# Medicaid Managed Care: Model Variations and Arkansas Applications

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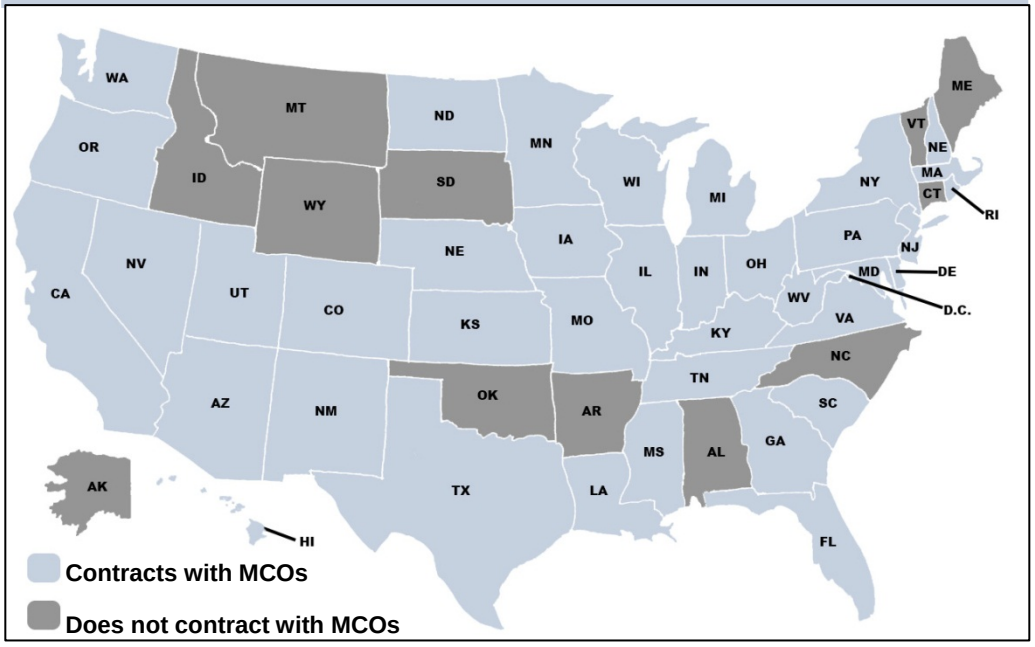
*Twenty-eight states and the District of Columbia (DC) opted to expand Medicaid in 2014, with the majority expanding coverage through existing Medicaid managed care arrangements.[1] While Arkansas has used care management approaches to provide services to certain populations, the state's Medicaid program has refrained from shifting the clinical and financial responsibility for beneficiary care to a third-party managed care organization like many other states. So when faced with the 2014 coverage expansion decision, Arkansas took quite the unique approach, electing to use an individual plan premium assistance model for eligible individuals to purchase private coverage in the newly created health insurance marketplace. The premium assistance approach was beneficial, in part, because it offered the opportunity for the state to extend the reach of the care management approaches adopted by the Arkansas Health Care Payment Improvement Initiative (AHCPII), namely patient-centered medical homes (PCMHs). A legislative task force is currently considering options for providing services to Medicaid populations post-2016, including those covered by the state's individual plan premium assistance model. Legislation establishing the task force directs them to consider capitated payment models, including third-party managed care. This fact sheet provides background information regarding Medicaid managed care, variation in managed care models, the use of managed care in Arkansas, and a comparison of managed care and premium assistance models.*

## BACKGROUND

Variations in managed care models have emerged over the past half-century, but when people think of managed care, most migrate toward the more common "health maintenance organization" (HMO), or prepaid health plan. Managed care began in the private sector, but major expansions of managed care did not begin until after the enactment of the federal HMO Act of 1973[2] and the proliferation of Medicaid managed care in the late 1990s with latitude provided to states under the Balanced Budget Act of 1997.[3] Since that time, managed care has become the dominant healthcare delivery model for Medicaid beneficiaries, with more than half of all Medicaid beneficiaries nationwide now receiving some or all of their care from risk-based managed care organizations (MCOs). As of September 2014, 39 state Medicaid agencies, including DC, contract with MCOs and 12 do not, including Arkansas (see Figure 1).[4]

**Figure 1: States Contracting with Medicaid Managed Care Organizations***




*Adapted from: Paradise J. "Key Findings on Medicaid Managed Care: Highlights from the Medicaid Managed Care Market Tracker." *The Kaiser Family Foundation*, December 2014.

## APPLICATIONS OF MANAGED CARE

Managed care does not always involve the shifting of risk and responsibility for beneficiary care to a third party. Some states incentivize care management by providing financial support directly to providers rather than to an MCO. When states shift financial risk for Medicaid beneficiary care to MCOs, either partially or fully, they generally do so in the form of capitation. A capitated payment is a predetermined amount that a state pays an MCO to provide services for a population during a specific period of time. The MCO assumes responsibility for the care regardless of

the actual volume or magnitude of services provided. States have moved to capitated managed care with the lure of lower and more predictable Medicaid program costs and MCO flexibility to respond to beneficiary needs, while providers and consumers maintain that capitation provides strong incentives to limit access to services or providers in favor of profit. Table 1 describes Medicaid managed care models and the variation in financial risk and provider control for each approach.[5]

**Table 1: Medicaid Managed Care Applications[5]**

| Model | Model Description | | Financial Risk |
|---|---|---|---|
| Primary Care Case Management (PCCM) | Medicaid reimburses treatment services on a fee-for-service (FFS) basis to the providers; pays primary care provider (PCP) monthly fee for care coordination of patients that have selected provider as PCP | More | No financial risk for the provider |
| Patient-Centered Medical Home (PCMH) | Medicaid reimburses treatment services on an FFS basis to the providers; pays PCMH monthly fee for attributed beneficiaries; requires practice transformation and measures quality and total cost of care | PROVIDER CONTROL | No financial risk for the PCMH, but PCMH must meet quality metrics and exceed a system-wide cost threshold or its own benchmark cost to receive shared savings |
| Partial-Risk Managed Care Organization (MCO) | Medicaid pays a capitated amount to the MCO to provide a select set of services for each patient selecting an MCO; other services are paid by Medicaid on an FFS basis | | MCO assumes financial risk only for the select services covered by the MCO; assumes no risk for care outside the MCO |
| Full-Risk Managed Care Organization (MCO) | Medicaid pays an MCO a capitated amount to provide all services for each patient selecting an MCO; also known as full capitation | Less | MCO at full financial risk for services used that exceed capitation payments; if patients use fewer services, the MCO may get to keep or reinvest unused funds |

The delivery and payment models described in Table 1 can be implemented in isolation or in combination; they are not mutually exclusive models. For example, Tennessee Medicaid delivers healthcare services through full-risk MCOs statewide.[6] The state is also engaging in value-based purchasing, implementing PCMH and episodes of care programs by requiring MCOs to participate in an effort to build a statewide, aligned purchasing and delivery model for Medicaid and commercial carriers as Arkansas has done.[6] In addition to the models described in Table 1, accountable care organizations (ACOs) are emerging integrated delivery systems with financial risk models that range from shared savings to partial capitation.

## MEDICAID MANAGED CARE IN ARKANSAS

Although Arkansas Medicaid does not contract with a managed care organization, it manages beneficiary care in several ways. In 1994, Arkansas introduced the Primary Care Case Management (PCCM) program to assign Medicaid beneficiaries a primary care provider (PCP). The state contracts with PCPs to manage care for enrollees in the PCCM program and coordinate their medical needs. PCPs receive a monthly per-member case management payment in addition to regular Medicaid fee-for-service (FFS) reimbursement for medical services.[7] In 2013, the Arkansas Health Care Payment Improvement Initiative (AHCPII) began to provide per-member-per-month financial support for physician practices in the patient-centered medical home (PCMH) model to help patients stay healthy, promote improved care access, increase the quality of care received, and curb total cost of care for attributed patients.[8] The model complements federal programs supporting PCMHs and has been adopted by private payers participating in the health insurance marketplace. It provides an opportunity for PCMHs to invest in an infrastructure to support care coordination outside the clinic walls and the potential for shared savings for cost avoidance. In addition to the PCCM and PCMH programs, Arkansas currently participates in the Program of All-Inclusive Care for the Elderly (PACE) to manage Medicaid and Medicare services for individuals over 55 that need nursing home-level care.[7] While there has been some development of accountable care organizations (ACOs) in Arkansas spurred by Medicare opportunities, Medicaid has not yet applied this model in its delivery system.

## MANAGED CARE VERSUS PREMIUM ASSISTANCE REGULATION

Is Arkansas's use of individual plan premium assistance just another form of Medicaid managed care? The short answer is no, although both models use the private market for the care of Medicaid beneficiaries. A complex set of federal regulations developed over several decades governs Medicaid managed care, with the most recent being a 653-page rule proposed by the Centers for Medicare and Medicaid Services (CMS) in May 2015.[9] The federal

government has provided little guidance related to individual plan premium assistance. This is primarily because use of individual premium assistance on such a broad scale is relatively new. Also, the qualified health plans purchased by Arkansas Medicaid for individuals are governed by a separate regulatory structure designed for the private market. A March 2015 report to Congress by Medicaid and the CHIP Payment and Access Commission noted some of the distinguishing characteristics between the two models as described in Table 2 below.[10]

**Table 2: Comparing Medicaid Managed Care and Medicaid Premium Assistance Programs[10]**

| | Medicaid Managed Care | Medicaid Premium Assistance |
|---|---|---|
| **Contracting** | Medicaid conducts bidding process and selects a minimum of two MCOs to serve a specific Medicaid population | Medicaid purchases qualifying individual plans that are available through the marketplace and that meet Medicaid cost-sharing restrictions |
| **State Oversight** | State Medicaid program establishes terms and conditions for MCOs in accordance with federal regulations | State insurance department governs plans through existing state law and marketplace certification requirements |
| **Benefit Offerings** | MCOs cover majority of federally-required benefits, with the remaining required benefits (wrap-around coverage) covered directly by Medicaid | Medicaid purchases essential health benefits (EHBs) required in all marketplace plans, with remaining federally required benefits (wrap-around coverage) covered directly by Medicaid |
| **Provider Rates** | MCOs establish reimbursement levels through provider contracts; Medicaid may require minimum payment levels to ensure access | Marketplace plans establish reimbursement levels through provider contracts; state insurance department ensures |
| **Market Impact** | Medicaid population is segregated from privately insured risk pool | Medicaid population is integrated into privately insured risk pool in the marketplace |

## CONCLUSION

States have used a variety of delivery models to provide care to Medicaid populations since its inception 50 years ago. While some states have opted to shift financial risk and care management to third-party MCOs, others, like Arkansas, have chosen to invest in the local provider community to manage patient care and partner with private payers to create systematic change in the healthcare system. Integrating the Medicaid population into the privately insured risk pool through the marketplace has markedly lowered the average age of the risk pool, resulting in lower marketplace premiums. Enabling legislation charged the Arkansas Health Reform Legislative Task Force[11] to examine all avenues for healthcare delivery systems, including capitated managed care payment models. For complex populations with specialized needs for whom Medicaid has traditionally been the primary payer with the most available resources, a transition to third-party managed care may be an option to tailor individual care and achieve cost avoidance. However, proposed Medicaid managed care regulations may increase complexity and erode attractiveness, which may cause states to examine their own insurance markets for solutions.

## REFERENCES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