Federal Requirements and State Options: Delivery Systems

States can elect to provide Medicaid services to enrollees through a variety of delivery systems (Table 1). The default delivery system in Medicaid is fee for service (FFS), but as of July 1, 2014, most Medicaid enrollees receive services under managed care arrangements. Almost 60 percent of Medicaid enrollees were enrolled in comprehensive managed care, which covers acute, primary, and specialty care services. Smaller shares of enrollees were enrolled in limited-benefit managed care plans, which cover specific types of benefits such as long-term services and supports and behavioral health care, or primary care case management (PCCM), which provides additional incentives for care coordination in an otherwise FFS delivery system (MACPAC 2016).[1]

In FFS delivery systems, states must enroll any willing and qualified provider and beneficiaries can choose to visit any participating provider. States can establish their own provider qualifications and payment policies, but enrollees must have access to comparable benefits statewide. States establish fee schedules or other methods to pay providers directly for the Medicaid services that they provide to enrollees.

PCCM is a variation on the FFS model that aims to provide additional incentives for coordinated care. PCCM programs typically make nominal per member, per month payments to providers who provide care coordination services similar to what a managed care plan would provide. States can assign enrollees to PCCM providers, but enrollees can opt out of the PCCM entity if they choose and receive care through the traditional fee-for-service delivery system. As of 2014, 21 states have PCCM programs (MACPAC 2016).

Under a managed care delivery system, the state contracts with managed care organizations to provide Medicaid services. Managed care plans establish their own provider networks, which may differ from the providers that accept fee-for-service Medicaid, and states can require Medicaid enrollees to enroll in a managed care plan. Managed care plans are paid on a capitated basis for services covered under the managed care contract, and managed care plans have flexibility to establish their own payment rates to providers. Managed care plans are at financial risk if spending on benefits and administration exceeds the capitation rate.

The type and amount of care for which managed care plans are responsible varies:

- Limited-benefit managed care contracts some but not all Medicaid services to managed care organizations. Specifically, states can contract with prepaid inpatient health plans (PIHPs) that cover some inpatient or institutional services, such as inpatient mental health, and prepaid ambulatory health plans (PAHPs) that provide limited ambulatory or outpatient services, such as non-emergency medical transportation. PIHPs and PAHPs are paid on a capitated basis for the services included in

their contracts. Twenty-five states and the District of Columbia enroll a portion of their Medicaid population in at least one limited-benefit managed care plan (MACPAC 2016).

- Comprehensive managed care contracts acute, primary, and specialty Medicaid services to managed care organizations. Some comprehensive managed care plans also include behavioral health, long-term services and supports, and other benefits in some states. Twenty-nine states and the District of Columbia enroll more than half of their Medicaid population in comprehensive managed care (MACPAC 2016).

Under all types of managed care, states must provide beneficiaries with a choice of managed care plan (unless the enrollee is located in a rural area) and an opportunity to appeal coverage decisions made by plans. States are required to provide assistance to help enrollees chose between health plans and understand the state's managed care program.

Managed care plans must maintain a sufficient provider network to provide adequate access to covered services for all managed care enrollees. States are required to develop their own network adequacy standards for plans, including— beginning in July 2018— standards based on an enrollee's travel time and distance to provider sites.

If the managed care plan covers long-term services and supports (LTSS), then the state and plans are also be required provide additional assistance for these services in consultation with an LTSS stakeholder advisory group. In order to include LTSS in managed care delivery system, the state must also receive CMS approval to provide LTSS, either through the state plan or a Section 1915(c) waiver. More information on authorities for providing LTSS is available in MACPAC's fact sheet, *Federal Requirements and State Options: Benefits*.

Capitation rates for managed care plans are required to be actuarially sound, which means that they cover reasonable, appropriate, and attainable costs when providing covered services to enrollees in Medicaid managed care programs. More information on provider payments, including capitated payments under managed care, is available in MACPAC's fact sheet, *Federal Requirements and State Options: Provider Payment*.

Demonstrations and Waivers

Fee-for-service delivery systems are permitted for all Medicaid populations, but under the state plan authority for managed care (Section 1932 of the Social Security Act), only certain populations can be required to enroll in managed care. Specifically, states cannot enroll disabled children, foster care children, Medicare beneficiaries, and Americans Indians mandatorily. In addition, Section 1932 does not permit the state to selectively contract with one managed care plan.

Section 1915(b) waivers permit states to enroll all Medicaid enrollees in managed care on a mandatory basis and allows states to selectively contract with a single managed care plan (typically for the purposes of limited-benefit managed care). In addition, Section 1915(b) waivers permit states to spend managed care savings on additional services (Section 1915(b)(3) of the Social Security Act and 42 CFR 431.55).

States have also sought waiver and expenditure authority under Section 1115 demonstrations to obtain additional flexibility to implement managed care and various delivery system reforms. For example, several states have implemented Delivery System Reform Incentive Payment (DSRIP) programs, which support provider-led efforts to change the delivery of care that are implemented alongside Medicaid managed care (MACPAC 2015). In addition, Oregon has used a Section 1115 demonstration to support a variation of managed care referred to as coordinated care organizations, which are provided with a global budget and additional flexibility to invest in population health initiatives. The managed care components of these demonstrations are similar to those permitted under Section 1915(b) waivers, allowing states to enroll exempt populations on a mandatory basis; however DSRIP demonstrations and Oregon's Section 1115 waiver demonstrations also permit a time-limited investment of federal matching funds for additional supplemental payments to incentivize providers to meet selected metrics.

TABLE 1. Federal Requirements and State Options: Summary of State Flexibilities Related to Delivery System

Delivery system option	Federal statutory and regulatory requirements	State plan options
Fee for service (FFS)	• States must enroll any willing and qualified provider and enrollees have the freedom of choice of participating providers (often referred to the free choice of provider provision) (§1902(a)(23), 42 CFR 431.51). • Comparable benefits must be available statewide for most Medicaid enrollees (§1902(a)(1), 42 CFR 431.50, 42 CFR 440.240).	• States can define provider qualifications and covered Medicaid benefits (42 CFR 431.51(c)). • States can define payment methodologies (42 CFR 447.200).
Primary care case management (PCCM)	• States must enroll any willing and qualified provider (42 CFR 431.51). • Enrollees have the freedom of choice of participating providers (§1902(a)(23), 42 CFR 431.51). • Comparable benefits must be available statewide for most Medicaid enrollees (§1902(a)(1), 42 CFR 431.50, 42 CFR 440.240). • PCCM organizations that provide care management services similar to a managed care plan must provide similar beneficiary protection standards (as discussed below) (42 CFR 438.52, 42 CFR 438.71).	• States can assign enrollees to a PCCM, but enrollees have the choice of opting out of the PCCM receiving services through FFS instead (42 CFR 438.54). • States can define coordination services that PCCM entities must provide (42 CFR 440.169). • States can define payment methods that reward quality (42 CFR 447.200).
Limited-benefit managed care	• Plans—with the exception of NEMT PAHPs—must meet most beneficiary protection standards, including providing enrollees a choice of health plans (unless located in a rural area), an opportunity to appeal coverage decisions, and a mechanism for reporting grievances (42 CFR 438.52, 42 CFR 438.400-424). • Plans must maintain a sufficient provider network to provide	• States can enroll all populations voluntarily and non-exempt populations mandatorily (§1932(a)(2), 42 CFR 438.54). • States can enroll all populations on a mandatory basis under Section

TABLE 1. (continued)

Delivery system option	Federal statutory and regulatory requirements	State plan options
	adequate access to covered services (42 CFR 438.68). • States cannot require disabled children, foster care children, Medicare beneficiaries, and American Indians to enroll (§1932(a)(2), 42 CFR 438.54). • Additional beneficiary protections are required for managed long-term services and supports, including consultation with a stakeholder advisory group (42 CFR 438.70, 42 CFR 438.71, 42 CFR 438.110).	1915(b) waivers (§1915(b), 42 CFR 431.55). • States can set access and quality standards for plans, including incentive payments for quality (42 CFR 438.6, 42 CFR 438.206, 42 CFR 438.310-438.370).
Comprehensive managed care	• Plans must meet beneficiary protection standards, including providing enrollees a choice of health plans (unless located in a rural area), an opportunity to appeal coverage decisions, and a mechanism for reporting grievances (42 CFR 438.52, 42 CFR 438.400-424). • Plans must maintain a sufficient provider network to provide adequate access to covered services (42 CFR 438.68). • States cannot require disabled children, foster care children, Medicare beneficiaries, and American Indians to enroll (§1932(a)(2), 42 CFR 438.54). • Additional beneficiary protections are required for managed long-term services and supports, including consultation with a stakeholder advisory group (42 CFR 438.71).	• States can enroll all populations voluntarily and non-exempt populations mandatorily (§1932(a)(2), 42 CFR 438.54). • States can enroll all populations on a mandatory basis under Section 1915(b) waivers (§1915(b), 42 CFR 431.55). • States can set access and quality standards for plans, including incentive payments for quality (42 CFR 438.6, 42 CFR 438.206, 42 CFR 438.310-438.370).

Notes: PAHP is prepaid ambulatory health plan. MCO is managed care organization. NEMT is non-emergency medical transportation.
Sources: MACPAC analysis of the Social Security Act and the *Code of Federal Regulations*.

Endnote

[1] Medicaid beneficiaries may be enrolled concurrently in more than one type of managed care program (e.g., a comprehensive managed care plan and a behavioral health organization).

References

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