	Paramount Insurance Company	OH	HMO	Yes	3.0	3.5	3.0
3.5	Summa Insurance Company, Inc	OH	PPO	Yes	3.0	3.0	3.0
3.5	The Health Plan of the Upper Ohio Valley, Inc. dba The Health Plan	OH, WV	HMO	Yes	3.5	2.5	2.5
3.5	United HealthCare Services, Inc. (Ohio)	OH	PPO	Yes	2.0	3.0	3.0
3.5	UnitedHealthcare Insurance Company (Ohio)	OH	PPO	Yes	2.0	3.0	3.0
3.0	Aetna Health Inc. (Pennsylvania) - Ohio	IN, KY, OH	HMO/POS	Yes	3.0	2.0	3.0
2.5	Cigna Health and Life Insurance Company - Ohio	OH	HMO/POS/PPO	Yes	3.0	1.5	2.5

http://healthinsuranceratings.ncqa.org/2018/search/Commercial/OH

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Examples of Ways States Leverage Value Base Payments (VBP) In Medicaid Managed Care

As of May 2018 states used the following techniques to encourage value based payment in Medicaid managed care:

- Set mandatory VBP targets for plans (18 states)
- Require a VBP strategy (12 states)
- Require MCOs to adopt a standardized VBP model: ACOs, PCMHs, Health Homes, Bundles (10 states)
- Require MCOs to adopt a standardized VBP model (a standard % of payments (10 states), a standard % of patients (5 states), a % of premium revenue (1 state) or an escalating % over time)
- Impose financial penalties or provides financial rewards based on the amount and type of VBP arrangements the plan has in place (13 states)
- Set a target for the % of plan contracts that include VBP arrangements (2 states)

Source: https://www.manatt.com/Insights/Newsletters/Manatt-on-Health-Medicaid-Edition/Leveraging-Medicaid-Managed-Care-to-Advance-Value

Supplemental Payments and Medicaid Managed Care

- Supplemental payments are made to providers through Medicaid including in Oklahoma.
  - Approximately $500 million dollars are paid annually to hospitals and other providers
  - These payments can be preserved under an MCO model if they are tied to utilization and outcomes or other measures of value
- The Centers for Medicare & Medicaid Services (CMS) no longer allows directed pass through supplemental payments from plans to those providers. However:
  - The payments can be built into actuarially sound rates
  - The payments can be transitioned to value based or outcomes driven payments paid through managed care rates to providers

Questions?

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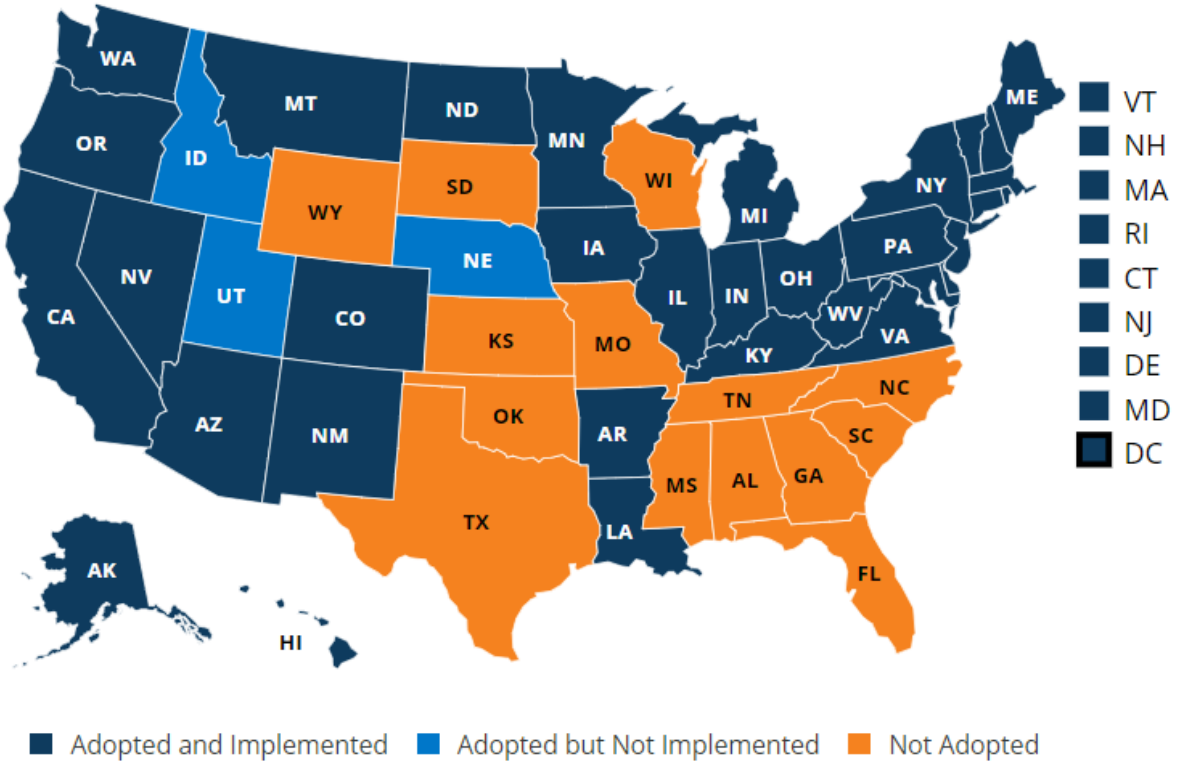
Appendix – Supplemental Materials

37 states have adopted Medicaid expansion



Source: Kaiser Family Foundation; August 2019

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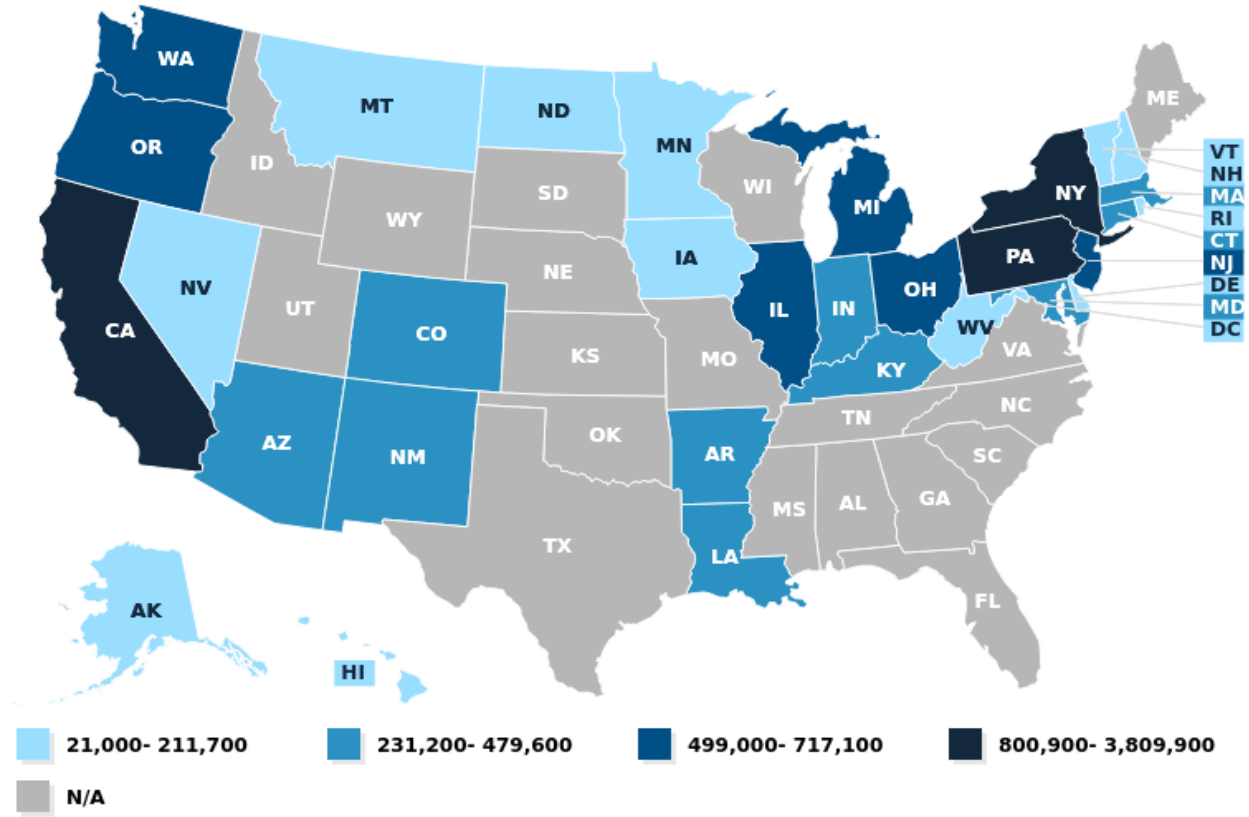
Expansion Group Enrollment 2017



In 2019, 37 states have adopted the expansion and 14 have not – Missing from this map are Maine, Virginia, Nebraska, Idaho and Utah

SOURCE: Kaiser Family Foundation's State Health Facts.

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Medicaid Enrollment by Managed Care Model By State 2017 (slide 1 of 3)

State	Total Medicaid Enrollees	Comprehensive MCO with or without MLTSS	PCCM	MLTSS only	BHO (PIHP and/or PAHP)	Dental
TOTALS	80,242,585	55,558,073	2,914,483	367,600	10,727,803	6,974,762
Alabama	1,037,814	--	396,912	--	--	--
Alaska	155,865	--	--	--	--	--
American Samoa	n/a	n/a	n/a	n/a	n/a	n/a
Arizona	1,917,183	1,617,558	--	--	--	--
Arkansas	993,792	--	469,634	--	--	--
California	13,515,168	10,798,374	--	--	23	903,991
Colorado	1,381,208	137,240	--	--	1,322,757	--
Connecticut	860,758	--	--	--	--	--
Delaware	222,859	207,997	--	--	--	--
District of Columbia	265,547	196,704	--	--	--	--
Florida	3,916,490	3,181,088	--	97,638	--	--
Georgia	1,813,016	1,247,705			--	--
Guam	n/a	n/a	n/a	n/a	n/a	n/a
Hawaii	365,087	360,905	--	--	--	--
Idaho	299,253	2,290	276,411	--	290,463	290,463
Illinois	3,192,569	1,884,379	320,335	28,223	--	--
Indiana	1,475,463	1,138,236	--	--	--	--
Iowa	623,501	556,389	--	--	--	153,985

Source: https://data.medicaid.gov/Enrollment/2017-Managed-Care-Enrollment-by-Program-and-Popula/vcjc-yq9z/data

Medicaid Enrollment by Managed Care Model By State 2017 (slide 2 of 3)

State	Total Medicaid Enrollees	Comprehensive MCO with or without MLTSS	PCCM	MLTSS only	BHO (PIHP and/or PAHP)	Dental
TOTALS	80,242,585	55,558,073	2,914,483	367,600	10,727,803	6,974,762
Kansas	416,645	398,013	--	--	--	--
Kentucky	1,403,257	1,251,070	--	--	--	--
Louisiana	1,626,037	1,377,682	--	--	114,982	1,489,131
Maine	273,451	--	147,296	--	--	--
Maryland	1,326,080	1,161,213	--	--	--	--
Massachusetts	1,874,779	847,708	393,076	--	453,630	--
Michigan	4,668,815	2,411,048		11,428	2,286,950	965,789
Minnesota	1,107,499	846,115	--	--	--	--
Mississippi	708,992	487,201	--	--	--	--
Missouri	983,835	733,120	--	--	--	--
Montana	230,296	--	175,012	--	--	--
Nebraska	247,894	246,472	--	--	--	0
Nevada	653,968	448,513	38,543	--	--	--
New Hampshire	204,458	133,811	--	--	--	--
New Jersey	1,678,888	1,559,423	--	--	--	--
New Mexico	898,965	695,017	--	--	--	--
New York	6,105,120	4,520,640	--	184,298	--	--
North Carolina	2,110,914	--	--	--	1,600,547	--
North Dakota	92,595	20,515	49,399	--	--	--
Northern Mariana Islands	n/a	n/a	n/a	n/a	n/a	n/a

Source: https://data.medicaid.gov/Enrollment/2017-Managed-Care-Enrollment-by-Program-and-Popula/vcjc-yq9z/data

Medicaid Enrollment by Managed Care Model By State 2017 (slide 3 of 3)

State	Total Medicaid Enrollees	Comprehensive MCO with or without MLTSS	PCCM	MLTSS only	BHO (PIHP and/or PAHP)	Dental
TOTALS	80,242,585	55,558,073	2,914,483	367,600	10,727,803	6,974,762
Ohio	3,083,411	2,550,962	--	--	--	--
Oklahoma	808,267	--	538,738	--	--	--
Oregon	1,067,322	858,382	--	--	--	--
Pennsylvania	2,835,800	2,259,379	--	--	2,552,587	--
Puerto Rico	1,401,921	1,401,921	--	--	--	--
Rhode Island	337,809	270,257	--	--	--	104,666
South Carolina	1,217,302	772,074	456	--	--	--
South Dakota	124,676	--	93,369	--	--	--
Tennessee	1,522,658	1,409,266	--	--	--	--
Texas	4,038,159	3,730,231	8,573	--	--	2,933,650
Utah	284,316	235,408	--	--	279,889	133,087
Vermont	183,918	96,823	--	--	--	--
Virgin Islands	n/a	n/a	n/a	n/a	n/a	n/a
Virginia	1,083,750	722,399	--	--	--	--
Washington	1,824,730	1,611,793	6,729	--	1,824,730	--
West Virginia	521,186	424,662	--	--	--	--
Wisconsin	1,197,770	748,090	--	46,013	1,245	--
Wyoming	61,529	--	--	--	--	--

Source: https://data.medicaid.gov/Enrollment/2017-Managed-Care-Enrollment-by-Program-and-Popula/vcjc-yq9z/data

Comparison of Models Across the Risk Continuum

	Fee for Service	Primary Care Case Management (PCCM)	Accountable Care Organizations (ACOs)	Risk-Based Capitation (MCOs)
Quality	There are no consistent quality metrics for the FFS system	PCCM programs do not have extensive quality metrics and are not measured on quality	Results are measured relative to an ACO-specific benchmark	MCOs are held to rigid quality standards
Provider Contracting	Providers contract with the state	PCPs may be required to sign a separate contract to receive a PCCM fee. These contracts are between the PCP and the state	ACOs generally prefer their participating providers but networks generally include all participating Medicaid providers regardless of cost or quality	Providers contract with the MCO
Reimbursement	Providers are reimbursed according to FFS rates for each service	PCPs receive a fee, usually per- member-per-month to coordinate care for its panel of patients. Services are reimbursed on a fee-for-service basis.	Providers are generally reimbursed on a fee for service basis with a limited amount of shared risk determined retrospectively against an ACO-specific benchmark	Providers are reimbursed a negotiated rate between the MCO and provider with pay-for-performance incentives

Comparison of Models Across the Risk Continuum

	Fee for Service	Primary Care Case Management (PCCM)	Accountable Care Organizations (ACOs)	Risk-Based Capitation
Provider Network and Referrals	Medicaid beneficiaries must find their own doctors and other service providers that will accept Medicaid	All Medicaid participating providers regardless of quality or value. Beneficiaries may be required to obtain a referral from their PCP to access certain services	ACOs consist of a voluntary group of providers. They are not required to create a comprehensive network of services	Medicaid MCO members choose from within a defined network of providers. The goal of managed care is to ensure the provision of the right care at the right time
Services and Care Coordination	Limited to persons in disease management or Waiver programs	There is limited care coordination between the PCP and the specialty providers. A referral is general required from the PCP	ACOs are not required to provide a full range of services and coordinate those services across a comprehensive package	MCO provides Service/Care Coordinators for any member with a need for coordination or on request

Overview of ACOs in Medicaid

State	Program Name	Governance Structure	Scope of Service	Payment Model	Quality Measurement
CO	Accountable Care Collaborative	Care coordination entity / behavioral health organization	▪ Physical health ▪ Behavioral health	Care coordination payment and pay-for-performance; capitated behavioral health payment	Eight key performance indicators tied to payment
CT	Person Centered Medical Homes Plus (PCMH+)	Provider-led	▪ Physical health ▪ Behavioral health	Upside only shared savings	27 quality measures, including 9 scoring, 4 challenge, and 14 reporting only measures
IA	State Innovation Model Accountable Care Organization Program	Provider-led	▪ Physical health	VBP options via MCO contracting (e.g., shared savings or incentive payments linked to quality)	14 measures in 6 domains; shared savings or incentive payments dependent on ACO performance
MA	Accountable Care Organizations	Provider-led organizations that may partner with managed care organizations	▪ Physical health ▪ Behavioral health (via community partners) ▪ Long-term services/supports (LTSS) (in year three, via community partners)	Three models: (1) full risk capitation; (2) shared savings and losses with MassHealth; and (3) shared savings and/or loss contracts with MassHealth MCOs	(Proposed) 38 quality measures, including 32 tied to payment in second and subsequent years (first year, reporting only)
ME	Accountable Communities Initiative	Provider-led	▪ Physical health ▪ Behavioral health ▪ LTSS *(optional)* ▪ Dental *(optional)*	Shared savings using two tracks: (1) upside only; and (2) upside/downside	17 quality measures, including 14 core measures and three elective measures; all tied to payment
MN	Integrated Health Partnerships	Provider-led, with two tracks: (1) smaller providers and care coordination entities; (2) larger, integrated systems that manage TCoC for beneficiaries	▪ Physical health ▪ Behavioral health ▪ Pharmacy	Two tracks: (1) risk-adjusted, population based payment tied to quality metrics; (2) shared savings with upside and downside risk	Core measures drawn from patient care, health IT, and pilot domains; focus on alignment with MACRA/MIPS
NJ	Medicaid Accountable Care Organization Pilot	Community-led (geographic)	▪ Physical health	ACOs and MCOs negotiate an upside only shared savings agreement[1]	27 quality measures, 21 mandatory measures and six voluntary measures; all tied to payment
NY	Accountable Care Organizations	Provider-led	▪ Physical health	Shared savings or shared savings/risk contracts are negotiated between ACOs and MCOs	ACO must propose a quality management and improvement program (which includes quality metrics) to the state for approval
OR	Coordinated Care Organizations	Payer-led (geographic)	▪ Physical health ▪ Behavioral health ▪ Dental	Global budget capped at 2% growth rate. Quality pool bonus available via 4% withhold	17 incentive measures tied to quality pool payments based on CCO achievement or improvement
RI	Accountable Entities (AE)	Provider-based entities contracting with MCOs under shared savings arrangement; two potential tracks: (1) all populations; (2) LTSS population	▪ Physical health ▪ All Medicaid services that are covered by Executive Office of Health and Human Services' (EOHHS) contracts with MCOs ▪ Does not include services reimbursed by EOHHS fee-for-service programs ▪ For LTSS track, long-term care services	Shared savings/loss via MCO contracting	11 required core measures; 4 additional optional measures identified by the AE and the MCO
UT	Accountable Care Organizations	Payer-led	▪ Physical health	Capitated payment	25 quality measures, not tied to payment
VT	Next Generation Accountable Care Organization	Provider-led	▪ Physical health	Prospective capitation plus quality withhold, with risk corridor capped at 3% savings/losses	Quality withhold (increases from 0.5% to 3% over 3 years) tied to performance on 10 out of 12measures

[1] New Jersey ACOs form their own gainsharing arrangements with managed care organizations, but a recommended model was developed by Rutgers University to guide those negotiations.

Source: https://www.chcs.org/resource/medicaid-accountable-care-organizations-state-update/