



# Medicaid Managed Care

Medicaid managed care encompasses a variety of strategies for the delivery and financing of Medicaid services. Under managed care, state Medicaid agencies contract with health plans or providers who are responsible for managing and coordinating the care of their assigned members. The two most commonly utilized Medicaid managed care strategies are Primary Care Case Management (PCCM) and risk-based managed care in which states contract with Managed Care Organizations (MCOs). The use of Accountable Care Organizations (ACOs) among Medicaid agencies is also being examined by a growing number of states as a potential management strategy.

Within these different models, states have a variety of policy and program options available. For example, the State may exclude certain populations from mandatory enrollment and carve-out specific covered services. States can also incorporate reimbursement strategies which tie financial incentives to quality outcomes such as pay-for-performance, shared savings, capitation withholds and bonuses.

While the reimbursement mechanism and contracting methodologies differ between the models, managed care is intended to achieve a variety of quality goals such as improved coordination of care and reduction in the duplication of services. Managed care is also utilized to achieve cost-savings goals and provide more budget predictability for states.

PCCM	MCOs	ACOs
<ul style="list-style-type: none"> <li>• State contracts directly with providers</li> <li>• Providers responsible for management of beneficiaries assigned to their panel</li> <li>• Providers typically receive a small per member/per month fee in addition to FFS payments for services rendered</li> </ul>	<ul style="list-style-type: none"> <li>• State contracts with Managed Care Organization (MCO)</li> <li>• MCO receives monthly capitation for each member &amp; is responsible for managing all covered benefits for assigned population</li> </ul>	<ul style="list-style-type: none"> <li>• State contracts with provider run organizations</li> <li>• Shared responsibility among providers for enrollees' care</li> <li>• When quality metrics are met, may share in savings gained from quality improvement and increased efficiency</li> <li>• May also put providers at financial risk</li> <li>• Reimbursement model can include either FFS or capitation</li> </ul>

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