Members Brief

An informational brief prepared by the LSC staff for members and staff of the Ohio General Assembly

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Medicaid Delivery Systems

Medicaid provides health insurance for low-income individuals by two different methods, called delivery systems: fee-for-service and managed care. This brief reviews the differences and similarities of the delivery systems and includes some recent figures for reference.

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Medicaid Overview

Medicaid is a health insurance program for low-income individuals. State governments administer state-specific Medicaid programs subject to federal oversight by the U.S. Centers for Medicare and Medicaid Services (CMS) in the U.S. Department of Health and Human Services (HHS). Funding for the program comes primarily from federal and state government sources. Healthcare providers participating in a state's Medicaid program bill for services provided to covered individuals and receive payments based upon the state's Medicaid rate for the particular service rendered. The federal government then reimburses the state for a portion of the payment. This reimbursement is known as federal financial participation (FFP), and the rate of reimbursement, the Federal Medical Assistance Percentage (FMAP), differs by state economic conditions and is updated each federal fiscal year.[1]

Ohio's Medicaid program is administered primarily by the Ohio Department of Medicaid (ODM), with nine other "sister" agencies overseeing smaller facets of the program. In FY 2024, Ohio spent $38.88 billion on Medicaid. ODM spent 88% ($34.23 billion) of those funds, and the Department of Developmental Disabilities (DODD) spent 11% ($4.28 billion).

[1] See *Ohio's Medicaid Financial Landscape and FMAP Members Brief* for more detail.

Delivery Systems

As a health insurance program, Medicaid does not provide medical services directly to Medicaid recipients. Instead, it provides financial reimbursement to healthcare professionals and institutions for providing approved medical services, products, and equipment to Medicaid enrollees. Medicaid reimbursements are provided through one of two delivery systems: fee-for-service (FFS) or managed care. Both delivery systems provide medically necessary primary care, specialty and emergency-care services, and preventive services. Under FFS, Medicaid pays a set fee for the specific type of service rendered. Payments are based on the lower of the state's fee schedules or the actual charge. FFS gets its name from the fact that the amounts paid are tied to which services have been provided.

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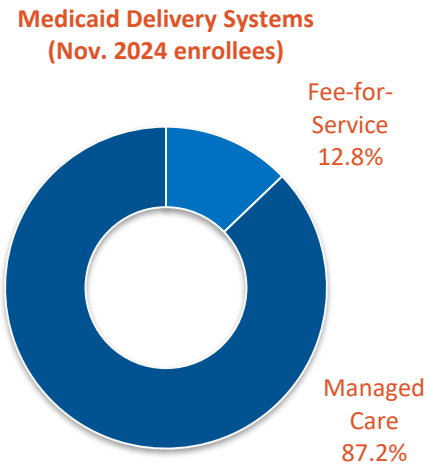
An alternative to FFS reimbursement is managed care. Managed care was introduced to slow the growth rate of Medicaid expenses. It does this by introducing the possibility of profit and loss. The primary managed care model involves managed-care organizations (MCOs), which offer comprehensive benefit packages and are risk-based.

Ohio began using managed care plans in 1978 and gradually expanded the groups participating in them, but not until 2006 was managed care enrollment of most participants mandatory. Today, most Medicaid recipients are required to enroll in managed care. November 2024 data from ODM shows over 87% of Medicaid recipients are in the managed care delivery system. In addition to those with developmental disabilities, for whom managed care remains optional, the nearly 13% of recipients in FFS include new enrollees who are in the process of choosing and becoming enrolled in a managed care plan.[2]



An MCO is a capitated at-risk plan. This means that the MCO is paid an amount for each covered beneficiary (capitated, or "per-head") and that the MCO's exposure to profit or loss is subject to economic conditions (at risk). The MCO is paid a negotiated fixed monthly premium per beneficiary for any healthcare included in the benefit package, regardless of the number or type of services actually used by beneficiaries. The beneficiary is responsible for, at most, modest copayments for services and the MCO is at risk for the remaining cost of care. MCOs are at financial risk for losses if they spend more on services and health plan administration than they are paid by the state. On the other hand, MCOs are allowed to retain a portion of excess

[2] Because of delivery system cost differences, these figures do not represent the share of Medicaid spending in managed care or FFS.

premiums for profit or reinvestment, provided their spending on medical care and quality initiatives is beyond a required threshold. A capitated plan can be a network of physicians and clinics, all of whom participate in the plan while also participating in other plans or FFS systems, or it can be a plan that hires the physicians who provide all required care.

The managed care provider is paid a fixed monthly premium per beneficiary for any healthcare included in the benefit package, regardless of the services used.

Medicaid recipients in both types of delivery systems can receive care through Primary Care Case Management (PCCM). PCCM is a special form of managed care. When enrolled with a PCCM entity, the recipient's primary care provider receives a small fee per person per month to provide basic care and coordinate specialist care and other needed services, like an MCO's capitation rate. When medical services are provided, those are usually paid through FFS. For example, Ohio's Comprehensive Primary Care program allows participating medical practices to receive a per-member-per-month (PMPM) payment in addition to existing payment arrangements. PCCM can help the state enhance the coordination and management of care for enrollees with chronic illnesses and disabilities. States may structure payment strategies and incentives to support the "patient-centered medical home" model for Medicaid recipients. This model emphasizes continuous and comprehensive care, care teams directed by a personal physician, and care for all stages of life. It also seeks to enhance access through expanded hours and other improvements. Information technology and quality improvement activities promote quality and safety.

Other special forms of managed care are Prepaid Inpatient Health Plans (PIHPs) and Prepaid Ambulatory Health Plans (PAHPs). These limited-benefit plans generally manage a subset of benefits or manage services for certain populations, which may include both managed care and FFS Medicaid recipients. PIHPs provide limited benefits that include inpatient hospital or institutional services. In Ohio, OhioRISE (Resilience through Integrated Systems and Excellence) is a PIHP that coordinates care for youth with complex behavioral health and multisystem needs. PAHPs provide limited benefits that do not include inpatient hospital or institutional services. PAHPs are usually very narrow in the scope of the services provided. Such a plan may be used to provide dental or transportation services. Ohio currently has one PAHP, the Single Pharmacy Benefit Manager (SPBM) Gainwell Technologies, which administers pharmacy benefits for Medicaid members enrolled in managed care.

Federal Rules for Managed Care Delivery Systems

States must comply with the federal regulations that govern managed care delivery systems. CMS reviews and approves these plans, which must observe some general requirements for the state to receive reimbursement. Under Section 1932(a) of the Social Security Act, which permits states to require Medicaid recipients use a managed-care plan, a state may implement a managed care delivery system which follows basic regulations, such as the requirement for a managed care plan to have a quality program and to provide appeal and grievance rights, reasonable access to providers, and the right to change plans.

Some additional managed-care plan requirements may be removed if the state receives a waiver for exemption. This allows states to test innovative care changes for volunteering

Medicaid recipients. These waivers are referred to by the section of law that allows them as either Section 1915(a) and (b) waivers or Section 1115 waivers. The three requirements which can be removed by waiver are:

1. Statewideness. States may implement a managed care delivery system in specific areas of the state rather than the whole state.
2. Comparability of Services. States may provide different benefits to people enrolled in a managed care delivery system.
3. Freedom of Choice. States may require people to receive their Medicaid services from a managed care plan.

Demonstration Models of Care Delivery

Under The Patient Protection and Affordable Care Act (ACA), enacted in 2010, states were given more opportunities to experiment in an attempt to improve care delivery in Medicaid. These are called demonstration models and typically allow for a time-limited innovation in managed care provision. The ACA established the Center for Medicare and Medicaid Innovation (CMMI) to (1) test, evaluate, and expand innovative care and payment models to foster patient-centered care, (2) improve quality, and (3) slow cost growth in Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP).[3] The ACA also established the Federal Coordinated Health Care Office (FCHCO) within CMS. FCHCO works to align Medicare and Medicaid benefits and improve state and federal coordination when distributing benefits to dual-eligible beneficiaries (those who qualify for both Medicaid and Medicare).

Ohio's managed-care program for dual-eligibles is a demonstration model called MyCare. This program integrates Medicare and Medicaid benefits into one program. Currently, MyCare features five possible plans and is available in 29 counties containing nearly 74% of Ohioans. Statewide expansion is planned for the future. As part of ODM's Next Generation MyCare plan which will begin service in January 2026, participants have four available plans for selection.

Demonstrations can enable states to test healthcare provision approaches, such as bundling payments around hospital care, setting global payments for safety-net hospital systems, allowing pediatric providers to organize as Accountable Care Organizations (ACOs), and encouraging healthy lifestyle changes. Ohio's substance-use disorder (SUD) demonstration model, which was set to expire in late 2024, is under review for a possible extension for five more years.

[3] SCHIP is a separate program that covers children who are ineligible under regular Medicaid. Many states, including Ohio, have incorporated SCHIP as a Medicaid expansion.